Self Neglect Workshop

Todays Session

10:00 am – Background to Policy & Procedures

10:30 am – Sally Hyde, A Health Perspective

11:00 am – Break

11:15 am – Alexa Kersting-Woods, Kent Fire & Rescue

11:45 am – Case Studies

12:15 pm – Questions & Answers

Background to policy

- Self-neglect has long been something of a 'grey area'
- *No Secrets* (Department of Health, 2000) focused entirely on abuse and neglect by a third party, leaving how to respond to the demands of self-neglect largely at the discretion of local authorities and their partner agencies
- Safeguarding Adults Boards' policies and procedures commonly contain no reference to self-neglect
- Only 11 Serious Case Reviews have been published
- The debate has been a factor in raising awareness of the challenges that self-neglect poses to the social care workforce

So what?

- 2009 - Research commissioned by the Department of Health
- 2010 - University of Sussex commenced a scoping study of the concept of self-neglect as defined in the literature and interpreted in Adult Safeguarding Practice
- 2011 - SCIE published – Adult Services SCIE Report 46 (www.scie.org.uk)
- 2013 – Skills for Care research - 'How can workforce development equip social care practitioners to work with the challenges of self-neglect?'

Four major factors in effective working:

- **knowledge of self-neglect and of the legal framework surrounding it**
- **assessment skills**
- **relationship-building skills and a client-centred approach**
- **effective multidisciplinary working**

Care Act 2014

"14.2. The safeguarding duties apply to an adult who: has needs for care and support (whether or not the local authority is meeting any of those needs) and; is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect." (p.229)

But….. "Local authorities should not limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the criteria at paragraph 14.2 will need to be met before the issue is considered as a safeguarding concern." (p.233)

However….self–neglect is now included in types of abuse :

> **"Self-neglect** – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding." (p. 234)

Department of Health – Safeguarding Principles

So what difference can you make?

"Services don't get together soon enough and work together constructively; we create barriers for each other...it's very hard to join it all up." "Everybody's got their own agenda and what often happens is that the person's voice gets lost."

(Practitioner views from 2013 research)

Care Act (2014) says:

"Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety." (p.233)

Self Neglect
The Health Perspective

Sally Hyde

Head of Adult Safeguarding

East Kent Hospitals University Foundation Trust

What is Self Neglect?

* Self-neglect is abuse of self. It differs from the other forms of abuse because it does not involve a perpetrator

* A refusal or failure to provide himself / herself with adequate food, water, clothing, shelter, personal hygiene, healthcare, medication (when indicated) and safety precautions

Self Neglect is a journey

Seen in all ages - more common in older people

Complex causes, poorly understood

Increased incidence of depression

Feelings of low self esteem

History of trauma, abuse or bereavement

Hoarding or no possessions at all

Reclusive or co-dependent, sibling or pet

Substance misuse

Self harm

A Word on Hoarding

* Can start in early teens
* Hoarders often also suffer from OCD (Obsessive Compulsive Disorder)
* Linked to Depression, Phobia and Anxiety
* May 2013, Hoarding was formally classified as a Psychiatric condition

Signs and symptoms of self-neglect : (include but are not limited to)

* Dehydration, malnutrition (or obesity), untreated medical conditions, poor personal hygiene
* Hazardous living conditions e.g. improper wiring, no indoor plumbing, no heat, no running water
* Unsanitary living quarters e.g. animal / insect infestation, no functioning toilet, excrement present
* Inappropriate and / or inadequate clothing, lack of the necessary medical aids e.g. glasses, hearing aids, dentures
* Grossly inadequate housing or homelessness

Mental Capacity?

* Mentally competent person, who understands the consequences of his / her decisions, makes a conscious and voluntary decision to engage in acts that threaten his / her health or safety as a matter of personal choice
* May have had an important high profile job!

Mental Capacity Act 2005

Some times they have a learning disability, dementia or known mental health condition

This does not always means they lack capacity……..Unwise decisions!

Engagement with Health Services?

Late presentation of illness

Engagement driven by fear-of authority or of their own demise

Limited concordance with Care Plan

Acute Hospital Involvement
A Case Study

* Mother and daughter
* Owner occupier
* Admission via 999 call, ambulance
* Daughter rang for help when mum became very ill. Ambulance crew decided to convey both people

Presentation

* Mum (72yrs) – multiple health conditions. Acutely unwell. Lacked capacity at point of admission. Treated under Best Interests
* Daughter (38yrs) – Anorexic. Mental capacity questioned
* Mother cared for daughter
* House deemed uninhabitable. Daughter admitted to hospital as a place of safety

Management

* Nursed on separate wards. No choice – beds very limited
* Daughter had a side room. Appeared Agoraphobic. Did not engage with staff
* Referral for Psychiatric Assessment
* Referral to Hospital Social Worker
* Referral to Environmental health
* Not really known to GP

Progression

Could not be discharged to their own home. Unfit for human habitation

* **Mum** – medical conditions addressed. Health improved. She regained capacity. Chose to be discharged to a Care Home.
* **Daughter** – deemed medically fit. Not eligible for a psychiatric bed. Too heavy for admission to an In-Patient Anorexia Programme. Plan for community treatment. Issues with finding suitable accommodation. Extended debates about her mental capacity. Court rulings about capacity and Anorexia.

Delayed Discharges

* Son appeared. Initially, a good reunion. Thought he was going to be able to address the housing problem but then old tensions resurfaced and he disengaged

* Both were in-patients for months. Issues around lead responsibility, Health or Social Care? No overarching plan. Fragmentation. Very little known about the family as they had avoided the Statutory Services

* Continuing Care Funding for mum

Outcome

* **Mum** – went to a Care Home
* **Daughter** – went to B&B with Psychiatric Support from Community Services
* **It all took far too long**

  Daughter started to become institutionalised and dependent on Ward Staff

What works?

* Understanding and accepting that there are complex psychological mechanisms at work
* Address immediate physical needs
* Identify the lead agency
* Gentle, persistent contact, building trust with an individual, over an extended period of time
* Person centred approach
* A clear framework and plan which can be shared with the individual