Mrs. J

- 90 year old seen at home; angry at first
- PMH: Low Back Pain, Colon polyps, Childbirth x2
- Meds: Bufferin PRN
- SH: Widowed since 1986; Never smoked, rare ETOH. Hasn’t left apartment for at least 2 years. Education: 1 year college.
- ROS: recurrent headaches
Mrs. J/Collateral History

- Originally referred to APS by apartment manager because she left signed blank checks in unlocked mailbox.
- Daughter can’t continue with current level of support, wants NH placement.
- Mrs. J hasn’t seen a physician for several years & refuses to go outside. Weight was 118 per old records from 10 years ago.
BUT I DON’T WANT TO!

SELF-NEGLECT, THE MOST COMMON FORM OF ABUSE

July 12, 2008
Deb Mostek, M.D.
Objectives

- Describe the prevalence, etiologies and common situations of self-neglect.
- Summarize the process of evaluation of a patient with self-neglect.
- List resources to assist in the evaluation and management.
- Apply techniques and strategies to the management of a patient with self-neglect.
Types of Elder Mistreatment

- Community prevalence: 32 per 1000
- Physical abuse
- Psychological abuse
- Neglect
  - By others
  - SELF-NEGLECT (50-75% of all elder mistreatment)
- Financial exploitation
- Sexual abuse
“The result of an adult’s inability due to diminished capacity to perform essential self-care tasks such as providing essential food, clothing, shelter, and medical care; obtaining goods and services necessary to maintain physical health, mental health, emotional well-being and general safety; and/or manage financial affairs.”
Historical perspective

- 1960 Granick and Zeman: “The aged recluse”

Poythress et al., J Elder abuse and Neglect, 2006
Self-Neglect: multi-factorial etiologies

- Passive
- Active
- Diogenes Syndrome (less common)
Diogenes Syndrome

- 50% showed no evidence of psychiatric illness
- Unconcerned about living in squalor
- Reject outside world
- Personality traits: aloof, suspicious, domineering
- Often excessive hoarding: inability to discard clutter
- May be late life reaction to stress in certain personality type

Clark et al. Lancet 1975
Self-Neglect

- Annual incidence: 5.2 per 1000 elders
- Self-neglect: 50-75% of reported elder mistreatment
- Females > Males; Risk increases with age
- Self-neglecters more likely to die in nursing home

Lachs et al JAMA 1998
Self-Neglect Associated Risk Factors

- Living alone
- Advanced age
- Medical burden
- Depressive symptoms
- Cognitive impairment
Medical Implications

- Functional decline; Psychological decline
- Sensory impairments in 50%
- Malnutrition
- Increased risk of medical morbidity
- Increased risk of institutionalization
- Decreased life expectancy

Poythress et al., J Elder abuse and Neglect, 2006
Barriers to identifying self-neglecters

Self-neglecters:
- Extreme social isolation
- Suspicious of others
- Lack of insight

Surrounding community:
- Lack of awareness
- Neighbors’ reluctance to “get involved”
Evaluation

History and Physical

- Subjective history and collateral information
- Functional status, Nutritional status
- Assess cognition (MMSE, Geriatric Depression Scale, Screen for psychiatric illness, assess decision-making capacity)
- Constellation of physical exam findings
- Indicated lab/radiographic studies
PE findings: look for constellation

- Poor hygiene
- Overgrown nails, matted overgrown hair
- Infestations (lice, scabies, fleas)
- Functional impairment
- Decubiti
- Malnutrition
- Dehydration

Evaluation, con’t

- Social assessment
- Environmental assessment
  - Lack of food, stored unsafely, rotted food
  - Clutter
  - Multiple animals
  - Home in disrepair

Mrs. J / Physical Exam

- Wt 93 lbs; BP 144/68 sitting; 116/70 standing
- Gen: Apprehensive, vague historian, very thin
- HEENT: Multiple caries/ decay
- Breasts: 2.7 cm firm mass left breast
- Ext: Marked hypertrophy of toenails (3 cm long)
- Functional screen: Vision 20/70 OS; 20/50 OD; Hearing intact; UE & LE intact; daughter does all shopping & helps with bills; No falls, No UI
Mrs. J/ Mental Status

- STM 0/3 item recall
- MMSE 12/30
- GDS 8/14
- Ideation: paranoid flavor
Mrs. J / Environment

- Blinds were drawn
- No kitchen lights x 2 years—had refused to let electrician into her apartment
- Mild clutter
What community services might be available for Mrs. J?
Community resources for “at risk” patients

- Consult Home Health Care Agency
- Office on Aging (ENOAO)
- In-home services
  - Meals on Wheels
  - Housekeeping services
  - Home health aide, bath aide
  - Automatic medication dispensers
  - Respite care to lessen caregiver burden
Searching the medical literature for guidance
Risk Factors for Harm in Cognitively Impaired Seniors who Live Alone

- 18 month prospective study
- 139 community-dwelling subjects; ≥ 65y/o; Dementia Rating Scale score < 131; living alone
- Informant with weekly contact and PCP who agree to participate
- Informants and PCPs contacted Q 3 months re: subjects’ use of emergency services

Tierney MC et al. JAGS 52:1435-1441, 2004
Risk Factors for Harm...

Harm outcome (must involve all 3):
- (a) physical injury to self or other, property loss or damage;
- (b) due to self-neglect or behaviors 2° to disorientation
- (c) emergency service intervention

Tierney MC et al. JAGS 52:1435-1441, 2004
Risk Factors for Harm…

- Thirty participants (21%) had incident of harm
- Most common: failure to eat and drink (9)
- 73 avoided harm & remained in community
- Variables with significant ↑ risk of harm:
  - COPD (HR 7.7)
  - Perception of fewer social resources
  - Poor performance on MMSE
  - Cerebrovascular disease (HR 3.1)

Tierney MC et al. JAGS 52: 2004
Risk Factors for Harm...

- Regular monitoring of high risk individuals’ intake, medical conditions, potential for infection due to poor hygiene
- Limitations: these studies exclude the most vulnerable and challenging patients—those without family or close social relationships

Tierney MC et al. JAGS 52:1435-1441, 2004
Depression and Dementia in Elder Abuse or Neglect

- 82% of total cases of abuse or neglect carried diagnosis of self-neglect
- Prevalence of depression
  (62% vs 12%)
- Prevalence of dementia
  (51% vs 30%)

Dyer CB et al. JAGS 48:205-208, 2000
Self-neglect, depression and untreated medical conditions

- 50 self-neglecters and 50 non-self-neglect controls
- All assessed in their homes: H&P, medication review, Geriatric Depression Scale-SF, MMSE, Self-Rated Health and Mortality scale, Physical Performance Test
- Depression rates 51% in SN vs 14% Non-SN
- Untreated medical conditions in 56% of depressed SN vs 21% non-depressed SN

Burnett, Journal of Elder Abuse & Neglect 2006
APS use and nursing home placement

- 2812 community-dwellers followed for 9 years (New Haven EPESE)
- 202 referred to APS; Nursing Home Placement rates:
  - Self-neglect 69.2% (83 of 120)
  - Mistreated elders 52.3% (23 of 44)
  - No contact with APS 31.8%

Lachs MS et al. The Gerontologist 2002
Healthcare costs of self-neglecters

- Mental disorders were diagnosed more frequently in self-neglecters.
- Self-neglecters had lower healthcare utilization and medical costs than controls the year prior to referral for geriatric assessment.
- The year after referral:
  - utilizations and costs were about equal.
  - Self-neglecters received more house calls

Franzini & Dyer, JAGS 2008
How do we best intervene?

- Often refuse services
- No evidence-based research comparing different interventions
- Often present in crisis
Multi-disciplinary and multi-agency approach, con’t

- APS investigator
- Social worker
- Office on Aging (Eastern Nebraska Office on Aging)
- Home health care nurse
- Occupational therapist
- Physical therapist
Multi-disciplinary and multi-agency approach

- Case manager
- Mental health care provider
- Medical health care provider
- Law enforcement
- Judicial system
APS Interventions

- Advocating for the elder
- Develop natural support systems
- Coordinate services
- Help client obtain benefits for which he/she is eligible
- Refer for medical evaluation

“Interventions” from The Medical Management of Elder Abuse: A Practical Approach. Program Director: Carmel Bitondo Dyer, MD
APS Interventions

- One time clean up of house/apartment
- One time payment of rent or utilities
- Provide client with emergency shelter, food, clothing, medication, adaptive equipment, transportation

Nebraska Adult Protective Services
APS Interventions

- Referrals for family violence programs
- Protect client assets
- Alternative placement
- Guardianship, conservatorship
- Legal interventions (less than 1 in 10 cases)

Limitations of APS Interventions

- Immediate danger: Call 911
- Individuals with intact decision-making capacity are “allowed to make bad decisions”
- Case is investigated and usually has to be closed after 6 months unless ongoing concern
The health care provider’s role

- Treat medical illness
- Educate patient (and caregiver)
- Treat psychiatric symptoms that are interfering with elder’s function/safety
- Substance abuse treatment
- Cooperate with other disciplines, social agencies
Considerations when intervening

- Capacity evaluation
- Patient’s culture and previous standards
- Risk assessment
- “Active or passive” neglect?

Guidance for Interventions, con’t

- HCP needs to be aware of one’s own beliefs, values, and attitudes affect intervention decisions
- Risk tolerance
- Protect clients from unnecessary interference

Ethical Issues and Interventions

- Is the plan focused on safety or autonomy?
- Are the elder’s choices being considered?
- Does the intervention cut off the elder from his/her social support system or family?

Mrs. J’s physician wrote a letter outlining the results of Mrs. J’s clinical evaluation which showed evidence of dementia, paranoia, and limited insight with impaired decision-making capacity. Her unintended weight loss and poor nutrition status indicated difficulty with self-care. Her physician recommended that she have a guardian/conservator appointed.
Mrs. J’s daughter was appointed her legal guardian. To coax Mrs. J to leave her apartment peaceably, the APS worker and Mr’s J’s daughter explained that Mrs. J needed to leave her apartment for some time to allow an electrician to repair the nonfunctioning kitchen lights. Mrs. J was admitted to a dementia unit at a local long term care facility.
After Mrs. J arrived at the dementia unit she developed increasing delusions, worsening agitation and oral intake was poor. She was very fearful and resistant to cares. One evening she attempted to lock herself in her room by pushing her dresser against the door. She fell two days later and suffered a hip fracture within one week post-admit to nursing home. She underwent hip fracture repair. Post-op course was complicated by pneumonia. Three months later she required psychiatric hospitalization for severe behavioral disturbance.
Risks of Relocation

- Increased mortality rate
- Change in psychological status
- Increased fall rates
- Friedman SM et al. 1995:
  3 mos after the move, fall rate increased from 0.34 to 0.7 falls per resident per quarter overall

Friedman et al. JAGS 1995 43:1237-1242
Inpatient vs outpatient treatment of self-neglect

- Inpatient hospitalization resulted in worse outcomes compared to those treated as outpatients (MacMillan and Shaw, 1966; Clark et al., 1975; Wrigley and Cooney, 1992)

Poythress et al. Journal of Elder Abuse & Neglect 2006
Pearls

- Gradually develop rapport and encourage to accept services
- Difficult to get adequate cognitive assessments (test scores may underestimate true abilities due to uncooperativeness and poor motivation)
Pearls

- Case manager—can establish ongoing relationship and build patient’s trust

- Multi-faceted problem which is best approached using multi-disciplinary & multi-agency expertise
Pearls

- Problem Resolution Team (representatives from multiple agencies including APS, Health Department, Humane Society, law enforcement)
  - Animal hoarding (provides probable cause to assist in gaining access to self-neglecters)
  - Contact information:
    Kevin Denker, Chief Code Inspector
    (402) 444-5488
    kdenker@ci.omaha.ne.us
Risk Assessment and management of patients who self-neglect: a ‘gray area’ for mental health workers

- Underclass (disadvantaged re: relationships, employment, housing)
- Medical disempowerment
- Threat (danger to others)
- Vulnerability
- Self-harm
- Dependency

Decreasing the “gray areas”

- Develop a clear philosophy of care
- Assessment tools when used in conjunction with clinical assessment
- Know policies, procedures, legislation
- Guidance from interdisciplinary team
- Balance intervention with self-harm and dangerousness

Summary

- Be alert for signs/symptoms of self-neglect

- Multi-disciplinary team approach with common goal to meet the unique needs of the elder while maximizing independence

Web Based Resources


- National Center on Elder Abuse http://www.elderabusecenter.org
References/Bibliography


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