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Safeguarding Adult Reviews: Informing and Enriching Policy and Practice on Self-Neglect

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Safeguarding Adult Reviews: Informing and Enriching Policy and Practice on Self-Neglect?

Introduction

This article has two purposes. The first is to update the database of safeguarding adult reviews (SARs) featuring self-neglect, reported annually since 2015 (Braye et al., 2015a; Preston-Shoot, 2016a; 2017a; 2018; 2019). The database continues to expand. Although data held by NHS Digital[1] and reviews held by the SCIE repository[2] do not allow conclusive statements, it is likely that self-neglect cases are more regularly reviewed than most if not all other types of abuse and neglect. In thematic reviews (Braye and Preston-Shoot, 2017; Manson, 2017; Preston-Shoot, 2017b) cases involving self-neglect have been prominent.

The second purpose is to explore the degree to which SARs are research-enriched. Historically, use of research has been variable. Cambridge (2004) found little attempt to link inquiries to broader knowledge or research. He argued that use would add conceptual depth to reports and inform the distillation of positive policy, organisational and practice responses to abuse and neglect. Braye and Preston-Shoot (2017) found that only a minority of SARs drew explicitly on research evidence to support analysis. More positively, perhaps, Preston-Shoot (2017b) found that 57% of his sample referenced research reports and/or national guidance. However, just under a third drew on other SARs and serious case reviews (SCRs), representing a missed opportunity to learn from similar cases. The quality markers make only passing reference to research when focusing on the rigour of the analysis. Research evidence about what constitutes good practice should be accurate and up-to-date (SCIE and RiPfA, 2018).

Methodology

As previously, the research focused on four research questions: what is the nature of the self-neglect cases being reviewed? What types of recommendations are being made? What themes emerge as findings from reviewed cases and what are their implications for policy and practice? The main source for locating reviews was through searching SAB websites for published SARs (November 2019). This approach has been used by other researchers (Manthorpe and Martineau, 2015); Martineau et al., 2019). Websites demonstrate marked variability in terms of accessibility and quality. SAB annual reports for 2018/19 were also read where available since they should provide terms of reference and summary findings for commissioned reviews, including those unpublished (DHSC, 2018). Compliance with this statutory guidance requirement varied. One unpublished review was obtained through a personal contact.

The England repository for SARs, available through the Social Care Institute for Excellence website, was accessed. It remains incomplete; not all the SARs referenced in this database are available through the repository. It remains impossible to navigate its contents by type of abuse/neglect.

Although the legislative context differs, included in this database once again are reviews commissioned by Adult Protection Committees in Scotland and SABs in Wales.

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[1] NHS Digital publishes annually the number of SARs undertaken, breaking the number down regionally. However, it does not collect data on the types of abuse and neglect within the cases being reviewed.
[2] The SCIE repository is incomplete.

The same analytic approach is used here as previously (Braye et al., 2015a; 2015b), adapted from studies of SCRs in children's services (Brandon et al., 2011). Firstly, the key characteristics of each case and each review are recorded, followed by the frequency and content of recommendations. Secondly, themes are extracted from a cross-case analysis, organised around four domains. Termed descriptive research (Manthorpe et al., 2015), these four domains of analysis – direct practice with the individual, the professional team around the adult, the organisations around the professional team, and SAB governance – have enabled an evidence-based model to be built (Preston-Shoot, 2019), a set of practice standards that has been explicitly used in some of the reviews in this sample.

Case numbering continues the database sequence (Preston-Shoot, 2019). Not all reviews explicitly reference self-neglect. However, cases that contained reference to one or more of the constituent elements (living in squalor, hoarding, significant neglect of health and wellbeing, rejection of care and support) (DHSC, 2018) have been included.

Case Characteristics

In the complete sample (n=246) some cases involve the presence of more than one person. That said, where gender is specified, men outnumber women (147/106). The largest age group is now people aged 60 -75 (25%), followed by people aged over 76 (23%) and those aged 40-59 (22%).Those aged 21-39 comprise just 4% of the sample where age is known. Other researchers have also noted the predominance of cases involving older and especially older old people (for example, Bestjan, 2012). Ethnicity is not routinely recorded.

Within this sub-sample and across the sample as a whole, refusal of services (n=26 and 127) and lack of self-care (n=39 and 148) remain prominent, and often combined in cases. There were fewer cases in this sample involving lack of care of one's environment (n=4 and 58). All three components of self-neglect are present in 15 cases within this sub-sample and 72 cases overall. Prominent too within the reviewed cases are scenarios involving alcohol and/or drug abuse and/or episodes of homelessness. Finally, almost all the adults had died[3], a trend noted by other researchers (Bestjan, 2012; Manthorpe and Martineau, 2011). NHS Digital statistics[4] also show that, for 2018/2019 for example, a majority of reviews concerned adults who had died. Perhaps SABs should review SAR referral pathways.

One review was commissioned by a City Council rather than a SAB (242) and concerned a homeless person. Indeed, SABs have clearly engaged in reviewing the deaths of homeless people. Twelve other reviews[5] also concern individuals who were either homeless when they died or had experienced homelessness.

Table One: Case Characteristics			
Case	SAB, date, case	Gender, age	Living situation

[3] Case 226 and the wife in case 234 are the exceptions.
[4] https/:digital.nhs.uk/data-and-information
[5] Cases 203, 206, 207, 208, 212, 216, 225, 238, 239, 240, 245, 246.

196	Leicestershire and Rutland, 2017/18, NS	Female, 54	Not known
197	Scottish APC, 2018, Mrs A	Female, 70	Lived with husband
198	Barnsley, 2018, Mrs T	Female, 86	Lived alone
199	Barnsley, 2018, RG	Male 68	Lived alone
200	Barnsley, 2018, Jack	Male, 68	Lived alone
201	Devon, 2018, Adrian Munday	Male, 51	Lived alone but accommodation cuckooed
202	Walsall, 2016/17, no name	Female, not given	Homeless
203	Newham, Islington, City of London & Hackney and Lambeth, 2018, Mr Yi	Male, not given	Homeless
204	Haringey, 2019, Ms Taylor	Female, 71	Lived alone
205	Bromley, 2019, Ms A	Female, 28	Lived with grandmother
206	Milton Keynes, 2019, Adult B	Male, 33	Homeless
207	Wiltshire, 2018, Adult D	Male, 40	Homeless
208	North Tyneside & Northumberland, no date, Leanne Patterson	Female, 36	Multi-occupancy hostel
209	Lancashire, 2019, Adult G	Male, 51	Lived alone
210	Wiltshire, 2019, Adult C	Male, not given	Lived alone
211	West Berkshire, 2018, Aubrey	Male, 45	Lived alone
212	Bexley, 2018, Ms AB	Female, 45	Lived alone
213	Rochdale, 2019, Adult 2	Female, not given	Unclear
214	Slough, 2018, Mrs M	Female, 91	Lived with son
215	Buckinghamshire, 2019, Adult V	Male, early 70s	Lived alone
216	Essex, 2018, Frank	Male, 55	Homeless, living temporarily in a hotel
217	Hertfordshire, 2017, Stanley	Male, 60s	Lived alone
218	Salford SAB and Community Safety Partnership, no date, Mary	Female, 85	Lived alone
219	Lincolnshire, 2017, thematic review		Multiple cases of financial abuse
220	Lancashire, 2019, May	Female, 70	Lived alone
221	Greenwich, 2019, Mrs A and Miss B	Female, not given	Mother living alone and daughter visiting regularly
222	West Berkshire, 2018, Paul	Male, not given	Lived with cousin
223	Lambeth, 2019, Mr E	Male, 62	Lived alone
224	Lambeth, 2019, Martin	Male, 51	Lived alone
225	Kingston-upon-Thames, 2018, SU	Male, 61	Lived with partner

226	Cheshire West and Chester, 2019, David	Male, 78	Care home resident
227	Enfield, 2019, Mr A	Male, 70	Lived alone
228	Newham, 2019, thematic review	4 mean aged between 75 and 97	3 lived alone; one lived with son
229	Barnet, no date, YY	Male, not given	Nursing home
230	Warrington, no date, Robert	Male, 74	Lived with partner
231	Wolverhampton, 2019, Edith	Female, 80	Lived with nephew
232	West Sussex, 2019, Mrs Patricia Pelham	Female, 70	Lived with husband
233	Waltham Forest, 2018, Mark	Male, 48	Lived alone
234	Leeds, 2020, Mr Mrs A	Male, 50; Female, 45	Couple living together
235	Leeds, 2020, Mr B	Male, 64	Lived alone
236	Sutton, 2019, EE	Male, 61	Supported living accommodation
237	Cornwall, 2019, thematic review with one new case	Female, 87	Lived with family
238	Tower Hamlets, 2020, Ms H and Ms I thematic review	Female, 52; Female, 33	Living in flat temporarily; homeless
239	Oldham, 2020, thematic review	3 men, aged 43, 62, 76; 1 woman, 34	One homeless, three living alone
240	Manchester, 2020, thematic review	Seven men aged between 28 and 60	Homeless
241	Tower Hamlets, 2020, Mr F and Mr G themed review	Two men, aged 73 and 68	Both men lived alone
242	Worcester City Council, 2018, C	Male, 74	Homeless
243	Gwent, 2018, Caroline	Female, 64	Lived alone
244	Havering, 2018, GR	Male, 91	Lived alone
245	Bournemouth & Poole and Poole Community Safety Partnership, 2016, Harry	Male, 22	Lived independently
246	Solihull, 2019, Rachel	Female, 20	Lived in supported accommodation

SAR Characteristics

Within this sub-sample, self-neglect is predominantly the central focus[6]. Across the whole sample (n=246), where information is available, it is the central focus in 65% of cases, implicit in 18% and peripheral in 13%. Where detail is given, the dominant methodology adopted a systemic orientation that used a combination of learning events and/or interviews alongside independent management

[6] Self-neglect was judged implicit in 4 cases (207, 242, 245, 246) and peripheral in 8 (201, 203, 206, 209, 219, 225, 226, 232).

reviews, combined chronologies and panel deliberation[7]. Eight reviews used a learning lessons approach. Seven adopted a thematic approach[8]. Thematic reviews enable SABs to adopt a proportionate approach where SAR referrals focus on the same type of abuse/neglect. They also facilitate a deeper dive into systemic issues across a number of cases of self-neglect and/or social isolation and financial abuse. Another interesting development is joint commissioning, with SARs being combined with DHRs or mental health homicide investigations[9].

Most reviews in this sub-sample have been published either in full or as executive summaries[10].

Recommendations

Within this sub-sample (n=51), 30 reviews contained ten or fewer findings/recommendations. Numbers, however, can be misleading since individual recommendations sometimes comprised several elements. Within this sub-sample, recommendations are most commonly directed to a Safeguarding Adult Board (37/51), in 18 cases just to the SAB that then has the responsibility to determine what action to require from partner agencies. Frequently allocated specific recommendations are Adult Social Care (22), NHS Trusts (16), Police (5) and Clinical Commissioning Groups (CCGs) (7). There are occasional recommendations for GPs, care providers and third sector organisations, Children's Social Care, the Fire and Rescue Service, Ambulance Trusts, the National Probation Service and Housing. Ten reviews make recommendations to all the SAB's partner agencies. Across the entire sample (n=246), 70% of SARs make recommendations to a SAB and 37% to Adult Social Care. NHS Trusts receive recommendations in 26% of cases, Clinical Commissioning Groups in 17%, Housing in 11%, GPs in 9% and the Police in 10%; safeguarding is everyone's business.

Some reviews reference recommendations offered by agencies as part of IMRs and/or reflective interviews. Ten cases in the sub-sample do not allocate named responsibility for implementing specific recommendations, 33% of cases across the entire sample, undermining the quality marker of transparency.

Themes within recommendations

Four broad categories of recommendations are retained – staff support, review process, best practice and procedures (Braye et al., 2015a), the contents of which mirror what other researchers have also found (for example, Manthorpe and Martineau, 2011).

Staff support

Within the sub-sample (n=51), 36 reviews recommend training and 17 improvements to supervision, support and managerial oversight. Across the full sample, 60% of reviews contain recommendations

[7] 28 SARs adopted this approach. Two reviews employed the Welsh model (Kingston et al., 2018). Appreciative inquiry (Sharp et al., 2016), multi-agency partnership review, significant incident learning process (Clawson and Kitson, 2013) and learning together (Fish et al., 2008) were each used once.
[8] Cases 219, 228, 237, 238, 239, 240, 241.
[9] Cases 218, 221, 245.
[10] Cases 196, 197 and 202 do not appear to have been published. Cases 196 and 202 are mentioned in a SAB annual report. Case 237 is referred to in conference and SAB presentations.

regarding training and 31% supervision, including access to specialist advice. Investing in training will prove ineffective without also focusing on workplace development to ensure that staff can embed in practice acquired knowledge and skills (Braye et al, 2013). Perhaps implicitly acknowledging this observation, 11 reviews make recommendations relating to staff workloads and resources available to practitioners.

Review process

This sub-sample continues the trend of small numbers of recommendations regarding how the review process was managed; 3 contain recommendations, for instance about the impact of Coroner inquests on timely completion of reviews and, significantly in the context of central government concern[11], about approaches to reviewing deaths of homeless people. Of greater concern remains the importance of learning from reviews, possibly cognisant of Wood's (2016) criticisms of the lack of impact of Serious Case Reviews (SCRs). Nineteen make recommendations about dissemination locally and nationally, whilst 23 contain recommendations regarding subsequent quality assurance, auditing outcomes of learning and SAR impact on service development and practice. Nine offer recommendations concerned with following through action plans. Again, on the theme of reviews making a difference, five highlight the SAB's leadership role on developing strategic approaches to concerns about sexual exploitation, fire risk, mate crime and transient homeless people. Two recommend changes to SAB membership or structure. Across the whole sample, 13% contain recommendations concerning future management of the review process and 31% about using the report for learning and service development.

Best practice

Within the best practice theme in this sub-sample, mental capacity assessments drew 10 recommendations, including the importance of exploring people's choices, executive capacity and unravelling the notion of lifestyle choice. Five contain recommendations about person-centred, relationship-based approaches, and 15 about different ways of seeking to engage with people who are refusing services. Nine SARs contain recommendations concerning knowledge and use of the law, and 15 on assessment and involvement of family carers. Noticeable in this sub-sample are 6 SARs that contain recommendations regarding transitions, especially hospital discharge, 5 that focus on appropriateness of, and standards within placements, and 8 that focus on planning, monitoring and reviewing care packages. Five SARs refer explicitly to advocacy provision and seven to community awareness-raising about self-neglect.

Across the entire sample, best practice in mental capacity assessments continue to dominate; 34% of reviews contain recommendations here. Mindful of the challenges of working with adults who self-neglect, 26% of reviews contain recommendations concerning engagement and 22% remind practitioners and managers of the importance of relationship-centred practice. The relationship focus extends to family members; 22% of reviews highlight assessment of carers, thinking family and understanding family dynamics. 17% of SARs contain recommendations about legal literacy.

Procedures

[11] https://www.gov.uk/government/publications/the-rough-sleeping-strategy

Recommendations continue to place faith in procedures. Within the sub-sample, 39 SARs recommend the development and/or review of guidance. 28 focus on referral and assessment and 20 on case management, including the use of section 42 enquiries, safeguarding or self-neglect pathways, and reviews. Recommendations regarding working together occur in 27 cases, information-sharing in 23. Eighteen cases refer to the importance of recording. Five cases recommend that legal advice is available and/or obtained and three focus on the process of managing service design. Noticeable in this sub-sample, partly because of the focus on homelessness, are 18 SARs with recommendations regarding commissioning of services.

Across the whole sample (n=246), 69% of SARs recommend the development and/or review of guidance for staff; 52% focus on referral and assessment pathways. 57% make recommendations regarding inter-agency working, whilst 52% focus also on case management. Recommendations regarding recording occur in 35% of cases, information-sharing in 40%.

Cross-case analysis

This sample has a strong emphasis on homelessness, especially concerning people who experience multiple exclusion homelessness[12]. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care (Mason et al., 2017/18) and often results in self-neglect. Across the four domains, their findings represent a microcosm of familiar systemic issues, namely:

- In practice with the person, the need to assess likelihood and significance of risks, executive capacity and the impact of trauma; to consider advocacy; to challenge assumptions of lifestyle choice; to demonstrate creativity and persistence in attempting to engage.
- Working as a team around the person, the need to improve safeguarding and legal literacy, including scrutinising decisions about intentional homelessness; to strengthen integrated whole system working, including active use of high risk panels and key workers.
- Organisations around the team should provide support for staff as the work can be exceptionally challenging; commissioners and providers should review gaps in services, such as the availability of accommodation for people with co-morbidities.
- On governance, SABs should work with Health and Wellbeing Boards, Community Safety Partnerships and Local Children's Safeguarding Partnerships to ensure governance oversight of how services respond to multiple exclusion homelessness.

Four SARs[13] organise their findings around the self-neglect evidence-base of best practice, developed from research (Braye et al., 2011; 2014) and reviews (Preston-Shoot, 2019). That evidence-base is used explicitly here to reflect on the findings from the SARs in this sample.

Domain A: practice with the individual adult in their social situation

<u>Making Safeguarding Personal</u>

[12] Cases 196, 202, 206, 212, 216, 238, 239, 240, 242, 245, 246
[13] Cases 235, 238, 239, 240.

A person-centred approach comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes. Maintenance of contact and continuity is advised so that trust can be established. Concerned curiosity is helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills. Building up a picture of the person's history may help to uncover what is driving and maintaining self-neglect and hoarding.

Within the sample there are references to good practice, for instance using different approaches to engage individuals (210), taking time to establish trust and relationships (213, 215, 223, 230, 232), and persevering in the face of rejection (243, 244). Nonetheless, there are criticisms of the lack of curiosity about an individual's life journey (214, 220, 224, 228, 243), and of the failure to explore what lies behind behaviour, including hoarding and non-engagement (210, 211, 214, 215, 217, 220, 222, 223, 228, 230, 242). There are reminders to follow-up the failure to keep appointments (209, 215) and to not rely just on telephone calls when attempting to establish contact. In one case information about provider concerns was not shared with the service user (211).

Autonomy

Exploring what may appear a lifestyle choice should be attempted to understand what might lie behind a person's refusal to engage. Loss, trauma, shame and fear often lie behind refusals to engage. There is considerable criticism of assumptions about lifestyle choice, often revolving around attitudes or pre-judgement regarding misuse of alcohol, with consequent failure to explore the meaning behind patterns of behaviour (200, 207, 210, 212, 213, 215, 223, 224, 228, 231, 233, 238, 239, 243). As reviews observe, this can result in under-estimation of the impact of trauma and self-neglect (216, 233) and missed opportunities to prevent deterioration and to refer for mental health input (216).

Assessment

Assessment requires time to address the impact of adverse experiences, including issues of loss and trauma. It also should explore repetitive patterns. Comprehensive risk assessments are required, especially in situations of service refusal. Thorough mental capacity assessments are also advised, which include understanding and consideration of executive capacity, recognising that a person's articulate skills and good cognition test results might mask difficulties.

Good practice is noted with respect to mental capacity (217) and care and support assessments (209, 220). However, in relation to capacity, risk and/or care and support assessments, criticism falls into distinct categories, namely:

- Missed opportunities to assess, for example of co-morbidities, service refusal and/or non-compliance with treatment (209, 210, 211, 212, 214, 215, 216, 222, 223, 228, 233, 244);
- Incomplete assessments, for example of evidence of coercive control, loss and/or risk (213, 220, 221, 224, 231);
- Lack of thoroughness or robustness (208, 209, 210, 229, 236, 243), for example of fluctuating capacity when risks are high (205, 228), including underestimation of risk (209, 218), responding to individual episodes rather than seeing and addressing patterns (228) and not according mental and physical health parity of esteem (210, 216, 242);

- Assumption of capacity (200, 218, 224, 244) and failure to explore executive capacity through functional assessments, as advised in guidance (NICE, 2018) (209, 224);
- Delayed assessments and/or reviews, a lack of timeliness (209, 215, 216);
- Services not working together but conducting assessments in isolation (200, 239, 240).

Planning

Care plans should be thorough and reviewed regularly. Transition, for example hospital discharge and placement commissioning, requires particular attention. Good, person-centred planning, is found (205), for instance regarding hospital discharge (220) and arrangements for mental health treatment (210). Conversely, planning for hospital discharge is found to be rushed, with inadequate functional assessments and/or multi-disciplinary involvement, with necessary arrangements not in place (209, 211, 212, 215, 228, 231, 235). The adequacy of discharge summaries is also criticised, with information about care arrangements and/or safeguarding concerns not fully itemised (231, 243). NICE guidance (2015; 2016) does not seem to be embedded in practice. Elsewhere standards of planning are assessed as poor (213), with the suitability of different options not considered (242), and with inadequate arrangements to meet need or manage risks (208, 209, 216).

Family and social context

Family and friends may have significant contributions to offer to assessments and care planning, both to support the person to engage and to inform understanding of their circumstances. SARs in this sample provide timely reminders. Records do not consistently note details of next of kin (209, 239, 240). Family members are not involved in care planning or in supporting their relatives when appointments are missed (210, 211, 220). When family members are acting as a circle of support, carer assessments are overlooked (226, 227, 228). The role of the nearest relative in mental health legislation may not be understood (210). The main critique, however, is the absence of professional curiosity about family and relationship dynamics, including evidence of coercive and controlling behaviour, and the failure to explore and challenge what is being said, especially when information provided appears contradictory (198, 200, 214, 218, 222, 230, 231, 244). Lack of legal literacy about when it is lawful (Data Protection Act 2018) to share and request information about individuals at risk of abuse and neglect (including self-neglect) may be one reason for the findings here.

A person's social context should also be explored, their community networks (204, 210, 216, 235). Although not explicitly referenced in any SAR in this sample, attention to social networks and community presence draws attention to the need to embed contextual safeguarding (Firmin, 2017) in adult safeguarding.

Advocacy should be commissioned where this might assist a person to engage with assessments, service provision and treatment. Case 212 comments positively on use of advocacy. However, in other cases advocacy does not appear to have been considered (217, 231). Appropriate arrangements should also be made for interpreter services (207).

Domain B: the professional team around the adult

Counteracting silo working

Particularly important in complex and challenging cases, inter-agency communication and collaboration is facilitated where this is coordinated by a lead agency and key worker. Occasionally SARs comment on good practice, working together to establish contact with a person and/or to respond to needs and risks, such as pressure ulcer care (209, 216, 231). However, criticism of silo working and of agencies not pulling together emerges frequently (205, 208, 210, 214, 216, 217, 222, 233, 240, 243, 244). SARs highlight the lack of communication between services (217, 223, 224, 243), for example at key points of transition for a person (201), reflective of a lack of ownership and accountability (222).

One indicator of working together is referral practice. Some SARs in this sample identify good practice in sending and responding to referrals (209, 210, 211, 218). Others, however, observe that practitioners seemed unclear about referral pathways (214, 239) or that referrals were incomplete or unclear, for example about whether a care and support assessment (section 9 Care Act 2014) was being requested or a section 42 enquiry (200, 224, 226, 229, 232). Responses were not always timely (214) and thresholds could act as a barrier (233).

Whole system meetings

Multi-agency meetings should be convened to pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options. Outcomes of plans should be reviewed routinely. Occasionally SARs comment positively on the use of multi-agency meetings (216). More often, however, there are familiar criticisms. Meetings are considered but not convened, with differences of opinion between professionals remaining unresolved (211), or there does not appear to have been any consideration of taking cases to panels or holding conferences (205, 207, 210, 214, 217, 222, 229, 231, 233, 239, 240). Consequently, relevant information is not shared and there remains no agreement about how needs will be met or risks managed. Whilst multi-agency meetings and panel discussions can be used to support practice in complex cases, share responsibility, facilitate information-sharing and plan risk management, some reviews highlight uncertainty about which panels to use or how to escalate concerns (212, 231, 233).

Information-Sharing

Information-sharing should be comprehensive so that all agencies involved possess the full picture. Referrals should be detailed where one agency is requesting the assistance of another in order to meet a person's needs. Good practice is reported occasionally (210, 230). More often, reviews criticise the poor quality of information-sharing across services (205, 211, 215, 216, 218, 220, 221, 227, 228, 242) with the result that no single agency has a complete picture (200). Specific examples include hospital discharge letters giving incomplete information about a person's needs and vulnerabilities (217, 243), GPs not being aware of when Police send safeguarding or welfare concerns to the local authority (218) or not responding to information that they receive (224), and services not sharing safeguarding concerns with family members (220). One case (209) criticises the Police for limited information-sharing when taking a person to an emergency department.

Knowledge and use of safeguarding and legal pathways

Policies and procedures for working with adults who self-neglect, adopted by the SAB, should be evident in how staff approach each case. The duty to enquire (section 42, Care Act 2014) should be used where this would assist in coordinating the multi-agency effort. Some reviews in this sample

identify good practice when raising or escalating safeguarding concerns (205, 211, 214, 215, 220, 230). Others, however, identify situations where safeguarding procedures should have been followed (214, 215, 243) or referrals taken forward into strategy discussions or enquiries (216, 222, 231, 233). Use of safeguarding pathways is missing in self-neglect cases (207, 210, 216, 220, 227), opportunities are missed (229).

Practitioners and managers, for example in multi-agency meetings, should seek out and have access to specialist legal (199), mental capacity and mental health advice. It should be clear how the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy, was evaluated. Reviews frequently draw attention to lack of understanding of relevant legal rules and the need to consider all options, including Court of Protection and the High Court's inherent jurisdiction (210, 217, 231).

Recording

Clear and thorough records should be maintained of assessments, reviews and decision-making. Sometimes reviews advise on standards, namely that recording should be factual and clear, with judgements supported by evidence (230). More often, they observe that records are either incomplete, inaccurate or out-of-date (200, 209, 216, 218, 231). It may be difficult therefore to understand why a referral was made, or how self-neglect developed (209, 220). It may be difficult to track whether multi-agency discussions took place about risk (244). Also in focus is the use by agencies of different IT systems, with the result that key information may not be accessible when needed across services (205, 231).

Domain C: organisations around the professional team

Commissioning provision

Managers should demonstrate and record case oversight, including decision-making about commissioning and the outcome of contract monitoring of service providers. Reviews in this sample criticise the lack of management oversight, for example of case reviews, hospital discharges and ongoing concerns (204, 209, 220, 227, 244). Commissioning has a much stronger presence in this sample. Several reviews focus on commissioning for services to meet the needs of people experiencing multiple exclusion homelessness (238, 239, 240, 242) or point to gaps in services (212, 217, 220), for example with respect to dual diagnosis, supported accommodation and psychological support. Other reviews comment on the management of provider concerns (211, 217) and the identification and response to organisational abuse (226). There is also a focus on the need to improve monitoring commissioned packages of care (222, 243).

Working environment

Supervision promotes reflection and critical analysis of the approach being taken to the case. Regular supervision is essential (210, 217, 222, 227, 230), for example to explore the approach taken to a case.

Support should be available for staff working with people who are hard to engage, resistant and sometimes hostile. In one case (200) support was seen as crucial since there were complex legal, ethical and practice issues to be resolved. Specialist legal, mental capacity and safeguarding advice is

available and any guidance given should be recorded. There is little reference to such advice in this sample of reviews.

Workforce and workplace issues are addressed, such as staffing levels, organisational cultures, training and thresholds. The need for training (207, 227) and volume of cases (232) emerge occasionally. Case allocation should be based on an appreciation of staff knowledge, skill-sets, capability and capacity. This is not explored in this sample of reviews.

Procedural guidance

Practice guidance should be available and clearly embedded in case and supervision notes. Reviews in this sample point to the absence of frameworks to guide practice for work with adults who self-neglect and/or misuse substances (207, 223, 224, 230, 239). Occasionally, reviews also refer to procedural guidance being available but not used (213).

Domain D: SABs and inter-agency governance

Managing reviews

The SAB will require clear guidance on the process of commissioning and managing the review process in order to meet its statutory duties with respect to SARs (section 44, Care Act 2014). Not all reviews proceeded smoothly, as evidenced in delays in agencies providing information and poor attendance at learning events (215). Delay could also arise due to the complexities of reviewing several cases and the volume of material to consider (221). Adopting a pragmatic or proportionate response sometimes meant that reliance was placed on written documentation, not triangulated with staff interviews, resulting in some lines of enquiry not being fully explored (222).

Effecting change

The standard here is that SABs disseminate and audit the impact of policies, procedures and reviews regarding self-neglect. Learning from SARs for practice and the management of practice with adults who self-neglect should be routinely disseminated through such mechanisms as 7 minute briefings and workshops. Occasionally SARs refer back to other reviews completed by the SAB in order to explore what has (not) been learned (222, 238). Occasionally too reviews comment on the need to develop a framework for practice derived from the findings (230).

A learning mosaic – beyond SARs

Self-neglect has also featured in Domestic Homicide Reviews (DHRs), commissioned by Community Safety Partnerships, in Independent Investigations (previously known as Mental Health Homicide Reviews), commissioned by NHS England, and in Serious Case Reviews (SCRs) commissioned by Local Safeguarding Children Boards. Learning is also available from case law and judgements from the Local Government and Social Care Ombudsman (LGSCO). The available learning reinforces components of the model of good practice developed through SARs, identified in italics.

DHRs (McAteer, 2013; Hughes, 2014; Hunter, 2015) recommend inclusion of the potential for self-neglect alongside harm to others in *risk assessments*. They reach familiar conclusions about *thinking*

family - the importance of consistently *involving family members* in risk assessments, of *supporting carers* and of *exploring family dynamics*. *Concerned curiosity* is essential as close relatives may find it difficult to report their fears. They highlight that consistent and persistent *refusal to engage* or to acknowledge concerns should be treated as a *risk* factor.

DHRs contain other familiar themes. They emphasise the importance of treating patients in line with guidance for the enhanced care programme approach, highlighting again the importance of *legal literacy*. They highlight the importance of updated *care plans* and intervention that addresses *repeating patterns*. They debate the balance to be struck between Article 8 and Article 2 ECHR rights when considering whether and when significant risks might justify breaching confidentiality to seek information from family members without consent, rather than just listen to their concerns, highlighting again the challenge of *balancing autonomy with a duty of care*. Kennedy (2018), in a case where significant risks derived from self-neglect, substance misuse, non-engagement and domestic violence, recommended that staff be trained in using a *multi-agency risk management meeting* approach, including appointment of a lead agency and key worker. The importance of IT systems facilitating *information-sharing* was also emphasised.

Familiar themes also emerge from SCRs where self-neglect features (Few, 2014; Bournemouth and Poole, 2015). They include:

- *Carer's assessments* neither offered or completed;
- A culture of *professional curiosity* is required, for example when taking a history as family members may not easily disclose the full nature of relationship difficulties, which may lead to an under-estimation of risks and vulnerabilities;
- *Assessment* should include the impact of one person's mental ill-health and self-neglect on others in the family and also what behavioural patterns might suggest about family dynamics; assessment must give appropriate weight to domestic violence;
- Insufficient *supervision and management oversight* of a complex case;
- Agencies must *share information* if professionals are to be clearly sighted on all the issues;
- Agencies must follow standards of good practice within the care programme approach;
- Missed opportunities for *input from family* relatives;
- A *think family* approach;
- *Workloads* and lack of expertise in *risk assessment* affected responses by children's social care and the police.

Two SCRs involve young people under the age of eighteen who self-neglect (Dorset Safeguarding Children Board, 2014; Preston-Shoot, 2016b), demonstrating that this phenomenon is not just one affecting adults. The SCRs highlight the importance of communication between children's social care, adolescent mental health services and adult social care services. They recommend that agencies should:

- Have a *protocol for engagement* with hard to reach families and young people;
- Consider the *impact of case closure* decisions on other agencies;
- Assess *family dynamics* and *risks*;

- Assess causes and meaning of behaviour, see events not in isolation but as *patterns* and use *chronologies*;
- *Support* worker resilience;
- Reinforce *legal literacy* regarding parental responsibility, mental capacity and mental health.

Independent investigation reports add to the disparate strands of the evidence-base. The reviews (Marsden, 2012; Rooney, 2017) highlight the importance of *assessment* of needs and *risks* in the complex interaction between mental and physical health, and drug and alcohol abuse, alongside *information-sharing* and comprehensive *discharge planning*. *Resource shortfalls* in staffing and expertise contribute to poor assessments, failure to implement an enhanced care programme approach, and difficulty in responding to non-engagement and high level care and support needs.

The use of *legal literacy* is illustrated by two recent cases where the local authority applied to the High Court seeking orders through the use of its inherent jurisdiction. In one case the judge determined that the individual lacked mental capacity to understand the risks he was living in, namely extremely neglected accommodation and self-neglect. Orders in his best interest were made under the Mental Capacity Act 2005 (London Borough of Croydon v CD [2019] EWHC 2943 (Fam)). The second case (Southend on Sea v Myers [2019] EWHC 399 (Fam)) involved self-neglect and neglect. The High Court employed its inherent jurisdiction to safeguard an older person who had what was described as a relationship of co-dependency with his adult son.

LGSCO decisions recognise the complexity of self-neglect cases, especially when having to *balance autonomy and protection* (LGSCO and Buckinghamshire County Council, 2017), but emphasise the importance of taking action when *services are refused* in situations of obvious deterioration (LGSCO and Windsor and Maidenhead Council, 2019). They remind local authorities of the importance of clear and adequate *recording* of decisions-making, of *commissioners* monitoring the care that has been commissioned, of *timely assessments and reviews* of care and support needs, of avoiding delay in service provision to meet assessed needs, and of thorough *mental capacity assessments* when an individual's behaviour presents significant risks (LGSCO and Blackburn with Darwen Council, 2017; LGSCO and Buckinghamshire County Council, 2017; LGSCO and Dorset County Council, 2019; LGSCO and Windsor and Maidenhead Council, 2019).

Research Informed and Enriched?

Turning to the article's second purpose, how many SARs draw explicitly upon research and policy or practice guidance? How many draw on other SARs, including those completed previously by the commissioning SAB? 57% in this sample of SARs (n=51) referenced research studies and/or nationally available guidance. This percentage hides considerable variability. Some SARs make extensive use of research and guidance (for example 239, 240) whilst others may contain only a single reference (226). A word of caution is also necessary. Published executive summaries are often brief and it is possible that the full, unpublished SAR might have drawn on research/guidance and, indeed, other reviews. Nonetheless, greater use of research and/or national guidance would strengthen analysis and learning by enabling comparison with the organisational and practice environment being reviewed (Preston-Shoot, 2017b).

Only 22% of the sample made connections with other SARs that had been completed locally or elsewhere. In 31% of the sample no connection was made with other SARs or SCRs that the SAB had previously completed on self-neglect. This represents a significant missed opportunity to review the impact of learning lessons, namely what has (not changed) locally in terms of policy, organisational and multi-agency collaboration and practice.

It is not unusual to observe that little use is made of research about effective interventions in practice (Serbati et al., 2019) but why does this matter? Firstly, commissioning SARs and using evidence to inform their findings and recommendations is an acknowledgement and expression of accountability. SABs are accountable *to* several constituencies from which their mandate is drawn and accountable *for* the development, monitoring and review of adult safeguarding arrangements. Accountability is both explanatory and responsive (Preston-Shoot, 2020). Secondly, responding effectively to the complexities and challenges inherent in adult safeguarding requires that services and practice are based on a robust foundation of best evidence (Marsh and Fisher, 2005). That foundation draws on diverse sources of knowledge, including research alongside practice wisdom, to raise awareness, challenge attitudes and assumptions, and develop policy and practice in ways that respond to complexity, uncertainty, need and risk by assembling a coherent picture of the circumstances surrounding each case (Walter et al., 2004; Lorenz, 2016).

There are, at least, three barriers to confront. One concerns relationships between researchers and practitioners. Building bridges between different communities has been promoted through the development of researcher-practitioner partnerships in generating and discussing findings (for example, Mason et al., 2017/18; Serbati et al., 2019). A second concerns the inaccessibility of research, published behind paywalls. Researchers, historically, have arguably paid insufficient attention to dissemination and mobilisation of their findings through, for example, learning and service development events and briefings that draw out implications for policy and practice (Walter et al., 2004). Equally, however, it takes persistence to seek out research and SAR evidence (Mullen, 2016).

A third barrier is that research is not seen as relevant. This may be because research illustrates what needs to be done but not how it should be done (Marsh and Fisher, 2005), a challenge that may also be voiced about SARs. Doubt may be expressed about whether what has been found effective somewhere else transfers to the local context (Mullen, 2016). Alternatively, the implications of research findings may be edited down because they challenge current beliefs, assumptions and approaches to particular issues, or filtered through what is politically acceptable and financially possible either nationally or locally (Weiss, 1993). Nonetheless, a framework for positive practice can be devised from research and SARs, offering guidance for policy, multi-agency collaboration and practice, on which SABs and their partner agencies can build through training, supervision, commissioning and quality assurance. The model for best practice in responding to self-neglect (Preston-Shoot, 2019a) provides one example of this process.

For SABs and SARs, one conclusion from the foregoing is that the quality markers (SCIE and RiPfA, 2018) could be much more explicit about the value of drawing on research and review findings.

Another is that reviewers should be encouraged to draw more actively on research and review findings to inform their analysis.

Concluding discussion

Since the research was completed for this SAR sample, other reviews have been published[14]. These will be included in future analyses alongside reviews that have been commissioned but not yet concluded. Once again, as reported above, not all these reviews use learning from research and published SARs. So, what is to be made of this continuing stream of reviews on self-neglect?

The breadth of the concept of self-neglect, incorporating hoarding alongside behaviour that jeopardises health, may partly explain this picture. However, there are clearly systemic issues locally that individual SARs implicitly expose if not explicitly challenge. These include barriers to implementing the evidence-base for effective practice in self-neglect cases, such as embedding the use of case conferences and multi-agency strategy meetings, and building capability within the workforce.

The themes within the recommendations, and the findings across the domains, betray the layered complexity of transforming adult safeguarding. For example, the quality of practice with individuals in their social situation is inextricably linked to the organisational culture and multi-agency relationships within which it is located, not least supervision, workloads, staff support, strategic and operational collaboration across boundaries, and access to specialist advice. The ability of commissioners to construct an integrated architecture of provision, designed to address the needs of the whole person, is influenced by relationships across health, housing and social care, and political geography locally and nationally. The effectiveness of procedures will depend on whether they are co-produced and perceived to enhance practice or experienced as contributing to practice overload (Northway et al., 2007).

In these respects the onus falls on SABs to seek reassurance that the evidence-base is guiding practice and the management of practice.

Equally there are systemic issues nationally that SARs alone will be incapable of resolving. These include gaps in the law, for example when working with individuals in the long-term grip of substance misuse, and challenges created by current law, for example how legislation perceives of mental capacity or permits information-sharing. The impact of financial austerity on public services, reflected in workloads, thresholds for eligibility and resources to meet needs, will feature here. So too will the coverage in health, medical and social work education of the constituent components of the evidence-base for working effectively with self-neglect specifically, and adult safeguarding generally, such as legal literacy and the developing understanding of executive capacity. The next iteration of the statutory guidance (DHSC, 2018) could helpfully be informed by experiences of the impact of parallel processes on timely completion of reviews. It could also consider whether a strong mandate towards publication of reviews would assist SABs, individually and collectively, to conduct sustained, continuing conversations, drawing on SARs for policy and practice change.

[14] For example, by Teeswide SAB (2019) Josh; Camden SAB (2019) Ms UU.

Here the onus falls on SABs, individually and collectively, to use the authoritative knowledge gleaned from SARs to advocate for legislative and policy change, and on central government to learn the lessons.

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