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Self-Neglect Safeguarding Adults

Lindsay McAllister
Designated Nurse Safeguarding Adults

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Aim of the Session

This session will aim to give a brief understanding of self-neglect, reasons it may occur and types of behaviours you may observe in practice. The session will then explore barriers in supporting individuals and how to mitigate risk.

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Contents

- What is self-neglect
- Possible causes of self-neglect
- Behaviours
- Barriers
- Key areas
- Mental capacity
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What is Self-neglect?

- Self Neglect is a category of abuse identified by the Care Act (2014). There is no one definition of self-neglect but the term is used to cover a wide range of behaviours of a person neglecting their own health, personal hygiene or their surroundings and includes behaviour such as hoarding. It can be difficult to recognise particularly if a person has capacity to make their own decisions
- 45% of SARS involve Self-Neglect (learning from SARs October 2021)

Possible reasons for Self-neglect

- There are various reasons why people self-neglect. Some people have insight into their behaviour, while others do not.
- It is not always possible to establish a root cause for self-neglecting behaviours. Self-neglect can be a result of:

-a person's brain injury, dementia or other mental disorder
-obsessive compulsive disorder or hoarding disorder
-physical illness which has an effect on abilities, energy levels, attention span, organisational skills or motivation
-reduced motivation as a side effect of medication
-addictions
-traumatic life change
-Or is it a lifestyle choice? Your thoughts?

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Statistics

- UK: 20% of high-risk situations involving mental ill-health
- Hoarding: between 1.5%/6% of the population, pooled estimated prevalence of 2.5% (2,500 in 100,000)
- All ages, more common in older adults, severity increases
- Similar prevalence in men and women
- All socio-economic groups, more common in areas of deprivation

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Self-neglect Behaviours

- The type of behaviours that are considered self-neglect include;
- lack of self-care and not attending to personal hygiene, nutrition and hydration, or health needs, to an extent that it may endanger their safety or wellbeing
- lack of care of environment and living in situations that could lead to domestic squalor or elevated levels of risk in the domestic environment (for example, health or fire risks caused by hoarding)
- refusal of assistance that might alleviate these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment
- Remember Self-Neglect would have built up over time

Barriers to providing care

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- Working with people who self-neglect can be very challenging.
- People who self-neglect may refuse support or fail to acknowledge the problem.
- The risks associated with self-neglect can be high and the options for intervention are limited.
- There can be pressure on professionals to take action, but often very little they can do.
- There is often a lack of clarity about who should take responsibility for supporting people who self-neglect.
- Work patterns and resources don’t support long-term, relationship-based work.
- Individuals don’t always have care and support needs – so safeguarding responses may not be appropriate.
- Information sharing is sometimes problematic, particularly when the person refuses help.
- Limited legal knowledge – professionals may not have a good understanding of the law that can be utilised in relation to self-neglect.
- Application of the Mental Capacity Act can be very complex in relation to self-neglect.
- Lack of resources can prevent appropriate service responses.

Key areas to consider

- Practitioners in the community can find working with people who self-neglect extremely challenging.
- SARs tell us that we are quick to assume capacity, respect autonomy (and walk away)
- But life stories tell us otherwise
- The important thing is to not make assumptions, try to engage with people, to offer all the support we are able to without causing distress, and to understand the limitations to our interventions if the person does not wish to engage.

Mental Capacity Act (2005)
5 Principles

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Every adult must be assumed to have capacity unless it is proven otherwise

All reasonable steps must be taken to assist the person to make a decision

People have the right not to be treated as lacking capacity merely because they make a decision that others deem 'unwise'

All actions on behalf of those who lack capacity must be in their 'best interests'

Least Restrictive Intervention

Mental Capacity Key Points

- A person lacks capacity when they have an impairment or disturbance which effects their decision-making ability.
- Capacity is time and treatment specific.
- Two-part process for assessing capacity.
- Four-part functional test
- Cases of Self-Neglect – consider mental capacity and persons understanding of risks

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Mental Capacity

- Person assessed to not have capacity following assessment
- Involve family/next of next of kin
- Best interest decision making
- Involve other services
- Plan of care to be implemented taking into account care needs, risk assessments and safeguarding
- Consider safeguarding criteria

Mental Capacity

- Person assessed to have capacity
- Discussion with the individual regarding their behaviour and how it may have an impact on the overall health and wellbeing
- Offer referrals to appropriate services e.g., social care, mental health, drug and alcohol
- MDT discussions
- Risk assessment and actions to mitigate risk
- Consent to speak with family/next of kin for additional support
- Peer supervision
- Consider safeguarding criteria
- Seek safeguarding advice


Case
Example

Safeguarding Adult Review

- Cheshire East

- Mervyn was an adult at risk who lived in a privately rented property. He was admitted to the Burns Unit on 24th February 2020 following a house fire. He sadly died a few days later (28th February) from the effects of smoke inhalation and severe burns. He was aged 86.

- Case referred to SAR. The referral identified concerns around high-risk self-neglect and hoarding, coupled with a refusal to engage with services. It was stated that Mervyn had been referred to Adult Social Care around 12 months prior to his death. He was assessed by Adult Social Care but declined input. He was deemed to have capacity to make this decision. The referral form also stated the Fire Service had made several attempts to provide advice around fire safety, but this was also declined by Mervyn.

Case Example

- The Fire Service reported that Mervyn was living in a quarter of his living room as the rest of the property was inaccessible due to hoarding. There was a motorbike in the living room. He was using an outside toilet. He slept on the sofa and the only heating was from a 2-bar electric fire which was surrounded by piles of papers. This posed a huge fire risk both to Mervyn and to his neighbours as he lived in a terraced house. His kitchen was not useable and so he cooked in a microwave in the living room. He is reported to have gone to one of his neighbours' houses every day for breakfast and to have visited a friend weekly for a meal.

Case Example

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- The referral also observed that it had been reported to the Hospital that Mervyn's GP suspected that he had dementia but that he refused to be formally assessed for this. However, the Independent Reviewer has been told that it was a Pharmacist who had made reference to Mervyn being muddled about medication and that there had been no mention of dementia.

- He was admitted to Hospital with inhalation injuries, carbon monoxide poisoning and extensive burns following a house fire. It was established soon after arrival that the injuries were too significant for him to recover from and so he was provided with supportive care focussed on maximising comfort. Mervyn's death was referred to the Coroner. At an inquest in November 2020, a verdict of accident was recorded.

- The referral raised concerns around the input of the agencies involved and what appeared to be a lack of intervention, escalation and multi-disciplinary team working in a high-risk situation where there was a risk to both an individual and other members of the public.

Case Example

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- The Serious Case Group Panel, when discussing the referral, observed that Mervyn was an adult at risk whose case was not open to any agency at the time of his death. He had been referred to Adult Social Care around 12 months prior to his death by his new landlord after he had to force entry into the property and was concerned at how Mervyn was living. A home visit was conducted by a Duty Social Worker, but Mervyn declined input and he was deemed to have capacity to make this decision. Adult Social Care did not notify the Fire Service of this referral and no referral was made to the High-Risk Forum. Mervyn agreed that a letter outlining support could be sent to him and this was sent following the visit.

- Mervyn had no running water. He was hoarding electrical items in boxes, mechanical parts, and children's toys. He was using an outside toilet that he flushed with a bucket of water. There was no inside bathroom, the property was an early 1900's terraced house and had never had a bathroom fitted. Mervyn had lived in the property with his mother since he was born; it was unclear when his mother died but it was believed his self-neglect escalated following this bereavement

Case Example

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- Limited professional curiosity. Rather than immediately foregrounding his autonomy, further outreach may or may not have led to doubts concerning whether Mervyn had decisional capacity and whether his executive functioning was impaired

- Mervyn was socially isolated

- Any thoughts, what could have been done differently?

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In Practice

- When developing an approach to engage the person 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. If the individual is more inclined to engage with one organisation over others, then this should be made the most of in working with the person.
- Person centred – respect the views and the perspective of the individual, listen to them and work towards the outcomes they want. What is their desired outcome?
- Risk management may be the best achievable outcome, it may not be possible to change the person's lifestyle or behaviour. Is there any risk to others
- Curiosity - about the meaning of behaviour , 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
- Other consideration – Trauma Informed Approach to Care

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In Practice

- 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 and negotiation – making agreements to achieve progress can be helpful but it is important that this approach remains respectful
- Consider 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

Key Points

- Mental Capacity - The persons understanding of the risks associated with non-engagement
- Risk Assessment – Mitigation of risks to reach the best outcome
- Recognising self-neglect as a safeguarding concern
- Follow safeguarding duty as per the Care Act
- Seeking advice from Safeguarding professionals
- MDT approach to care –avoid working in silo
- Social care referral/advice
- Contact family – with the person's consent, try to engage family or friends to provide additional support
- In house discussion/supervision
- Risk assessments, explore and negotiate the mitigation of risk for persons displaying self-neglect who have capacity
- Revisit referrals to support services
- Document all actions/interventions, decisions and rationale. THIS IS YOUR AUDIT TRAIL

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