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Etiology and Management of Elder Self-Neglect

Mary Zagari K. MacLeod and Kathryn Z. Douthit

This article addresses the challenges of defining and accurately identifying elder self-neglect and explores an interdisciplinary team model, including counselors and mental health professionals, designed to implement prevention and intervention strategies. The challenge of striking a balance between the need to respect the individual elders' autonomy and the need to attend to their health care needs is underscored.

Keywords: elder self-neglect, older adults, interdisciplinary, public health, prevention

Approximately 1 million cases of elder self-neglect (ESN) are reported in the United States each year (Iris, Ridings, & Conrad, 2009). Estimates indicate that 50% of all reported elder abuse and neglect cases are related to ESN (Naik, Burnett, Pickens-Pace, & Dyer, 2008). Surprisingly, self-neglect occurs more frequently in older adults than any other form of abuse or neglect (O'Brien, 2010) and is a public health issue that crosses all demographic and socioeconomic strata of the aging population (Mosqueda & Dong, 2011). With the aging baby boomer population entering retirement and living longer than previous generations (Spira, 2001; U.S. Census Bureau, 2011), dwindling state and federal resources (Koenig, George, & Schneider, 1994), and an increasingly geographically dispersed family structure (O'Brien, 2010), it follows that the number of older Americans unable to meet their personal or functional needs and the incidence of ESN will increase. ESN is thus becoming a public health crisis in need of urgent attention.

One of the greatest challenges is identifying ESN in its earliest stages with the aim of averting potentially disastrous outcomes. This challenge is because of ESN's slow, insidious progression and its consequent failure to capture the attention of mental health professionals, health care workers, adult children, and public health agencies (Bartley, O'Neil, Knight, & O'Brien, 2011). To meet the challenges of the impending crisis of ESN among the aging population, counselors need to be able to identify cases of self-neglect, learn how

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to effectively manage this phenomenon, and, ideally, have the knowledge to implement preventive strategies.

The underlying problems of older adults displaying the symptoms of ESN can often be conceptualized as psychological and include diagnoses related to forms of dementia, depression, and alcoholism. Unlike ESN, these psychological diagnoses are well defined and come with long-established, empirically supported intervention strategies. In contrast, the complex behavior patterns associated with ESN make identification and intervention more challenging. In light of these challenges, this article aims to increase counselors' awareness concerning ESN by addressing the following: (a) current thinking regarding defining and identifying ESN, (b) the etiology of ESN, (c) complexities raised in the absence of a standardized definition, (d) the importance of interventions that use a multidisciplinary health team that includes mental health counselors, and (e) the utility of instituting preventive measures while balancing the complex ethical issues that arise.

DEFINING ESN

A logical first step in understanding ESN is to present its definition and identifying features. Unfortunately, because there is no universal or commonly used definition of ESN, the task of defining and identifying presents a significant challenge. In 1960, when awareness of ESN began to emerge, the United States and Great Britain coined the expressions "social breakdown syndrome" and "senile breakdown" when referring to apparent cases of self-neglect and used the term "diogenes syndrome" (Dyer, Goodwin, Pickens-Pace, Burnett, & Kelly, 2007, p. 1671) for extreme cases where individuals hoard, in addition to living in squalor. More recently, the National Association of Adult Protective Services Administrators (see Duke, 1997) defined self-neglect as the result of an adult's inability, due to physical disability or diminished mental capacity, to perform essential self-care tasks, including those related to nutrition, clothing, shelter, and medical care; to obtain goods and services necessary to maintain physical health, mental health, emotional well-being, and general safety; and/or to manage financial affairs. Duke (1997) noted that it is also common among people who self-neglect to resist contact with others, be disinclined to share personal information, minimize or deny risk of harm in their actions, be reluctant to receive social or in-home services, and refuse to submit to health care evaluations. One of the difficulties in defining self-neglect is that neglect is a concept that varies in relation to context. "Self-neglect highlights the crucial role that community members play, not just in relation to services, but as definers of what is and is not to be tolerated in their neighborhood" (May-Chahal & Antrobus, 2012, p. 1478).

O'Brien, Thibault, Turner, and Laird-Fink (1999) clarified the definition of ESN and underscored five attributes that must be present for an identification of self-neglect to occur. The attributes are the following: (a) Behaviors displayed by

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the individual have the potential to be harmful or life threatening, (b) the individual gives no specific purpose as to the reason for engaging in the behavior, (c) behavior by the individual is not intended to end his or her life immediately, (d) an accumulation of effects of the behavior is realized over time, and (e) behaviors occur in a repetitive pattern that neglect several dimensions of self-care needs. Oftentimes, ESN is identified when there is a shift in one's formally held standards of home and personal hygiene, at which point a red flag is raised to an attentive observer. Although most professionals are inclined to define ESN in reference to the inability to care for one's self because of depleted personal resources, such as family support or transportation, other explanations for the phenomenon have emerged from research. For example, Dyer, Goodwin, et al. (2007) found that some adult protective service workers believe elder abuse and neglect are the result of inadequate structural social supports rather than an inherent person-related problem. Likewise, Choi, Kim, and Asseff (2009) attributed ESN to public policies that fail to address the needs of older adults rather than the shortcomings of the individual and family.

Typically, individuals do not self-neglect when they understand the ultimate consequences of their actions; this type of intentional self-harm is more in line with suicidal ideation or intent. However, everyone self-neglects at one point or another, ranging from acts such as exceeding the speed limit to indulging in tasty yet unhealthy foods or postponing seeing the doctor because of time constraints (O'Brien et al., 1999). Hence, a threshold needs to be exceeded before the label of self-neglect is attached, and a degree of subjectivity is thus introduced into the assessment process. That is, questions are raised regarding how a threshold is defined and by whom and whether the threshold is cross-culturally applicable.

Despite all the definitions and characteristics of ESN that have been discussed, the question still remains as to whether a minimally experienced mental health or health care provider would be able to reliably identify ESN. According to Dyer et al. (2006), because many agencies and interdisciplinary teams have no validated screening procedures for ESN, they must rely on "gut feelings" that lend themselves to discrepancies and subjective assessments.

IDENTIFYING ESN

In addition to the lack of consensus in defining ESN, there is no single reliable tool to identify it (Dyer et al., 2006) or to measure its severity (Poythress, Burnett, Naik, Pickens, & Dyer, 2006). Without a valid and reliable tool to detect and rate the severity of ESN cases, it is challenging to implement preventive measures or to provide effective treatment. Both Naik et al. (2008) and Dyer and Goins (2000) discussed various assessment tools that can be used in combination, such as the Kohlman Evaluation of Living Skills (KELS; Kohlman Thomson, 1993) and the Texas Elder Abuse and Mistreatment Battery (TEAM; Texas Elder Abuse and Mistreatment Institute, n.d.). KELS assesses five areas: self-care, safety and health, money management, transportation/telephone access, and work and

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leisure. TEAM is a comprehensive tool that uses several well-validated tests in combination to assess psychosis, alcoholism, dementia, depression, cognition, executive function, physical performance, psychiatric symptoms, and quality of life. A comprehensive screening tool developed by Dyer et al. (2006), called the Consortium for Research in Elder Self-Neglect of Texas–Self-Neglect Severity Scale (CREST-SSS), identifies the presence and severity of self-neglect by examining the upkeep of one's environment, personal hygiene, and cognition. However, Dyer et al. noted that cross-validation of the CREST-SSS's performance is necessary in future research. Additionally, without having a universal definition of self-neglect, this scale relies largely on subjective observation (Mosqueda et al., 2008). Because of the significance of ESN as a public health issue, a valid and reliable tool is essential, and it is hoped further research will work toward developing this resource. Such a tool would most likely reflect the interdisciplinary nature of ESN and would hence be the work of an interdisciplinary team of clinical researchers.

ETIOLOGY

The root causes of ESN, discussed in detail in this section, have a complex ecology. In general, there are commonly accepted risk factors, such as age; dependency; functional and medical decline; mental health issues, including personality disorders, living alone, isolation, alcohol/drug abuse, poverty, and cognitive impairment resulting in confusion; and other symptoms of dementia (Dyer & Goins, 2000). "Depression and dementia have been shown to be independent predictors of this type of behavior, which carries with it a high risk of mortality and nursing home placement" (Bartley et al., 2011, p. 2163). To explore the etiology of ESN more specifically, we consider four status domains, including social, functional, mental health/cognition, and medical causes.

Social Causes

Within the social domain, there are multiple factors that potentially contribute to ESN, ranging from social isolation to financial hardship. Mauk (2012) cited social isolation as an important criterion for ESN, whereas Iris et al. (2009) asserted that living arrangement is the single most important predictor of ESN. When an older adult is living alone, he or she is at greater risk for limited access to needed support services because of the inability to complete the tasks needed to obtain them. For example, an older woman no longer able to drive and not wanting to ask family members to assist for fear that they are too busy with their own lives consequently fails to fill her necessary prescriptions, go to the grocery store, visit her dentist, or make scheduled doctor visits. Because older adults want to maintain control and autonomy, they may place themselves at higher risk of self-neglect by refusing help when it is offered.

Family involvement or noninvolvement is often a key component of ESN. With society becoming more mobile and dispersed, it is common for family members to live many miles away from each other. Generations ago, it was common for

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extended families to live nearby or even within the same home. The distancing of family puts older adults at greater risk of living alone and with fewer reliable supports. Family breakdown can also precipitate social exclusion, particularly among individuals ages 80 and older (Smeaton, 2011). In some extreme instances, family conflict can contribute to a situation in which an older adult is completely cut off from family attachments, leaving him or her vulnerable to social isolation.

A study in Texas by Choi et al. (2009) explicitly attributes ESN to older adults' and their families' inability to pay for essential goods and services. The study asserted that inadequate public policy coverage for the elderly is a significant cause of ESN. For example, Medicare, a federally funded program, oftentimes does not cover services and supports outside the medical realm. Medicare may cover short-term home care services if there is a skilled need (dressing changes, intravenous intervention, and physical therapy) but will not cover the cost of needed social support services. Frequently, the older adult cannot afford to pay privately for these social supports, such as day programs, as a way to prevent social isolation. Additionally, most older adults depend on their federally funded social security check, which does not adjust to the rising cost of medications. This fact places them at risk for not being able to afford their much-needed medications, even in the case of life-threatening conditions. In these cases, older adults may have to choose between medications, food, and utilities. An example of particular relevance to Texas relates to policies governing prescription coverage. Whereas states like New York do not limit Medicaid prescription coverage, Texas limits prescription coverage to three per month. In light of these policy-related hardships, Choi et al. strongly suggested that health care providers advocate at both the federal and state level to expand older adults' Medicaid coverage for essential goods and services.

Functional Causes

A study by Naik et al. (2008) uncovered evidence of an association between ESN and impairments in activities of daily living (ADLs), although they underscored that their study cannot distinguish whether self-neglect is the cause or effect of functional impairment. It follows that older adults would be at greater risk for self-neglect if they are functionally impaired, especially if they are also living alone. Unfortunately, many older adults cannot afford to pay privately for assistance with ADLs such as bathing, dressing, laundry, and home cleaning as a mechanism to ensure optimum functional status. Individuals who do not have the physical ability to clean themselves or their living environment will eventually become unclean and live in an unkempt environment. In addition, older adults who self-neglect, for example, by compromising their nutrition, may over time become physically debilitated and weak, which may further contribute to their functional impairment.

Mental Health, Cognitive, and Medical Causes

The etiologies of ESN under the mental health/cognition domain, including dementia, psychosis, alcoholism/drug abuse, depression, and decreased executive

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functional abilities, often share a blurred boundary with the medical domain. However, some mental health concerns may rest solely within the mental health/cognitive domain. For example, O'Brien et al. (1999) asserted that a maladaptive personality predisposes individuals to self-neglect in late life. Older adults who have had lifelong eccentricity may have established reclusive lives, making them more prone to ESN in later years. These individuals are likely to be socially isolated and apt to refuse services. More generally, people who exhibit maladaptive personality styles not extreme enough to qualify for a diagnosis of a mental disorder may self-neglect because of their underdeveloped interpersonal skills and discomfort in social settings, both of which can, in turn, lead to unmet needs. Personality characteristics that predispose individuals to ESN include aloofness, shrewdness, suspiciousness, being poorly integrated, lacking stability, seriousness, aggressiveness, and having a tendency to distort reality (O'Brien et al., 1999). Because of these characteristics, afflicted individuals will most likely respond less adaptively to common stressors that are often encountered by older adults, such as the loss of a loved one or retirement. They may mount an active expression of resentment or withdrawal from the community as a way to regain independence and control over their own situation and choices (O'Brien et al., 1999).

ESN is also associated with depression, dementia, alcohol/drug abuse, and psychosis (Dyer et al., 2006). It follows that when an individual's perception of reality is distorted or he or she lacks the cognitive abilities needed to make sound decisions, he or she would be at higher risk of ESN and oftentimes may fail to recognize dangerous situations. Older adults with dementia may forget to shower or take their medications, thus putting themselves at risk of harm. Persons with depression may be put at risk because they are not motivated to cook for themselves or to seek social contacts. Drug and alcohol abuse can lead directly to ESN or can be used to mask depression, a condition that leaves one vulnerable to self-neglect.

Dyer, Goodwin, et al. (2007) suggested that executive dysfunction may be one of the root causes of ESN. They maintained that specific regions of the frontal lobe, a part of the brain associated with executive function, are related to behaviors that impair ADLs (e.g., judgment and insight). Diabetes, stroke, head trauma from a fall, cardiovascular disease, and normal aging processes are a few examples of possible causes contributing to damage in the frontal lobe. Because of the medical issues described, there is a clear need for collaboration between mental health professionals and physicians in providing comprehensive gerontological care.

COUNSELORS, PRIMARY CARE PHYSICIANS, AND THE VALUE OF INTERDISCIPLINARY TEAMS

Typically, older adults seek help from their primary care physicians (PCPs) when attempting to manage either physical or psychological problems. There

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are several reasons that older adults are rarely seen in mental health settings, including the stigma they associate with psychiatric care (Arean, Alvidrez, Barrera, Robinson, & Hicks, 2002) and the fact that many psychological problems in older adults manifest as physical symptoms (Abeles et al., 1998). Because PCPs have more contact than mental health professionals with older adults, they are positioned to play a major role both in the identification of ESN, especially in its early stages, and in linking older adults to needed services.

Unfortunately, despite being in an advantaged position to identify and intervene, PCPs lag behind other professionals in reporting elder abuse and neglect (O'Brien, 2010). PCPs fail to identify at-risk older adults in part because vulnerabilities to self-neglect are often not readily apparent during routine primary care visits (Naik, Kunik, Cassidy, Nair, & Coverdale, 2010). A primary concern is that PCPs lack the knowledge and skill to conduct an appropriate screening and assessment for ESN during the examination of suspected cases of mistreatment and neglect (O'Brien, 2010), and they sometimes feel ill equipped, unable, or even unwilling to provide supportive and therapeutic interventions to older adults (Spira, 2001). In addition, the reality of poor insurance reimbursement rates results in a short amount of time typically being assigned to a single PCP visit. The time constraints thus imposed result in truncated, disease-oriented interviews and examinations that omit important information about the older adult's home situations, relationships, and nonmedical concerns.

To meet the challenges of identification and intervention, medical professionals should be trained in identification of ESN and in recognizing the needs of those who self-neglect. In particular, the ability of PCPs to identify ESN in its very early stages is of great importance because it is common for older adults who self-neglect to eventually cease involvement with their PCP, at which point key opportunities for intervention and prevention are thwarted. At the very least, a PCP needs to routinely assess for quality-of-life issues during patients' medical visits. In addition, PCPs need to be encouraged to ask their patients and family members questions about self-neglect and be alert to the subtle cases of abuse/neglect (Gibbs, 2008).

To address gaps in PCP services related to ESN, some physicians, in what appears to be an emerging trend, rely on the services of mental health and social services professionals (Naik et al., 2010). Thus, in lieu of a PCP taking full responsibility for the many dimensions of ESN-related care, the services of a collaborative, interdisciplinary health care team can be employed, which would include a mental health counselor, legal services, and case management (Kates et al., 2011). Mental health counselors, with proper training in ESN assessment, intervention, and prevention, are well positioned professionally to work with PCPs to identify contributing factors that are related to self-neglect, such as depression, grief, or a decreased sense of worth; provide age-appropriate interventions; and implement effective preventive intervention strategies. Counselors can also work with interdisciplinary teams to evaluate the older adult's capacity

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for making sound decisions regarding his or her own care. Because restricting personal choice imposes on one's autonomy, clear and objective findings are required from assessment tools as well as clinical interviews. It is important to note, however, that only the legal system has the ability to deem someone incompetent; should it be determined that an individual is incompetent, a guardian is appointed to oversee the patient's care needs.

More generally, input from counseling services can help to counterbalance the primary care, medical-model approach to eldercare. The mental health counselor brings a repertoire of assessment, intervention, advocacy, and collaboration skills to the integrative interdisciplinary process. Included among these skills is the ability to assess the client and his or her needed resources from a systemic, contextual vantage point. In addition, collaboration is consistent with the emerging concept of the patient-centered medical home (Kates et al., 2011).

ETHICAL DILEMMAS

How does a counseling professional working in a gerontological setting assess self-neglect while maintaining respect for a client's autonomy, particularly given the fact that Americans so value their independence? If the patient has capacity, does he or she have the right to refuse care and intervention? These are the ethical dilemmas addressed in this section.

Ethical/legal issues associated with ESN are oftentimes difficult to resolve without knowing the contextual strengths and challenges of the individual. Generally, if individuals have the capacity to make decisions for themselves, they are free to make "poor" choices so long as those choices do not place others or self at risk of serious harm. Obviously, if a person lacks decision-making capacity and refuses help from family or other care providers, it may be unsafe for him or her to remain at home alone (Gill, 2009). However, the question remains: At what point is intervention a moral imperative when an older adult who has capacity places himself or herself at risk? The answer is that it depends on answers to pivotal questions, all of which could be within the purview of a mental health counselor who is part of an invested interdisciplinary health care team.

As stated earlier, one of the most important questions to consider is whether the individual, through self-neglect, is creating a life-threatening or seriously injurious risk for himself or herself or for others who live in close proximity. It is also critical to ascertain whether the individual who is self-neglecting has needed social resources should he or she choose to address the areas of neglect. Important related questions that can help to ascertain the adequacy of social resources include the following: Does the individual live alone? Does he or she have relationships with supportive individuals who can intervene? Is the self-neglecting person coping with an abusive child, spouse, or other close relationship in which he or she is being emotionally and/or physically abused? Another key question is whether the individual has the financial capacity to

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attend to needs that are being neglected. It is possible that someone with access to the individual's financial resources is pilfering assets. It is also important to know if the individual is suffering from psychological challenges, such as grief or complicated grief, that is impeding his or her ability to act on areas of need. Psychosocial assessments from mental health professionals can play an integral part in answering these questions and can be used in conjunction with the PCP's assessments in an effort to impose the least restrictive solution. However, most mental health professionals would agree that providing services related to health and safety overrides the right to self-determination. In essence, there is a higher value placed on individual and community welfare than individual autonomy. Additionally, there may be incidences where the ethical obligation to respect an older adult's autonomy conflicts with the ethical principle of "do no harm" (Mauk, 2012).

As mentioned previously, research is needed to develop nuanced, evidence-based screening tools so that helping professionals know when and how to intervene (Dyer, Pickens, & Burnett, 2007). These instruments, which would aim to clarify, contextualize, and rate the severity of the self-neglect, could allow professionals to balance the individual rights of the client with his or her health and safety needs (Dyer, Pickens, & Burnett, 2007; Poythress et al., 2006). Put simply, if counselors had a valid and reliable screening tool to assist in assessing the severity and circumstances surrounding ESN, they could then match the intervention needed to the severity of the client's self-neglect. This would help to minimize the risk of violating self-determination when it is unnecessary to do so. In addition, because of the complexity of ESN, social, legal, medical, psychiatric, and community services could then be mobilized, integrated, and tailored to individual need, thus providing older adults with comprehensive care, including prevention, while at the same time balancing their safety with their autonomy.

IDENTIFIED INTERVENTIONS

How do we, as counselors, provide interventions for at-risk older adults who are within their rights to refuse treatment and are found to have capacity? According to O'Brien et al. (1999), it is sometimes advantageous to approach self-neglecting individuals by "playing to their sense of isolation, their sense of their history, who they are, who they were when they were younger and who they are now" (p. 14). Research supports the use of interpersonal therapy, problem-solving therapy, and reminiscence therapy as effective, evidence-based practices in geriatric mental health (Bartels, Haley, & Dums, 2002), and these intervention strategies may be adapted to use in ESN. Best practice when working with ESN involves building a therapeutic relationship, supporting a person-centered approach, and listening to clients' perspectives of their current circumstances (Day & Leahy-Warren, 2008). There is also value in allowing older

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adults the opportunity to relay their life stories to support their "ego integrity" (Fraser, 2006, p. 33) or belief that their lives have meaning and purpose. In other words, active listening should take precedence over logical persuasion as a way to entice older adults who refuse any interventions or treatments to begin accepting them.

Given the complex array of needs of older adults who self-neglect, an interdisciplinary, multidimensional intervention is needed to address this problem in a comprehensive way. In addition, knowing the specific etiology of ESN for a particular individual can assist counselors in selecting the most effective interventions. In a study by Iris et al. (2009), which underscored a central principle in comprehensive ESN intervention strategies, an informal group of professionals from various disciplines was selected to brainstorm ideas related to the formulation of a conceptual model to understand ESN. Included in this team were senior service program supervisors, geriatricians, social workers, local policy analysts, program planners, elder law practitioners, university-based researchers, public health representatives, elder rights representatives, an ombudsman, and a representative from the local Department on Aging. This comprehensive team identified key points in shaping a conceptual model of ESN, which underscored the importance of examining personal, environmental, and social risk factors, as well as self-care barriers. Furthermore, Iris et al. proposed that it is necessary to "develop a protocol for collaboration with community-based service providers who can not only conduct mental health assessments but also are able to speak to the need for more multidisciplinary self-neglect assessment teams" (p. 11). Unfortunately, "older adults constitute a population that has been grossly underserved in counseling services" (Myers & Harper, 2004, p. 1), which may point to a key explanation for the alarming ESN prevalence. PCPs could "provide initial education about mental health services in their office or clinic and then persuade (at risk) patients to utilize them" (p. 5).

For those older adults who do not have a PCP, a holistic assessment and intervention could be conducted in an outpatient geriatric clinic. Dyer and Goins (2000) and Dyer, Pickens, and Burnett (2007) suggested that house calls should be used as a way to reach older adults who are immobile or isolated. In any case, it takes multiple collaborators, such as physicians, attorneys, nurses, physical therapists, and mental health providers, to provide comprehensive service delivery that meets the physical, medical, legal, cognitive, and socioeconomic challenges that affect older adults and lead to ESN. It also requires a coordinated effort to balance the duty to protect and the duty to respect civil liberties (Mosqueda & Dong, 2011).

PREVENTIVE MEASURES

Evidence suggests that the "best practice approach requires an early identification component of ESN as well as a preventive component" (Day & Leahy-Warren,

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2008, p. 28).However, the ideal goal of prevention will be difficult to achieve given the complex nature of ESN. As is true for intervention, the prevention of ESN will require comprehensive as well as integrative approaches involving mental health, social services, and governmental organizations (Naik et al., 2008). O'Brien et al. (1999) proposed developing *at-risk registers* to be used by various professions as a way to identify potential self-neglecters at an earlier stage in ESN development. For example, if a PCP knows that an older male adult has just lost his much relied-upon spouse, his children live out of state, and he is now living alone managing a chronic illness such as diabetes, the PCP may want to place this man in an at-risk register. An effective solution would be to refer this at-risk individual to an on-site geriatric assessment team or a mental health provider for a psychosocial evaluation of his functioning and coping abilities. This collaborative approach would not only allow for better medical and mental health care, but also has been found to reduce overall medical expenditures (Bartels et al., 2002). In addition, it is likely that the stigma associated with seeing a mental health provider may be lessened if care is provided within the context of medical care from one's PCP or a geriatric outpatient clinic.

Other important steps leading to prevention include providing ESN education to the general public and creating outreach services for older adults. In an effort to achieve early identification of older adults at risk for ESN, a centralized, publicly supported, "pre"–adult protective service could be developed. This idea expands on O'Brien et al.'s (1999) notion of an at-risk register, but rather than emphasizing the individual practitioner's record keeping, it extends the database to include a regional registry of adults in need of close attention. With the goal of minimizing the need for adult protective service by offering preventive services to older adults at risk of ESN, a geriatric task team could be assigned to assess these pre–adult protective referrals.

As a complement to this preventive measure, publicly subsidized services could be established to assist out-of-area families in helping their older family members to avoid becoming at risk of self-neglect. Currently, there are a few privately funded services of this nature available, but for many older adults and their families, the cost of these services is prohibitive. Financial case management, companion services, transportation, simple ADL assistance, basic home repairs, setting up electronic devices, and completing health care proxy/power of attorney forms are a few possible services that could be provided, in addition to having a geriatric team available for consultation as needed.

CONCLUSION

It is clear that multidimensional and holistic approaches are necessary to improve the quality of life of older adults and to decrease or prevent serious public health problems such as ESN. One important step toward implementing a multidimensional approach is to include counseling services as a treatment option within the

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medical primary care setting. Educating PCPs regarding the necessity of these services would be an essential step toward implementing change and would represent a significant effort toward closing the gap between research and service delivery.

At the most fundamental level, there needs to be a universal definition of ESN. Research is needed to devise a valid, reliable, and standardized clinical diagnostic tool to detect ESN, as well as identify when and how to intervene once ESN has been detected. It is hoped that reliable identification of self-neglect as a syndrome would allow for early identification and pave the way for third-party reimbursement (O'Brien, 2010). It is also hoped that changes in reimbursement structure would provide the resources needed to elucidate ESN etiology, in that uncovering the root cause of an individual's ESN is essential in ensuring that treatment options thereafter are appropriate and effective.

Medical care has become so specialized that caring for an individual entails multiple office visits to various locations. A return to comprehensive care delivered in a central location may be necessary to ensure there is continuity of care for older adults who are overwhelmed by the complexities of the current health and mental health care systems. An interdisciplinary style of practice, with the incorporation of other providers such as nurses, nurse practitioners, home health nurses, counselors, and case managers, provides an ideal arrangement for efficient management of neglect cases but requires a total overhaul of the reimbursement system. As O'Brien (2010) suggested, "Perhaps a new model of care, the patient-centered medical home, has the greatest potential for a more accessible, and interdisciplinary approach" (p. 103).

Public policy changes are necessary to ensure that older adults have adequate funding for needed services. Ultimately, the financial advantage of funding preventive services would far outweigh the cost of intervention related to more severe forms of ESN. In the interest of creating a social fabric woven with compassion and care for the most vulnerable, having necessary services in place (prevention as well as intervention) to ensure that older adults have much-needed safety nets ready must be a public imperative.

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