

# Elder Abuse and Self-neglect

## "I Don't Care Anything About Going to the Doctor, to Be Honest. . . ."

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### THE PATIENT'S STORY

Mrs O lives alone in a 2-story townhouse; she reports that she is 70 years old. She has a bachelor's degree in education. Twice divorced, she has 1 daughter from whom she has been estranged for many years. Her medical diagnoses include osteoporosis, alcoholism, tobacco use, and recurrent falls. In March 2010, she fell and sustained a hip fracture, necessitating hospitalization for surgical repair. She was discharged to a rehabilitation facility from the acute care hospital, was treated there briefly, then went home. She did not follow up with her family physician as instructed. An anonymous referral was made to adult protective services (APS).

### Home Environment

The APS worker went to the patient's home and found a cluttered and filthy environment. A tour of the kitchen revealed unopened meals from Meals on Wheels, 4 bottles of vodka, a full ash tray, and no food in the refrigerator. The rest of the home had fecal material on the carpet, more overflowing ash trays, 2 unused walkers, and multiple packages of unopened adult diapers. Several pill bottles were found: raloxifene, lorazepam, sertraline, and vitamin B<sub>12</sub>, but it was unclear if she was taking any of the medications.

### Social Support

One of her ex-husbands visited weekly and assisted with management of finances and purchasing groceries. A neighbor also helped on occasion with purchases. The local liquor store delivered a case of vodka on a weekly basis.

### Physical Examination

A nurse practitioner was asked by APS to see Mrs O at home. She found that Mrs O had normal vital signs (temperature

Elder mistreatment encompasses a range of behaviors including emotional, financial, physical, and sexual abuse, neglect by other individuals, and self-neglect. This article discusses the range of elder mistreatment in community-living older adults, associated factors, and consequences. Although self-neglect is not considered a type of abuse in many research definitions, it is the most commonly reported form of elder mistreatment and is associated with increased morbidity and mortality. The case on which this article is based describes a 70-year-old woman who neglects herself and dies despite multiple contacts with the medical community. Despite significant gaps in research, enough is known to guide clinical practice. This article presents the practical approaches a health care professional can take when a reasonable suspicion of elder mistreatment arises. Public health and interdisciplinary team approaches are needed to manage what is becoming an increasing problem as the number of older adults around the world increases.

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98.1°F, heart rate 84 beats/min, blood pressure 140/80 mm Hg, respirations 12/min) and an estimated height of 4'10" and weight of 90 lb. She appeared thin, ill kempt, and kyphotic. She was wearing a long, food-stained shirt and no undergarments or pants. She had elongated fingernails. Her dentition was poor. Cardiovascular, pulmonary, abdominal, skin, and neurological examination results were normal aside from muscle strength 3/5 throughout.

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### Functional Assessment

She was able to transfer out of a bed and out of a chair independently but with difficulty. Her gait was unsteady and she did not use an assistive device. She was unable to climb the stairs. Although continent of urine and feces, she used adult diapers because her toilet was located upstairs. Similarly, she did not have access to her shower and used moist wipes for daily cleaning. She was unable to cook, clean, launder, shop, or manage finances. Several assessment tools were administered to evaluate cognition, mood, and physical function. The Confusion Assessment Method<sup>1</sup> showed normal results (no delirium); Folstein Mini-Mental State Examination (MMSE),<sup>2</sup> a cognitive screening instrument, was borderline suggestive of cognitive impairment with a score of 24 out of 30; CLOX-1,<sup>3</sup> a test of executive function (clock drawing), showed abnormal results (FIGURE 1); Kohlman Evaluation of Living Skills (KELS)<sup>4</sup> revealed deficits in multiple areas; and results of the Geriatric Depression Scale short form<sup>5</sup> were normal (no depression).

### PERSPECTIVES

Mrs O, the APS caseworker, and the nurse practitioner from the geriatric abuse/neglect clinic were interviewed by a Care of the Aging Patient editor in September and October 2010.

#### Mrs O

Editor: When was the last time that you went to the doctor?

Mrs O: I don't know . . . I don't care anything about going, to be honest with you.

Editor: Would it be helpful to have someone like the nurse practitioner come out to the house?

Mrs O: No, I don't really like them coming over here to do that.

Editor: What about someone calling every so often to see how you are doing?

Mrs O: Well, that depends. If I've got my phone, I'll answer it, if I don't have it, I'll let the answering machine get it.

Editor: Do you eat anything beside that 1 meal [from Meals on Wheels]?

Mrs O: Not necessarily.

Editor: How many pills a day do you take?

Mrs O: I take Evista.

Editor: Do you remember every day?

Mrs O: Yeah, when I have it. . . . The thing about it is, my doctor won't refill it now because I haven't been over there.

The APS Caseworker: We received a report several months back about Mrs O. . . . There was concern that she was unable to take care of herself. . . . if I determine that there's some medical neglect going on or some question about the person's mental ability . . . and [if] we've determined that there isn't a primary care doctor who we can call for more medical information, then I'll make a referral to our medical team. They gave her a medical examination and there was further testing that was needed but she refused.

The Nurse Practitioner: [Mrs O] was a routine referral to our office. I have a tendency not to call the clients before I show up because a cardinal feature of self-neglect is that they refuse

Figure 1. Performance on CLOX-1 Test



CLOX-1 test completed by Mrs O had a score of 8 out of 15, revealing substantial limitations in executive function.

medical care. My big red flag of a safety hazard is that if her townhouse were to catch on fire, I don't know how she could possibly get off the bench or chair that she was sitting on and . . . unlock the door and get out.

### Overview

In 2003, the National Research Council (NRC) defined elder mistreatment as "intentional actions that cause harm (whether or not harm was intended) or create a serious risk of harm to an older adult by a caregiver or other person who stands in a trust relationship to the elder, or failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm."<sup>6</sup> Self-neglect was specifically excluded from this research definition. The National Center on Elder Abuse defines self-neglect as ". . . the behavior of an elderly person that threatens his/her own health and safety. Self-neglect generally manifests itself in an older person as a refusal or failure to provide himself/herself with adequate food, water, clothing, shelter, personal hygiene, medication (when indicated), and safety precautions."<sup>7</sup> Self-neglect is the most common form of mistreatment the practicing clinician will encounter.<sup>7</sup> The reporting mechanism and state laws typically lump self-neglect and abuse together, and it may be difficult for the clinician to distinguish between them. Although the dynamics leading to neglect by self or others may differ, both place the individual at increased risk of morbidity and mortality.

Title XX of the Social Security Act, passed in 1974, mandates states to develop and maintain protective services agencies for vulnerable older adults. In 2004, the United States

spent nearly \$500 million on these agencies to serve and protect older adults who are abused or neglected by others or negligent of themselves. Self-neglect, like many other geriatric syndromes, occurs along a continuum of severity and is likely to worsen over time.<sup>8</sup> Using the case of Mrs O as a backdrop, we present the risk factors, consequences, and the role the primary care physician and other health care professionals may play in diagnosing and responding to elder mistreatment.

Throughout the article, the terms *elder abuse* and *self-neglect* will be used to distinguish between mistreatment caused by others and self, respectively. Little research has been conducted on elder abuse and self-neglect, and most studies to date are small, cross-sectional, and limited by sampling techniques and definitional issues. In this article, we cite research results when available and note when comments are based on opinion and clinical experience.

### Methods

For specific clinical assessment (eg, functional status), relevant key terms with limits of *human, English language, aged 60 years*, were used to search MEDLINE via PubMed. For the inclusion in the compilation of the prevalence, incidence, and risk factor tables and discussion, the MEDLINE and CSA Illumina search terms *elder abuse, elder mistreatment, self neglect* with the same limits were used to identify published articles between the years 1960 and 2011. The search identified 1115 results, of which 752 were peer-reviewed journal articles. We used the key terms *incidence, prevalence, identification, risk factors, intervention, outcomes* to further limit the search. This coupled with the exclusion of nonempirical work resulted in the references cited in this article. The National Center on Elder Abuse and the American Bar Association Web sites were searched in April 2011 to provide reporting agency information and other data.

### Self-neglect: Scope of the Problem

Self-neglect is a public health issue that crosses all demographic and socioeconomic strata of the aging population. Studies to estimate the scope of self-neglect have been based on reports made to APS. These studies suggest that self-neglect is the most common form of elder mistreatment and is on the rise.<sup>9</sup> However, no population-based epidemiological study has uniformly measured self-neglect and systematically examined the prevalence/incidence of self-neglect or its associated behaviors.

Available evidence suggests that individuals older than 75 years of age, African Americans, and those with lower socioeconomic status are at higher risk for self-neglect.<sup>10,11</sup> Several cross-sectional studies have found that cognitive impairment<sup>12-18</sup> and physical disability<sup>19,20</sup> are associated with increased risk and severity of self-neglect. Recent studies suggest that older adults with higher levels of psychological distress<sup>11,14,15</sup> and lower levels of social relations<sup>11,14,15,21</sup> are more likely to be reported to APS for self-neglect. Although Mrs

O had a history of alcoholism, no population-based study has examined the relationship of alcoholism with self-neglect. However, common sense and the authors' clinical experience suggest that alcoholism or harmful drinking behaviors are correlated with self-neglect.

Few longitudinal studies have examined the factors associated with self-neglect (eTable 1 available at <http://www.jama.com>). One study of 2812 older adults in the Established Populations for Epidemiologic Studies of the Elderly (EPESE) cohort found that greater cognitive impairment and depressive symptoms predict self-neglect reports to APS.<sup>22</sup> A study of 5519 older adults from the Chicago Health and Aging Project (CHAP) demonstrated that decline in physical performance (both observed and self-reported) and executive function (but not the MMSE) predicted the presence and severity of self-neglect.<sup>23,24</sup> This finding is consistent with Mrs O's examination in which her degree of impairment was captured most clearly by the CLOX-1 rather than the MMSE.

### Elder Abuse: Scope of the Problem

Elder abuse at the hands of others is a significant and under-reported problem<sup>6,25-27</sup> and is gradually being understood as a public health issue.<sup>28-31</sup> The NRC's definition, which states that abuse is an intentional act causing harm, serious risk of harm, or failure to protect from harm by a trusted other highlights 3 components in its definition: harm, older adult, and trust relationship. Harm is divided into 5 categories: psychological abuse, financial abuse, physical abuse, sexual abuse, and neglect. Older adult is variously defined both in research and law but is usually defined as beginning after age 55 to 65 years. A trust relationship refers to individuals in whom the older adult would reasonably have confidence including family members, close acquaintances, professionals, and paraprofessionals.

A nationally representative sample of cognitively intact people older than 60 years of age revealed that the prevalence of elder abuse was 4.6% for psychological abuse, 1.6% for physical abuse, 0.6% for sexual abuse, 5.1% for potential neglect (defined by the authors as an identified need for assistance that no one was actively addressing), and 5.2% for financial abuse (eTable 2).<sup>32</sup> In this study, which used random digit dialing, 11% of cognitively intact individuals older than the age of 60 years reported being abused in the past year. Low social support and previous traumatic event exposure were strongly correlated with abuse in the past year.

Another study assessed a nationally representative sample of 3005 community-dwelling individuals aged 57 to 85 years, all of whom were cognitively intact.<sup>33</sup> Participants were asked if they had experienced verbal, financial, and/or physical abuse in the past year and, if so, their relationship to the person responsible. Ten percent had experienced abuse, and in 46% of these cases the perpetrator was a spouse or an adult child. In a Chinese population of 412 adults older than 60 years of age, caregiver neglect was the most commonly re-

ported form of abuse (16.9%), followed by financial (13.6%), psychological (11.4%), physical (5.8%), and sexual abuse (1.2%). Of those who reported abuse, 64% of participants reported a single form of abuse, 16% reported 2 different forms of abuse, and 20% reported 3 or more different forms of abuse.<sup>34</sup>

Abuse among older adults with cognitive impairment is markedly higher than for unimpaired adults. In an international study of 4000 individuals older than 65 years of age (mean age 82) receiving health or social community services in 11 countries, approximately 5% screened positive for abuse. Two-thirds of individuals who screened positive for abuse also screened positive for dementia.<sup>35</sup> In a US convenience sample of 129 adults with dementia and their nonpaid caregivers, investigations by APS workers were reviewed by an expert panel (2 geriatricians, a police detective, and a neuropsychologist) to confirm the presence/absence of abuse. In this study, 47.3% were found to have been abused by the caregiver. Of those who had been abused, 88.5% experienced psychological abuse, 19.7% physical abuse, and 29.5% neglect.<sup>36</sup> Similarly, in a convenience sample of 220 older adults and their unpaid caregivers in England, 33.6% were found to have experienced significant levels of abuse.<sup>37</sup>

The characteristics of older adults associated with a greater likelihood of abuse include cognitive impairment<sup>15,32,38,39</sup>; aggressive behaviors<sup>34,40,41</sup>; psychological

distress<sup>15,35-37,42-44</sup>; lower levels of social network and social support<sup>28,40,45</sup>; lower household income<sup>30,46,47</sup>; need for activities of daily living assistance<sup>47</sup>; and premorbid relationship to the abuser.<sup>32,33</sup> A shared living arrangement is also a risk factor.<sup>48</sup> Perpetrator characteristics include family relation,<sup>48</sup> substance abuse,<sup>49</sup> mental illness,<sup>32</sup> dependency,<sup>50</sup> and unemployment<sup>30</sup>(TABLE).

### Consequences of Elder Abuse and Self-neglect

Despite major gaps in knowledge about the ramifications of elder abuse and self-neglect, available evidence suggests that they are associated with significant adverse outcomes. Because many of the studies look at both abuse and self-neglect, the data are presented together (eTable 3). A study of 2812 older adults found that elder mistreatment was associated with an increased risk for nursing home placement and all-cause mortality.<sup>28,51</sup> Similarly, a study of 9318 older adults found that elder mistreatment was associated with a higher mortality rate, particularly for cardiovascular-related mortality,<sup>52,53</sup> as well as increased emergency services use.<sup>54</sup> In addition, among individuals who self-neglected, black older adults had a higher mortality rate compared with whites.<sup>55</sup> A study by Smith et al indicated that older adults who self-neglect have more nutritional deficiencies.<sup>50</sup> Thus, while more research is needed, it is clear that elder mistreatment is associated with myriad adverse outcomes.

**Table.** Role of Health Care Professionals in Reporting Abuse

	Abused Elder	Caregiver	Clinician
Risk factors	Cognitive impairment, aggressive behaviors, psychological distress, lower levels of social network and social support, lower household income, need for ADL assistance, premorbid relationship to the abuser, shared living arrangement	Family relation, substance abuse, mental illness, dependency, unemployment	
Abuse assessment questions asked by clinician	Has anybody hurt you? Are you afraid of anybody? Is anyone taking or using your money without your permission?	Are your mom's needs more than you are really able to handle? Are you worried that you might hit your mom? Have you hit your mom?	
Abuse assessment actions taken by clinician			Inform patient that you are making a report Tell patient: "I am concerned about this situation and want to help. I am going to call an organization called Adult Protective Services. They will send someone to see you at home and assess the situation. We need to see if there is something we can do to prevent this from happening again." Document injury and related history Check patient's injury for size, location, color and appearance, tenderness, swelling, and pattern (if present) Note if the patient seems fearful of the caregiver Document patient's language about any possible abuse incidents in the patient's own words

Abbreviation: ADL, activities of daily living.



### Diagnosing Elder Mistreatment: The Role of the Primary Care Clinician

The Nurse Practitioner: *[Some cardinal signs that indicate neglect] are that they lack follow-up when they do have a physician. Or, if they've gotten so sick that they end up in an ER, it turns out that they haven't been to a doctor in 15 or 20 years and they refuse to go. Usually they are disheveled. . . . They are usually malnourished. . . . They have untreated medical conditions even though they may have prescription medications.*

The primary care clinician is well positioned to identify elder mistreatment in its early stages (Table). During a routine office visit, answers to questions about how patients manage their daily lives can suggest incipient problems that will eventually impair the patient's ability to live independently. Minor difficulties in handling these activities may predict future self-neglect, which may evolve over months or years to a situation such as Mrs O's. Early detection and interventions, such as maximizing treatment of underlying conditions, providing community-based services, and appropriately involving family, may help delay or prevent self-neglect and abuse by others. Longitudinal studies that provide evidence for efficient, effective methods to detect and intervene are needed. Nevertheless, based on a combination of evidence and experience, there are several practical approaches the clinician should take.

During an office visit, the clinician should ask direct questions of the elder and, if available, the caregiver (Table). It is important to observe if an elder seems fearful of the caregiver and, if so, to conduct a private interview and examination. Bruises, lacerations, burns, and other injuries, particularly if in unusual locations without adequate explanation as to cause, should raise a suspicion of abuse. Documentation should include the patient's and caregiver's descriptions as to the mechanism of injury, using direct quotes when possible (eg, "my daughter hit me with a broom handle"). The documentation of the physical examination may include photographs and should include a clear, concise description of the injuries (Table). Assessments of the patient's functional and cognitive status are important adjuncts to understanding the mechanism of injury and any inconsistencies between the history and the physical examination findings. For example, a patient who reports that "I tripped over a rug and fell" but, on physical examination, has a normal gait and balance, multiple facial bruises, and circumferential bruises on the upper arm should raise concerns for abuse.

The primary care clinician with a long-standing patient-clinician relationship may notice a change in behavior indicative of self-neglect. For example, a new pattern of missing appointments; a long-standing patient who is hours late coming to the appointment because of getting lost or confused; or a new inability to take medications correctly may suggest cognitive decline and risk of self-neglect. Self-neglect should also be suspected when an older adult appears disheveled or has evidence of poor hygiene. Concern for self-neglect should trigger an assessment of cognition

and, often, a report to APS (FIGURE 2). A house call may be an illuminating experience, sometimes revealing shocking living conditions, such as Mrs O's. Even if the clinician is unable to perform a house call, there are many community partners who are able to do so such as a home health agency, a county agency, or a local nonprofit organization.

As noted by Widera et al,<sup>38</sup> possible financial abuse can be identified by the observant clinician—an elder who is no longer able to afford basic items, an elder who suddenly appears at appointments with a new friend or caregiver who seems intrusive or protective (eg, reluctant to leave the room so that the clinician can have a private conversation with the patient), or direct reports that an individual is taking or mishandling the elder's money. The clinician may ask a direct question about financial abuse such as, "Is anyone taking or using your money without your permission?"

Indicators of possible abuse should lead to a report to APS, the ombudsman, or local police. Health care professionals should know their own municipality's (country and state) definition of abuse and mandatory reporting requirements. For the United States, the National Center on Elder Abuse provides elder abuse reporting agencies and resources by state.<sup>7</sup>

### Reporting

Forty-four US states, as well as the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, have mandatory reporting laws that require health care professionals to report a reasonable suspicion of abuse or self-neglect.<sup>36</sup> APS is charged with taking a report and investigating alleged mistreatment if the potentially abused elder resides in the community. A long-term care ombudsman agency investigates alleged incidents that occur in licensed sites such as skilled nursing facilities. According to the 2000 Survey of State Adult Protective Services (the most recent data available), health care professionals were responsible for submitting 11.1% of elder abuse complaints or reports. Specifically, physicians made 1.0% of the reports.<sup>9</sup> A survey of APS workers in 43 states found that of 17 occupational groups, physicians were rated in the least helpful category for detecting abuse and neglect.<sup>57</sup> The reasons physicians cite for not reporting possible abuse or neglect include subtlety of signs, patient denial, and lack of knowledge about reporting procedures.<sup>58</sup> Other reasons described by physicians include concern about losing patient-physician rapport, doubts about the impact of agency intervention on the patient's quality of life, and perceived contradictions between mandatory reporting and physician ability to act in the patient's best interests.<sup>59</sup> Despite these concerns, most health care professionals in the United States are mandated reporters. Failure to report may lead to legal consequences ranging from monetary penalties to jail sentences.<sup>36</sup> Based on clinical experience, it is best for the clinician to tell the patient and caregiver that a report will be made except in the unusual circumstance where there is reasonable concern that re-

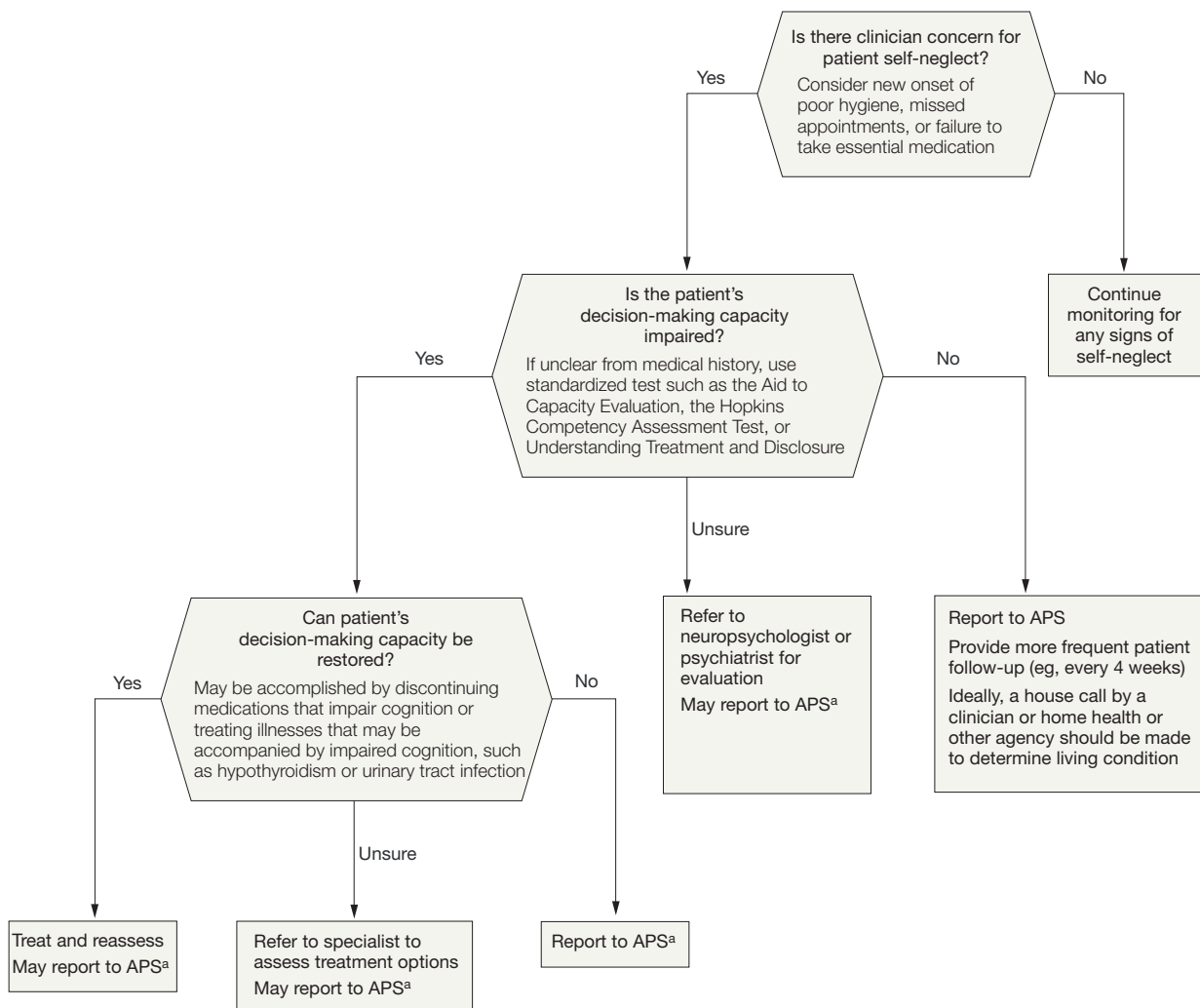
porting might escalate a violent situation. A compassionate clinician's explanation of the need to make a report and the desire to help improve a dangerous situation can help the APS worker have a more successful visit.

### After a Report Is Made, APS' Responsibility

The APS Caseworker: *Whenever we get a report, we go out and conduct an investigation. . . . We cover the home environment; we have to make sure that the home is clean and free of clutter. We have to make sure that all of the utilities are working and . . . that there is an adequate supply of food. The second area . . . is the financial background. In Mrs O's case, since*

*she needed in-home services, we have to determine what kind of income she has and who is managing the money. Also, we cover medical and physical . . . to determine if the person meets our criteria for being able to do their daily living tasks, do they have a disability, or if they are 65 or older. We try to find out if they are getting medical care on a regular basis and who is the person's primary care provider, what medications they are taking, and if their prescriptions are current. Then we cover mental status to determine if a person is oriented and if the person has mental problems. Mrs O has memory problems. The last area we cover is social . . . to find out if the person has a social system that they can rely on.*

**Figure 2.** Clinician's Approach When Self-neglect Is Suspected



Algorithm is based on the authors' clinical experience and review of the literature. APS indicates adult protective services.  
<sup>a</sup>Depending on severity, imminent danger, or level of risk.

The scope and delivery of services provided by APS agencies vary due to differences in state laws, how laws are interpreted, and levels of funding and interest in different jurisdictions. The authority of APS is limited. As summarized by Otto,<sup>60</sup> regardless of location, APS aims to provide abused and neglected elders with coordinated, interdisciplinary care that encompasses social and health systems. This is done with an underlying philosophy that promotes a client's rights to self-determination, maintains a family unit whenever possible, and provides recommendations for the least restrictive living situation.

The APS worker must presume the client has decision-making capacity and must accept the client's choices until the client is determined to lack capacity by a health care provider or the legal system. With Mrs O, the APS worker was fortunate to be allowed into the home since APS cannot enter a person's home without permission.

### Decision-Making Capacity

Does Mrs O have a right to live like this? Under what circumstance do the medical community and society at-large have a responsibility to override an adult's wishes? For health care professionals, this issue is typically framed in terms of decision-making capacity, something that clinicians assess on a regular basis in both formal and informal ways. The presence or lack of capacity is often a determining factor in next steps (Figure 2). However, capacity is often not completely present or absent. The clinician is forced to take a gray area and make it black or white for purposes of guiding next steps such as guardianship/conservatorship. Commonly used brief screening testing such as the Folstein MMSE are inadequate for determining capacity except at the extremes of the score, as was the case for Mrs O. Tests useful in assessing decision-making capacity are the Aid to Capacity Evaluation, the Hopkins Competency Assessment Test, and Understanding Treatment and Disclosure.<sup>61</sup> When the clinician does not have the time or expertise to assess decision-making capacity, a referral to a neuropsychologist or psychiatrist is appropriate. When impaired capacity is identified, the clinician should look for reversible causes such as medications that impair cognition or illnesses that may manifest as impaired cognition (eg, untreated hypothyroidism or urinary tract infection). Additional resources regarding guardianship and conservatorship are available (Resources).<sup>38</sup>

### The Role of Interdisciplinary Teams

The Nurse Practitioner: *The school of medicine has a contract with adult protective services. When an adult protective services caseworker needs a medical evaluation, they will fax a referral to us. Then I will triage the cases and usually I'm the one who goes out to do a comprehensive geriatric assessment.*

*If we determine that the client lacks capacity for self-care and protection, one of our geriatricians will go back out and do a follow-up assessment so they can submit the proper paperwork to adult protective services and file for a guardian.*

The proliferation of interdisciplinary teams in the field of elder abuse, despite a dearth of data regarding cost-effectiveness, is an indicator of the complexity of the problem. In Mrs O's case, such a team was critical to the evaluation process. In a study of 269 APS cases referred to a medical response team, 78% were referred for purpose of mental status assessments, physical examination for evidence of abuse, or both.<sup>62</sup> A survey of the APS workers who made referrals to a team indicated that the team was helpful in confirming abuse, documenting impaired capacity, reviewing medications and medical conditions, facilitating the conservatorship process, persuading the client or family to take action, and supporting the need for law enforcement involvement. Wiglesworth et al,<sup>63</sup> using mixed quantitative and qualitative measures, found that an elder abuse forensic center team consisting of APS and other community-based workers, medical professionals, and criminal justice professionals (police and district attorney) meeting to discuss whether abuse had taken place improved the efficiency and effectiveness of handling suspected abuse cases. Navarro et al<sup>64</sup> used a logic model to provide a framework for describing a similar type of elder abuse forensic center; meeting participants rated the team as highly effective. While interdisciplinary teams may be an example of the concept of action over evidence,<sup>65</sup> the team members' belief that these meetings are highly effective implies the utility of this mechanism for handling elder mistreatment and deserves further study. At present, however, there is no institutionalized funding mechanism to support their services.

### Postintervention Outcomes

It would be important to establish that APS referral in cases of elder mistreatment helps to improve outcomes for the elder, but no such studies have been published to our knowledge. Prospective studies are needed to systematically examine the relationship between elder mistreatment situations and encounters with the health care, financial, law enforcement, and criminal justice systems. In addition, studies are needed to examine the cultural appropriateness of the existing APS interventions in the rapidly growing nonwhite aging populations. Studies of interventions that address people with dementia, a particularly vulnerable population, are needed. Moreover, research is needed to examine the cost-effectiveness of the existing APS intervention as well as the impact of the APS intervention on the health status and quality of life of the elder.

### CONCLUSION

APS Caseworker: *The situation is not getting better. Mrs O sleeps on the couch and if she's too intoxicated to get up, she just won't answer the phone. And that can go on for days and days and days without anyone knowing if something is wrong or not.*

*Just a few months ago, she made another trip to the emergency department when she broke a bone in her ankle when she fell. She wanted to go back home and refused any type of*

skilled nursing placement. I went out to do a monthly visit with her and . . . I could see that she was in decline.

There were many opportunities for health care professionals to intervene with Mrs O—the emergency department, the acute hospital, the rehabilitation unit, and the primary care office. We do not know if professionals in these settings tried to help or simply felt useless or overwhelmed in the face of her chronic alcoholism. We do not know if health care professionals were aware that she was living in filth or if they appreciated that she was too impaired to grasp the severity of her situation. We don't know if assessing and improving her functional status at an early stage would have helped. Although data are lacking, it is fair to surmise that maximizing function and linking older adults to rehabilitation, community programs, social services, or a combination of these might help prevent situations such as Mrs O's in the future.

The complexities of elder self-neglect require the coordination of medical, social, and legal professionals as well as the broader community to balance the duty to protect and the duty to respect civil liberties. How self-neglect relates to other types of elder abuse is just beginning to be understood. As the number of older adults, and particularly the oldest old, those older than age 85 years, continues to increase at an exponential rate, the issue of elder mistreatment will also increase. Data and outcomes from longitudinal studies will be critical to inform future practice and policy to protect this vulnerable population. The more that is understood about root causes and outcomes, the more effectively prevention and intervention strategies can be targeted.

## EPILOGUE

In November 2010, Mrs O fell again and was taken to the hospital. During this hospital stay she had a cardiac arrest and died.

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## RESOURCES

### ELDER ABUSE REPORTING AND AGENCIES BY STATE

National Center on Elder Abuse: State Directory of Helplines, Hotlines, and Elder Abuse Prevention Resources.

[http://ncea.aoa.gov/NCEAroot/Main\\_Site/Find\\_Help/State\\_Resources.aspx](http://ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx)

### CAPACITY AND GUARDIANSHIP

American Bar Association Commission on Law and Aging. Guardianship law and practice.

[http://www.americanbar.org/groups/law\\_aging/resources/guardianship\\_law\\_practice.html](http://www.americanbar.org/groups/law_aging/resources/guardianship_law_practice.html)

American Bar Association; American Psychological Association; Jennifer Moye; ABA/APA; Assessment of Capacity in Older Adults Project Working Group. *Assessment of Older Adults With Diminished Capacity: A Handbook for Lawyers*. American Bar Association Commission on Law and Aging and

American Psychological Association. 2008.

<http://www.abanet.org/aging/publications/publicationslistorder.shtml#capacity>

National Guardianship Association, Inc. What is guardianship?

<http://www.guardianship.org/guardianship.htm>

### FOR MORE INFORMATION ON ELDER ABUSE

Academy on Violence and Abuse Web site.

<http://avahealth.org/>

American Bar Association, Commission on Law and Aging. Elder abuse Web site.

[http://www.americanbar.org/groups/law\\_aging/resources/elder\\_abuse.html](http://www.americanbar.org/groups/law_aging/resources/elder_abuse.html)

National Clearinghouse on Abuse in Later Life. Resources and publications.

<http://www.ncall.us/resources>

National Research Council (US) Panel to Review Risk and Prevalence of Elder Abuse and Neglect. *Elder Mistreatment: Abuse, Neglect, and Exploitation in an Aging America*. National Academies Press. 2003.

[http://www.nap.edu/catalog.php?record\\_id=10406](http://www.nap.edu/catalog.php?record_id=10406)

National Committee for the Prevention of Elder Abuse Web site.

<http://www.preventelderabuse.org/> Sellas MI, Krouse LH. *Elder Abuse*. Medscape Web site.

<http://emedicine.medscape.com/article/805727-overview>

US Administration on Aging, National Center on Elder Abuse Web site.

[http://ncea.aoa.gov/ncearoot/Main\\_Site/index.aspx](http://ncea.aoa.gov/ncearoot/Main_Site/index.aspx)

University of California, Irvine, Center of Excellence on Elder Abuse and Neglect Web site.

<http://www.centeronelderabuse.org/>