Guest Editorial

Neglect Assessment in Elderly Persons

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The American Medical Association defines neglect as the failure to provide the goods or services necessary for functioning or to avoid harm (1). Neglect connotes the refusal or failure to provide life necessities such as food, water, clothing, shelter, personal hygiene, medicine, comfort, personal safety, and other essentials (2). Persons who experience neglect are among the most frail and vulnerable of our society. In 1998, Lachs demonstrated that neglect is an independent risk factor for death (3).

Neglect is one form of elder mistreatment that also includes physical abuse, sexual abuse, and exploitation. One can neglect himself (self-neglect) or be neglected by a caregiver. A caregiver may be a family member, a friend, or an employee of the elder or of a nursing or other type of facility, or an entity responsible for providing care (4). A caregiver who maintains the elder in hazardous or unsafe living condition such as a home with improper heating or exposed wiring is neglectful.

Elder neglect can manifest in a number of ways. Deep pressure ulcers in multiple sites may indicate neglect (5). Malnutrition is a conspicuous marker of caregiver neglect, especially in institutional settings; more than 40% loss of body weight can result in death (6). Neglect may be present if inadequate fluids are offered or provided and patients become dehydrated (4). In clinical studies, dementia and or depression are independent risk factors for neglect (7,8). Poor personal hygiene is a marker of neglect (9–12). Individuals may present with dirty clothes, which reek of animal excrement, or multiple insect bites due to mosquitoes, scabies, or fleas, or filthy hair and nails. Oftentimes neglected patients present with advanced disease such as large growths or gangrenous extremities.

Obvious cases of neglect such as multiple deep pressure ulcers do not present clinicians with a diagnostic dilemma. However, among more subtle cases, such as contractures after a stroke, it is harder to distinguish which findings are due to old age versus disease or caregiver neglect. There are no gold standard exams for neglect. Instead the diagnosis is usually made through history obtained from collateral sources, sometimes from the negligent caregiver(s), physical examination, and laboratory testing. The absence of an established repository of forensic markers facilitates the underreporting of neglected elders. To the untrained eye, the neglected elder may simply look like a frail older person who is just quite sick. Since the findings may be masked, and the elder unable or unwilling to report the neglect, screening in health care settings is a must.

In this issue of the Journal (13), Fulmer and colleagues, building on research derived from protective service database analyses and other surveys, take a crucial next step in the study of caregiver neglect. Their project moves the study site from the computer lab into the emergency department, which, in practice, is a particularly important setting for elder mistreatment screening. Their study determined that victims of caregiver neglect presenting to four emergency departments in two cities were predominantly women, old (average age 80 years), frail, and more likely to be neglected by paid caregivers than nonpaid caregivers. Five percent of subjects in New York City and Tampa screened positive for neglect, while an interdisciplinary team of experts found 22% of subjects from this same sample to be neglected.

In this study, the prevalence data in Table 3 is aggregate data that serves to offer up a general description by way of percent prevalences of the 38 factors listed. A review of Table 3 informs readers of the vast array of social, medical, and functional status impairments seen in neglected patients. Thirty of the 38 variables evaluated were statistically significant (p value ≤ .05) (13). Stratification of the aggregate data on demographic factors such as age, race, and sex may yield additional insights. A logistic regression model would yield odds ratios to those factors selected for inclusion in the model characterizing risk factors for elder neglect.

The prevalence data call attention to several issues. It is difficult to compare the prevalence of neglect in sick, frail elders brought to the emergency department to those derived from community samples. However, the fact that the expert assessment team determined a prevalence rate four times that of the trained screeners demonstrates that the diagnosis of neglect is a complicated one that requires the assimilation of a large amount of information not easily captured by a checklist or study instrument. In cases that are reported to the police or come under the scrutiny of the medical examiner or coroner, the presence or absence of neglect should probably be confirmed by an interdisciplinary team with expertise in this area.

Although the prevalence of neglect determined by the assessment team was significant in this sample, one wonders about the true prevalence. The cutoff for enrollment included a Mini-Mental Status Examination (MMSE) score of 18, which was reasonable considering that participants had to sign consent forms. But what about the patients who...
had MMSE scores lower than 18, and who were certainly more frail and dependent? What about the 10% who refused to participate—were some protecting a family member or fearful of retribution by a paid caregiver? Furthermore, this sample included persons who came or were brought to the emergency department in order to receive medical attention. Some might argue that these are the good caregivers. But how many elders never make it to the hospital?

Unfortunately, the authors do not provide the reader with the ethnic or cultural backgrounds of the participants, except to indicate that a portion speak Spanish. Data from prior population-based studies demonstrate that a higher percentage of African Americans and Hispanics are reported to protective services programs (14,15). Some researchers suggest that this is a reporting bias, as these populations may be more reliant or have more faith in governmental agencies. If available, data from this study may shed some light on the issue of culture and neglect.

One note: the authors quote the prevalence of neglect to be as high as 70%, however, the majority of these cases are self-neglect. Self-neglect accounts for up to 56% of all reported neglect cases and ranges from 39% to 72% in published studies (14,16–18). Self-neglect is considered the most pressing problem facing protective service workers today. The authors were quite right, however, to screen for caregiver neglect in the emergency department, as confirmation of many self-neglect cases probably requires an in-home assessment of patient environments.

Fulmer and colleagues are to be commended for this significant contribution to the elder mistreatment literature. Their project is one of the few in this area funded by the National Institutes of Health. Since 1990, fewer than 15 studies on elder mistreatment were funded by the National Institute on Aging (NIA) (19). Approximately $1 million a year has been awarded for elder mistreatment research over the last 6 years. However, according to Dr. Sidney Stahl, chief of the Individual Processes Branch of the Behavioral Social Research Program at NIA, “The problem is that the topic has not gained the attention of researchers who might be able to transfer their expertise to what is . . . a very knotty and difficult conceptual, methodologic . . . problem” [Sidney Stahl, Personal Communication, e-mail received June, 17, 2004].

Medical professionals, along with researchers, have overlooked elder neglect. The data from this study clearly demonstrate that elder neglect is not simply a problem of lack of social support or functional impairment to be addressed solely by protective service agencies; there is a strong medical component as well. Now that this is known, and published, the need for medical professionals to screen for neglect is clear, the need to train all health professionals more urgent, and the need to conduct epidemiologic, medical intervention, and other studies, imperative.

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References
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