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EDITORIAL

Elder abuse: we are not doing enough in the ED

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Elder abuse is defined by the World Health Organization as "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" [1]. It includes abandonment and neglect, emotional, financial, physical, psychological, or sexual abuse; and commonly more than one type can occur simultaneously. It is a pervasive social and health problem affecting between 10 and 15% of older adults. Older adults who experience elder abuse are at increased risk of mortality, and victimization has been linked to poor medical outcomes including depression, dementia, and worsening of chronic conditions [2]. Many older adults will be reluctant to report abuse or neglect because of guilt, shame, or fear of reprisal. Although common, it is vastly underrecognized. Elder abuse is reported by ED health care providers in 0.01% of ED visits [3].

The role of screening in the ED has long been controversial and with ED overcrowding, the feasibility and appropriateness of screening may be further questioned. Medical and social determinants of health influence engagement with the health care system and for many older adults who present to the ED, it is their only access to medical care. Furthermore, older adults who experience abuse are often socially isolated, they are less likely to access primary care and more likely to receive medical care in an ED. Thus, an ED encounter is critical opportunity to identify and intervene in situations of abuse.

Gagnon et al. conducted a prospective Canadian multicenter cohort study of older adults presenting to the ED that evaluated the prevalence and predictors of elder abuse [4]. In this study, research assistants asked patients two simple questions, (*Do you think you are being abused emotionally (humiliation, intimidation, threats,* etc.*) or physically (violent acts)? Have you noticed behavior towards you in your environment that could be considered as abuse (physical or psychological) or neglect?*). Five percent of respondents reported they were experiencing abuse. This prevalence is likely underestimated for several reasons. First, they excluded those with moderate to advanced cognitive impairment, an established risk factor for abuse. Second, older adults living in long-term care, where the prevalence of abuse is known to be higher than in the community, were also excluded. Third, the screening questions utilized did not incorporate questions regarding financial abuse, one of the most common forms of abuse, sexual abuse or abandonment. Despite these limitations, this study is important because it demonstrates that identification of elder abuse is possible in the ED. When asked, older patients may disclose their abuse. What it offers is a simple way for ED providers to explore threats to their older patient's safety. Is it the perfect test? Likely not, but when compared to the alternative status quo, it is an important step in the right direction.

There are several tools for screening elder abuse; most are not feasible for use in the ED. The ED Senior AID tool which has been developed and validated in the ED, has excellent sensitivity and specificity [5], however, likely takes longer to administer than the two screening questions in the Gagnon et al. study. Very brief screening tools have been used to detect other underrecognized phenomenon in the ED, such as delirium, and may have a role in the identification of elder abuse. With further validation, the two screening questions

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may be useful and prove to have increased uptake due to simplicity and speed of administration.

Identification of elder abuse is the first step; a meaningful impact on patient centered goals, including improved physical, mental and financial health is the objective. It is imperative that once abuse is identified, there is a local process to intervene in these situations. Management of acute medical issues, safety planning, which in some cases may necessitate admission, and reporting are key components to an elder abuse support process. Interdisciplinary assessments may facilitate this process. These professionals provide counseling and assess patients' financial resources, support system, and social service needs. The importance of their role, particularly for older adults, has been increasingly recognized. Their social evaluation may reveal risks for or evidence of abuse or neglect not identified to medical providers. Information about local resources and knowledge of mandatory reporting responsibilities are essential. Incorporating practices of trauma informed care will enhance patient autonomy and safety. Management of these situations can be complicated by patients that refuse interventions. In these cases, patient capacity must be assessed. If deemed capable, a patient's wish to return to the unsafe environment must be respected, with information for resources provided to them, should they choose to seek assistance in the future.

Elder abuse is a complex medical and social problem to which there are no easy solutions. Additional funding and research aimed at preventing, identifying and managing elder abuse is urgently needed as this global problem continues to increase. Gagnon et al. should be commended for this study which demonstrates that practical screening measures in the ED setting can improve detection of this important global health problem. We as health care providers have a duty to protect those who are vulnerable. That duty involves identifying elder abuse and working to find solutions that protect the health and the safety of the older adult.

Declarations

Conflict of interest The authors have no conflicts of interests to declare.

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