**Impact on the individual who experiences 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.

Cases show diverse influences for self-neglect. (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).

**Causes of Self-Neglect**

It is not always possible to establish a cause for self neglecting behaviours. Self-neglect is often seen in older people for whom physical or mental decline means that the person is no longer able to meet all their personal or domestic care needs. In an ageing society, people may outlive their friends and relatives, and become increasingly isolated and lonely which in itself may contribute to depression and helplessness. Poverty and lack of mobility may exacerbate this, and all these factors may contribute to the adult becoming unable to access health, care or maintain their home.

Self neglect can and does occur throughout adult life. Issues such as mental illness, learning disability, adverse childhood experiences and trauma may reduce a person’s ability to self-care.

Issues of pride and or shame and a refusal to accept declining skills to self-care may also play a part in refusing support.

In some instances, neglect occurs when an adult who is unable to self-care and who is dependent on a family carer does not receive the care they need; and in some cases, offers of assessment and support may be prevented by the carer.

People on the autistic spectrum may also struggle to self-care and to manage their environment and may be fearful of intervention because of difficulties communicating and engaging with others.

**Indicators of Self-Neglect**

Self-neglect is often defined across three domains – neglect of self, neglect of the environment and a refusal to accept help.

**Neglect of self may include:**

* Poor hygiene
* Dirty/inappropriate clothing
* Poor hair care
* Malnutrition
* Health deterioration (physical/ mental) needs unmet (e.g.diabetes – refusing insulin, treatment of pressure ulcers)
* Lifestyle behaviours leading to harm
* Alcohol / substance dependency
* Social isolation
* Situations where there is evidence that a child is suffering or is at risk of suffering significant harm due to self-neglect by an adult

**Neglect of the environment may include:**

* Unsanitary, untidy or dirty conditions which create a hazardous situation that could cause serious physical harm to the individual or others
* Hoarding
* Fire risk (eg. smoker with limited mobility / hoarder)
* Poor maintenance of property
* Keeping lots of pets who are poorly cared for
* Vermin
* Lack of heating
* No running water / sanitation
* Poor finance management (e.g. bills not being paid leading to utilities being cut off, unexplained money drawn from bank/savings account)

**The above is usually accompanied by a refusal to accept help / engage with services. This may be because of:**

* Not recognising the concern at all, or not seeing it as significant
* Pride, shame or personal experiences
* Not wishing to accept that there has been a decline in their ability to self-care
* Fear about what might happen if they do engage
* There may see the driver/ reason for their behaviour as more important than the impact of the self-neglect.

Self-neglect 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.

Remember:

* Professionals dealing with concerns about self-neglect and hoarding are grounded in, and influenced themselves by, personal, social and cultural values and professionals should always reflect on how their own values might affect their judgement.
* Professionals dealing with concerns about self-neglect and hoarding need to find the right balance between respecting a person’s autonomy and meeting their duty to protect the person’s wellbeing.

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## Making Safeguarding Personal (MSP) – working with the individual

## *Initial contact*

Concerns regarding people who self-neglect may be raised by any number of different sources, including concerned family members or neighbours who may raise an alert via the council. Voluntary organisations or churches and faith groups, who are already supporting a person may also become aware of self-neglect concerns. Other statutory agencies may also raise alerts, such as the Ambulance, Fire Service or health providers including GP’s, mental health services, addiction services and hospital staff. Housing providers are also often key holders of important information about people who self-neglect and may be the first to pick up on serious concerns about a tenant.

It has become increasingly evident that a short-term approach to people who self-neglect is unlikely to be successful. Research available on the Social Care Institute of Excellence website [here](https://www.scie.org.uk/self-neglect/policy-practice/key-research-messages).

Case examples of successful work with people who self-neglect demonstrate the need for professional values of relationship building, gaining trust, listening to people, assessing capacity at both a decision making and executive functioning level, taking account of the person’s history and why they may have begun to self-neglect. The concept of through put of cases and early closure must be varied when working with adults who self-neglect; managers and supervisors need to take this into account in terms of case load allocation. Our local learning indicates that our responses to people self neglecting in Somerset is negatively impacted by early closure of situations that are not easily resolved.

It is also clear from research into adults who self-neglect that intervening at an early stage is more effective than waiting until the concerns have become more severe and entrenched. Therefore, too rigid an adherence to eligibility criteria in these cases may be counterproductive and lead to more intensive, intrusive and costly support being required later on.

Research (Research In Practice- Working with people who self neglect) evidences the importance of:

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| **Approach** | **Example** |
| **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 |

*Referrals*

In making referrals or following up on concerns, the aim is to gather as much of the below information as possible to inform an assessment of need which should include:

* Name, address and date of birth
* Details of GP, District Nurse/Health Visitor
* Whether there is outside agency involvement
* Details of family involvement / contacts
* Information about any social or family contacts
* Whether the adult lives alone
* Whether the individual knows a referral is being made and whether they have given consent
* The nature of the concern including any risks and person’s views about these as far as these can be ascertained
* Whether there has been an on-going issue or sudden deterioration in the individual’s wellbeing
* Whether there any children at risk of harm as a consequence of the adult’s behaviour

What the practitioner needs to find out:

* 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 upon?
* 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?

*Assessment of Risk*

This could be undertaken as part of safeguarding enquiries or assessments of care and support needs, both under the Care Act 2014. Assessment in self-neglect is a constant feature. Initial assessment will be driven by the need to identify levels of risk and determine whether any immediate action is called for. Assessment is likely to be a long drawn-out and repetitive process, as an individual perhaps warms to the persistence of a practitioner who does not walk away at the initial rejection of help.

*Assessment of Risk information gathering*

In situations of hoarding, clutter scales may provide a useful benchmark, (see SSAB Self Neglect toolkit - Hoarding guidance) but they do not substitute for careful investigation, through dialogue and observation. Practitioners should consider completing the SSAB Self Neglect risk assessment tool.

When an adult refuses to engage and appears to be at serious risk of harm, a detailed and specific mental capacity assessment of both decision making and executive functioning skills is critical in helping to determine how best to intervene.

Capacity assessment in these circumstances is not a one-off event but a series of repeated assessments to build an understanding of a person’s ability to make informed decisions and to carry out these decisions.

If the person refuses initial contact, it is important not to close the case whilst uncertainly remains about the level of risk and the person’s capacity to make informed decisions about their circumstances and need for support. See section SSAB Self Neglect Toolkit - MCA and self neglect guidance.

## *Ongoing work with people who self neglect*

## There is no standard approach in self-neglect intervention, no one approach that ‘works’. Key themes in constructing effective interventions, where an individual has capacity to make relevant decisions but is reluctant to accept supportive services, are:

## Flexibility: constructing interventions around an individual’s unique circumstances.

## Negotiation: finding what measures might be tolerated, allowing intervention to take place with consent rather than imposition.

## Proportionality: acting to contain and manage risk, rather than seeking to eradicate it altogether.

Examples of intervention include:

* Simply remaining in contact, so that risk and capacity can be monitored, and small changes in motivation picked up.
* Practical input – provision of household equipment, repairs, benefits, housing application.
* Risk limitation through the provision of fire safety measures, repairs, safe drinking schemes.
* Attention to health concerns through doctors’ appointments or hospital admissions.
* Explicit use of motivational interviewing approaches that work directly with the individual’s ambivalence about change, using person-centred counselling based on warmth, empathy, reflective listening and negotiation.
* Small care and support packages, working with what is acceptable – domestic cleaning is sometimes easier to secure agreement to than personal care, initially.
* Proportionate cleaning or clearing, supporting the person to make some voluntary changes.
* Using networks: family and community resources can help negotiate and implement an action.
* Therapeutic input: psychotherapy or counselling, exploring underlying life experiences that may be associated with the self-neglect; paying attention to the significance of what is being given up when valued hoarded collections are removed and finding ways of replacing it to avoid the risk of repeat.

**Positive engagement and best practice**

The research on self-neglect suggests beneficial approaches and a range of options, levers and practical measures that could help engagement with individuals.

*Approach*

In the past we may have intervened in ways that prioritised the views of others rather than trying to work from the perspective of the individual. Research has shown that those who self-neglect may be deeply upset and even traumatised by interventions such as ‘blitz’ or ‘deep cleaning’. When developing an approach it is important to try to understand the individual and what may be driving their behaviour. There are some general pointers for an effective approach:

* **Multi-agency** – work with partners to ensure the right approach for each individual
* **Person centred** – respect the views and the perspective of the individual, listen to them and work towards the outcomes they want
* **Acceptance** – good risk management may be the best achievable outcome, it may not be possible to change the person’s lifestyle or behaviour
* **Analytical** – it may be possible to identify underlying causes that help to address the issue
* **Non-judgemental** – it isn’t helpful for practitioners to make judgements about cleanliness or lifestyle; everyone is different
* **Empathy** – it is difficult to empathise with behaviours we cannot understand, but it is helpful to try
* **Patience and time** – short interventions are unlikely to be successful, practitioners should be enabled to take a long-term approach
* **Trust** – try to build trust and agree small steps
* **Reassurance** – the person may fear losing control, it is important to allay such fears
* **Bargaining** – making agreements to achieve progress can be helpful but it is important that this approach remains respectful
* **Exploring alternatives** – fear of change may be an issue so explaining that there are alternative ways forward may encourage the person to engage
* **Always go back** – regular, encouraging engagement and gentle persistence may help with progress and risk management

*Practical tasks*

* **Risk assessment** – have effective, multi-agency approaches to assessing and monitoring risk
* **Assess capacity** – ensure staff are competent in applying the Mental Capacity Act in cases of self-neglect
* **Mental health assessment** – it may, in a minority of cases, be appropriate to refer an individual for Mental Health Assessment
* **Signpost** – with a multi-agency approach people can be signposted to effective sources of support
* **Contact family** – with the person’s consent, try to engage family or friends to provide additional support
* **Decluttering and cleaning services** – where a person cannot face the scale of the task but is willing to make progress, offer to provide practical help
* **Utilise local partners** – those who may be able to help include the RSPCA, the fire service, environmental health, housing, voluntary organisations
* **Occupational therapy assessment** – physical limitations that result in self-neglect can be addressed
* **Help with property management and repairs** – people may benefit from help to arrange much needed maintenance to their home
* **Peer support** – others who self-neglect may be able to assist with advice, understanding and insight
* **Counselling and therapies** – some individuals may be helped by counselling or other therapies. Cognitive behaviour therapy, for example, may help people with obsessive compulsive disorder, hoarding disorder or addictions.

**What different professionals/ agencies can do to help**

* **Clinical psychologists** can support people who self-neglect by developing a psychological understanding of their situation and helping them to find strategies to help manage their situation, including psychological therapy
* **Community Nurses** provide healthcare to people in their own homes. They will refer to other services, such as the Continence Service, or for specialist equipment like hospital-type beds.
* **Environmental Health** aim to reduce the risk to the self-neglecting person themselves but also to the community, through practical direct work with the person, invoking relevant legislation where necessary.
* **Fire & Rescue Services** can provide fire safety advice and put practical measures in place to reduce the risk of a fire. They may refer on to other agencies for more support.
* **General Practitioners (GPs)** can identify people who seem to be self-neglecting, provide support and refer to other agencies to enable people to get support and help if required and consented to.
* **Hospital Nurses** will identify patients who seem to be self-neglecting, support the patient and refer to other agencies to enable patients to gain help and support if required and consented to whilst in hospital.
* **Housing staff** can help people very practically to support their tenancies if they are at risk of being evicted because of problems with self-neglect or hoarding.
* **Independent Advocates** support the person to make their own decisions, ensures their views, wishes, feelings, beliefs and values are listened to, and may challenge decisions that they feel are not in the person’s best interests.
* **Occupational Therapists** work with individuals to identify any difficulties they experience in day to day living activities and find ways to alter or solve them. They support independence where possible and safety within the community and build confidence and motivation.
* **Paramedic**s are called by the patient or a third party caller due to medical concerns or health deterioration. They will deliver appropriate emergency treatment, assess mental capacity in relation to the health issues presented (particularly if a person is refusing to go to hospital), and refer on to other agencies with concerns.
* **Physiotherapists** can help with treatment of injury, disease and disorders through physical methods. A physio helps and guides patients, prescribes treatment and orders equipment.
* **Police** can investigate and prosecute if there is a risk of wilful neglect, they can provide safeguarding to families and communities by sharing information, refer to specialist partner agencies, and use force to gain entry/access if there are legal grounds to do so. The PCSO Early Help Team will refer to other agencies and signpost.
* **Probation Service** will identify problems via home visits, provide regular monitoring and may refer on to other agencies. They will complete risk assessments and risk management plans, making links to the risk of serious harm.
* **RSPCA** investigate complaints of cruelty and neglect to animals and offer support and advice.
* **Social Workers** will complete an assessment by having conversations with the person, building a relationship and considering strengths and risks. They may carry out a Mental Capacity Assessment if indicated in relation to specific decisions. Social workers may provide social work interventions, support the person to develop social networks and/or engage in their community, arrange a package of care or refer to other agencies for the services that they provide e.g. to fire services for a fire safety check. They might arrange multiagency meetings to discuss concerns and ways forward.
* **Voluntary, Community and Faith Sector** (VCFS) staff/volunteers can provide a range of social opportunities and support services that connect people with their communities, e.g. luncheon clubs, support groups. Health advice, food banks, advocacy etc. Staff and volunteers can be a key part of formal as well as informed plans and support. Village agents.

*Non -engagement/ withdrawal of services*

When services withdraw it is important that there is a clearly considered multi agency discussion re whether there is sufficient risk management planning to identify and act upon any self-neglect relapse. The SSAB Multi agency Risk Management process may assist practitioners in setting up a multi agency discussion to address this.