Adults who self-neglect

Learning from serious case reviews

Self-Neglect Definition

- lack of self-care – neglect of personal hygiene, nutrition, hydration, and health, thereby endangering safety and well-being, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- refusal of services that would mitigate risk of harm.

Research Focus

- What is the nature of the self-neglect cases reviewed through SCR processes?
- What themes emerge from the SCRs and how do these add to understanding about professional intervention in cases of self-neglect?
- How many and what kind of recommendations are made by SCRs and to which agencies are they addressed?

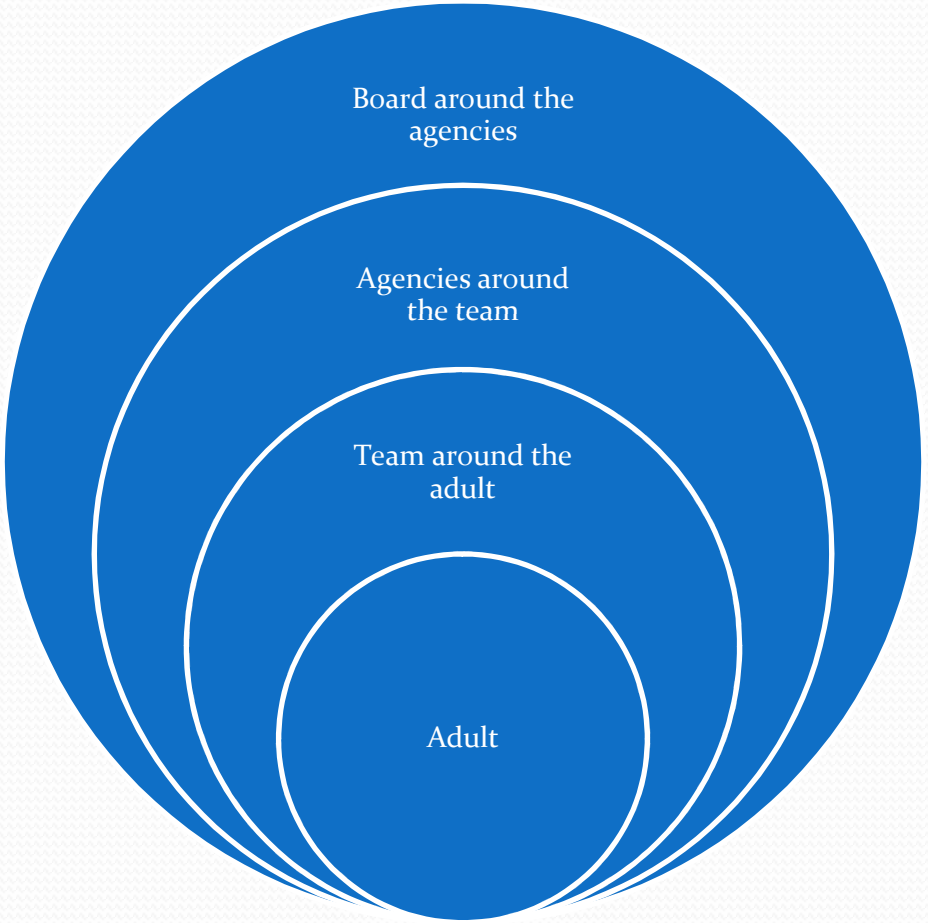
Numbers

- 153 Local Authority and Local Safeguarding Adult Board web pages reviewed.
- 21 SCRs identified in the public domain.
- Personal contacts with Independent Chairs & Board Managers.
- 11 additional SCRs obtained, not all published.
- Total of 38 SCRs known to have been commissioned; some yet to be completed.

Analysis Methodology

- Key characteristics of each case (n=38): gender, ethnicity, age, domestic living status, disability, details of agency involvement;
- Key characteristics of the SCRs (n=38): publication, length, whether self-neglect comprised a central dynamic, number of recommendations, availability of action plans;
- Frequency of recommendations in the SCRs (n=31) for individual agencies and for LSABs;
- Themes extracted from the recommendations in the SCRs (n=31).

Thematic Analysis of SCRs



Case Characteristics

- Published reports do not always give exact details of how the individuals concerned died.
- Where known (n = 36), 56% of the sample are male and 44% female.
- Where age was known (n = 27), the largest group were over 76 (41%); 19% of the sample were aged between 21 and 39, 30% between 40 and 59 and 10% between 60 and 75.
- Ethnicity was not routinely recorded in the reports.
- 21 lived alone, 10 with family or friends, 3 in sheltered accommodation or care homes, 4 not known

SCR Characteristics

- In available reports, self-neglect a central focus in 14, implicit in 12 & peripheral in 5.
- Considerable variation in length: 5 – 63 pages.
- Similar variation (between 4 and 30) in the number and detail of the recommendations.
- Different approaches towards naming SCR author & independent oversight of process.
- Mixed attitudes towards publication.

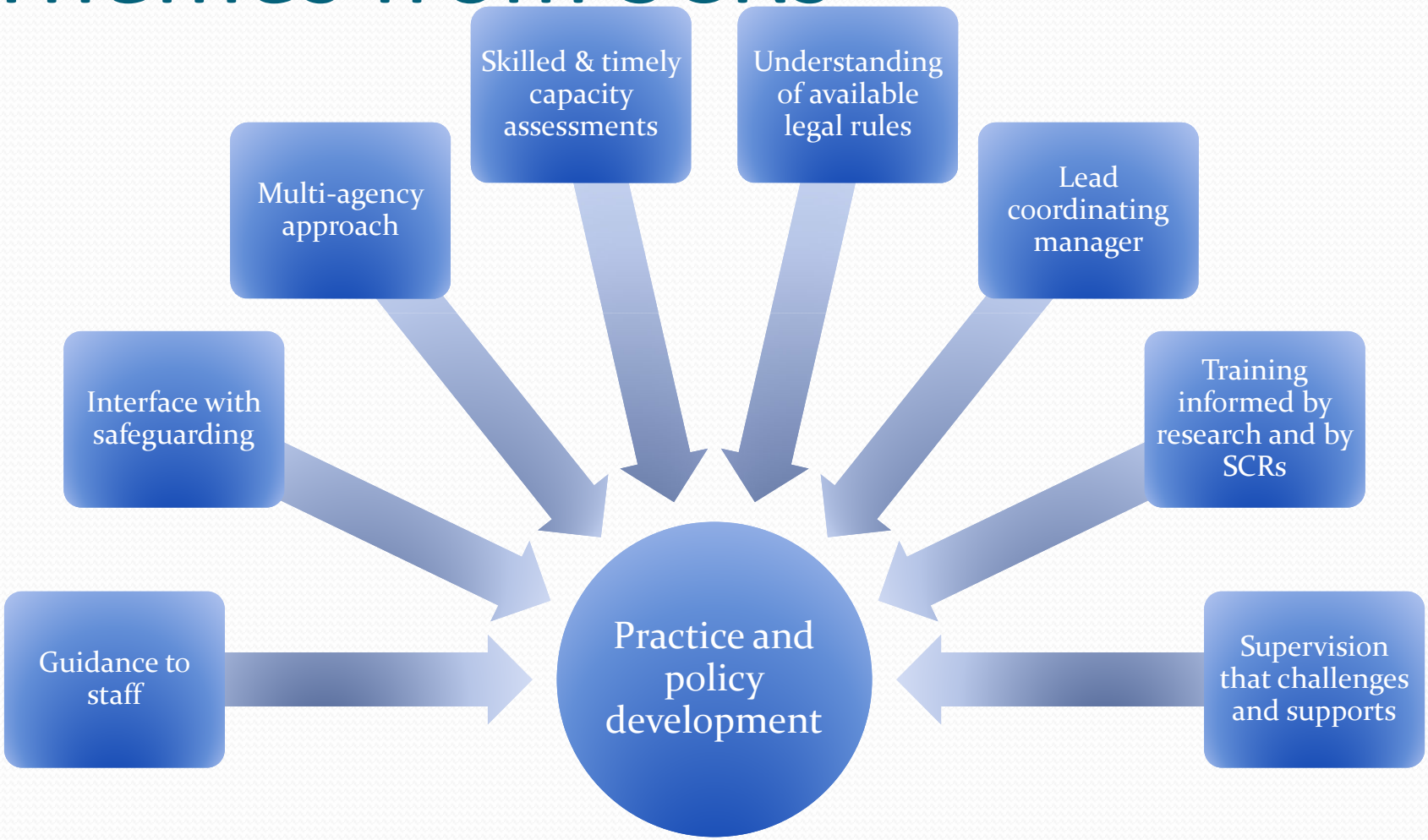
Recommendations to Agencies

- 81% contained recommendations for the SAB itself, with adult social care also targeted (71%).
- NHS commissioners (42%), Housing (29%), Mental health and acute care sectors (23%), Police (19%), GPs (16%)
- Some recommendations where it was not possible to identify the healthcare organisation (5 reports) or other agency (21 reports – 68%) charged with taking forward particular actions.
- Recommendations often directed simultaneously at a number of agencies and/or professionals, making audit of progress difficult.
- Only 14 SCRs (45%) contained action plans.

Types of Recommendations

- Broad categories relating to procedures, best practice, SCR process, and staff training and support.
- Support – training (84%), supervision (48%)
- Procedures – develop guidance (77%), referral & assessment (71%), case management (65%), recording (58%), working together (45%), information sharing (39%)
- Best practice – relationship-centred (48%), engaging hard to reach (48%), mental capacity (48%), carer involvement, (42%) legal knowledge (19%)
- SCR process – action plan (48%), managing process (45%), using SCR (45%)

Themes from SCRs



Thematic Analysis – Adult

- History – explore questions why; curiosity
- Person-centred approach – be proactive
- Hard to reach – try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Mental capacity – ongoing assessment & review, guidance for staff regarding people with capacity who refuse services and are at risk
- Carers – offer assessments, concerned curiosity & challenge, explore family dynamics, engage neighbours

Thematic Analysis – Team around the Adult

- Recording – clarity & thoroughness of work done, agreed plans, outcomes achieved, discussions held
- Legal literacy – know and consider available law
- Safeguarding literacy – awareness of guidance & procedures, of risks and vulnerabilities, of safeguarding systems; adequate exploration of apparent choices
- Working together – silo working, threshold bouncing, shared assessments & plans, liaison & challenge, follow-through
- Information sharing
- Advocacy – consider use with hard to engage people
- Use of procedures – DNAs, safeguarding alerts, risk assessments
- Standards of good practice – thoroughness of assessments, challenge professional optimism, lack of assertiveness & curiosity, authoritative practice

Thematic Analysis – Organisations around the Team

- Support – cases are complex, high risk, stressful & demanding, so support systems essential; review scope and adequacy of policies
- Culture – encourage challenge & escalation of concerns; balance personalisation with duty of care; review case management approach
- Supervision & managerial oversight – senior managers should take responsibility for overseeing complex cases; effective supervision; use risk panels; audit cases
- Staffing – practitioners must have appropriate experience & resilience; review allocation of work; mindful of health & safety

Thematic Analysis – LSAB around the Organisations

- Conducting SCRs – involve family & carers, avoid delay
- Monitoring & action planning – robust action plans and audits of impact needed
- Procedures & guidance – develop protocols on risk & capacity assessments, follow up of service refusal, cases where adults have capacity but at risk of harm
- Use of SCR – across LSABs, in training, with government departments, for procedural development
- Training – on mental capacity, law, procedures, writing IMRs, on person-centred approach & strategies to engage people; evidence outcomes

Final Observations

- Difficulty of obtaining SCRs limits learning.
- Emphasis on procedural development but guidance often ignored or not embedded.
- Emphasis on training but outcomes, if captured, variable.
- Does publication make a difference? Publication of executive summaries or full reports?
- Legal, ethical and organisational contexts important to explore in SCRs.
- Descriptive but do we know why things mapped out the way they did?
- To what degree will the Care Bill help with these cases – statutory LSABs, duty to cooperate, duty to review cases; likely absence of power of entry & protection orders

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