# North Lincolnshire Safeguarding Adults Board
# Multi - agency training on self - neglect

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# Housekeeping

SILENCE MOBILE DEVICES

# Learning outcomes

The aim of this course is to enable participants to develop an understanding of self - neglect, identify causes and characteristics, and provide effective support strategies.

# Quiz!

- **Question 1:** Self – neglect is usually a 'lifestyle choice?' True or false?
- **Question 2:** Self – neglect doesn't always have to be the subject of a safeguarding enquiry. True or false?
- **Question 3**: If someone who is self – neglecting has mental capacity and refuses to engage in intervention, there is nothing that can be done to impose solution. True or false?
- **Question 4:** Making Safeguarding Personal means you can only do what the person will allow you to do. We have to respect autonomy. True or false?
- **Question 5:** Making Safeguarding Personal takes too long – we don't have time, we need to find quick solutions. True or false?
- **Question 6:** Five frogs are sitting on a log. One decides to jump off. How many frogs are now sitting on the log…

# Self - neglect - definition

**Self – neglect:**

- This covers a wide range of behaviours - neglecting to care for one's personal hygiene, health or surroundings, and involves behaviours such as hoarding.

*(Definition from the Care Act Statutory Guidance, DH 2014 p234)*

- Supporting a person who self - neglects, or is at risk of self - neglect, is a highly complex human event.
- People in these situations are more likely to have experienced trauma, may have reduced capacity to tolerate change, and may have developed unhelpful behaviours as a result of their personal experiences.

# Forms of self - neglect

LACK OF SELF - CARE

LACK OF CARE FOR ENVIRONMENT

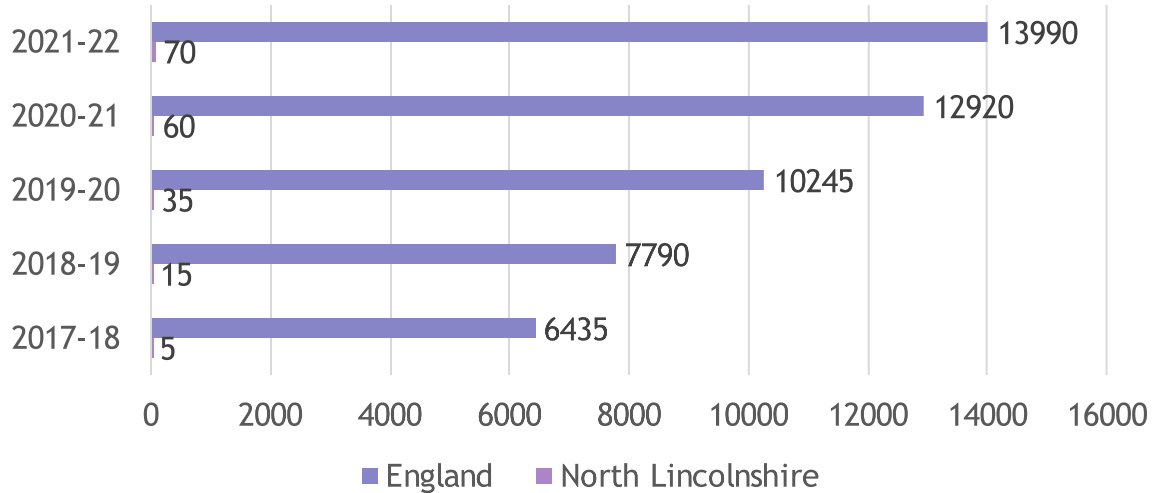
REFUSAL OF SERVICES

# What factors may contribute to self - neglect?

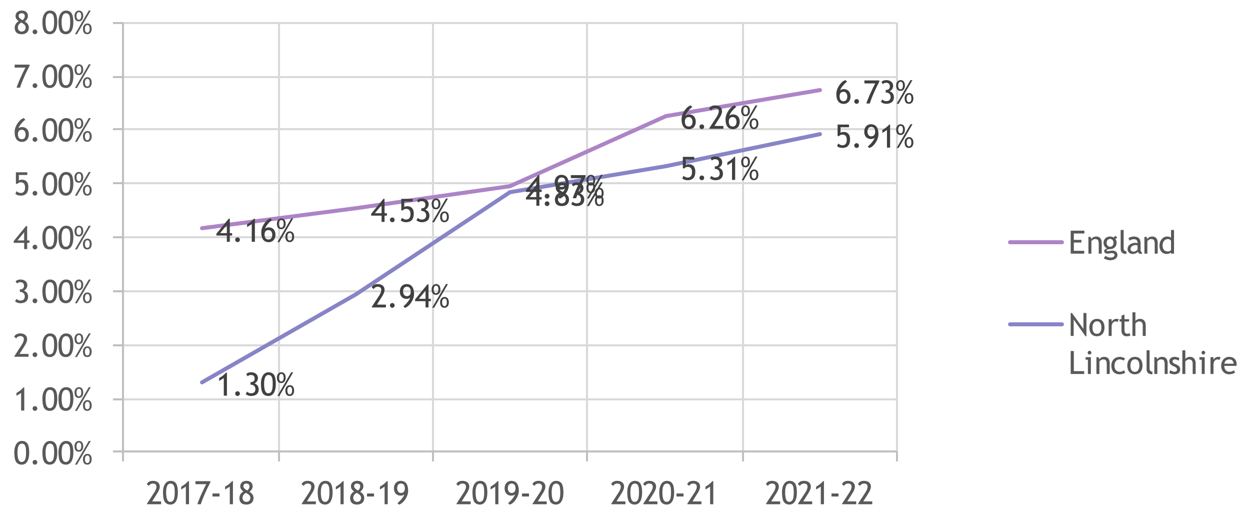
- Brain injury
- Dementia
- Mental health
- Obsessive compulsive disorder
- Hoarding disorder
- Physical illness
- Organisational skills
- Motivation
- Addictions
- Trauma

*Social Care Institute for Excellence, (2018)*

# Increase in the number of cases?




Over the last five years, the cases of self – neglect have been on the rise, both locally and nationally.




This graph represents a yearly % increase of self - neglect cases in concluded S42 enquiries.

# Case study - Merseyside Fire and Rescue Services (MFRS)

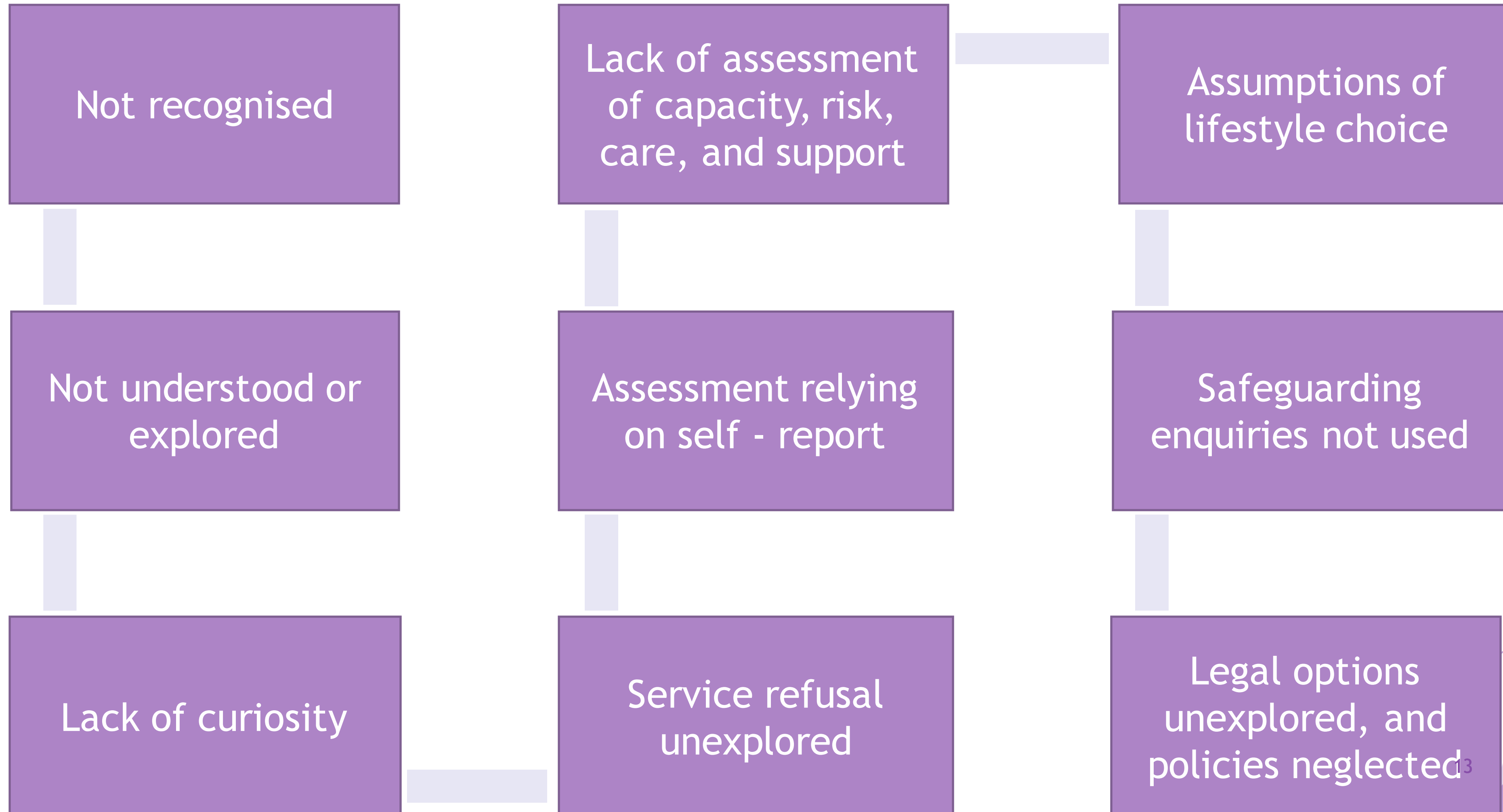
- Double fatality.
- Known to MFRS and Liverpool City Council (LCC) environmental health team.
- Refused to engage with any agencies.
- Assumed to have capacity.
- No access for MFRS breathing apparatus (BA) team.
- Major Incident declared and main route to Liverpool John Lennon Airport closed (eventually for a week).
- Multi - agency decision made to excavate whole property.
- Cadaver dog confirmed deceased person(s).

# ‘My story’ - A lived experience of adult safeguarding and self - neglect

# Learning from safeguarding adult reviews (SARs)

- Statutory function under Section 44 of the Care Act 2014.
- The SAB must arrange a SAR of an adult in its area with needs for care and support (whether or not the local authority was meeting those needs) if:
  - ✓ There is reasonable cause for concern about how the SAB, its members or organisations worked together to protect the adult; **AND**
  - ✓ The person died and the SAB knows / suspects this results from abuse or neglect whether known or suspected and there is concern partner agencies could have worked more effectively to protect the adult; **OR**
  - ✓ The person has not died but the SAB knows or suspects that they have experienced serious abuse/neglect.
- SAB Conference recording - YouTube - Learning from SARs by Professor Michael Preston - Shoot.

# National findings analysis



[Responding to self-neglect - YouTube]

# Frontline practitioners - best practice

Person - centred, relationship - based

Professional curiosity (history)

Assessment of care and support, and mental health

Transitions - opportunities not cliff edges

Assessment and review of risk, and capacity

Family involvement (think family)

Availability of specialist advice

Legal literacy

Balancing autonomy with a duty of care

# Multi - agency best practice

- Guidance on balancing autonomy with a duty of care
- Information sharing and communication
- Working together on complex, stuck and stalled cases
- Use of multi - agency meetings and safeguarding enquiries
- Clear roles and responsibilities (lead agencies and key workers)
- Shared record - keeping

# Organisational environment - best practice

Development, dissemination, and review of guidance

Clarifying management responsibilities and oversight

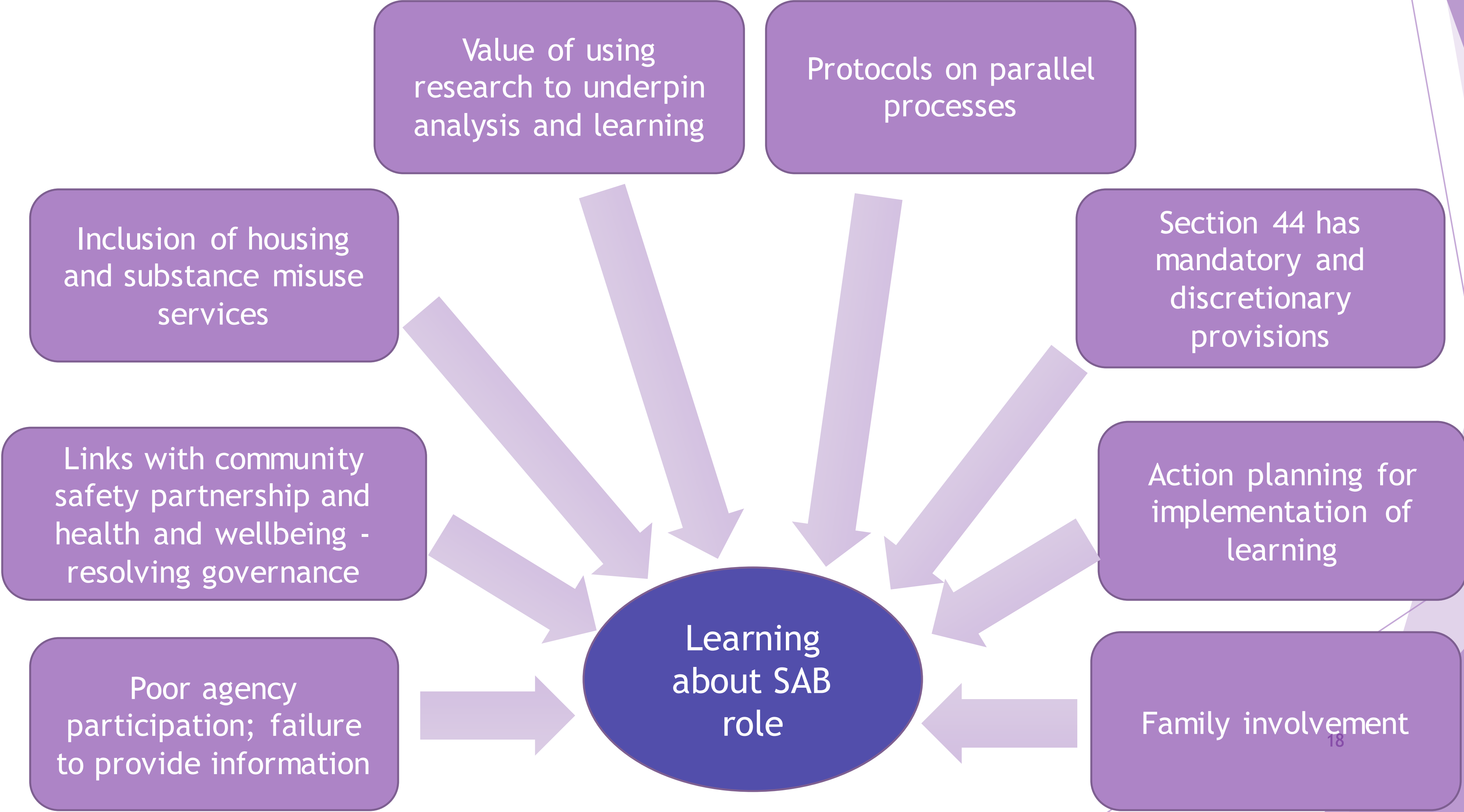
Staffing, supervision, support and training

Recording standards

Commissioning and contract monitoring

Culture of openness, challenge and escalation

# SAB governance



# Thinking about change - A whole system conversation with SAB as the guiding presence

- What are we trying to achieve?
- What is the evidence base for what good looks like?
- Where are we now, and how might we reach where we need to be?
- What actions are necessary and by whom, to achieve and sustain change?
- How will we promote and evaluate change – seminars, briefings, audits, reviews

# Person - centred strength - based practice

Person - centred, strength - based

Cultural, language, and communication needs

Respect for adult's wishes and views

Why is the person self - neglecting?

Get to know the person

Family and community networks

Robust risk assessment

Everyone has a role to play

Long term involvement

Self - neglect is not a 'lifestyle choice'

Communicate clearly and regularly

Mental capacity

Advocacy

Challenge decisions if you don't agree

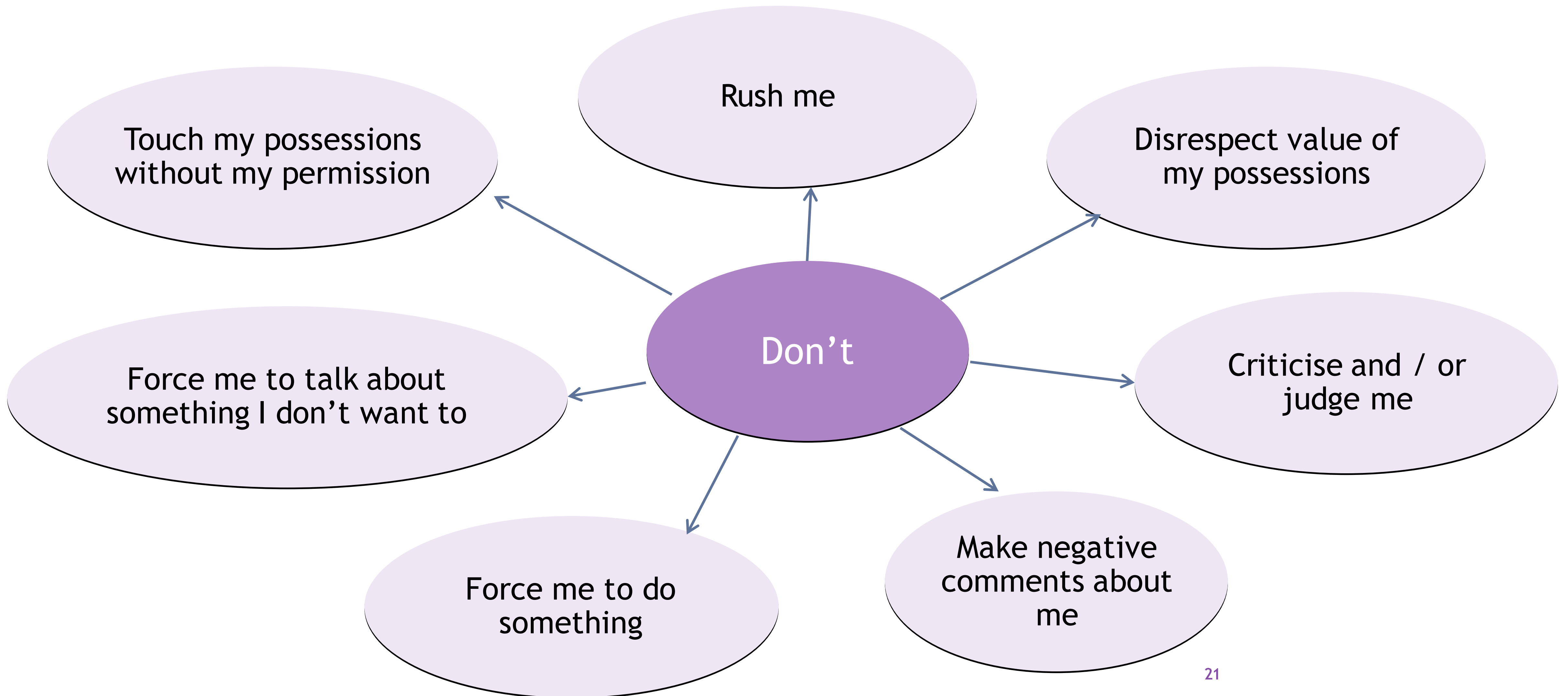
Avoid closing cases too early

Give the adult control

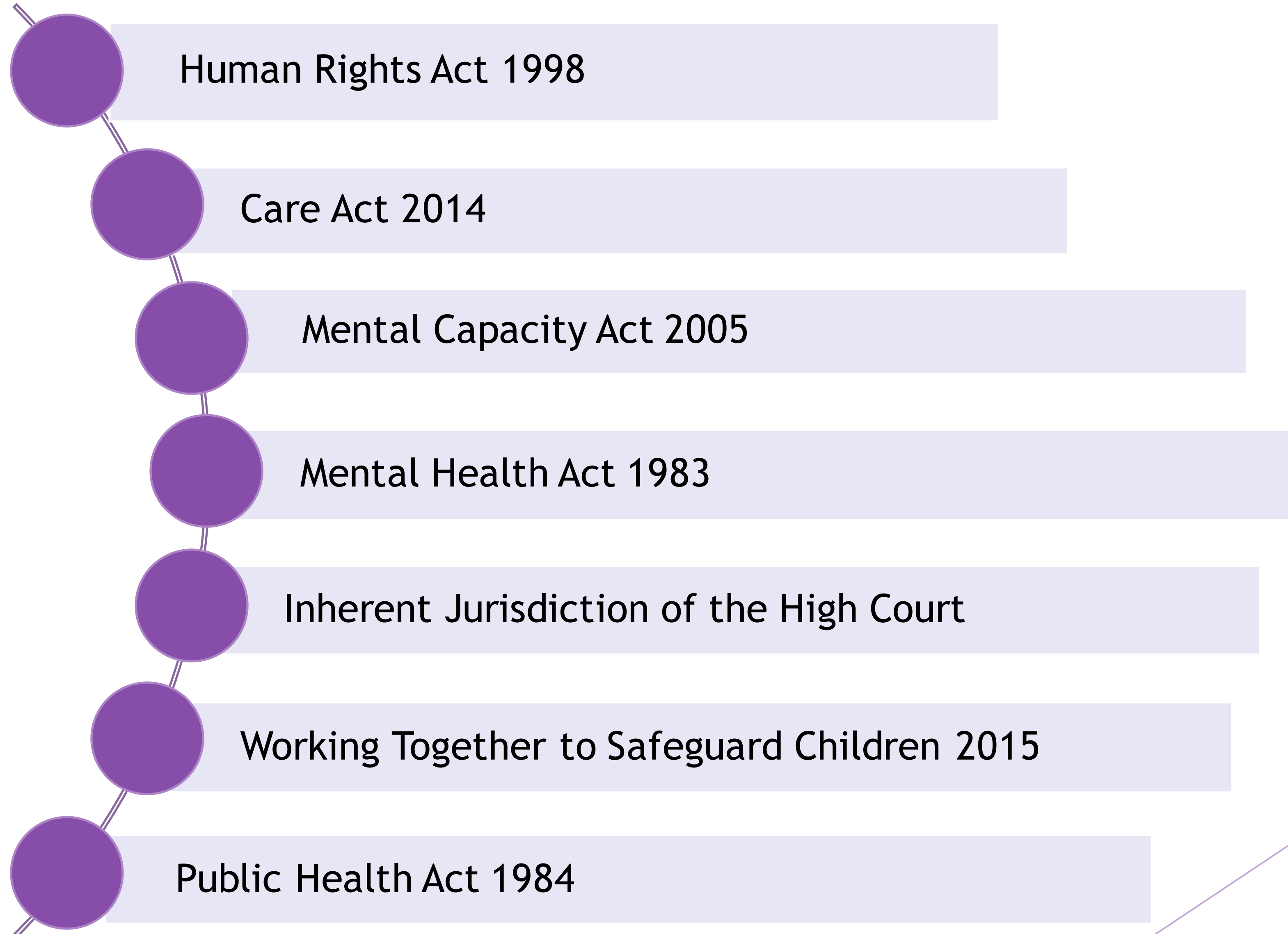
Creative solutions

'One family approach'

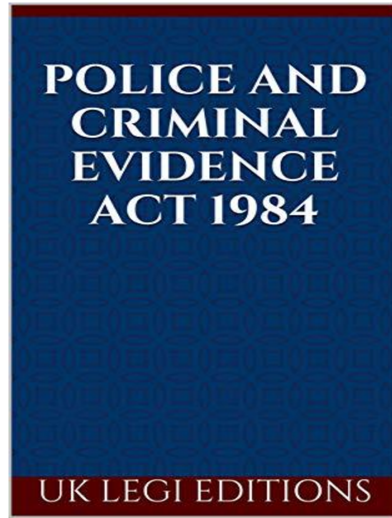
# What should we avoid?

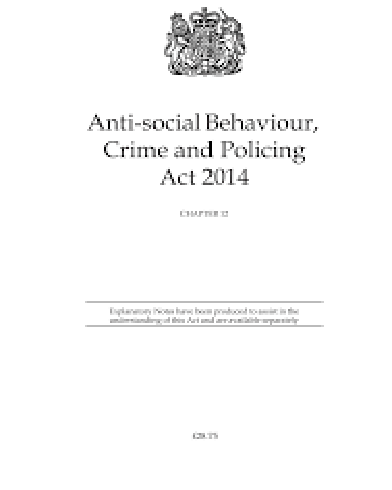


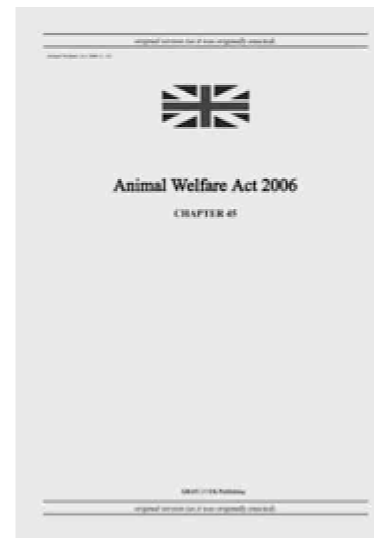
# Relevant legislation



# Relevant legislation (cont'd)





# Challenges for practitioners

Duty of care / Public expectation / policy requirements

Human rights / mental capacity / self - determination

# Challenges for practitioners

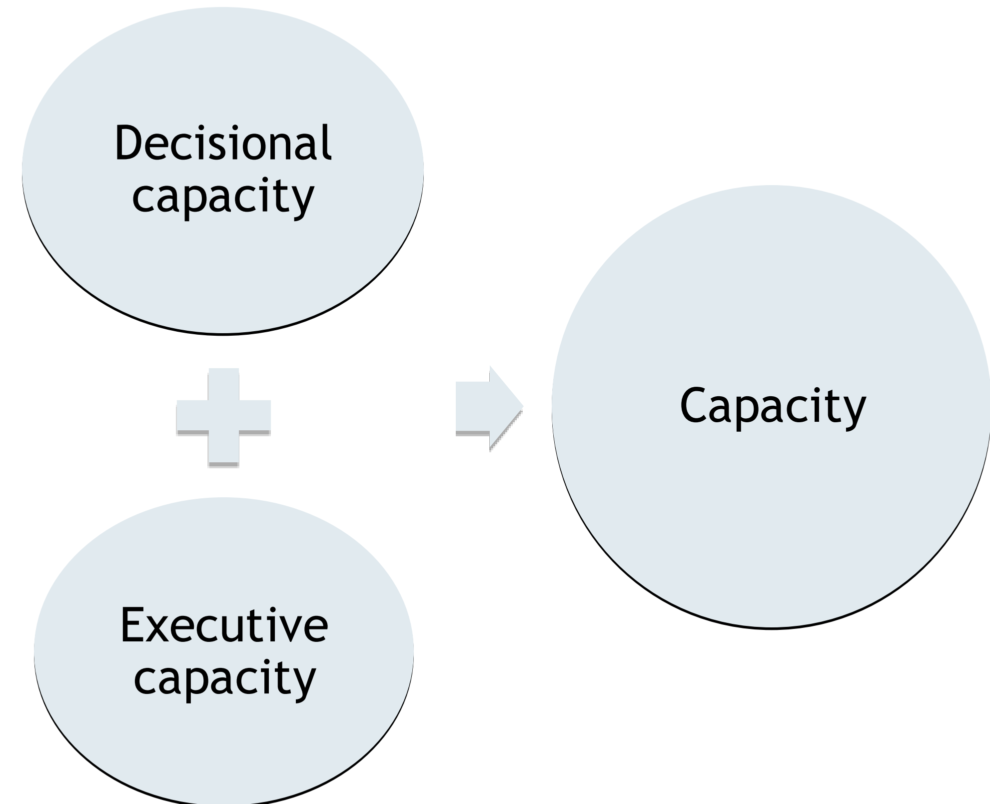
- Non - engagement with professionals, declining support.
- Professionals often criticised for ‘not doing anything to help.’
- Knowing when, and how far to intervene.
- Assessing mental capacity is often complex.
- A failure to engage with adults who self - neglect may have serious implications on their health and wellbeing.
- Varying personal judgements about what constitutes self - neglect.

# Mental capacity - challenges

- Mental capacity involves not only the ability to understand and reason through the elements of a decision in the abstract, but also the ability to realise when a decision needs to be put into practice, and executed at the appropriate moment – the ‘knowing / doing association.’

**Findings from the national SAR analysis on mental capacity identified the below shortfalls in practice:**

- Failure to assess or review.
- Poor assessments.
- Misunderstanding of MCA principles and diagnostic test.
- Neglect of executive capacity.
- Neglect of advocacy.
- Assumptions about lifestyle choice.
- Poor recording.
- Lack of confidence.

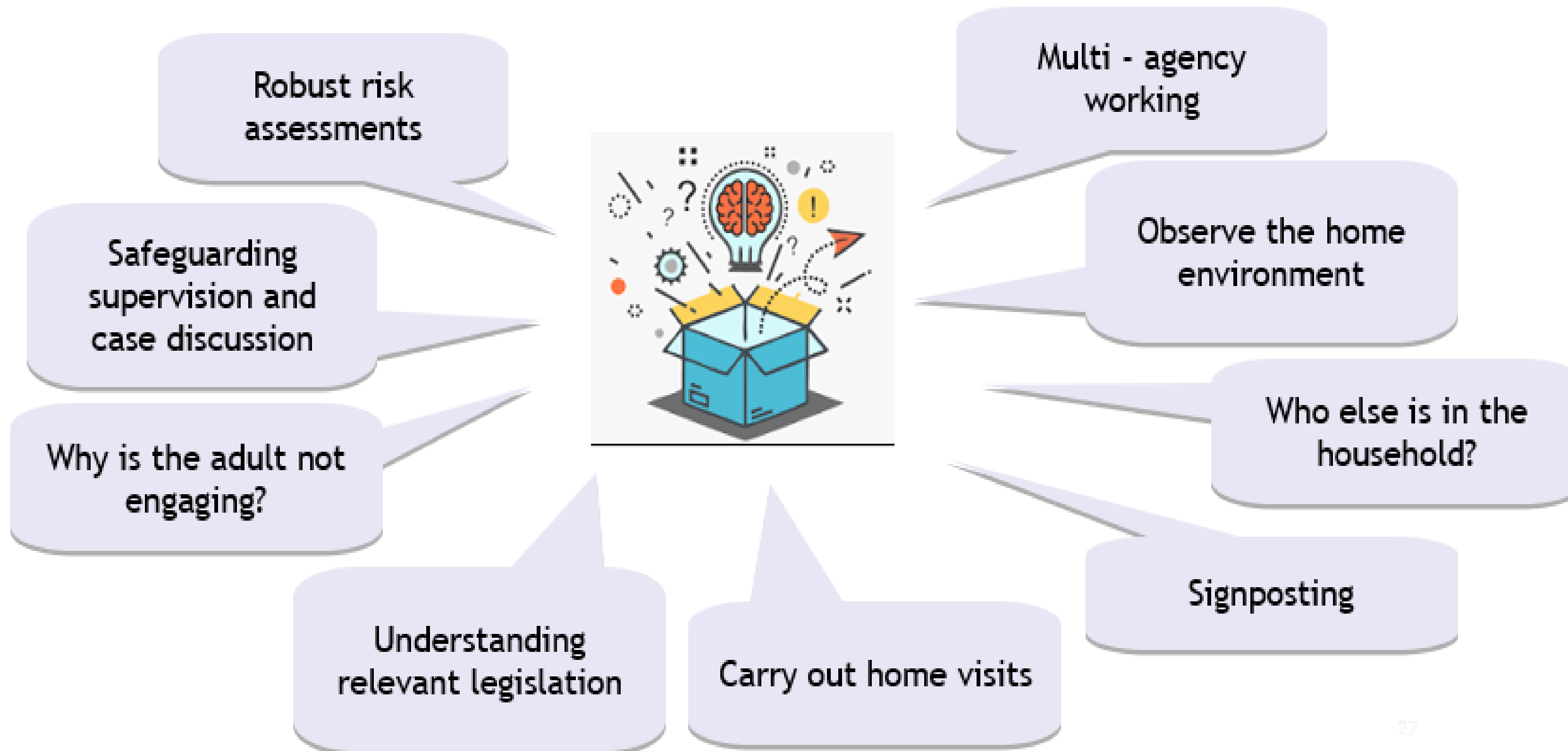





*Professor Michael Preston – Shoot, (2022)*

# Professional curiosity

- Professional curiosity is the capacity and skills of communication to explore and understand what is happening for a person, rather than making assumptions or accepting things at face value.




7-Minute-Briefing-Professional-Curiosity-FINAL.pdf (northlincssab.co.uk)

# Listening to the voice of the adult

**As you watch the video:**

- Think about the multiple influences on Keith's behaviour, and how they have affected his self - neglect journey.
- Reflect on how it felt for him, and what helped.
- Consider how his account helps us in understanding self – neglect.

Keith's story: a personal and touching film about hoarding - YouTube

# A multi - agency approach to self - neglect – What is available to support you?

- All organisations have a role in supporting people who self - neglect.
- **The Care Act 2014** states that local authorities must cooperate with each of its relevant partners, and each relevant partner must cooperate with the authority, in the exercise of its respective functions relating to adults with needs for care and support and carers.

- Professional curiosity across multi - agency working - agencies working effectively together prevents and identifies the risk of abuse and neglect earlier, and helps to protect when it's happening.
- Each professional offers a different perspective to the case, and holds vital pieces of the puzzle.

# What is available to support you? – National clutter image rating tool

12. Clutter Image Rating Scale - Bedroom

Please select the photo that most accurately reflects the amount of clutter in the room

1 2 3

4 5 6

7 8 9

13. Clutter Image Rating Scale – Lounge

Please select the photo that most accurately reflects the amount of clutter in the room

1 2 3

4 5 6

7 8 9

14. Clutter Image Rating Scale – Kitchen

Please select the photo that most accurately reflects the amount of clutter in the room

1 2 3

4 5 6

7 8 9

# Tools to support practice

7 Minute Briefing

Line of Sight to Practice (self-neglect)

**1 Background**

In December 2021 the Protection & Accountability subgroup undertook a Line of Sight to Practice panel event in relation to the theme of self-neglect.

The event was led and chaired by a nominated member of the subgroup who was independent. Panel members included representatives from SAB partner agencies as well as frontline practitioners and managers from agencies who worked with the people.

The event enabled panel members to discuss how we supported two people in depth, engage in active challenge and identify a number of learning points from areas which worked well, and those which could be further developed.

**2 Safeguarding and self-neglect**

The Care Act 2014 defines self-neglect as covering a wide range of behaviours – neglecting one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

It should be noted that self-neglect does not always prompt a S42 enquiry, an assessment should be made on a case by case basis.

It is however important to recognise that without early intervention, existing health problems may be made worse.

Neglect of personal hygiene may mean that the person suffers social difficulties and isolation, physical and mental health breakdown. Dilapidated property or excess rubbish can become infested and can be a fire risk, which is a risk to the adult, family, neighbours and others.

**3 Identified good practice**

- Person-centered practice was evident and the views and wishes of the people were taken into consideration throughout the enquiry.
- Strengths-based practice was evident, the positive aspects of the people's circumstances and networks were recognised, and these were used in the development of care and support plans.
- Collaborative working was evident which led to the reduction of risk and positive outcomes for the people.
- Timely and appropriate information sharing took place between agencies.
- Decisions, where appropriate were made in Best Interests and recording / rationale was robust.
- Complexities of the situations were recognised, and periods of transition were put in place between agencies and teams.

**4 Key learning**

- There was some uncertainty as to when a concern about self-neglect may require a safeguarding response under S42 of the Care Act 2014.
- The difficulties in respecting people's right to private life, verses a safeguarding duty to keep people safe from abuse and neglect were recognised.
- There would have been benefit in one agency taking the lead to co-ordinate the management of risk.
- There was inconsistency in relation to safeguarding terminology which may have caused confusion.
- The use of the Humber-wide Hoarding Protocol and clutter index would have been useful in identifying thresholds.
- Consideration could have been given earlier as to whether responses to circumstances may have been as a result of physical or mental ill health.

**5 Top actions**

- Continue to ensure the voice of the person with a lived experience is embedded in the design of policies & procedures, training and in the delivery of future services.
- Develop multi-agency guidance, and tools and raise awareness to support partner agencies and frontline practitioners in relation to self-neglect.
- Co-ordinate the delivery of multi-agency training specific to self-neglect to help ensure that partner agencies and frontline practitioners are supported and have the appropriate tools when working with people who may be at risk from self-neglect.
- Continue to develop the tools and guidance available to partner agencies and practitioners in relation to safeguarding adults' legal literacy.

*** Please note – all details of all updated guidance, policies and multi-agency training available will be published on the SAB website* www.northlincssab.co.uk *and shared via our communications network.*

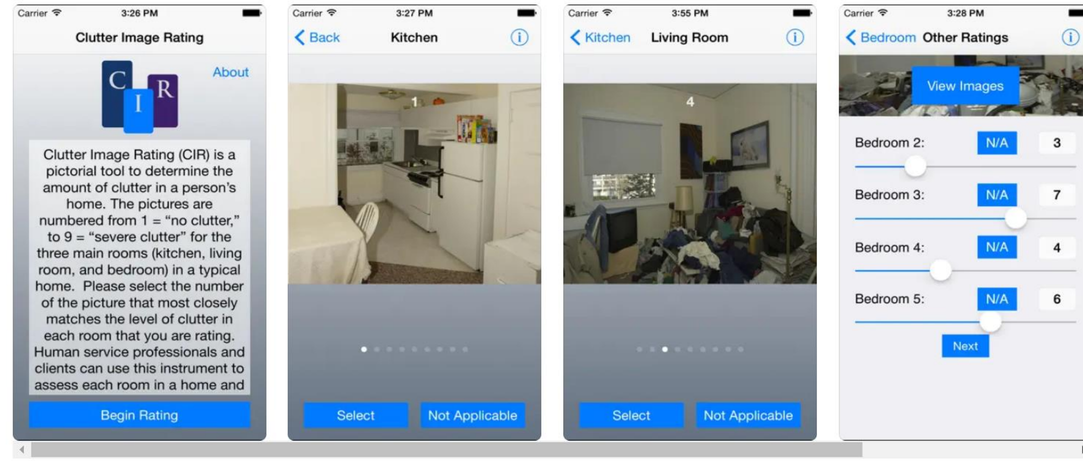
**6 Develop your learning**

To inform your practice you can:

- Ensure you are familiar with the Humberside-wide Hoarding Protocol https://www.northlincssab.co.uk/wp-content/uploads/2019/08/Hoarding-Protocol-10.pdf
- Refresh your knowledge and understanding of the SAB Multi-agency Policy and Procedures https://www.northlincssab.co.uk/wp-content/uploads/2021/06/North-Lincolnshire-MA-PP-v3.pdf
- Access the policies and research relating to self-neglect published by SCIE https://www.scie.org.uk/self-neglect
- Discuss complex situations with your supervisor, consider whether there is any research which may deepen your understanding of the experiences (this could be with your supervisor, or with colleagues)
- Use reflective practice as a way of reviewing your experiences to help make positive changes to your future practice. Turn your experiences into learning.

**7 Effective approaches**

- **Multi-agency** – work with partners to ensure the right approach for each people
- **Person centered** – respect the views and the perspective of the person, 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
- **Non-judgmental** – 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
- **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




[LoSP-self-neglect-Final-1.pdf (northlincssab.co.uk)]

[Clutter Image Rating on the App Store (apple.com)]

# Tools to support practice

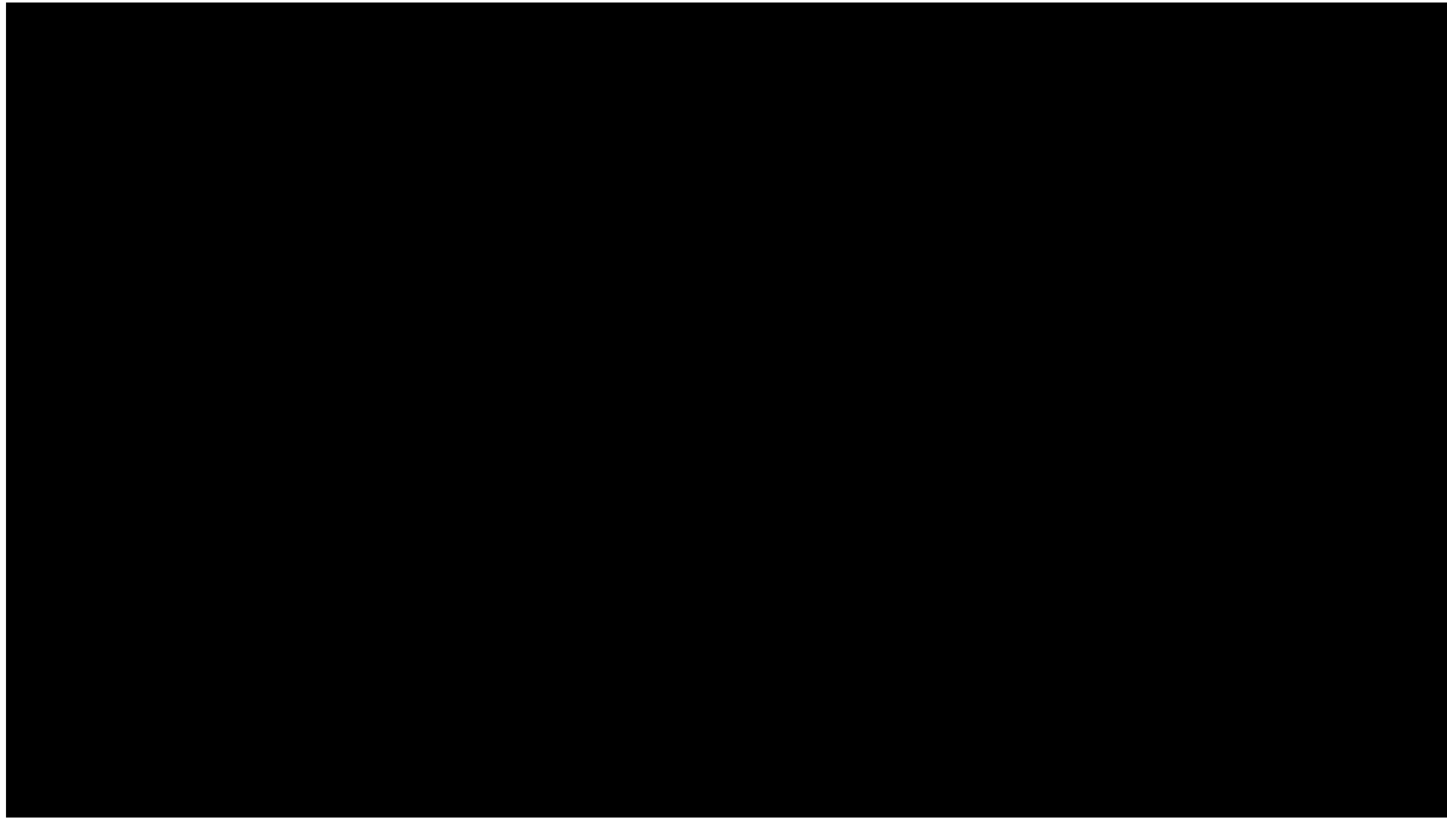
[Making Safeguarding Personal in self-neglect workbook | Local Government Association]

**North Lincolnshire**

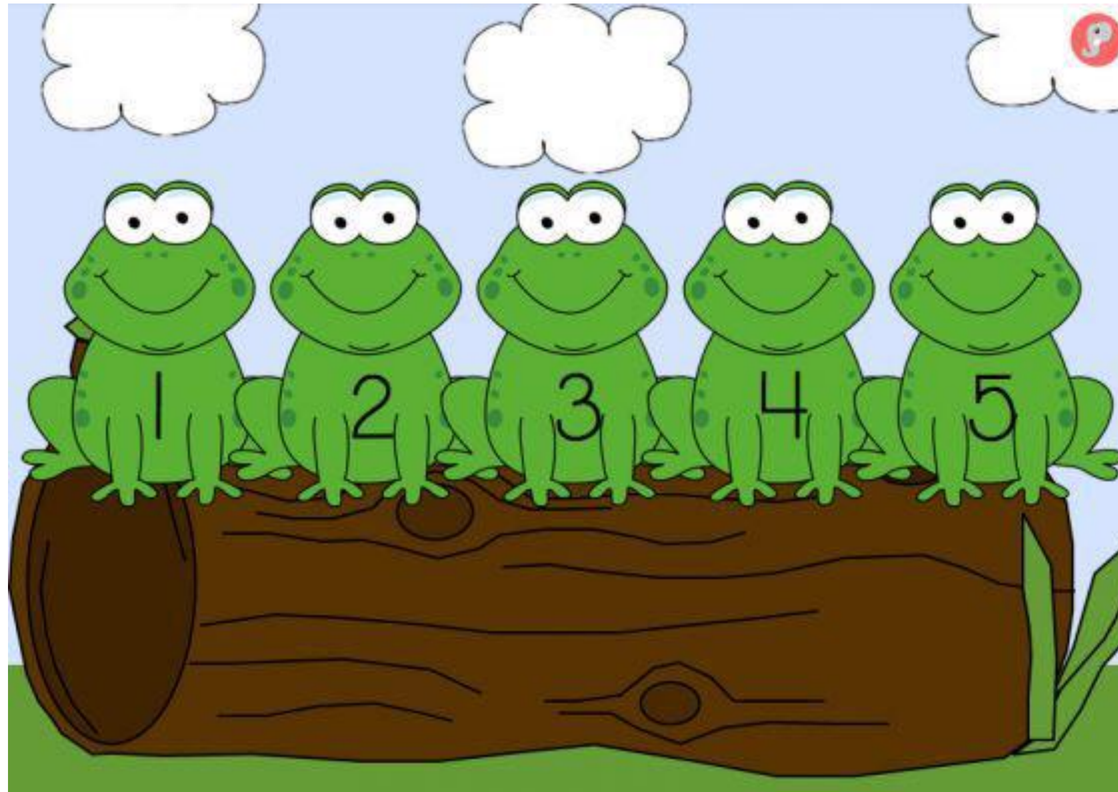
**Vulnerable Adults Risk Management (VARM)**
**Policy and Guidance**

North-Lincolnshire-VARM-Policy-FINAL.pdf (northlincssab.co.uk)

# Experts together workforce tool



# Reflections and summing up



# Further reading

- Andy, Salford SAR SAR Andy 2019 | Salford Safeguarding Adults Board
- MS, City of London and Hackney SAR ms-a-safeguarding-adult-review.pdf - Google Drive
- SAR Library https://nationalnetwork.org.uk/search.html
- Learning from reviews SAB Conference recording - YouTube

# Further reading - SAR examples

| Andy – Salford, died April 2018, aged 32 | MS – London and Hackney, died July 2019, aged 63 |
|---|---|
| ➢ Safeguarding procedures not applied to manage the risk and employ multi – agency working.<br>➢ Limited evidence of mental capacity assessments.<br>➢ Impact of life experiences on mental capacity was not recognised.<br>➢ Multi – agency self – neglect policy and procedures were not followed.<br>➢ Lack of professional curiosity.<br>➢ Lack of escalation when it was required.<br>➢ Overreliance on phone contact and letters.<br>➢ Lack of understanding how poverty affects health.<br>➢ Repeated patterns of non – engagement.<br>➢ Professionals unaware of vital information provided by family. | ➢ Seeking assurance around the use of interpreters and advocacy.<br>➢ Understanding person's lived experience.<br>➢ Reviewing the structure of multi - agency meetings for people experiencing homelessness, to ensure that there is a structured approach to engagement with services users.<br>➢ Audit mental capacity decision making for substance misuse or homelessness cases, and how we need to support staff in their understanding around this.<br>➢ Revise and publicise the escalation policy for high risk cases.<br>➢ Review the best ways to ensure practitioners maintain their legal literacy. |