research in practice

Practice Tool

Working with people who self-neglect

Dartington Trust

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Contents

Introduction

This resource aims to support adult social care practice with people who self-neglect through lack of self-care (for example, neglect of personal hygiene, nutrition, hydration and/or health) and/or lack of care of the domestic environment (for example, squalor or hoarding) where risks to health or wellbeing are extreme and there is reluctance to take action to mitigate those risks.

The term 'self-neglect' is commonly used by practitioners to describe widely differing behaviour or lifestyle. Statutory guidance (Department of Health and Social Care (DHSC), 2020) defines it as 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'. There is inevitably a subjective element to using the term and the person concerned may not use it to describe their own situation.

The resource includes:

- an overview of research findings on self-neglect
- guidance on understanding and engaging with the experience of self-neglect
- guidance on practice approaches that can support positive outcomes
- an overview of the legal framework for self-neglect practice
- an outline of the key organisational features that support self-neglect practice
- a practice model illustrating the key decisions to be taken by practitioners
- signposting to research findings and further resources.

This resource draws on two strands of evidence. The first is research conducted by the authors for the Department of Health & Social Care: an evidence scope (Braye et al, 2011) and an investigation of policy and practice approaches that have produced positive outcomes in self-neglect work (Braye et al, 2014). A study of workforce development needs (Braye et al, 2013) provided further insights into the challenges of practice.

The second strand of evidence is the rich seam of learning from Safeguarding Adult Reviews (Braye et al., 2015a; 2015b; Preston-Shoot (2016; 2017; 2018). The two strands come together in an evidence-base for positive practice in self-neglect (Preston-Shoot, 2019; 2020).

Until 2014, self-neglect in England was located outside adult safeguarding systems and procedures. Statutory guidance (Department of Health (DH), 2000) described 'vulnerable adults' as those at risk of abuse and neglect from others. Thus, many Safeguarding Adults Boards (SABs) excluded self-neglect from their remit. Although some areas found ways of involving agencies in shared risk management, there was a danger elsewhere that, instead of being everybody's business, self-neglect was nobody's, or somebody else's, business (Braye et al., 2014).

Implementation of the *Care Act 2014* changed this. The Act gives a broad definition of adults in need of care and support and clearly articulates duties towards them. SABs have a statutory objective to help and protect adults with care and support needs who are experiencing, or at risk of, abuse and neglect and are unable (as a result of those needs) to protect themselves. The statutory guidance to the Act (DHSC, 2020) includes self-neglect within the list of circumstances that constitute abuse and neglect, thus locating it firmly within SABs' remit.

The tools that follow in this resource focus on different aspects of good practice:

- understanding self-neglect
- building a relationship
- planning and implementing intervention
- using the legal framework for care, support and protection
- creating a supportive organisational context.

They should be used in conjunction with each other, as effective outcomes will require some element of each of these.

Key research messages about good practice in self-neglect

Self-neglect is challenging for practitioners due to:

- its varied presentation, influenced by a complex mix of personal, mental, physical, social and environmental factors
- the high risks it poses, both to the individual and sometimes to others
- the possibility that adult social care intervention is not welcomed by the individual, making engagement difficult
- the challenges of assessing mental capacity
- ethical dilemmas between respecting autonomy and fulfilling a duty of care
- workflow systems that prioritise short-term, task-focused involvement rather than long-term relationships with people
- the need for coordinated interventions from a range of agencies.

Practice with people who self-neglect is more effective where practitioners:

- build rapport and trust - showing respect, empathy, persistence and continuity
- seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- work patiently at the pace of the individual, but know when to make the most of moments of motivation to secure changes
- complete thorough assessments of care and support needs.
- constantly keep in view the question of the individual's mental capacity to make self-care decisions
- take full account of their mental health
- undertake comprehensive risk assessment
- communicate about options with honesty and openness, particularly where action that is not of the person's choosing may be imposed
- ensure options for intervention are rooted in sound understanding of legal powers and duties
- think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- work proactively to engage and coordinate agencies with specialist expertise to contribute towards shared goals.

Effective practice is best supported when:

- strategic responsibility for self-neglect is clearly located within a shared inter-agency governance arrangement such as the Safeguarding Adults Board
- agencies share definitions and understandings of self-neglect
- inter-agency coordination and shared risk-management is facilitated by clear referral routes, communication, information-sharing and use of shared decision-making systems such as multi-agency risk management meetings
- longer-term supportive, relationship-based, involvement is accepted as a pattern of work
- training and supervision challenge and support practitioners to engage with the ethical challenges, legal options and skills involved in self-neglect practice.

(Braye et al., 2011; Braye et al., 2014)

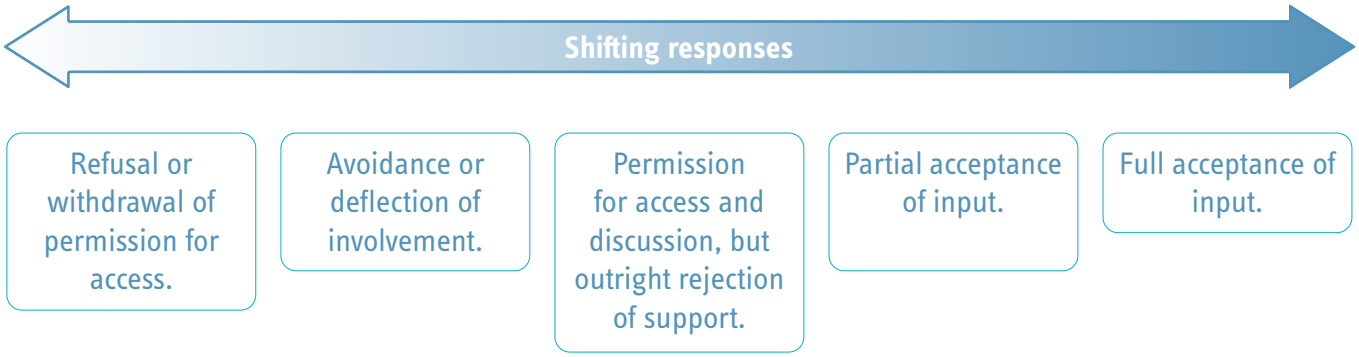
Tool 1 - Understanding and engaging with people who self-neglect

Aims and content of this practice tool

The aim of this tool is to help practitioners think about how to initially engage with people who self-neglect and what they might need to find out in order to understand their situation. It briefly summarises the contributory factors that can lie behind self-neglect and presents what people in situations of self-neglect have said about their lived experience. It advises on some approaches that have proved useful to practitioners in engaging with people who self-neglect. Finally, it provides a case study with reflective questions, designed to assist in thinking through the relevant issues.

Starting to work with people who self-neglect

Individuals may respond in various ways when practitioners try to engage with them about self-neglect. They may or may not agree that there is a problem with which social care input might help, and they may or may not feel that it amounts to self-neglect. Sometimes they may respond unpredictably, shifting between different responses at different times:



The shifting responses to the practitioner may reflect the individual's own internal ambivalence about modifying behaviours and the practitioner needs to be aware that the shifting responses to them, or to what they are offering, might simply be the individual externalising an inner conflict.

It is therefore very important to try to understand what lies behind the person's response and why it might not be settled and consistent. The best outcomes in self-neglect result from working closely with the person to understand what it means to them. Working to build a relationship with the person from the outset is a key element in this. It is essential to try to 'find the person' by learning as much as possible about their life history and social, economic, psychological and physical situation. The *Care and Support Statutory Guidance* (DHSC, 2020) makes clear that working in a person-centred and outcomes-focused way is at the heart of 'Making Safeguarding Personal,' a key goal of the statutory framework.

Tool 1 - Understanding and engaging with people who self-neglect

What causes self-neglect?

Just as self-neglect can take many different forms, there may be many different contributory factors. Sometimes a disturbance in physical or mental health prevents the person from managing their self-care effectively. This may affect their ability to wash, tidy or perform other everyday tasks. It may also, or instead, affect their ability to recognise when such tasks need carrying out or to act on this recognition.

The literature shows diverse influences on the journey into self-neglect (Braye et al., 2011; Braye et al., 2014). At times, very low mood, diagnosed depression, or feeling that they do not deserve any better, can discourage the person from taking steps to change their situation. Conversely, health issues may not be implicated at all. Many people who self-neglect are very proud of their ability to cope independently and may be reluctant to accept help as a result.

Self-neglect may reflect views on cleanliness, hygiene or order that do not conform to general social norms. It may have come about in response to past losses, abuse or trauma. At times, it may be a coping mechanism that serves a useful purpose in enabling the person to deal with challenges or difficulties in life. Equally, it may reflect the impact of poor nutrition and hydration, affecting the ability to manage self-care. People may also reach the tipping point into self-neglect when they lose family assistance, social support or financial means that have previously helped them to cope.

It is impossible to generalise universally about the causes of something as varied as self-neglect. Practitioners should therefore be alert to the possibility of any of these factors, while recognising that any or all of them may not be relevant to the person they are working with.

What people who self-neglect have said:

- I'm demotivated because of what else is going on in my life.
- Other things, or people, are more important than my self-care.
- I guess I have different standards to other people, but I'm happy living like this.
- I'm managing with some things but have had to let other things go.
- It's not something I have any control over. My physical and/or mental health makes self-care impossible for me.
- I don't really know.
- My self-neglect is because of things in my past:
  - that have affected me in ways that have led to self-neglect; or
  - self-neglect [hoarding, or living in poor environmental conditions] helps me keep part of my past.

People often do not accept they are experiencing 'self-neglect' but may still talk about their situation in ways such as those shown on the next page.

"I wouldn't say I'm losing the will to live, that's a bit strong but ... I don't care, I just don't care."

"Well I don't know, to be honest. Suddenly one day you think, 'What am I doing here?'"

"My possessions are my family ... I'm very fearful of throwing something away."

"I put everyone else first – and that's how the self-neglect started."

"I got it in my head that I'm unimportant, so it doesn't matter what I look like or what I smell like."

"I've noticed over the years that I didn't give two monkeys ... I seemed to have plenty of time to do everything but I don't seem to have the time now."

"I can't physically bend down and pick things up."

Understanding the individual's experience of self-neglect

There are some key areas for inquiry that will help in understanding the factors at work in any individual situation.

What the practitioner needs to inquire into:

- What is the person's own view of the self-neglect?
- Is the self-neglect important to the person in some way?
- Is the self-neglect intentional, or an unintended consequence of something else?
- Is the self-neglect a recent change or a long-standing pattern? Does the person have mental capacity in relation to specific decisions about self-care and/or acceptance of care and support?
- What strengths does the person have – what is he or she managing well and how might this be built on? What motivation for change does the person have?
- Have there been recent changes of experience, attitude or behaviour that might provide a window of opportunity for change?
- Are there links between the self-neglect and health or disability?
- Is alcohol consumption or substance misuse related to the self-neglect?
- How might the person's life history, family or social relations be interconnected with the self-neglect?
- Does the self-neglect play an important role as a coping mechanism? If so, is there anything else in the person's life that might play this role instead?

Tool 1 - Understanding and engaging with people who self-neglect

What practitioners have found useful in engaging with people who self-neglect

Practitioners may need to take time to build up trust, through persistence, patience and continuity of involvement. The following approaches have sometimes been found useful:

The approach	Examples of what this might mean in practice
Building rapport	Taking the time to get to know the person; refusing to be shocked.
Moving from rapport to relationship	Be considered and thoughtful in reactions to self-neglect; talking through with the person their interests, history and stories.
Finding the right tone	Being honest while also being non-judgemental; expressing concern about self-neglect, while separating the person from the behaviour.
Going at the individual's pace	Moving slowly and not forcing things; showing concern and interest through continued involvement over time.
Agreeing a plan	Making clear what is going to happen; planning might start as agreeing a weekly visit and develop from there.
Finding something that motivates the individual	Linking to the person's interests (for example, linking to recycling initiatives if they are hoarding because they hate waste).
Starting with practicalities	Providing small practical help at the outset may help build trust.
Negotiating reciprocal actions	Linking practical help to another element of agreement (for example, "I'll bring round a replacement for your heater, then shall we then go to see the doctor?").
Focusing on what can be agreed	Finding something to be the basis of initial agreement, that can be built on later.
Keeping company	Being available and spending time to build up trust.
Straight talking	Being honest about potential consequences.
Finding the right person	Working with someone who is well placed to get engagement - another professional or a member of the person's network.
External levers	Recognising and working with the possibility of enforcement action.

Case study

Michael, an Irish man in his 70s, has been referred to adult social care for assessment of his care and support needs following a small fire at his flat. When the fire service responded they found filthy and squalid conditions in the flat, which was full of hoarded items, papers, furniture, soiled clothing and rotten food. The heating and lights were not working, but the gas cooker that Michael used to cook meals was and posed a fire hazard as did the candles that he used to provide light. The Fire Service say he responded well to them, agreeing to the installation of a smoke detector and to this referral being made.

At the time of the fire, an ambulance crew had treated Michael for smoke inhalation and burns. It had become apparent that he was also diabetic but had discontinued medication. He had refused to go to hospital but did agree to referral for GP and community nursing support, although the surgery's attempts to contact him have been unsuccessful.

The social care records reveal that this is not the first time concerns have arisen about Michael's living conditions. In the past he has received both community-based and in-patient mental health services. When admitted, his hygiene and physical state have been very poor, and periodic deep-cleans of his property have been carried out. On discharge, practitioners have attempted to support him to maintain a habitable living environment but he has not willingly engaged with their efforts and contact has always ended with him refusing support. An enforced clearance and cleaning of his flat by Environmental Health took place three years ago following concerns about infestation.

When the adult social care practitioner arrives at the flat, it appears at first as though no-one is home. Michael eventually comes to the door but does not open it. Through the letterbox, he calls out that he is not going to open the door, doesn't want to talk to anyone, is managing fine and just wants to be left alone.

Reflective questions

The task here is not to work out an intervention plan for Michael. It is to use the first encounter to establish a supportive rapport with him, sufficient to enable a further conversation to take place and a relationship of trust to be built. It will help to consider the following questions:

- There are many factors that could be behind Michael's refusal to engage with adult social care. What might they be?
- How might he be feeling? How could the practitioner show him they understand?
- There are also many factors behind the conditions in his flat. From knowledge about the contributory factors to self-neglect, what might these be?
- How could what might be known about Michael's racial identity and ethnicity be taken account of by the practitioner? How might cultural competence influence the approach taken?
- What approaches might the practitioner take to gaining Michael's confidence, so that they are able to establish a rapport that would enable them to work with him?

Cultural competence

Cultural competence is an essential aspect of the search for meaning in an individual's self-neglectful behaviour. One SAR that illustrates this is the story of Mr B, an Irish man who had lived in England for some years. He had a history of mental health difficulties and was living in unclean and unhygienic housing conditions, without heating or hot water, neglectful of his health, personal hygiene, clothing and diet. In all weathers he would walk the area, travelling miles on foot and spending much of his day on a bench outside a local supermarket, foraging for food from bins or receiving food donations. It was here that he died.

It is likely that Mr B's cultural heritage played an important role in shaping both his behaviour and his response to attempts to help him. As part of the SAR, an agency working to support people of Irish origin in accessing culturally sensitive services advised that Mr B may not have regarded 'keeping house' as his responsibility and that long rambles may have been part of his cultural background and identity. But awareness of his background was not evident in how agencies viewed or understood his situation, or in how they tried to work with him. Greater cultural competence could have been significant in shaping effective strategies for engaging and supporting him. The SAR recommends that staff in statutory agencies should have a means of accessing advice from culture-specific organisations in order to improve their cultural competence in direct work with individuals.

The full report can be accessed here:
https://leedssafeguardingadults.org.uk/Documents/Board/Final%20SAR%20Report%20Mr%20B.pdf

Further detail on cultural competence can be found in Research in Practice resource here:
https://practice-supervisors.rip.org.uk/wp-content/uploads/2019/11/Developing-cultural-competence.pdf

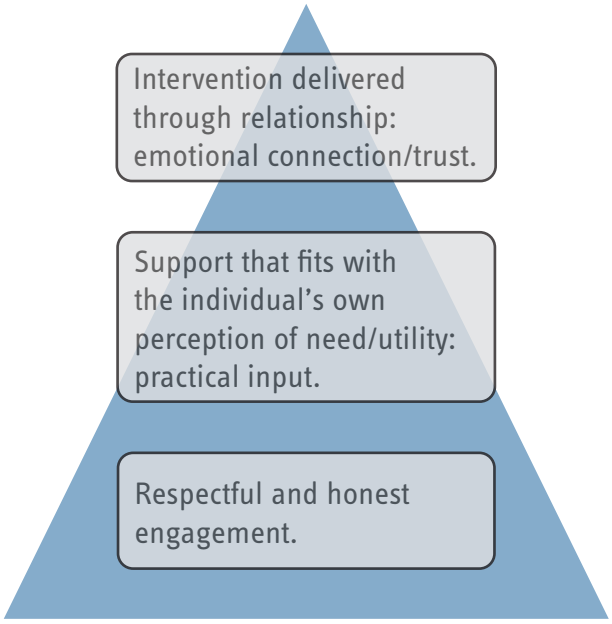
Tool 2 - Planning and implementing interventions

The aim of this tool is to help practitioners think about interventions that may be useful in working towards positive outcomes with people who self-neglect, including in situations where the measures may need to be imposed. It lists a number of interventions that have been found to be useful and shows how these call for a combination of **'Knowing, Being and Doing'**.

What approaches have been useful in self-neglect interventions?

Self-neglect is very diverse, so no one set of interventions is consistently useful. However, one consistent message that emerges from the research evidence is that a relationship of trust is essential to the successful negotiation of measures to reduce risk and improve wellbeing. Practical help is valuable too, acting both as a symbol of support and as a risk-reduction measure.

Perspectives on intervention



"She got it into my head that I am important, that I am on this earth for a reason."

"He has been human, that's the word I can use; he has been human."

"Tenancy support ... weren't helping ... just leaving it for me to do. Whereas when x came, they were sort of hands on: '*Bumph! We've got to do this' ... shall we start cleaning up now?*'"

"With me if you're too bossy, I will put my feet down and go like a stubborn mule; I will just sit and just fester."

Shown on the next page are approaches that practitioners have found useful, some of which may be appropriate to integrate within practice, depending upon the circumstances of a person's self-neglect and the factors that contribute to it.

Thinking about someone who self-neglects, the invitation in this exercise is to consider each of the interventions and, for those that may be appropriate, identify the pros and cons of adopting such an approach with that person.

Interventions	Likely benefits	Likely drawbacks
> **Monitoring** - periodic visits to build and maintain contact and relationship, monitoring capacity and risk.		
> **Fire risk minimisation** - provision of equipment and advice.		
> **Adaptations and repairs** - reduction of risk through changes to enhance safety.		
> **Provision of equipment and/or furniture** - may improve food hygiene, fire risk, cleanliness as well as build relationship.		
> **Attention to health concerns** - input to address aspects of health experienced by the individual as problematic.		
> **Family/neighbours/community involvement** – recognising the value of people or organisations in the individual's network who may be able to make a contribution.		
> **Safe drinking schemes** - social care staff involvement in limiting alcohol intake.		
> **Emergency respite** - a chance to test an alternative environment and/or to improve home conditions.		
> **Hospital admission** - to address acute health concerns.		

Interventions	Likely benefits	Likely drawbacks
> **Change of living environment** - a new start, minimised risks, care and support.		
> **Deep cleaning -** key areas of the domestic environment made safe.		
> **De-cluttering** - selected items removed with agreement.		
> **Life management** - skills in setting priorities, attending to finance, cleaning, food.		
> **Care packages** - small beginnings that can lead to greater trust and acceptance.		
> **Therapeutic activity** - activities that can replace what is given up through giving up hoarded materials or making lifestyle changes.		
> **Mental health services** – counselling and therapies addressing deeper-rooted issues' contribution to self-neglect.		
> **Using family members and social connections** - engaging trusted people to support motivation and task completion.		
> **Peer support** - enabling links to be made between people addressing similar challenges.		

Tool 2 - Planning and implementing interventions

Multi-agency working

When people self-neglect there are almost always many dimensions involved, requiring the involvement and collaboration of different agencies and practitioners. Safeguarding Adult Reviews have frequently identified failings in multi-agency coordination as contributing to negative outcomes in self-neglect, so it is important to ensure the necessary elements for effective collaboration are in place.

This table presents a checklist of inter-agency issues that can commonly arise in self-neglect work. The invitation in this exercise is to consider these in relation to the approach being taken in a current situation.

Possible difficulty	Yes / No	If no, what can be done about this?
Is there involvement from all agencies, groups and networks who could make a contribution to the individual's wellbeing?	Yes	
Have any barriers that service boundaries present to securing useful input been discussed and addressed?	Yes	
Have any differing organisational priorities or thresholds that present a barrier to working effectively been identified and addressed?	Yes	
Is everyone involved clear on their own roles and relationships, and those of others?	Yes	
Is there shared understanding of goals and priorities between the different practitioners involved?	Yes	
Is there a lead professional coordinating the efforts of all those involved?	Yes	
Is appropriate communication and information-sharing happening effectively?	Yes	

One key challenge is to ensure that agencies reach a shared understanding of whether thresholds for collective concern and action are reached. While there are no objective measures of self-neglect, the use of resources such as clutter-rating images can be helpful in determining the scale and level of self-neglect, and shared risk assessment tools are helpful in evaluating levels of risk.

Remedies to non-cooperation in the multi-agency context include explicit reference to the duties of cooperation (sections 6 and 7 of the *Care Act 2014*) and escalation of concerns through operational management routes. Many Safeguarding Adults Boards have escalation policies that can be used to resolve inter-agency disputes in the safeguarding context.

The feasibility and effectiveness of interventions will be heavily influenced by the single and multi-agency context in which practitioners operate. Approaches may be affected by organisational constraints, such as those on time and funding, and by the nature of inter-agency relationships and cooperation.

The features of organisations that support and facilitate good practice in self-neglect are set out in Tool 4. Research (Braye et al., 2014) and SAR analysis (Preston-Shoot, 2019) highlight the importance of staff training, supervision and management oversight and support, and workloads that allow space for reflection and relationship-based practice. Equally important are the availability of procedural guidance and legal advice, and close working relationships between commissioners and service providers.

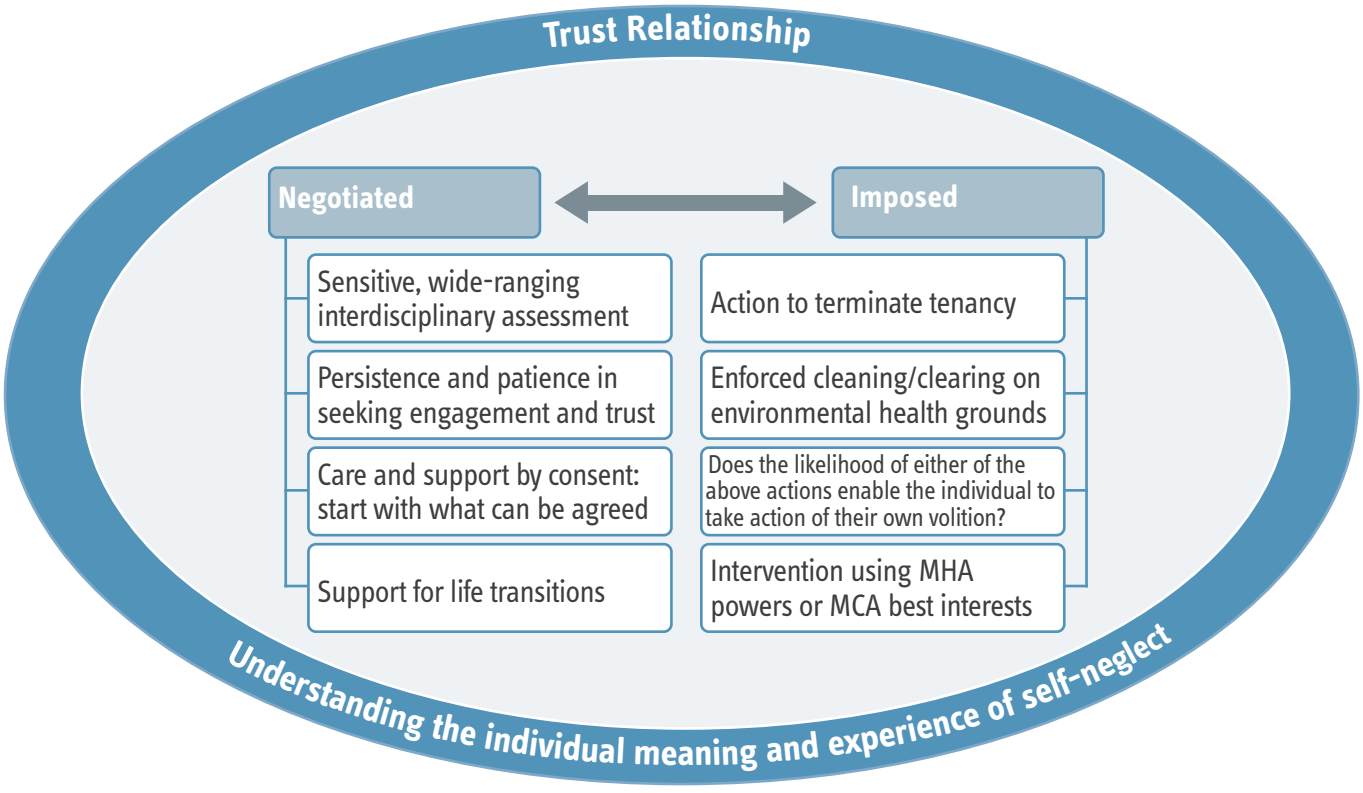
Negotiated and imposed approaches to self-neglect

While it is preferable to work with the consent of the person whenever possible, there are legal duties to consider too, such as those under the *Care Act 2014*, the *Mental Health Act 1983* and the *Mental Capacity Act 2005*, all of which provide for health and social care intervention without the individual's consent in certain circumstances. Equally, the risks involved can lead to proposals for enforcement action under housing, environmental health or anti-social behaviour legislation, requiring effective collaboration with a wide range of agencies. It is, however, essential to ensure that consensual health and social care assessments and support planning have first been attempted, that an individual's mental health has been considered, and that they have mental capacity in relation to the decisions being asked of them.

It is important to be honest about enforcement measures that may be taken, preferably within the context of a supportive, trust-based relationship with the person. This can sometimes enable them to take informed and supported steps so that the imposed action does not finally become necessary. Even when avoiding imposed solutions is not possible, the existence of a relationship of trust supports the person through the process and its aftermath, and perhaps to think through how it can be prevented from happening again (which is often a risk when enforced clean-ups take place). Where there is no such relationship, imposed intervention rarely produces a long-term solution to the problem.

Reflective exercise

In relation to an individual whose self-neglect is reaching the threshold for imposed intervention, the model below can be used to consider where on the spectrum the approach so far might be located and how the prospect of imposed interventions can be integrated within a relationship-based approach.

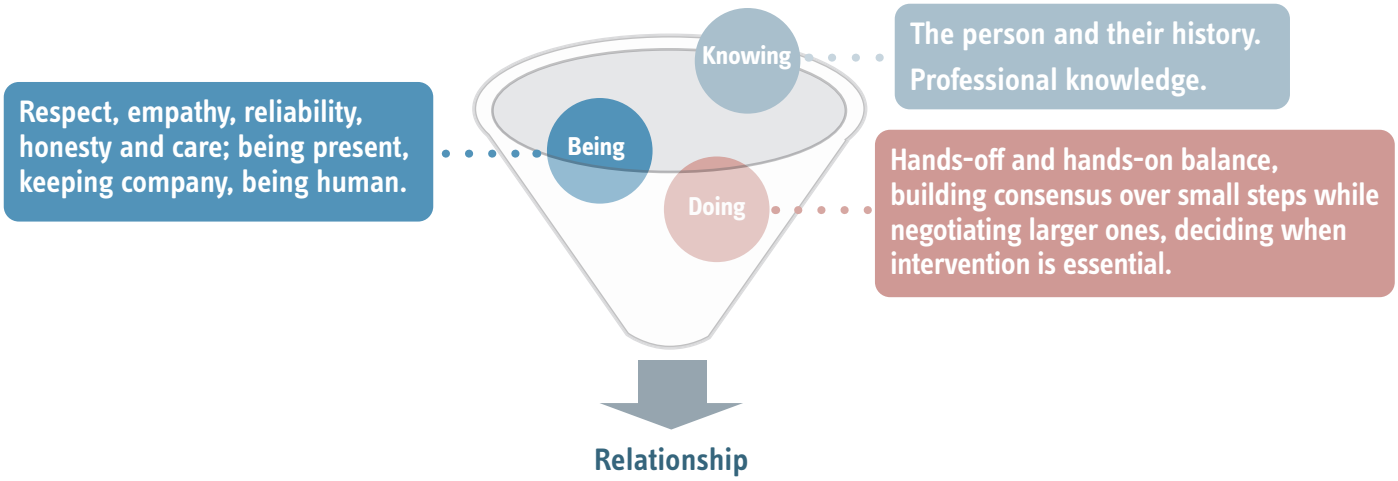


Tool 2 - Planning and implementing interventions

Integrating the elements of self-neglect practice

Self-neglect practice involves a complex interaction between **'Knowing, Being and Doing'** – integrating knowledge, skills and use of self. Consider whether, in any individual case, particular domains could be strengthened.

- What is known about the individual's life history and experience? How can their self-neglect journey be understood? Are there are any aspects of professional knowledge that need to be strengthened in order to work with them?
- What personal qualities in the practitioner does this person's circumstances draw on? How can empathy, persistence, respect, honesty and humanity be shown?
- What are the priorities in terms of what needs to be done here? Are there things to hold back from doing just now?



Positive outcomes in working with people who self-neglect will often show these three elements combined:

- The practitioner will draw on a carefully considered knowledge base, matching professional knowledge with understanding of the individual and their unique life experience and personal circumstances.
- They will show authenticity and humanity in their interaction with the individual.
- They will carefully consider what they need to do (or not do), particularly in relation to risk management, while building relationship-based engagement.

Tool 3 - Legal frameworks

Two pieces of primary legislation provide the framework for responding to self-neglect. ***The Care Act 2014*** sets out the local authority's powers and duties towards adults with care and support needs. The statutory guidance to the Act (DHSC, 2020) specifies that self-neglect is included in definitions of abuse and neglect, thus linking self-neglect to statutory safeguarding duties.

The Mental Capacity Act 2005 provides the principle that a person must be assumed to have capacity to make a decision, even one that appears eccentric or unwise, unless an assessment using criteria set out in the Act has shown that they lack capacity. Between these key statutes lie a range of other powers and duties that can, in specific circumstances, enable intervention by agencies such as housing providers, environmental health, the police and mental health services.

In addition, in line with the *Human Rights Act 1998*, use of legal powers and duties must comply with the ***European Convention on Human Rights*** which provides, for example, the right to liberty and security (article 5) and the right to respect for private and family life (article 8), along with the principle of proportionality and procedural safeguards in circumstances where rights may be infringed. Local authorities must act in accordance with the *Equality Act 2010,* including implementation of the public sector equality duty (section 149) requiring proactive engagement with outcomes for people with protected characteristics.

The key elements of the legal framework are illustrated here through thirteen key questions a practitioner might ask in relation to Alice in the case study below, including one essential question relating to mental capacity. Not all options will be necessary or appropriate and they should be considered in parallel rather than sequentially; the pathway will depend on the level and nature of Alice's needs, her mental capacity, the degree to which she engages with services and the level of risk. The same questions can be applied to the work being undertaken with any individual about whose level of self-neglect there are concerns. The ***Care Act Statutory Guidance*** (DHSC, 2020), in particular chapters 6 and 14, will also help.

Case study

Alice is a 61-year-old retired teacher who lives alone in a maisonette owned by the local authority. She first came to the attention of adult social care services after an ambulance crew was called out because she was experiencing a loss of vision and had fallen. The ambulance crew were very concerned about both her physical state and her living environment, which they described as filthy, infested and cluttered, with documents and newspapers piled high and hundreds of partly empty milk bottles covering every available surface. The toilet did not appear to function and both the fridge and cooker appeared to be broken.

Alice herself seemed malnourished and there was little sign of food in the house, other than accumulated packets of ready meals well past their use-by date. Burns were seen on her clothes and hands, with discarded cigarette ends scattered on the floor. Alice refused to go to the local hospital but did not explicitly object to a referral being made to social care. However, in the past she has refused to answer the door and to engage with assessments. She continues to call 999 frequently when feeling unwell. On the last occasion, when leaving, the ambulance crew encountered another local resident who complained about the smells emanating from Alice's flat.

Thirteen key questions linking to legal frameworks

1. What guidance is available to practitioners across the multi-agency adult safeguarding partnership?

The need for guidance on responding to situations of squalor, hoarding and other self-neglectful patterns is strongly recommended by safeguarding adult reviews that have investigated deaths associated with self-neglect. In addition, the *Care Act Statutory Guidance* (DHSC, 2020) requires adult safeguarding policies and procedures in every organisation, and these should reflect the inclusion of self-neglect within the definition of abuse and neglect. In response many Safeguarding Adults Boards have published guidance and procedures for working with cases of self-neglect.

2. Is the information about Alice sufficient to trigger the local authority's duty (which may be delegated to others) to make safeguarding enquiries (section 42, *Care Act 2014*)?

Where an adult with care and support needs is experiencing, or is at risk of, abuse and neglect (including self-neglect) and, as a result of the care and support needs, is unable to protect him or herself, the local authority must make (or cause to be made) whatever enquiries it thinks necessary. The purpose is to establish whether any action needs to be taken to prevent or stop the abuse and neglect, including a plan for protection and support to promote wellbeing; this should, where possible, reflect Alice's views and wishes or, if she does not have mental capacity, her best interests. Making Safeguarding Personal requires it to be person-led and outcome-focused. Statutory guidance (DHSC, 2020) clarifies that section 42 enquiries will be appropriate in self-neglect cases where an individual is unable to take self-protective action by controlling their own behaviour. Helpful briefings have been published on decision-making on referrals of safeguarding concerns (see Hodson and Lawson, 2019, for guidance).

3. Is the *Care Act 2014* provision (section 9) for assessment of care and support needs triggered in this case?

The *Care Act 2014* (section 1) establishes that local authorities have a duty to promote the wellbeing of adults in need of care and support, while having regard to their wishes and feelings; wellbeing includes dignity, physical and mental health, protection from abuse and neglect, and suitable living accommodation. Even if Alice's circumstances do not trigger an enquiry under section 42, they will trigger a duty to carry out an assessment of her care and support needs under section 9 as she clearly meets the threshold. Her mental capacity to agree to or refuse an assessment would need to be considered (see further details on mental capacity below); if she lacks capacity, then assessment would be required if it is in her best interests. Her care and support needs (identified under section 9) may well be deemed eligible to be met by reference to the national eligibility threshold criteria, which focus upon the extent to which wellbeing outcomes are compromised.

4. Has the local authority fulfilled the duty to consider whether an independent advocate might be appointed to support Alice's involvement (sections 67/68, *Care Act 2014*)?

Advocacy might be necessary to assist Alice to be involved in a s.42 safeguarding enquiry and/or in a s.9 assessment of her care and support needs. The duty to provide advocacy applies if it seems that, without an advocate, she would have substantial difficulty in doing one or more of the following:

- understanding or retaining relevant information
- using or weighing it as part of the process of being involved
- communicating her views, wishes and feelings and there is no appropriate person to represent and support her during the assessment.

5. How might duties under the *Human Rights Act 1998* be engaged in Alice's case?

All public authorities, including councils with social services responsibilities, have a positive obligation to promote the human rights in the European Convention on Human Rights and Fundamental Freedoms (ECHR), which have been incorporated into UK law by the *Human Rights Act 1998*. In cases involving self-neglect and adult safeguarding, the most relevant rights are the right to life (Article 2, ECHR), the right to live free of inhuman and degrading treatment (Article 3), the right to liberty (Article 5), the right to private and family life (Article 8) and the right to enjoy all ECHR rights and freedoms without discrimination (Article 14). Article 3 is an absolute right. Other rights may be limited or qualified by the State providing that this is for a lawful purpose, such as safeguarding an adult at risk. None of the human rights automatically have primacy. A thorough and detailed assessment will be required in order to determine in each unique case how the different Articles interface and which, in the final analysis, should be foregrounded (Re Z (An Adult: Duty) [2004] EWHC 2817). Reasons for the decision should be recorded.

Any interference with Alice's human rights must be lawful, in other words permitted by statute, and proportionate to the level of risk. For example, the *Data Protection Act 2018* would permit information to be shared without Alice's consent under certain circumstances but any information that is shared, for example to safeguard her wellbeing, should be limited to that deemed necessary to achieve the objective. It would be unlawful, for example, to enter Alice's home without her consent unless lawful authority could be found to do so, such as the power available to the police to force entry to save life and limb and/or prevent serious damage to property (Section 17, *Police and Criminal Evidence Act 1984*). It would be unlawful to remove Alice from her home without lawful authority, such as may be found in the *Mental Health Act 1983*.

To meet the obligations towards Alice under Article 2 requires assessment of risk and decision-making on how to protect Alice's life and wellbeing. Article 3 requires assessment of whether care and support are necessary to avoid actual bodily harm or intense mental suffering and physical harm. Any deprivation of Alice's liberty must be authorised according to law (Milton Keynes Council v RR [2014] EWCOP B 19).

6. How might duties under the *Equality Act 2010* be engaged in Alice's case?

Public bodies must promote equality and have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations (section 149). Advancing equality of opportunity means taking steps to minimise or remove disadvantages associated with the protected characteristics of age, disability, sex and sexual orientation, religion and belief, race, marriage and civil partnership, gender reassignment, pregnancy and maternity. Fostering good relations means tackling prejudice and promoting understanding of the needs of particular communities. Due regard means that public authorities must consider how to advance equality.

There are unequivocal links here to anti-discriminatory practice. By the *Equality Act 2010* Alice falls within several groupings of protected characteristics, such as age and sex. Other characteristics may be hidden, such as some forms of disability. Thus, assessment of her care and support needs, for example, should thoroughly consider any disability (R (AM) v Birmingham City Council [2009] 12 CCLR 407). Information should be provided in a language and form that Alice finds accessible. Recorded consideration must be given to the use of interpreters. Supervision and management oversight of assessment and decision-making about Alice's care and support needs should challenge any evidence of unconscious bias and social stereotypes.

7. Have the duties to cooperate in the *Care Act 2014* resulted in good inter-agency working in this case?

Section 6 provides a general duty of cooperation between the local authority and relevant partners when carrying out their respective roles in relation to adults with care and support needs. Thus, there should be appropriate mechanisms for communication, information-sharing and decision-making. Section 7 enables the local authority to make a specific request for cooperation in Alice's case, with which a partner agency must comply provided it is compatible with their own duties and would not adversely affect how they carry out their own functions.

8. Is this a case where the local authority might use its powers relating to housing?

A risk assessment of residential premises may be conducted (*Housing Act 2004*) to identify hazards likely to cause harm and, if appropriate, act to remove them or reduce the risk of harm. This applies to owner-occupied property as well as to rented property. If she is tenant, Alice may be in breach of her tenancy agreement and a tenancy support officer may be able to engage with her to reduce the risks to her tenancy as well as to her quality of life. For both social and private landlords, there is ultimate recourse to possession proceedings (*Housing Act 1985*, amended 1996, and *Housing Act 1988)*. Under the *Building Act 1984* the local authority also has the power to deal with any premises in such a state as to be prejudicial to health where the owner or occupier refuses to take remedial action.

9. Is this a situation where public health protection powers could be activated by Environmental Health?

Under the *Public Health Act 1936* (sections 83/84) the local authority has power to require an owner or occupier to remedy the condition of premises that are 'filthy, verminous or unwholesome' and therefore prejudicial to health. The powers include cleansing and disinfecting, and the destruction and removal of vermin, which the local authority may carry out and charge for. Section 85 allows cleansing to free a person and their clothing from vermin.

The *Public Health Act 1961* (section 36) enables the local authority to require a property to be vacated whilst it is fumigated, with temporary housing being provided. The *Public Health (Control of Disease) Act 1984* provides powers to intervene in situations of disease or infection posing significant risk of harm. The *Environmental Protection Act 1990* (sections 79/80) empowers the local authority to issue an abatement notice with regard to any premises in such a state, including through 'accumulation or deposit', as to be prejudicial to health or a nuisance, thus requiring the home conditions to be improved. The Act provides a power of entry and a notice can also apply to the area outside a property. The *Prevention of Damage by Pests Act 1949* requires the local authority to take action against owners and occupiers of premises where there is evidence of rats or mice.

10. Is use of the *Mental Health Act 1983* necessary in this case?

Assessment by an Approved Mental Health Professional (AMHP), supported by medical recommendations, would establish whether Alice is experiencing 'mental disorder of a nature of degree' that warrants her detention in a hospital for assessment (section 2) or treatment (section 3) and 'whether she ought to be so detained in the interests of (her) own health or safety or with a view to the protection of other persons'.

Alternatively, guardianship (section 7) can give the guardian powers to determine place of residence and ensure attendance for medical treatment and access by professionals. An AMHP has the power to enter and inspect premises where someone with a mental disorder is not receiving proper care (section 115).

An AMHP may also request a warrant to enable the police (with the AMHP and a doctor) to access a property where it is thought a person believed to have a mental disorder may be being ill-treated or neglected or is living alone and unable to care for themselves (section 135) and, if need be, remove them to a place of safety in order to consider what should further be done to secure treatment or care.

11. Might the local authority, housing provider or the police need to consider use of Injunctions to Prevent Nuisance and Annoyance (*Anti-Social Behaviour, Crime and Policing Act 2014*)?

Injunctions to prevent nuisance or annoyance (IPNAs) may be considered in cases where there is persistent conduct that causes or is likely to cause housing-related nuisance or annoyance. Application may be made by the police, the local authority or a landlord. Community Protection Notices are also available to the local authority and the police to address unreasonable conduct that has, or is likely to have, the potential to be detrimental to the quality of life of a resident or visitor to the area. While unlikely to be a remedy of choice in Alice's case, it is included here in order to note its possible relevance in other circumstances.

12. Who has power of entry to Alice's premises?

In England there is no specific adult safeguarding power of entry. The *Police & Criminal Evidence Act 1984* (section 17(1) (e)) permits the police to enter premises without a warrant in order to save life or prevent injury, or prevent serious damage to property. It is applicable only in a genuine emergency, not in response to general concerns about welfare.

Section 135 of the *Mental Health Act 1983* empowers an approved mental health professional (AMHP) to request a magistrate's warrant authorising a police constable (accompanied by an AMHP and a doctor) to enter Alice's house if it is believed she has a mental disorder. The grounds for the warrant are that there is reasonable cause to suspect she is being ill-treated or neglected, or lives alone and is unable to care for herself. She may be taken to a place of safety for 24 hours (with the possibility of extension to 36 hours if necessary), in order to assess the need for hospital admission or other care arrangements.

With granted warrants, environmental and housing officers are permitted to enter premises, to identify and manage hazards that pose a risk of harm to health and safety. It is relevant to note, however, that although the conditions in Alice's home may present a fire hazard, Fire & Rescue Services have no power of entry to take preventive measures in a private dwelling. The power in the *Regulatory Reform (Fire Safety) Order 2005* to prohibit or limit the use of premises applies only to non-domestic premises.

13. Finally, an overarching legal consideration - does Alice have mental capacity?

The question of whether Alice has mental capacity to make the decisions she appears to be making (for example, in relation to her living conditions, diet and self-care, and whether to have an assessment of her care and support needs) is crucial to determining which, why, when and how the legal powers and duties described above might be used. In SARs it is common to find failure to undertake a mental capacity assessment or to adequately explore how an individual understands, retains, uses or weighs relevant information. Thorough mental capacity assessments are a central component for working effectively with self-neglect (Preston-Shoot, 2019).

The *Mental Capacity Act 2005* (MCA) (section 2) defines lack of capacity as being unable to make a decision for oneself in relation to a specific matter because of an impairment or disturbance in the functioning of the mind or brain. Being 'unable to make the decision' is defined as being unable to understand, retain, use or weigh up information relevant to the decision, or to communicate the decision.

Assessment of mental capacity may not be a single event; capacity may fluctuate and need to be considered over time. Alice would need to be given any necessary support to enable her to make and express a decision. The use of 'articulate and demonstrate' models of assessment (see information on executive capacity below) may be appropriate if Alice appears not to carry out actions that she in theory appears to understand the need for.

If Alice is found not to have mental capacity in respect of self-care decisions then there is a duty to act in her best interests, with the MCA (section 4) setting out a range of factors to be taken into account when determining what those are. In line with the principle set out in section 1 of the MCA, regard must be taken to whether they can be effectively achieved in a way that is less restrictive of her rights and freedom of action. Where best interests intervention will nonetheless involve a deprivation of liberty, additional Deprivation of Liberty Safeguards (DoLS) provide scrutiny and authorisation of such arrangements in a hospital or care home; the Court of Protection may authorise arrangements in other types of accommodation. (Note that the DoLS are due to be replaced by the Liberty Protection Safeguards, which will apply in a wider range of settings (*Mental Capacity (Amendment) Act 2019.*)

Where, following assessment, capacity is uncertain, or where best interests decisions are complex or contested, the Court of Protection may be asked to make a determination or order, or give directions. In one case the judge determined that the individual lacked mental capacity to understand the risks he was living in, namely extremely neglected accommodation and self-neglect, aggravated by alcohol abuse. Orders in his best interest were made under the MCA (London Borough of Croydon v CD [2019] EWHC 2943 (Fam)).

Inherent jurisdiction of the court also remains available in cases where the decision-making of an individual may be affected not by a lack of mental capacity within the meaning of the MCA but by coercion or duress from a third party. In Southend on Sea v Myers [2019] EWHC 399 (Fam), a situation involving both self-neglect and neglect, the High Court employed its inherent jurisdiction to safeguard an older person who had what was described as a relationship of co-dependency with his adult son.

Case study: Ama

Ama is a woman in her 40s who is homeless. She is of African heritage, but her country of origin is not clear. Little is known about her background; it is believed she arrived in England as a young woman, possibly as a result of trafficking, and subsequently held employment in the UK but lost her job and was unable to claim benefits as her immigration status had not been regularised.

Her personal care and hygiene are severely neglected; she uses alcohol, is malnourished and in very poor health. Her behaviour at times evidences mental distress and she recounts experiences of sexual harassment, but she has been reluctant to engage with outreach services in any way that enables her to access services. She spends much of her time in a local church or the shopping centre, when they are open, coming to the attention of others due to distressed or sometimes aggressive behaviour. Although the police have sometimes been called, no action has been taken to raise concerns about her potential care and support needs.

Homelessness outreach services have referred her to the local authority for assessment of her care and support needs, but no assessment has taken place; the adult social care department has deemed this to be 'a housing problem'. Similarly a safeguarding referral, raised by the church due to concerns about her self-neglect and risks of exploitation. The local authority did not progress this to a section 42 enquiry, on the grounds that she is homeless as a 'lifestyle choice' and also that she did not consent to the referral.

Tool 3 - Legal frameworks

Reflective questions:

1. How might race and ethnicity be affecting community and professional attitudes to Ama? How might race and gender dynamics, unconscious bias, assumptions and stereotyping have played a role in how services have responded to her situation? How might intervention better take account of her racial and ethnic identity and pay attention to her position and experience as a black woman?

2. What would be the local authority's duties here? Are the decisions not to conduct a safeguarding enquiry or care and support needs assessment justifiable? How is the *Human Rights Act 1998* relevant to the local authority's decisions?

   Points for consideration:

   - Do Ama's circumstances meet the grounds on which the section 42 and section 9 duties are engaged, both in the *Care Act 2014* and in the statutory guidance?
   - Homelessness does not exclude someone from the scope of section 42, and consent to assessment is not required in the circumstances set out in the statutory guidance.
   - Article 3, European Convention on Human Rights, is relevant to questions of whether an individual should have recourse to public funds.
   - For guidance on section 42 enquiry threshold decisions: Hodson, B. and Lawson, J. (2019) *Making Decisions on the Duty to Carry Out Safeguarding Adults Enquiries*. London: LGA and ADASS. **www.local.gov.uk/sites/default/files/documents/25.130%20Making%20Decisions%20on%20the%20duty_06%20WEB.pdf**

3. How do the legal rules on no recourse to public funds affect Ama's situation?

   These, and other legal duties relating to homelessness and safeguarding, are explained in: Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. London: LGA and ADASS. **www.local.gov.uk/sites/default/files/documents/25.158%20Briefing%20on%20Adult%20Safeguarding%20and%20Homelessness_03_1.pdf**

For guidance on the interface between the *Care Act 2014* and asylum law consult Ramezankhah, F. and Brammer, A. (2019) 'The interface between the *Care Act 2014* and asylum law: exclusions and innovations.' In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage. (pp. 144-158)

For research findings on health and care provision for people sleeping rough, including evidence of negative attitudes towards people misusing substances, consult: Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020) *Delivering Health and Care for People Who Sleep Rough: Going Above and Beyond*, London: The Kings Fund.
www.kingsfund.org.uk/sites/default/files/2020-02/Delivering-health-care-people-sleep-rough.pdf

For SAR findings on safeguarding and homelessness, consult: Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews*. London: Kings College London.
kclpure.kcl.ac.uk/portal/en/publications/safeguarding-homelessness-and-rough-sleeping(8500d110-7a16-47c2-bba7-dd5b33b42d7e).html

Executive capacity

It is sometimes important when assessing mental capacity, especially when there are repeating patterns of risk, not just to rely on what a person says but also to take account of what they do. Indeed, the MCA Code of Practice (DCA, 2007), while emphasising that an unwise decision does not of itself indicate a lack of mental capacity, recommends that capacity may need to be questioned in circumstances where repeated unwise decisions place an individual at significant risk.

'Articulate and demonstrate' models of assessment (Day and Leahy-Warren, 2008; Naik et al., 2008) evaluate not just what an individual says but also what they do. They can identify difficulties an individual has in using or weighing relevant information in the moment a decision is to be enacted, rather than merely in abstract discussion. NICE (2018) recommends that structured assessments of capacity (for example, by way of interview) may need to be supplemented by real-world observation of the person's functioning and decision-making ability in order to provide the assessor with a complete picture. A similar approach has been adopted to inform judicial decision-making (GW v A Local Authority [2014] EWCOP 20). This advice arises because dysfunction in the frontal lobe of the brain, caused by a range of factors such as acquired brain injury, health conditions or long-term alcohol use, can inhibit how an individual plans, organises and implements actions in the moment, even when they can reason and discuss a decision in the abstract (Hazelton et al., 2003; Restifo, 2013; Hildebrand et al., 2014).

Further resources on executive capacity will be found in the References section on page 31.

Reflecting on the legal rules

Which aspects of the legal rules do I need to find out more about?	Which resources or colleagues can help me develop my understanding?

The resources listed at the back of this tool provide a useful place to start to add to and fill any gaps in understanding.

Tool 3 - Legal frameworks

Coronavirus Act 2020

The *Coronavirus Act 2020* has not eased the adult safeguarding provisions in the *Care Act 2014*, such as the duty to enquire (section 42). In response to the Covid-19 pandemic, however, it has enabled local authorities to implement easements with respect to the Act's care and support provisions. These easements, which are meant to be temporary adjustments, relate to duties to assess (sections 9 and 10), to consider if assessed needs meet eligible criteria (section 13), financial assessment (section 17), and duties and powers to meet needs (sections 18 and 19). There are also changes to the legal rules regarding care plans and reviews (section 24, 25 and 27).

Guidance has been issued: - Covid-19: Our Action Plan for Adult Social Care (DHSC, 2020): www.gov.uk/government/publications/coronavirus-covid-19-adult-social-care-action-plan/covid-19-our-action-plan-for-adult-social-care

www.gov.uk/guidance/overview-of-adult-social-care-guidance-on-coronavirus-covid-19

The principles and safeguards within the *Mental Capacity Act 2005* and DoLs arrangements remain in place, but with some modifications to procedures. Guidance has been issued - The *Mental Capacity Act* (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) During the Coronavirus (Covid-19) Pandemic (DHSC, 2020): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878910/Emergency_MCA_DoLS_Guidance_COVID19.pdf

Commentary is available here:
www.sciencedirect.com/science/article/pii/S0160252720300194?via%3Dihub

Further guidance has been issued on caring for people who lack mental capacity:
www.gov.uk/government/publications/coronavirus-covid-19-looking-after-people-who-lack-mental-capacity

The 2020 Act has also made some modifications to the *Mental Health Act 1983* for the duration of the pandemic. These include changes to the requirements for applications for compulsory admission (sections 2 and 3) and compulsory admission for patients already in hospital (section 5), and detentions in placements of safety (sections 135 and 136). Details are available here:
www.legislation.gov.uk/ukpga/2020/7/schedule/8

Tool 4 - The organisational context for self-neglect practice

Negotiating the organisational context for self-neglect practice

In addition to challenges that arise from the self-neglect itself, and of securing engagement and finding an appropriate intervention, research and SARs also highlight key challenges arising from the organisational context in which practice takes place:

Interface with safeguarding

The inclusion of self-neglect as a form of abuse and neglect within the statutory guidance to the *Care Act 2014* (DHSC, 2020) necessitates higher priority in Safeguarding Adults Board networks, greater strategic level ownership, clarity in thresholds and routes for referral, and processes for communication, shared decision-making and risk management. It does not mean that every case of self-neglect will of necessity trigger a safeguarding enquiry; however, the duty will be engaged if it appears the individual is unable to self-protect by controlling their self-neglectful behaviour.

Practitioners will still need to consider how individuals fit best in relation to safeguarding and adult social care structures, and ensure they get appropriate follow-up from the agencies involved. A widely understood and clear interface with safeguarding will mean that self-neglect work is less likely to take place in organisational silos, with strategic-level agreements in place to support practice. Self-neglect can sometimes mask other forms of abuse and neglect, either by or towards someone else, and practitioners must explore this possibility too.

Key questions

- Are referral routes for self-neglect clear in the locality?
- Is the guidance issued by the Safeguarding Adults Board accessed and used?
- Is there agreement about inter-agency ownership of self-neglect cases?

Thresholds for adult social care services

The national eligibility thresholds introduced by the *Care Act 2014*, focusing on the potential for wellbeing outcomes to be compromised if needs are not met, are likely to ensure that the assessed needs of someone who is self-neglectful are eligible to be met. However, the requirement for 'physical or mental impairment or illness' to be present before eligibility is established could exclude self-neglect where clear choice is exercised in the context of mental capacity.

Key questions

- How do eligibility criteria affect practice in self-neglect work?
- What impact does the threshold have on care and support planning?

Timescales that don't fit workflow systems and processes

Building rapport and engagement often takes more time than is routinely allocated in workflow arrangements. Relationship-building, and indeed risk management, may be compromised if work with people has to be closed prematurely.

Key questions

- Is practice constrained by standard timescales, or is there flexibility to build continuity of involvement and work on building a relationship, even where there appears to be no early progress towards desired outcomes?
- Is there a clear escalation route through which practitioners can advocate for longer involvement in high-risk cases?

Charging

Reluctance to engage with services has in some cases been exacerbated by service charges that the individual refuses to meet.

Key questions

- How does the organisation's charging policy affect self-neglect practice?
- How well known are the routes that exist for exercising discretion in relation to charging for services where case circumstances and risk warrant it?

INTERVENTION

Managing the personal experience of self-neglect practice

Working with people who self-neglect has a high impact on practitioners; this work affects people in a way that can leave people feeling distressed, emotionally drained and exposed. It can cause physical reactions through the sensory experience and pose risks to health and safety. **These are some of the experiences practitioners report:**

"Why am I, at 6.30pm when everyone else is at home, here with a washing-up bowl with this 80-year-old lady and nobody else in the world knows that's happening; that feels very unsafe doesn't it, somehow?"

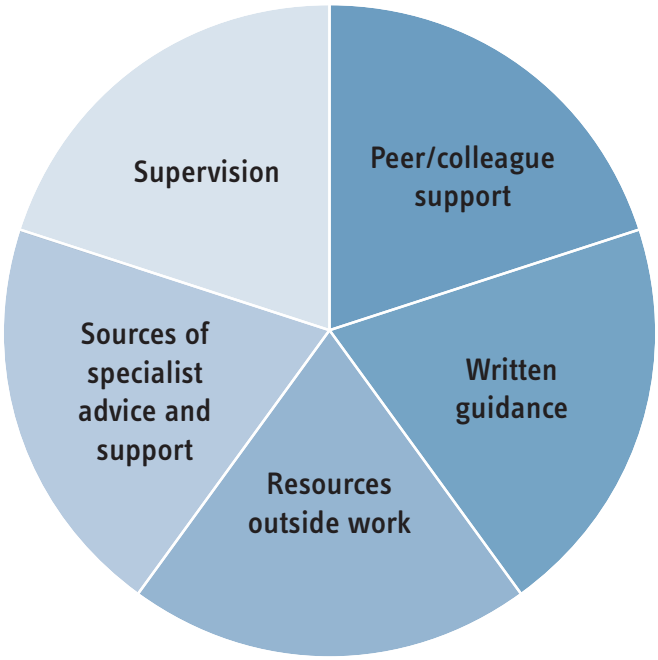
"I think it's very emotive as well and you're entering quite regularly into someone's personal life and their world they don't want you to go to, so it can be a really uncomfortable place."

"Sometimes it makes me feel very sad..."

"You have to give a lot of yourself I think to win the trust of somebody who's not engaging with any other services."

A number of mechanisms can provide the necessary support. **Supervision** that offers opportunity for reflection, and supports innovation and creativity, is key, as are **opportunities to discuss** practice approaches with team colleagues. Access to **specialist advice**, such as legal or health input, often through formal liaison with colleagues from other agencies, is essential, and guidance from **policies and procedures** provides an important framework to support accountable practice. Practitioners in some roles will need access to **protective equipment.** Equally, **people and resources** outside the immediate work context can help manage emotion at a personal level.

Using the diagram below, consider who can provide these key components of an effective strategy for managing the personal experience of self-neglect work:



What features of organisations support good practice in self-neglect?

This tool may be used by either practitioners or managers, or as part of a management development exercise on self-neglect. It can provide a means of preparation for dialogue within an organisation on actions that may need to be taken to create an organisational environment in which good practice in self-neglect work can flourish. The features listed are those that emerge from research and SARs as significant facilitators.

The template below can be used to:

- record the evidence for the degree of confidence that can be held in the 'self-neglect readiness' of the organisation
- capture the key outcomes of the evaluation, focusing attention on priority areas, by using a Red Amber Green (RAG) rating system:
  - Red = We have a lot more work to do on this.
  - Amber = We're getting some of this right but have more to do.
  - Green = We do this really well.
- identify action steps for securing improvements.

Organisational feature	Evaluation of the current position	RAG rating	Actions for addressing this
Strategic responsibility for self-neglect is clearly located within a shared inter-agency governance arrangement such as the SAB.		Amber	
Inter-agency coordination and shared risk-management is facilitated by clear referral routes, communication and decision-making systems.		Amber	
Training and guidance on self-neglect is available and shared across agencies.		Amber	
Longer-term supportive, relationship-based involvement is accepted as a pattern of work within this organisation.		Amber	
Supervision both challenges and supports practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice.		Amber	
Support for legal literacy is in place and legal advice is available to practitioners and supervisors when required.		Amber	
Commissioning has ensured that a range of community resources are available to support people who self-neglect.		Amber	

Tool 5 -Mapping self-neglect practice

The diagram below links the key decision points in work with people who self-neglect (in the first column) with the factors that affect or underpin the decision (in the middle column) and the core objectives of the key decision points (in the last column). It is intended to provide a summary 'roadmap' of the key issues for consideration in work with people who self-neglect. It can be used to identify any decision points that may require attention in relation to any individuals with whom work is being undertaken.

<table>
<tr><th>Key decision-points in self-neglect work</th><th>Factors affecting or underpinning the decision</th><th>The core objectives at key decision points</th></tr>
<tr><td>What initial response should this referral receive? How can the individual's own perspectives be sought?</td><td>Care Act 2014
> s.42 duty to make enquiries
> s.9 duty to assess care and support needs.

Previous or gathered knowledge of the individual.</td><td>To create an appropriate framework for the initial approach to the individual.</td></tr>
<tr><td>Who is best placed to make the initial approach? What combination of agencies – adult social care, housing, environmental health, GP, nursing, fire service, police, RSPCA, specialist mental health or learning disability service?</td><td>Level and nature of presenting needs and/or risk.

Agency thresholds.

Who might be most likely to create rapport?</td><td>> To create rapport and seek the individual's engagement.
> To make initial assessment of capacity, risk, care and support needs.
> To ascertain the individual's own motivation and aspiration.</td></tr>
<tr><td>Does the individual have mental capacity?

NO

> What is in best interests?
> Should an advocate be appointed?
> Should the Court of Protection be involved?

YES

> What legal powers and duties might apply?</td><td>Legal powers and duties:
> Mental Capacity Act 2005 and Deprivation of Liberty Safeguards
> Care Act 2014
> Mental Health Act 1983
> Environmental and Public Health legislation
> Housing or anti-social behaviour legislation
> Inherent jurisdiction.</td><td>To ensure intervention takes account of all relevant powers and duties:
> Autonomy is respected where decisions are made with capacity.
> Judgements are made taking account of thresholds for imposed interventions.
> Best interests interventions are made where appropriate and take full account of the individual's wishes, feelings, beliefs and values.</td></tr>
<tr><td>How do we understand the self-neglect?</td><td rowspan="2">Knowledge from research.
Knowledge of the person's life history.
The person's own perspective on their journey – the lived experience.</td><td>To find and understand the person behind the behaviour.</td></tr>
<tr><td>What support networks does the individual have?</td><td>To connect with people who may support wellbeing.</td></tr>
<tr><td>What are the risks here?</td><td>Knowledge of research, learning from reviews of serious cases.
Understanding of the person's own concerns – what is important to them?</td><td>To support the person to find safe ways of managing the risks in their situation.</td></tr>
<tr><td>What are the options for intervention?</td><td>Use of inter-agency forums or panels for discussion.</td><td>To formulate an inter-agency plan with shared goals and clear roles.</td></tr>
<tr><td>Which options, of those that are possible, should be followed?</td><td>Awareness of all available legal options.

Professional ethics and values.

Understanding of the individual's own aspirations and goals.</td><td>To find a balance between the moral mandates:
> respecting autonomy
> fulfilling a duty of care.
To support the individual in achieving the outcomes they value.</td></tr>
<tr><td>How can options acceptable to the individual be pursued?</td><td>Recognition that trust-based intervention over time can achieve more lasting change.</td><td>To build a relationship that enables small steps to lead to larger ones, while monitoring risk, capacity and wellbeing.</td></tr>
</table>

References and additional resources

Alcohol Change UK (2019). Learning from Tragedies. *An Analysis of Alcohol-Related Safeguarding Adult Reviews* Published in 2017. London: Alcohol Change UK.

Birmingham Safeguarding Adults Board (2016). *Keith's Story: A Film About Hoarding.* **www.youtube.com/watch?v=fhmfptpwNZc&t=47s**

Braye S., Orr D., & Preston-Shoot M. (2011). *Self-Neglect and Adult Safeguarding: Findings from Research*. London: Social Care Institute for Excellence.

Braye S., Preston-Shoot M., & Orr D. (2011). Conceptualising and responding to self-neglect: Challenges for adult safeguarding. *Journal of Adult Protection* 13, 4, 182-193.

Braye S., Orr D., & Preston-Shoot M. (2013). *A Scoping Study of Workforce Development for Self-Neglect Work.* Leeds: Skills for Care.

Braye S., Orr D., & Preston-Shoot M. (2014). *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.

Braye S., Orr D., & Preston-Shoot M. (2015). *Self-Neglect Policy and Practice: Research Messages for Practitioners.* London: Social Care Institute for Excellence.

Braye S., Orr D., & Preston-Shoot M. (2015a). Learning lessons about self-neglect? An analysis of serious case reviews. *Journal of Adult Protection* 17, 1-16.

Braye S., Orr D., & Preston-Shoot M. (2015b). Serious case review findings on the challenges of self-neglect: Indicators for good practice. *Journal of Adult Protection* 17, 75-87.

Cream, J., Fenney, D., Williams, E., Baylis, A., Dahir, S. and Wyatt, H. (2020). Delivering Health and Care for People Who Sleep Rough: Going Above and Beyond, London: The Kings Fund. **https://www.kingsfund.org.uk/sites/default/files/2020-02/Delivering-health-care-people-sleep-rough.pdf**

Day, M.R., & Leahy-Warren, P. (2008). Self-neglect 2: Nursing assessment and management. *Nursing Times* 104, 25, 28-29.

Department for Constitutional Affairs (DCA) (2007). *Mental Capacity Act 2005: Code of Practice*. London: Department for Constitutional Affairs.

Department of Health (DH) (2000). *No Secrets: Guidance On Developing And Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. London: Department of Health.

Department of Health and Social Care (DHSC) (2020). *Care and Support Statutory Guidance, Issued under the Care Act 2014*. London: Department of Health and Social Care.

George M., & Gilbert, S. (2018). Mental Capacity Act (2005) assessments: Why everyone needs to know about the frontal lobe paradox. *The Neuropsychologist* 5, 59-66.

Hazelton, L., Sterns, G., & Chisholm, T. (2003). Decision-making capacity and alcohol abuse: Clinical and ethical considerations in personal care choices. *General Hospital Psychiatry* 25, 130-135.

Hildebrand C., Taylor M., & Bradway C. (2014). Elder self-neglect: The failure of coping because of cognitive and functional impairments. *Journal of the American Association of Nurse Practitioners* 26, 452-462.

Hodson B., & Lawson J. (2019). *Making Decisions on the Duty to Carry Out Safeguarding Adults Enquiries: Suggested Framework to Support Practice, Reporting and Recording*. London: Local Government Association (LGA) and Association of Directors of Adult Social Services (ADASS).

Holloway M. (2020). Hidden in plain sight: Acquired brain injury and missed opportunities for change'. In Braye S., & Preston-Shoot, M. (eds.) *The Care Act 2014: Wellbeing in Practice*. London: Sage/Learning Matters.
LGA (2020). *Making Safeguarding Personal Toolkit*. London: Local Government Association.
www.local.gov.uk/msp-toolkit

LGA and ADASS (2017). *Making Safeguarding Personal for Safeguarding Adults Boards*. London: Local Government Association and Association of Directors of Adult Social Services.

Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019). Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews. London: Kings College London.
https://kclpure.kcl.ac.uk/portal/en/publications/safeguarding-homelessness-and-rough-sleeping(8500d110-7a16-47c2-bba7-dd5b33b42d7e).html

Naik A., Lai J., Kunik M., & Dyer C. (2008). Assessing capacity in suspected cases of self-neglect. *Geriatrics* 63 (2), 24–31.

National Institute for Clinical Excellence (NICE) (2018). *Decision-Making and Mental Capacity: NICE Guideline*. London: National Institute for Clinical Excellence.
www.nice.org.uk/guidance/NG108

Preston-Shoot M. (2016). Towards explanations for the findings of serious case reviews: Understanding what happens in self-neglect work. *Journal of Adult Protection* 18 (3), 131-148.

Preston-Shoot M. (2017). On Self-Neglect and Safeguarding Adult Reviews: Diminishing Returns or Adding Value? *Journal of Adult Protection* 19 (2), 53-66.

Preston-Shoot M. (2018). Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change. *Journal of Adult Protection* 20 (2), 78-92.

Preston-Shoot M. (2019). Self-neglect and safeguarding adult reviews: Towards a model of understanding facilitators and barriers to best practice. *Journal of Adult Protection* 21 (4), 219-234.

Preston-Shoot M. (2020). Safeguarding Adult Reviews: Informing and enriching policy and practice on self-neglect? *Journal of Adult Protection* 22(4), 199-215.

Preston-Shoot, M. (2020). *Adult Safeguarding and Homelessness: A Briefing on Positive Practice*. London: LGA and ADASS.
www.local.gov.uk/sites/default/files/documents/25.158%20Briefing%20on%20Adult%2 Safeguarding%20and%20Homelessness_03_1.pdf

Ramezankhah, F. and Brammer, A. (2019). The interface between the Care Act 2014 and asylum law: exclusions and innovations. In S. Braye and M. Preston-Shoot (eds) *The Care Act 2014: Wellbeing in Practice*. London: Sage. (pp. 144-158)

Research in Practice for Adults (2013). *Self-neglect: Strategic Briefing*. Dartington: Research in Practice for Adults.

Restifo, S. (2013). A review of the concepts, terminologies and dilemmas in the assessment of decisional capacity: A focus on alcoholism. *Australasian Psychiatry* 21 (6), 537-540.

Ruck-Keene, A., Butler-Cole, V., Allen, N., Lee, A., Kohn, N., Scott, K., Barnes, K, & Edwards, S. (2019). *A Brief Guide to Carrying Out Capacity Assessments*. London: 39 Essex Chambers.
www.39essex.com/wp-content/uploads/2017/11/Mental-Capacity-Guidance-Note-Capacity-Assessment-March-2019.pdf

Ward M., & Holmes, M. (2014). *Alcohol Concern's Blue Light Project. Working with Change Resistant Drinkers. The Project Manual*. London: Alcohol Concern.

Webber S. (2013). *Getting the most out of supervision: Practice Tool*. Dartington: Research in Practice for Adults.

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