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Flowchart of elderly care victms of abuse: an interdisciplinary perspective

Fluxograma descritor no atendimento à pessoa idosa vítima de violência: uma perspectiva interdisciplinar

Fluxograma descriptor en la atención a la persona idosa víctima de violencia: una perspectiva interdisciplinária

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Abstract

Objective: To identify the flows of service for older people, victims of violence in different care services and to analyze the main critical issues. **Method:** This is a descriptive and exploratory study based on interviews with professionals responsible for: health services; judicial and social care, and with elder abuse victims, in a medium-sized city in the countryside of the state of São Paulo. Data enabled the creation of a flowchart to describe and define the critical issues, according to the model created by Franco and Merhy. **Results:** The following critical issues were identified: lack of centrality when directing complaints; difficulty to contact 100 hotline; collection of insufficient data on the event; lack of communication among services; victim's withdrawal in the middle of the process; lack of knowledge by the services and the population on social care functions; conflict among services in cases of difficult situations to solve, and lack of intervention by primary health care teams in response to a violence complaint. **Conclusions and implications for practice:** Critical issues point to the need to enhance interventions from the intersectoral perspective, with the aim to improve older people's quality of health.

Keywords: Aged; Violence; Aging; Health of the Elderly.

Resumo

Objetivo: Identificar os fluxos de atendimento da pessoa idosa vítima de violência nos diferentes serviços de assistência e analisar os principais nós críticos. **Método:** Estudo descritivo e exploratório realizado a partir de entrevistas com profissionais responsáveis por serviços: de saúde; de assistência jurídica e social e com idosos, vítimas de violência, em um município de médio porte do interior paulista. Os dados coletados possibilitaram a construção do fluxograma descritor e definição dos nós críticos conforme modelo criado por Franco e Merhy. **Resultados:** Foram identificados nós críticos referentes: à falta de centralidade nos encaminhamentos das denúncias; dificuldade para fazer contato com o disque 100; coleta de dados insuficientes sobre a ocorrência; falta de comunicação entre os serviços; desistência da vítima na continuidade do processo; falta de conhecimento dos serviços e da população sobre as funções da atenção social; conflito entre os serviços nos casos de situações de difícil solução e falta de intervenção da equipe da atenção básica à saúde frente queixa de violência. **Conclusões e implicações para a prática:** Os nós críticos apontam para a necessidade do aprimoramento das intervenções na perspectiva intersetorial, com vistas à melhoria da qualidade de assistência ao idoso.

Palavras-chave: Idoso; Violência; Envelhecimento; Saúde do Idoso.

Resumen

Objetivo: Identificar los flujos de atención del anciano víctima de violencia en los diferentes servicios de atención, y analizar los principales en los críticos. **Método:** Estudio descriptivo, exploratorio, realizado a partir de entrevistas con profesionales responsables de servicios de salud; de asistencia jurídica y social, y con ancianos víctimas de violencia, en municipio de porte mediano del interior paulista. Los datos recolectados permitieron construir el flujograma descriptor y definir los nudos críticos, conforme modelo creado por Franco y Merhy. **Resultados:** Fueron identificados nudos críticos referentes: a falta de centralización en la derivación de las denuncias; dificultad para contactarse con el "Disque 100"; colecta insuficiente de datos sobre el hecho; falta de comunicación entre servicios; desistimiento de la víctima para dar continuidad al proceso; desconocimiento de los servicios y de la población sobre las funciones de la atención social; conflicto entre servicios en casos de situaciones de difícil solución; y falta de intervención del equipo de atención básica de salud ante la denuncia de violencia. **Conclusiones e implicaciones para la práctica:** Los nudos críticos demuestran la necesidad de mejorar las intervenciones en sentido intersectorial, apuntando a mejorar la calidad de la atención al anciano.

Palabras clave: Anciano; Violencia; Envejecimiento; Salud del Anciano.

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INTRODUCTION

Population aging is a demographic phenomenon that has marked the 20th century, bringing numerous changes around the world. In 2015, Brazilian older people already represented 14.3% of the general population, and the estimate for 2050 is of 29%.[1]

In old age, people become increasingly vulnerable to changes in their living conditions, including social, economic and biological aspects, making them increasingly prone to illness and dependence on basic activities of daily living.[2]

Faced with this vulnerability, older people are predisposed to situations of violence, which is considered a condition of multiple causes, high magnitude and worldwide transcendence. Violence is characterized by the use of power, either physical or psychological, against an individual or community, resulting in physical, psychic suffering, death or impairment to the victim's development.[3] This is a complex problem because it involves historical, cultural, economic and social aspects, and manifests itself in different ways.[4]

There are some classifications in the literature on types of violence; however, the most accepted classification is described in the Brazilian Plan of Action for Coping with Elder Abuse, such as: neglect, psychological violence, financial and economic abuse, physical violence and abandonment.[5]

Although one in four older people is at risk of domestic violence, the proportion of reported cases is limited, and is usually exposed only when violence takes place through physical manifestations.[6] This situation is due to the fact that victims do not accept they are being attacked by a family member or friends, due to: religious and cultural beliefs, social norms, fear of retaliation, protection of the aggressor, shame, guilt and helplessness.[6]

According to the Violence and Accident Surveillance System (VIVA), in 2014, 12,297 cases of violence against older people were reported in Brazil, with 43.7% being repeated. Among the reported cases, the victims were mostly white and had a low level of education, with 70.4% of the cases taking place in the victim's home. Among the types of abuse found, 64.0% were physical/sexual violence, 28.2% psychological/moral, 26.4% neglect/abandonment, and 7.4% financial, most of which were practiced by the victims' children.[7]

To propose a way for aging with safety and quality of life and safeguarding the rights of this population, decree no. 1.448/96 emphasizes the obligation of all persons to report any type of violence to older people.[8]

The Statute of Older People (Law No. 10,741), approved in 2003, establishes the obligation of the family, the community, society and, above all, the public power to ensure the right to life, food, health, culture, education, leisure, sport, work, citizenship, dignity, freedom, respect, and interaction with the family and the community.[9]

To help in the mediation of older people's access to social policies, the organic law allows the social service professional to intervene in care services, aiming to support the population with violated rights. Considering this, the Specialized Reference Center for Social Assistance (CREAS) was created, which is part of the Unified Social Assistance System (SUAS), aiming to offer specialized services to families and individuals who are in situations of vulnerability.[10]

Even the Civil Police plays a key role in the care of older people who are victims of violence. It is responsible for registering the complaints made in-person through police reports, as well as for checking the veracity of the information collected in the complaints made by the Crime Stoppers 100/180 hotlines.[11]

At the same time, in 2006, the Ministry of Health launched the Pact for Health, which has health care for older people among its priorities, and led to the need to create the National Health Policy for Older People.[12]

This policy aims to guarantee the rights and direction of care for healthy aging, the development of integrated and intersectoral actions, health promotion, and comprehensive care for older people and their families in situations of domestic and/or institutional violence.[12]

Thus, in order to achieve comprehensive and effective care, an intersectoral action of the different services involved in the care of elder abuse victims and their families is required. Intersectoriality is linked to the conception of integration, coordination of knowledge and services, as well as the formation of partnerships within the collective areas to meet the needs of individuals, emerging as a method of integrated management to address social problems with the maintenance of autonomy of each sector involved in the process.[13]

Undoubtedly, the complexity that involves the care of elder abuse victims demands intersectoral actions; however, it is observed that the different sectors that deal with the situation do not develop complementary actions, leading to difficulties to solve the problems, or preventing care from occurring in its entirety and in the perspective of comprehensiveness.

Therefore, reflecting on these issues can contribute to the development of appropriate policies to address violence against this population. Therefore, the use of tools is warranted, allowing the understanding of how care to elder abuse victims takes place, which can be done through a descriptor flowchart.

Descriptive flowchart is a tool created by Franco and Merhy based on the elaboration of cartography of daily life dynamic processes, which can only be described through provisional reports.[14] It aims to trace work flows and processes, using a graph representation, enabling understanding, identification of critical issues, and planning and reorganization of work processes. Critical issues are the identified gaps, that is, the problems that the workflow presents. In addition, it aims to trigger a process of shared work management, and allows professionals to be instrumental when managing their own process.[15]

In view of the above and considering the difficulties of the different sectors in the care of the elder abuse victims, the following questions arise: what is the flow of care to elder abuse victims in the sectors involved, and what are the main difficulties encountered during this process? Thus, the objective of the present investigation was to identify the care flows of the elder abuse victims in the different care services, and to analyze the main critical issues.

METHOD

This article is part of a larger project entitled: *Idoso vítima de violência: a interface da assistência à Saúde, Jurídica e Social para o desenvolvimento de intervenções* [Elder abuse victim: the interface of Healthcare, Legal and Social assistance for the development of interventions].

This is a descriptive, exploratory and qualitative study using the descriptive flowchart technique, aimed at understanding the path of elder abuse victims in the search for care.

This approach considers the existence of a dynamic relationship between the real world and the subject, trying to understand, describe and explain social phenomena in different ways, analyzing the experience of individuals or groups and worrying about the deepening of understanding of the social phenomenon.[16]

The research was carried out in a medium-sized municipality in the countryside of the state of São Paulo, in the following data collection settings: the Civil Police Judicial Center of the state of São Paulo, more specifically the Women's Police Station; the Specialized Reference Center for Social Assistance (CREAS); Public Prosecutor's Office; primary and tertiary health care services, and houses for elder abuse victims, as well as elder abuse victim follow-up in the course of care. It is worth noting that this municipality does not have a specialized police station for older people; thus, this population is assisted by the Women's Police Station.

Nine professionals working in the different sectors involved in assisting and coping with violence against older people participated in the study: a police chief; a public prosecutor; two family health strategy nurses; a community health worker; a nurse from a tertiary hospital in the municipality; three social workers from CREAS, and two older people, one of them being a victim of intrafamilial physical and financial violence, and the other, a victim of theft.

For the interview with the older person victim of physical and financial aggression, a home visit was conducted by three researchers, and he was asked to talk about the situation experienced and the care received. In addition, in order to understand the flow of care to the elder abuse victim, a researcher followed one of them during the complaint report at the police station.

The inclusion criterion for professionals was to work at services providing care and support for elder abuse victims for at least 3 months; the exclusion criterion was to be on vacation or on a medical leave during the period of data collection. Data were collected between August and September 2017, through non-directive interviews, on days and times previously agreed, according to the availability of professionals. Contact with the older people was done for convenience, based on the complaint report at the police station during data collection; the interview was performed at home.

The non-directive interview was used to allow participants to talk freely, according to their knowledge, ideas and conceptions about the subject explored.[16] The interview with the professionals was conducted by the following guiding question: How is the flow of care to elder abuse victims at your service? And the question addressed to the older people was: "What was the path taken to make this complaint?".

The interviews lasted an average of 40 minutes, were carried out by the first author of the study, and recorded in digital media, with the consent of those involved. The meetings with the professionals were held in their workplace, being previously scheduled, as agreed by the participants.

The data of the interviews were transcribed in full after their completion. After successive readings of the information, by all the researchers, the descriptor flowchart was constructed, according to the model proposed by Franco and Merhy.[14]

For its construction, universally standardized symbols are used; they indicate the entry and exit in the process in a graphic, as well as the moments in which important work guidance takes place. The beginning is drawn as an ellipse, the rectangle represents the next action, and the diamond represents the possibilities of paths to follow. The squares bring the possible actions, and the final ellipse represents the end of the flow.[14]

Thus, the data collected in the interviews allowed the identification of each service flows and the main critical issues. Following graphic elaboration, it was presented and discussed with the study participants for the analysis to be validated. After revisiting the flowchart, considering the participants' suggestions, it was presented in a meeting of the Network for Abused Women's Assistance, promoted by the City Hall, allowing new perspectives and suggestions.

The research project was approved by the Human Research Ethics Committee of the School of Medicine of the city of Marília, under report no. 2.253.887, on September 1, 2017, which is linked to the National Research Ethics Committee, in accordance with resolution 466/2012 for human research, and analyzed by the Women's Police Department; Municipal Secretariat of Social Assistance; Municipal Secretariat of Health, and the Public Prosecutor. The professionals, who voluntarily participated in the research, previously signed a free and informed consent form.

Speeches extracted from the interviews performed with the professionals are presented as follows and identified with the letter P followed by an increasing numerical sequence (P1...P9).

RESULTS

The results of the present study show the flow that the report of violence against older people can follow. This flow can begin in different instances, for example: 100/180 hotlines, police station, Public Prosecutor's Office, CREAS, and primary, secondary or tertiary health services in the municipality. However, the three main entrance doors are the Police Station, the Public Prosecutor's Office, and CREAS. Both primary care and hospital care health services, when finding a situation of violence, make the complaint on the 100 Complaint Hotline.

Complaints made to the 180 and 100 hotlines are sent to the police units. The complaints made through the 100 hotline are sent simultaneously to the Public Prosecutor's Office, police units and CREAS, which begin the interventions concomitantly. Thus, the first critical issue (CI1) is identified, which refers to the lack of centrality in the referral of complaints made through 100 Hotline.

Regarding the 100 hotline, health professionals report difficulties in getting into contact with this service and, in addition, they express the sensation that these services have low effectiveness because they finally do not know how the situation was conducted and even if the referrals were made, as can be seen in the following statements:

> *[...] the telephone doesn't answer, I've tried for an hour to talk to them and when I did, after a while, the call got disconnected ..." (P4)*
>
> *[...] every time I needed it, I wasn't successful ..." (P5)*
>
> *[...] it gives me the feeling of impersonality, of being something very distant and inoperable [...]". (P4)*

In view of the above, the second critical issue (C12) was identified: "Difficulty of contact with the 100 Hotline and the sensation it is inoperable".

When the complaint is made directly at the police station, after being registered by a staff on duty, the investigation is initiated and may be triggered in three ways: the first when there is a flagrant situation, and the offender is immediately arrested; the second situation occurs when there is an indication of crime, leading to criminal investigation of the complaint data, and the third situation is when there is no indication of crime and the complaint is filed.

At the police station, the third critical issue (CI3) is identified, because due to work overload there is often insufficient collection of the event data, and stress is generated in the team and in the victim due to the service delay. However, this study's main author, when following an elder abuse victim with the objective of complementing the flowchart, observed that care took place immediately after arrival, and both the older person and the companion were satisfied with the assistance they received.

At the Public Prosecutor's Office (PPO), the complaint is sent to evaluation by different sectors (judicial, health and assistance) in order to stop what is causing the violence. The services should give a response to the PPO on whether or not they have been able to resolve a particular situation. If the return is positive, the case is filed; however, if the return is negative, the PPO files a case, making the responsible sector organize and take the appropriate measures.

Regarding the Public Prosecutor's Office's case, it was possible to identify the fourth critical issue (CI4), which refers to the lack of communication between the sectors involved in the care of elder abuse victims, leading to delays to solve cases, and increasing PPO demand.

At CREAS, as soon as the complaint arrives, an assessment is carried out to determine if the claim is within its jurisdiction. In this case, specialized assistance is provided to the victim and the family. Otherwise, CREAS refers the victim to other sectors, as shown in Figure 1.

For the people interviewed by CREAS, the main difficulty of the sector is the population's lack of knowledge, as well as that of the other sectors involved in assisting elder abuse victims about their role, and any situation involving social assistance is referred, by the other sectors, especially health, to CREAS, with the belief that it will intervene in the situation to solve the problem. Therefore, CI5 is identified, which refers to the lack of knowledge of the different services and the population about the real roles of CREAS.

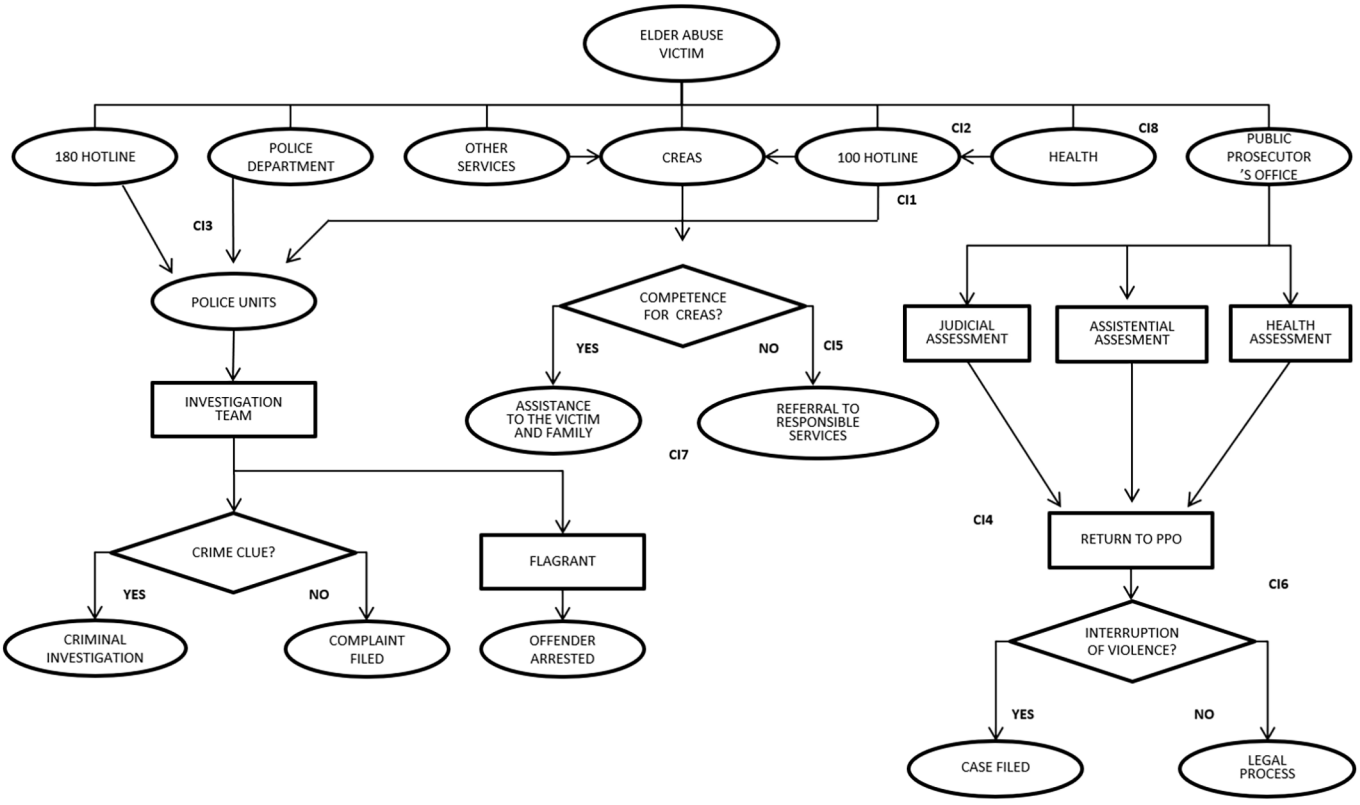
In all the services, the professionals said that older people do not always want to go on with the complaint made, especially when it involves people with some degree of kinship. Therefore, CI6 is evidenced, which consists of the victim's lack of interest in continuing the process. This condition leads to disappointment among professionals, because for them the complaint should follow its path.

In the course of the interviews, especially with CREAS's social workers and primary health care professionals, they expressed intense anxiety related to situations in which services do not have the resources for effective care, such as the case of older people who are taken care by other older people, by a person with mental disorder, by drug/alcohol users, or when older people live alone.

Thus, the existence of conflicts among the different services is observed, since there is a tendency to make others responsible for care. Then, CI7 emerges: conflict between CREAS and primary health care services when facing difficult situations.

A concern that emerged at the time of the home visit with the elder abuse victim refers to the lack of intervention of the primary care team regarding the complaint of violence that was identified as the eighth critical issue (CI8).

Figure 1. Care flowchart to elder abuse victims. Marilia, 2017. Source: Flowchart created with the information collected in the interviews.



It was observed that when an elder abuse victim seeks basic health care, he/she does not receive the adequate embracement and assistance from the professional, whose justification is often based on the lack of instruments to deal with situations of violence.

DISCUSSION

Many complaints originate from the 100 hotline, which consists of a telephone service of the national complaint hotline, located in the federal capital, and which is responsible for receiving, analyzing and directing complaints.[17]

When receiving the call, the telephone operator tries to know: the place where violence has been occurring or occurred; victim data, giving priority to name and address, and information about the offender. Following registration, the degree of priority of the complaint is defined and letters are sent to all relevant agencies.[17]

These agencies, as detected in the present study, trigger concomitant actions, sometimes conflicting or in duplicity, generating demand accumulation, delays in procedures, team stress and unnecessary work.

Although the centralization of a given demand can guarantee its dimensioning, and a more specific approach to the situation, when it comes to the 100 hotline, health professionals show both a difficulty in contacting this agency, and a sense of inoperability due to the distance that separates the complainant and the complaint's recipient.

It is important to highlight that the 100 hotline was taken over by the Federal Government in 2003, focusing on complaints related to the sexual abuse of children and adolescents, and considering their advances, the actions for any complaints related to the violation of human rights were expanded.[18]

The difficulties mentioned by the professionals of the present study respond to the realization that, due to the increasing popularity of the 100 hotline, the number of calls has increased over the years and this has overloaded the service, causing the calls to be disconnected, or a delay in care, even leading the person to give up the complaint.[17] In view of this, it is worth questioning whether health professionals and the general population are being discouraged from reporting cases of violence against older people, especially those who work in primary care, who, due to the bond they establish with the users, could even detect situations of risk.

It is noteworthy that Law No. 10,741/2003, which regulates the statute of older people, provides that suspected or confirmed cases of maltreatment against them should be mandatorily reported.[9] Even so, it is common among health professionals to be unaware of this obligation and the importance of the notification, as well as of the necessary interventions. Other limitations of health professionals, which lead to underreporting, are related to work overload, lack of safety and work dynamics uncoordinated with the safety network.[18]

Locally, in the municipality in question, care for elder abuse victims also runs through difficulties in the police station, and it is possible that the service delay occurs because there is no such specific service, even in municipalities that have older people's police stations, where it is possible to cover the specifics of this age group.

Moreover, when information is incompletely collected, delays and difficulties may occur in the investigation service. In addition, the delay in care is considered one of the main reasons that older people give up filing complaints, which leads to data underreporting, and masks the reality regarding the number of cases of violence that a particular place has.[19]

As in the present study, when talking about violence against older people, community health workers address, in addition to problems related to underreporting and refusal to continue with the complaint, the lack of dialogue among the institutions responsible for care, that is, the socialization of information.[19]

Coordination among different sectors is considered as an effective means of solving complex problems; however, this coordination, also called intersectoriality, presents many challenges regarding how to make it work properly,[20] because it involves different practices, routines and points of view. However, it was clear that respondents felt they lacked effective communication, exchange of information and of definition of actions, which could simplify interventions and increase the effectiveness of services.

The development of a communication flow was noted as an important tool to have the different sectors working well, because it is a way to connect one sector to another.[21] It was pointed out that institutions that do not communicate with each other lose important links both with other institutions and with the actors in the process (aggressors and victims), and the possibility of promoting greater support and protection for elder abuse victims.[22,23] The lack of communication among sectors also refers to the lack of knowledge of the role played by each sector, as it was pointed out by CREAS's professionals.

The fact that many older people decide not to continue the process of complaint leads to discomfort among professionals involved in the care of elder abuse victims. The problem is that most cases of violence have an intra-family origin, that is, the authors are children, grandchildren, friends, neighbors or someone who lives close to the older people. [23]

As regards the protection of older people, in the Brazilian reality, the family is the main resource available, and in its absence, or when their resources are insufficient for this support, there are few possibilities for the older people to be embraced and survive in another place. Long-term care institutions have a limited number of vacancies, define conditions for care, work with few resources and, most of the time, are not well accepted by older people.

As observed among the interviewees, when the family is unable to offer adequate assistance, and violence persists, most often characterized by negligence and maltreatment, distress emerges in the different sectors, especially in CREAS and in health services, which have a more direct contact with the situation, leading to the attempt to transfer responsibility and to mutual blame.

However, when there is a situation in which the older person is cared for by another older person, a drug user, an alcoholic, or a person with mental disorders, among other situations that place him/her at risk, it is observed that there are few possibilities of adequate care, although there are important definitions in the legal provisions to guarantee the rights of older people, in order to maintain health and life. Its operationalization is still based on interventions that require less resources for its solution.[24]

For example, there is the Older People Accompanying Program and the possibility of transfer to hospitalizations in long-term care institutions; however, few municipalities have adhered to the mentioned program, and the number of vacancies available in long-term care institutions does not always meet the existing demand, especially when it comes to older people with few financial resources. In addition, there is often the older person's resistance to this alternative.[24]

It is important to consider that intrafamily drug use results in a disrupted environment, even if it is not the official older person's caregiver that uses drugs. Interprofessional, interdisciplinary and interinstitutional intervention to combat violence is considered essential.[25]

These situations, together with the condition of family disintegration and poverty in which the majority of the population lives, especially older people, show the need for more effective programs to receive and care for this part of the population.

However, primary care, more specifically family health strategy teams, often has some difficulties to take a stand when facing the situation of violence complaints, because there is no instrumentalization and support for this confrontation. The fact that primary care health teams have difficulties even to embrace victims, as well as to have access to the formal or intersectoral network of social protection corroborates this finding.[26]

In places where urban violence is present on a daily basis, professionals report the feeling of fear, oppression, impotence and coercion in such situations, because most of them involve people linked to drug trafficking. In addition, reporting a case of violence can pose a major threat to these professionals and their families, as they often live near their work place. Therefore, dealing with a complaint/victim of violence becomes increasingly complex.[26]

Finally, it can be stated that the construction of the flowchart allowed the identification of the complexity permeating care provided to elder abuse victims, because it shows this problem from an intersectoral perspective, in a systematic way. In addition, it can guide discussions and organize reflections with the different sectors involved in this process, in the search for alternatives that aim at improving care for elder abuse victims.

This finding is in line with the assertion that the descriptive flowchart is a powerful tool for understanding the work process of different health care scenarios, allowing, through the survey and analysis of critical problems, the planning of significant interventions to overcome the difficulties encountered.[27]

CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

In the search to understand the flow of care of elder abuse victims through the construction of a flowchart describing the reality in different assistance sectors of a municipality in the countryside of the state of São Paulo, it was possible to notice the existence of eight critical issues, which indicate the difficulties of this flow beginning when filing the complaint, especially through the 100 hotline, since there is a lack of centrality of this agency when sending the complaint to the services in charge of the intervention, sometimes hindering the investigation or causing duplication of interventions. In addition, the professionals who make the complaint on the 100 hotline said there are some barriers to this communication, as well as the sensation of impersonality.

The lack of communication among the different sectors of care for elder abuse victims permeates the whole process and culminates in important consequences, such as: lack of understanding of the roles of each service, duplicity of work, and difficulty in conducting interventions due to lack of information.

Finally, the critical issues involves blaming other services, especially when it comes to situations of high complexity in which there are no family, social and state resources that account for the resolution, generating great distress for the teams involved, which, in one way or another, wish to see the problem solved.

Considering the complexity of the care given to elder abuse victims, the results of the present study bring contributions to professional practice, because through them it is possible to activate reflections, and to redefine the care flows involving the different sectors caring for these people.

Intersectoral actions are suggested to overcome the identified critical issues and, thus, improve the quality of care provided to elder abuse victims.

The limitations of this study are related to the failure, so far, to establish and apply a new flowchart of assistance to elder abuse victims, which should seek to overcome the critical issues identified through the collective construction among the sectors involved in the research.

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