

delirium might be an exceptionally good marker for comorbid diseases. In fact, in the bivariate analysis only the CIRS-G was associated with mortality. Previous studies have shown that there is evidence for a disease spectrum between delirium and SSD, but our study fails to show this spectrum. Our population study is considerably older and shows a higher prevalence of functional and cognitive impairment, so the life expectancy is lower with high competing mortality risks that make it difficult to find significant associations for some health outcomes. In fact, our patients are probably the oldest population in SSD studies. If we had used a stricter definition of SSD, such as fulfilling at least two CAM items instead of just one, perhaps we could have shown a theoretical gradient in outcomes along the delirium spectrum according to our complex patients with a high prevalence of cognitive impairment.

Although some researchers do not support the hypothesis of a spectrum of disease (no-delirium, SSD, delirium), we think that it is important to investigate about the validity of the SSD criteria. This approach could help get early diagnoses and improve patient management. We believe that it is essential to make progress in the investigation of SSD diagnostic criteria. Probably these criteria should be different in patients with a high degree of cognitive impairment. Future studies should include older patients as well as different degrees of cognitive impairment.

Conflict of interest

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Self-neglect: a survey of old age psychiatrists in Ireland

Self-neglect in old age is complex, challenging, and likely to increase in the future. Self-neglect is characterized as the behavior of an elderly person that threatens his or her own safety. Self-neglect is the most common form of abuse and neglect reported to Adult Protective Services in the United States (see Teaster, 2000). Self-neglect is also associated with a significantly increased mortality in victims (Dong *et al.*, 2009). Self-neglect has become a significant public health problem affecting not just the victims but also family members, friends, and frequently the

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community at large. Characteristics of self-neglect include a failure to provide oneself with adequate food, water, clothing, shelter, or a safe environment and neglect of personal hygiene and medical treatment (O'Brien, 2011).

It is likely that self-neglecting individuals have significant contact with the medical community and frequently require an evaluation and assistance by old age psychiatrists. On this basis, it was decided to survey old age psychiatrists in Ireland. To our knowledge, this is the first time this group has ever been surveyed regarding the subject of self-neglect in old age.

To accomplish this, a survey was prepared as a collaborative effort among academic old age psychiatrists and geriatricians. Approval for the study was

granted by the Ethics Committee of Adelaide and Meath Hospital, Dublin.

The questionnaire was developed on the basis of previous surveys of general practitioners and geriatricians and adapted to reflect the particular practice patterns of old age psychiatrists, including specific roles in diagnosis, capacity determination, and management. All 22 old age psychiatrists in Ireland were surveyed utilizing a 33-item questionnaire via Survey Monkey.

Fifteen psychiatrists participated in the survey completing at least one non-demographic item representing a 68% response rate. Females comprised 69% of the sample who responded to the demographics, while only one respondent was older than 50 years. Eighty-five percent had been in practice for over ten years and over three-quarters had an urban or suburban practice.

Ninety-two percent (12 out of 13) of the respondents had seen a case of self-neglect in the previous year, with over 23% (3 out of 13) seeing between 6 and 10 patients in the year. More than half (59%; 7 out of 12) felt that the outcome for the patient was unsatisfactory, and almost three-quarters (72%) deemed the outcome to be unsatisfactory for themselves as physicians. Personal characteristics, namely loss of self-care and poor hygiene, were the most common characteristics of self-neglect encountered in all cases. Non-compliance with medications and hoarding or clutter in the home were the next most common characteristics, at 93% (12/13) for both. Vermin infestation was the least common of all the characteristics reported, although still worryingly high at 64%.

Of the four features of self-neglect (personal, environmental, social, and refusal of services), personal neglect was the most common and social withdrawal was the least common features. The top three contributing causes to self-neglect were dementia, lifelong personality disorder, and alcoholism.

Approximately one-quarter (three out of 13) of old age psychiatrists listed alcohol and drugs as contributing to self-neglect “very often.” Poverty was identified as making “some contribution” by 78% and a “large contribution” by 13%. By far the primary referral source for these patients to old age psychiatrists was the public health nurse, a valuable resource in the community, typically providing services in the home, followed by the general practitioner and home help services.

Old age psychiatrists have significant exposure and have a key role to play in the management of older self-neglecting adults. The vast majority surveyed had encountered patients in the previ-

ous year. Most felt they possessed sufficient technical skills (92%) and ethical knowledge (85%) to deal with self-neglect patients. Interestingly, there was no consensus with regard to gender vulnerability.

Contributing causes include dementia, lifelong personality disorder, alcoholism, schizophrenia, depression, and physical frailty. This is consistent with other authors (Dyer *et al.*, 2007). The typical presentation, loss of self-care and poor hygiene, was identified as common to all. In addition, most (69%) felt that noncompliance with medication should be included.

From most frequent to least frequent, typical sources of referrals were public health nurses, general practitioners, and home health services. Refusal of services was identified by 90% as common or very common.

Irish and Scottish geriatricians when questioned about self-neglect (Bartley *et al.*, 2011), 70% described the outcome for the victim as satisfactory whereas 93% in this study felt the outcome was unsatisfactory and 72% felt the outcome for themselves was unsatisfactory. Old age psychiatrists estimated that at least one in five patients of self-neglect had an element of elder abuse.

When asked to compare the problem of self-neglect with other clinical issues, 77% felt that self-neglect was more frustrating to deal with, highlighting the challenges in dealing with self-neglect. Finally, when asked to identify specific roles for old age psychiatrists, 100% felt their role should be limited to psychiatric management with 82% feeling social services should provide follow-up care.

Old age psychiatrists have significant involvement with self-neglect in old age and play a key role in managing these challenging patients, but need to be part of a broader interdisciplinary coordinated team to effectively deal with this problem.

Conflict of interest

None.

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