

Medical Implications of Elder Abuse: Self-Neglect



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KEYWORDS

• Self-neglect • Squalor • Geriatric assessment • Capacity

KEY POINTS

- Self-neglect is the most common report received by Adult Protective Service Agencies.
- Self-neglect is associated with multiple medical comorbidities and increased mortality.
- Comprehensive geriatric assessment coupled with capacity assessment is the best practice for case identification and evaluation.
- Medical and social interventions are indicated in cases of self-neglect.
- Self-neglect is a significant public health issue, and policies are needed to address the clinical needs of this vulnerable population.

CASE STUDY: "THE POSSUM HOUSE"

Mrs L.J. is a 79-year-old white widowed woman, who lives in a one-story house with her 40-year-old daughter. Mrs L.J. worked as a secretary but has been unemployed for about 20 years. She has a family history of abuse by her father and her deceased husband. Her medical diagnoses include hypothyroidism, gastrointestinal reflux disease, hypertension, urinary incontinence, arthritis, fatigue, and a history of breast cancer. She complains of falling, vision problems caused by cataracts, and tooth pain when eating. She denies any alcohol, tobacco, or illicit substance use. She has refused to see her physician for more than a year. Adult Protective Services (APS) was concerned about an unhealthy and dangerous environment, and referred her to the Texas Elder Abuse and Mistreatment Institute (TEAM) for a physical and mental evaluation. TEAM is a consortium of medical and academic institutions, APS, and

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law enforcement groups working collectively to investigate, assess, and assist victims of elder abuse and self-neglect.^{1,2}

Home Environment

The visit to Mrs L.J.'s home revealed an overgrown lawn, trash around the property, and lack of upkeep (eg, holes in the roof) in an otherwise clean, pleasant neighborhood. She has been living in her house for more than 30 years and has been reported to the homeowners association, the Houston Police Department, and the local Society for the Protection of Cruelty to Animals (SPCA) on multiple occasions. She recently went to jail for multiple unpaid city warrants for her refusal to clean up piles of trash in her back yard.

Most of the interior of the house was inaccessible because of clutter and old boxes that stood 4 feet high. The home was roach-infested and smelled of trash and urine. Piles of articles, cans, and old food were noted throughout the residence. There was a mattress in the middle of the living room floor, and both the daughter and mother slept in the same bed. An open-faced electrical heater sat approximately 1 foot from the mattress, creating a significant fire hazard. Roaches crawled around the piles of trash in the home and on Mrs L.J. herself, including through her hair. Multiple animals lived in the house including 2 cats, a parrot, and a wild pregnant possum who had taken up residency in an old shopping cart full of cans in the kitchen. When asked if she would like for animal control to be called to remove the wild animal, she replied, "I think it's better if she stays in the kitchen...she's like my pet!" The sink was filled with dirty dishes, roaches, and cat food. There was moldy food in the refrigerator, and its temperature was inappropriate for food storage. The bathroom was unusable because of roof collapse. Mrs L.J. and her daughter used a nearby bucket when they needed to use the bathroom. A significant plumbing leak was present from an inaccessible rear bathroom, and stagnant water was pooling in the back of the house.

Social Support

Mrs L.J. was isolated and had rare contact with individuals other than her daughter. The daughter reported having technical training; however, she worked as a cashier and was the sole income provider. She exhibited some evidence of developmental delay.

Clinical Impressions and Capacity Assessment

During the TEAM visit Mrs L.J. wore a dirty nightshirt, had marginal personal hygiene, and was lying on a mattress about 6 inches off the ground. Vital signs were normal. Multiple dental caries were visible on her teeth. There were no obvious signs of physical trauma. She had a history of bilateral breast removal and weakness in the legs, but otherwise her physical examination was normal. She could rise from the mattress to a standing position, but with considerable effort. She used a cane to brace herself while getting up, but almost stumbled head-first into the wall.

Mrs L.J. was awake and oriented to person, place, and time. She was often tangential and lost her train of thought. Her Confusion Assessment Measurement score was negative for delirium.³ She did not complete the Geriatric Depression Scale or the Clox 1 test for executive function, owing to a combination of suspicion of the interviewers and inability to answer the more challenging questions.^{4,5} Her St Louis University Mental Status score was 23 out of 30 (normal range 27–30) and her Clox 2 score 6 out of 15 (normal range 12–15), which showed cognitive impairment with severe executive control dysfunction.^{5,6} She failed the Kohlman Evaluation of Living Skills test (KELS) with a score of 8 out of 16 (score of 5½ or less indicates client is capable of

living independently), indicating a need for assistance or supportive services to live safely in the community.^{7,8}

Her connection to low-value items was consistent with hoarding behavior.^{9,10} Mrs L.J. also exhibited a suspicious personality trait and paranoid thoughts. These cognitive deficits suggested a diagnosis of dementia, Alzheimer disease.⁹

Mrs L.J. lacked the capacity to remain living independently in the community, based on the following^{11,12}:

- Failure to take appropriate steps to rectify her situation by accepting assistance provided by APS (animal control, extermination or cleaning services)
- Unable to recognize dangerous situations related to the electric heater and its proximity to combustibles
- Failure to recognize the dangers of having a wild animal living in her home (physical harm, parasites, or transmission of *Salmonella*)¹³
- Unable to recognize the degree of insect infestation and its risks for health
- Failure to recognize squalor and the degree of work required to improve conditions, in addition to her inability to clean the home

Recommendations and Outcome

Mrs L.J. was referred for guardianship and transfer to an assisted living facility for supervision of activities of daily living and self-care. She received medical follow-up and physical and occupational rehabilitation. She was able to take her parrot to the facility and enjoyed socialization with other residents, which helped to alleviate some of her anxiety related to hoarding and loss of other pets. Mrs L.J.'s daughter willingly moved to a group home nearby to her mother, and visits her daily.

BACKGROUND

Definitions

Self-neglect is defined by the National Committee for the Prevention of Elder Abuse and the National Adult Protective Services Association as

*...an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including (a) obtaining essential food, clothing, shelter, and medical care; (b) obtaining goods and services necessary to maintain physical health, mental health, or general safety; and/or (c) managing one's own financial affairs.*¹⁴

A self-neglecting elder has been also defined as a person who exhibits at least 1 of the following: (1) persistent inattention to personal hygiene and/or environment; (2) repeated refusal of some/all indicated services that can reasonably be expected to improve quality of life; (3) self-endangerment through the manifestation of unsafe behaviors (eg, persistent refusal to care for a disease).¹⁵

Personal and/or domestic squalor, used extensively in the literature to describe elder self-neglect, has also been phrased to include "the aged recluse,"¹⁶ "senile breakdown,"¹⁷ "lack of cleanliness,"^{18,19} "Diogenes syndrome,"²⁰ "social breakdown in the elderly,"^{21,22} "squalor syndrome,"^{23,24} or "gross self-neglect."²⁵

To characterize the severity of this condition, 3 domains of self-neglect indicators have been identified: (1) personal hygiene (eg, dirty hair and clothing, poor condition of nails and skin); (2) impaired function (eg, decline in cognitive function and activities of daily living); and (3) environmental neglect (eg, evidence of subject's inability to clean the house and yard, and manage material goods acquired over the years).²⁶ Mrs L.J. was affected by all domains.

Clinical Findings

The etiology of self-neglect is unknown, but may be associated with premorbid personality traits (aloof, detached, suspicious, quarrelsome), behaviors (reclusive, hoarding), or disorders (obsessive-compulsive, paranoid, schizoid).^{20,21,27–30} Indeed, hoarding (accumulation of rubbish or sylogomania), is considered an important clinical characteristic of the self-neglect syndrome,^{28–30} and has been linked to obsessive-compulsive disorder.^{10,31} For example, in an English study including referral cases living in squalor conditions in the community, hoarding was present in 51% of households.²⁸ In an Australian survey conducted in 12 community health centers, hoarding occurred among 72% of subjects living in unclean conditions.^{10,19,30} As in the case with Mrs L.J., hoarding behavior results in stacks of trash and other objects that significantly reduce the total living space and present risks for falls, fire, and safety, and interfere with daily tasks such as cleaning, cooking, sleeping, and socialization.^{10,31}

The development of executive dysfunction, a condition whereby an individual is unable to translate simple tasks into complex, goal-directed behaviors such as cooking, dressing oneself, and performing basic housework, has been proposed as an important etiologic factor in elder self-neglect.^{32,33} Related to this, some cases of severe domestic squalor or self-neglect have been found to have frontal lobe dysfunction or frontal lobe dementia.^{11,30,34}

Risk factors for the development of self-neglect include old age, male gender, cognitive impairment, depression, delirium, medical illness (stroke, hip fracture), functional and social dependence, stressful events (eg, bereavement), history of social isolation, and alcohol and substance abuse.^{11,29,33,35} For example, in a cohort study, the New Haven Established Population for Epidemiologic Studies in the Elderly (EPESE), cognitive impairment (odds ratio [OR] 4.63, 95% confidence interval [CI] 2.32–9.23) and clinically significant depressive symptoms (OR 2.38, 95% CI 1.26–4.48) were independent predictors of self-neglect after 9 years of follow-up.³⁶

Mental disorders are commonly described in elders with severe self-neglect. These disorders include schizophrenia, dementia, alcohol abuse, and psychosis, with dementia being the most common.^{17,20,30,37–39} In a community study of people living in squalor, 70% of the individuals were classified as having an ICD-10 mental disorder. Identifiable psychiatric illnesses are more common among younger individuals who manifest self-neglect.^{19,28,38}

Self-neglect, like other geriatric syndromes, is associated with significant comorbidity, including hypertension, dementia, diabetes mellitus, arthritis, stroke, depression, urinary incontinence, and delirium.³³ Self-neglecting elders may exhibit greater functional limitations when compared with other elders in cross-sectional or longitudinal studies.^{17,27,40,41} Individuals with severe self-neglect were often described as having sensory impairment.^{17,20,27} As a consequence of living in squalor conditions, self-neglecting elders may have altered nutritional status, which includes multiple nutritional deficiencies such as iron, folate, vitamin B₁₂, vitamin C, β -carotene, α -tocopherol, serum proteins/albumin, calcium, and vitamin D.^{20,42}

Outcomes

Self-neglect is an independent risk factor for death. Indeed, in the New Haven EPESE study, self-neglecting elders had an increased risk of 13-year all-cause mortality (OR 1.7, 95% CI 1.2–2.5) when compared with other members of the cohort.³⁵ Also, in the Chicago Health and Aging Project (CHAP), self-neglecting elders had an increased risk of 1-year mortality (hazard ratio [HR] 5.82, 95% CI 5.20–6.51), which

remained significant over the entire 9-year follow-up period, but was greatly reduced starting in year 2 (HR 1.88; 95% CI 1.67–2.14).⁴³

Self-neglecters may make increased use of health services because of the severity of self-neglect and the accompanying comorbidity or health complications. Thus there is an increased risk for nursing home placement,⁴⁴ and hospice,⁴⁵ hospital,⁴⁶ and emergency department utilization.⁴⁷ However, once self-neglecters are brought into the health care system, they are no more expensive than other similar patients.⁴⁸

Acute hospitalization of patients who self-neglect has often resulted in worse outcomes in comparison with patients treated in the outpatient setting for the same conditions.^{17,20,27} In addition, self-neglect is also associated with other geriatric syndromes such as dementia, depression, or urinary incontinence.^{33,39} Nonadherence to treatments has been found to be a problem in the elder self-neglect population. Turner and colleagues⁴⁹ reported that 90% of 100 elder self-neglecters were nonadherent with at least 1 medication, and even more were nonadherent with approximately 4 medications. Nonadherence was associated with the number of prescribed medications and lower objective physical function.

MODEL

Etiology of Elder Self-Neglect

After more than 10 years of practice by TEAM, Dyer and colleagues³³ developed a biopsychosocial path model proposing causal links between health conditions and the development of elder self-neglect. In addition to clinical practice, case studies and findings from a large descriptive study of more than 450 APS clients with self-neglect informed this model.³³ The TEAM model depicted in [Fig. 1](#) illustrates the path from certain illnesses to self-neglect within specific social contexts. The syndromes or diagnoses included in the top box may be due to a variety of reasons

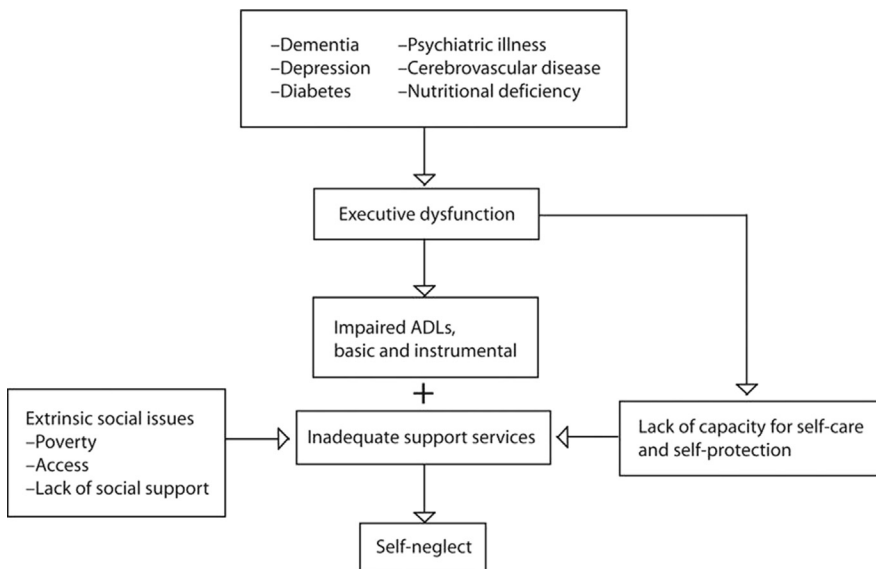


Fig. 1. Model of self-neglect among the elderly. ADLs, activities of daily living. (From Dyer CB, Goodwin JS, Vogel M, et al. Characterizing self-neglect: a report of over 500 cases of self-neglect seen by a geriatric medicine team. *Am J Public Health* 2007;97:1675; with permission.)

including poor self-management skills, limited or fragmented health care, reduce resources, psychiatric illnesses, delusional disorders, and substance abuse.^{10,11,15} Resulting memory impairment and or lack of executive function may then reduce the older adult's ability for self-care and self-protection, requiring social, medical and functional interventions⁶ to impede the onset of elder self-neglect.

In many instances family members step in to address these deficits, and provide the assistance needed. For instance, family members may move their loved one to an assisted living facility, provide in-home help, or reduce their work load to help the individual at home. Individuals who develop functional deficits without the memory deficits or executive dysfunction may themselves voluntarily stop driving, move to a senior center, or hire assistance. Self-neglect occurs when seniors fail to recognize their deficits or lack the social support or financial resources to accomplish activities of daily living.³³

Work by Dong and colleagues, Dyer and colleagues, Mosqueda, Lachs, and others have demonstrated that this model holds true in different jurisdictions.^{40,41,50-55} There are various disparities in social services across the United States that may contribute to the prevalence of elder self-neglect. Services in rural areas differ significantly from those in urban settings. In rural areas there may be more cohesive communities, whereas in urban settings more medical resources and social resources may be available to individuals who develop executive memory problems or executive dysfunctions. APS agencies also differ across the country. For example, in the state of Texas there is a relatively large protective service organization, organized at the state level and integrated into the fabric of the social community and health care community. In many jurisdictions, the expertise of the medical practitioners in addressing self-neglect cases differs. There are also variances in state statutes regarding the definitions and remedies.

Many aspects of the TEAM model³³ have been tested, but more work is needed to determine the ideal timing and type of interventions.

ASSESSMENT

Approach

When a clinician evaluates a suspected self-neglecter, he or she will attempt to determine the ways in which one is not taking care of oneself, the cause, and what support would help meet the identified needs.

It is necessary to seek information about the circumstances of the elder and his or her functional abilities from all available sources. More accurate information may be available from neighbors, bank tellers, apartment building managers, and others, than is available from the elder. Visiting the self-neglecter in his or her usual living environment is often more informative than seeing the patient in the clinical environment. At the home, more accurate information about the living conditions can be gathered, providing more evidence of how patients are functioning in their everyday environment.⁵⁶ Self-report in these cases is often grossly incorrect and misleading.⁵⁷

A comprehensive geriatric assessment with medical, functional, and social history is considered best practice. This information, when added to that from alternative credible sources, may help determine the self-neglecter's appreciation of the circumstances. A clinician such as a physician or nurse practitioner should conduct a physical examination and screen for depression, delirium, dementia, and functional abilities.⁵⁸ The goal is to identify physical or mental conditions that interfere with their understanding and function.

There are key questions to be answered when evaluating self-neglect, which have been developed based on the literature and TEAM's clinical experience.

To live independently without supervision, the self-neglector must be able to arrange to have the following needs met if he or she cannot perform them independently: activities of daily living (dressing, bathing, toileting, feeding oneself, moving about their home); instrumental activities of daily living (managing finances, preparing meals, performing housework, using the telephone, shopping, use of transportation, taking medications, or managing medical issues); protection from harm (from strangers or nonstrangers); and a reasonably safe and hygienic living environment.^{59,60}

Important considerations include whether the elder is able to make decisions about his or her needs, and is able to take reasonable steps to meet these needs. Some with capacity may simply decide not to address their needs. For instance, an impoverished individual may want a better home environment, but elect to stay in a dilapidated home with pets.

Capacity Assessment

All adults are presumed to have full capacity to live independently. Finding one incapacitated in some or all areas is a joint medical and judicial decision, based on expert clinical opinion. The state definitions of incapacity are usually based on the functional abilities of the person to meet, or arrange to meet, the essential requirements for physical health, safety, or self-care (American Bar Association/American Psychological Association, 2006).⁶¹ Other questions posed during a TEAM evaluation are noted in **Tables 1** and **2**.

The cognitive domains thought to be important to independent living are: attention; working memory; short-term memory; long-term memory; receptive language; expressive language; understanding of basic quantities and making simple calculations; verbal reasoning; visual-spatial reasoning; and executive function.⁶⁰ Stated more concisely, the person must have the ability to make decisions, and carry out decisions, with respect to his or her needs.¹¹ A person's decision-making capacity requires the ability to receive and understand relevant information, reason through the options, communicate a choice, and appreciate the situation.⁶² Appreciation of the patient's own circumstances is critical to patient's decision making. An adequate memory is needed for this appreciation.

Executive function has been found to be a necessary cognitive ability for independent functioning in the community. This ability allows the individual to plan, direct, sequence, organize, monitor, and supervise his or her own behavior.^{32,63–65} It is possible to have an intact memory, but fail to live independently with success because of poor executive function, a necessary capability when taking reasonable steps to carry out individual decisions and intentions.³³ Screening instruments may test for this ability, but observation of how well the individual is able to carry out intentions without supervision may be a better test for this.

The assessment approach described here, including answering the questions in **Tables 1** and **2**, should provide the needed information for the clinician to arrive at an opinion about the patient's capacity to live independently without supervision. It should also help the clinician to identify unmet needs and possible interventions to support the patient besides guardianship.

INTERVENTIONS

Adult Protective Services

Research conducted over the last decade has increased the understanding of how varying health conditions, both chronic and acute, can lead older adults to neglect themselves.^{33,40,66,67} Less known is how to effectively intervene in this population,

Table 1

TEAM checklist for determining capacity

Key Question	ADL	IADL	Housing	Self-Protection
Does the person understand their circumstances?	(T/F) Despite adequate resources, the person is failing to perform an ADL and <i>does not understand this fact</i>	(T/F) Despite adequate resources, the person is failing to perform an IADL and <i>does not understand this fact</i>	(T/F) Despite adequate resources, the person is exposed to an unsafe/unsanitary/inadequate housing condition and <i>does not understand this fact</i>	(T/F) Despite adequate resources, the person is the victim of abuse, neglect, exploitation, or self-neglect, and <i>does not understand this fact</i>
Is the person failing to self-care and self-protect?	(T/F) Despite adequate resources, the person is failing to perform an ADL and <i>does not take appropriate steps to correct the problem</i>	(T/F) Despite adequate resources, the person is failing to perform an IADL and <i>does not take appropriate steps to correct the problem</i>	(T/F) Despite adequate resources, the person is exposed to an unsafe/unsanitary/inadequate housing condition and <i>does not take appropriate steps to correct the problem</i>	(T/F) Despite adequate resources, the person is the victim of abuse, neglect, exploitation, or self-neglect, and <i>does not take appropriate steps to correct the problem</i>

The documentation should be made of each finding to justify a “T” response. The documentation should include the source of the alleged fact (personal observation, information from a third party, and so forth). Effort should be taken to find multiple sources of information for each significant finding. Care should be taken to try to determine if the person is arranging for assistance or if assistance is being provided without the person arranging for it. What we would like to know is how well persons would take care of themselves if arranging for their own care and protection. Developed by John M. Halphen.

Abbreviations: ADL, activities of daily living (toileting, feeding, dressing, grooming, physical ambulation, bathing); IADL, instrumental activities of daily living (ability to use telephone, shopping, food preparation, housekeeping, laundry, arrange for transportation, ability to handle finances, responsible for taking own medications); T/F, true or false.

whose members are known to eschew conventional medical and social intervention. The complexities in the often unique biopsychosocial profiles of elder self-neglecters limit the effectiveness of standard medical interventions, and there is a need for more comprehensive approaches.

When the suspicion of elder self-neglect is raised, clinicians can substantiate these suspicions through a comprehensive geriatric assessment as already noted, and/or by making a referral to APS. Including APS services provides a more comprehensive understanding of the causes for the unmet needs of the older adult. In fact, interprofessional teams of health care and social services professionals are recommended for effective treatment and intervention in elder self-neglect. These teams provide a comprehensive assessment and treatment approach designed to meet the intermixed medical, social, mental health, and behavioral problems that facilitate self-neglect and impede effective treatment.² Intervention using the interprofessional team approach has reported success in reducing self-neglect behaviors and risk factors such as depression, impairments in activities of daily living, and lack of self-perceived social support.^{68,69}

Clinical Interventions Teams

The inclusion of other disciplines is important and reduces the treatment burden of the primary care provider. The traditional “treat and release” approach may not be effective for reducing or preventing elder self-neglect. Older adults who neglect themselves often fall along a continuum of able self-care, which includes progressive categories such as autonomous, collaborative, structured, and subordinate. Autonomous individuals are those who are able to self-manage on their own with minimal need for external support. Collaborative individuals also self-manage on their own, but the clinicians and external support are jointly involved in the decision making. Structured individuals are those who have very limited ability to adequately engage in self-management and thus require even more active external support. Subordinate individuals are those who have very modest patient discretion and require very controlling and supervisory environments to manage their health conditions.⁷⁰ Older adults with limited mental capacity or executive functioning fall into the structured and subordinate groups that require more supervisory care. Evidence shows that elder self-neglecters with mental health issues simultaneously neglect multiple life domains, and thus may fall into the structured and subordinate categories that require more supervision.⁷¹ In this instance it is important for the clinician to first determine which factors may be limiting adequate self-care and whether these deficiencies can be reversed.³³ Depending on the findings, temporary or long-term provider or guardianship services will be warranted to protect the older adult from further self-neglect and harm.

Recent evidence suggests that self-neglect is not always associated with mental health problems, whereas mental health problems are not always associated with elder self-neglect; therefore, other avenues of intervention are needed.⁷¹ Some elder self-neglecters are cognitively capable of performing self-care behaviors, but lack the physical ability necessary for managing their health.^{33,71} Just as medication nonadherence in this population was associated with low physical functioning and the number of medications prescribed, interventions aimed at improving physical functioning and reducing the number of medications in this population could lead to better health outcomes and a reduction in self-neglect behaviors.⁴⁹

Moreover, many self-neglecters may not have the necessary problem-solving skills to effectively manage their health and mental health conditions. Studies show that low-socioeconomic older adults have reduced problem-solving skills, which may limit the

Table 2 TEAM report	
Domain	Information
Biographic data	Date client seen: Client name: Client address: Client DOB:
Adult Protective Services (APS)	Reason for the visit: APS concerned that... History of the problem (years): Allegations (concerns of APS and others): Prior History with APS:
History	Medical/surgical history of the patient (unaided awareness of medical circumstances): Medical/surgical history, from other sources: The medications the patient is aware of, and why they are taken (patient's unaided awareness of medical circumstances): The medications the patient actually takes, from other sources: Social history according to the patient: Social history from other sources:
Examination	Physical examination (conducted by MD or NP): Sensory issues: Delirium: CAM: Depression: GDS score and does it report depression?: SLUMS or MMSE: Score: Level of education: Where were the problems on the MMSE: CAGE: GET-UP-AND-GO:

ADL capacity	Is the person failing to perform an ADL and <i>not understanding this fact</i> ? Describe:	Is the person failing to take reasonable steps under the circumstances (considering resources) to correct the problem? Describe:
IADL capacity	Is the person failing to perform an IADL and <i>not understanding this fact</i> ? Describe:	Is the person failing to take reasonable steps under the circumstances (considering resources) to correct the problem? Describe:
Housing capacity	Is the person failing to secure safe/sanitary/adequate housing conditions and <i>not understanding this fact</i> ? Describe:	Is the person failing to take reasonable steps under the circumstances (considering resources) to correct the problem? Describe:
Self-protection capacity	Is the person the victim of abuse, neglect, exploitation, or self-neglect and <i>not understanding this fact</i> ? Describe:	Is the person failing to take reasonable steps under the circumstances (considering resources) to correct the problem? Describe:
Outcomes	ASSESSMENT: RECOMMENDATIONS: PLAN: Describe plan discussed in Interdisciplinary Team conference:	

Abbreviations: ADL, activities of daily living (toileting, feeding, dressing, grooming, physical ambulation, bathing); CAGE, Cut-Annoyed-Guilty-Eye (alcoholism screening test); CAM, Confusion Assessment Method; GDS, Geriatric Depression Scale; GET-UP-AND-GO, mobility assessment test; IADL, instrumental activities of daily living (ability to use telephone, shopping, food preparation, housekeeping, laundry, arrange for transportation, ability to handle finances, responsible for taking own medications); MD, physician; MMSE, Mini Mental State Examination; NP, nurse practitioner; SLUMS, St Louis University Mental Status.

effectiveness of traditional medical care that tends to focus more on the disease rather than the individual.⁷² This fact does not diminish the importance of treating disease, but indicates the need for alternative interventions that both treat disease and improve the ability of the elder self-neglector to self-manage, as many live isolated and alone in the community. Chronic disease self-management programs in older adults have been widely successful for improving the overall health and self-care behaviors of older adult populations with very similar biopsychosocial profiles to that of elder self-neglect.⁷³ Specifically, teaching physical and mental health–related problem-solving techniques has resulted in reductions in depression and improvements in overall chronic disease self-management in low-income, home-bound older adults.⁷⁴

Medical Interventions

There is no standard prescription for intervening in elder self-neglect. These cases are often medically complicated. Historically these patients may be recalcitrant and nonadherent to proposed interventions. In the past, many have considered intervention in cases of self-neglect to be impossible or futile; however, evidence supports the ability to intervene and improve outcomes in this population.^{69,71} The feasibility of intervening in elder self-neglect has been demonstrated by Burnett and colleagues,⁷⁵ who conducted a randomized clinical trial (RCT) in 50 community-living elder self-neglectors and reported clinically significant increases in vitamin D levels over a 10-month period. Likewise, in a separate RCT, Burnett and colleagues⁶⁸ compared APS usual care versus APS usual care with multidisciplinary team (MDT) medical recommendations, based on review of comprehensive geriatric assessment data. Implementing the recommendations provided by the MDT demonstrated statistically reliable reductions in elder self-neglect behaviors at 6-month follow-up in comparison with APS usual care.

In sum, the traditional approaches to successful aging outlined in Robert Butler's "longevity prescription" will likely not work in elders who neglect themselves.⁷⁶ Instead, nontraditional and more comprehensive approaches are likely necessary for effectively intervening in this population. Nevertheless, it is a challenge and obligation of health care professionals to determine the best interventions for improving the overall health and well-being of vulnerable self-neglecting older adults.

FUTURE IMPLICATIONS FOR POLICY

Although elder self-neglect is a comparatively new focus in aging research, there is sufficient evidence regarding its pervasiveness and deleterious outcomes^{14,33,35,43} to warrant the development of national, state-wide, and community-level policy and legislation around this issue (Fig. 2).

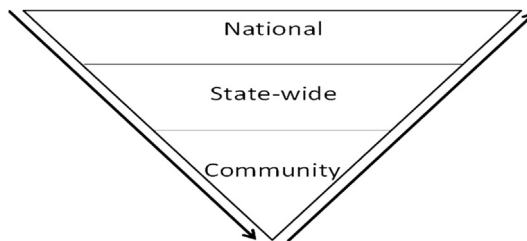


Fig. 2. Top-down approach to elder self-neglect policy development and impact, showing a feedback loop for how policy at the federal level can affect lower-level policy decisions leading to actions that then provide evidence for changing policy at the upper levels. (Designed by Jason Burnett.)

On a national level, much of the legislation and policies in aging focus on violence.⁷⁷ Thus, elder self-neglect does not meet the requirement for inclusion even though self-neglect is the most common report to APS agencies nationwide. Recent evidence suggests that elder self-neglecters will, by default, be covered by these policies and legislation because of the increased likelihood of subsequent abuse. Unfortunately, subsequent abuse occurs approximately 3 years after the substantiation of elder self-neglect, and for many frail older adults with reduced physiologic and psychological reserves such a latency period can be detrimental.⁷⁸ Broader and more inclusive legislation and policies, in addition to elder self-neglect specific policies and legislation, are needed to advance the field. This approach will require expanding the funding of federal programs such as the US Centers for Disease Control and Prevention, the National Institute on Aging, the Agency for Healthcare Research and Quality, the Administration on Community-Living, and APS, in addition to other federal organizations with interests in aging. Doing so will allow for the expansion of research capacity, which should focus on developing universal definitions and improving the detection, prevention, treatment, and management of elder self-neglect.

Consistent policies regarding reporting of elder self-neglect to state Adult Protective Service Agencies would be highly beneficial for establishing less biased national prevalence and incidence measures. Likewise, establishing policies for the use of standardized assessments to substantiate elder self-neglect would also help reduce inconsistent findings in this population. Accurate data would strengthen research findings regarding risk factors and effective treatment modalities across the country. In addition, policies for establishing medical and social service collaborations similar to the TEAM is of particular importance for the treatment and management of the comprehensive needs in vulnerable elder self-neglecters.

In 2012, Dong⁷⁷ provided a comprehensive discussion regarding the future directions of elder abuse and included self-neglect, which included the role of the community in helping to advance the understanding of self-neglect. There was little discussion, however, about the need for policies related to clinical settings. The US Joint Commissions have already established mandatory screening for elder abuse and neglect for emergency department patients who present with injury or advanced medical circumstances. It is unclear as to whether this mandate includes self-neglect, despite the evidence that elder self-neglecters frequently visit the emergency department.⁴⁷ Health care settings are primed for policies that promote screening and prevention. These settings have the potential to be the first line of prevention, and could make available a copious amount of biopsychosocial data to establish the etiology of elder self-neglect and identify the most robust risk factors.

Policies at all levels are needed to facilitate research development. There is a direct need for advancing the study of elder self-neglect beyond the epidemiology and to focus on the development of intervention and prevention. Future well-designed longitudinal trials should be used to understand effective ways to prevent and treat elder self-neglect. The ultimate goal is to improve the health of vulnerable older adults and to inform policy-makers and legislators at the community, state-wide, and national levels regarding the best way to limit associated societal costs and other public health burdens.⁵³

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