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 $5^1/_2$ or less indicates client is capable of