Self-Neglect Assessment and Management

GP Role

Knowing

Being

Doing

Manage as a long-term condition by combining knowing, being and doing

Understanding the person, their history and the context of their behaviours

Developing an effective relationship based on honesty, reliability & respect

**Diagnostic Triad of Behaviors**

1. Neglect of personal needs
2. Neglect of environment
3. Declines interventions

± Hoarding

± Neglected pets

Recognise behaviours

I

,

Facilitating incremental negotiated changes aimed at reducing risk of harm Refer to the MCA and your Non Attendance Policy and Guidance

Make a diagnosis

**Consider the temporal course of**

**self-neglect,** for example, is it recent or longstanding, has it varied in severity or simply progressed gradually over time. Does the chronology support the hypothesised causes? Use your professional curiosity.

|  |  |  |
| --- | --- | --- |
| **Mental** | **Social** | **Physical** |
| Personality OCD / loner | Personal values | Functional disability |
| Learning disability | Traumatic life history | Sensory impairment |
| Autism | Alcohol abuse | Nutritional deficiency |
| Anxiety& depression | Drug misuse | Chronic pain |
| Organic brain disorder | Isolation | Sleep deprivation |

Consider Causes and Chronology

|  |  |
| --- | --- |
| **Look for evidence of mental impairment**  which could affect the person's capacity  to avoid harmful choices.  What is it’s course (duration, progression &  fluctuation) and does this correlate with the  condition’s history or could there be another  factor at play which might require a different  approach? | |
| **Acute** | Toxic confusional state  Stroke |
| **Recent** | Tumour HIV |
| **Variable** | Mental illness Brain injury |
| Gradual | Dementia Alcohol related |

# 

Look for any impairment of mind

How do family, friends, visitors and neighbours interact with the person:

Supportive

Indifferent

Neglectful

Coercive

Do they lack a support network?

Protective or coercive others

I

The clinician should not default to the assumption that the person is choosing to make unwise choices in this situation. Sometimes the person may understand individual elements of what needs to be done to protect themselves but cannot complete the actions to keep themselves safe in an integrated and sustained manner and therefore lacks capacity.. This is lack of executive capacity as they can’t execute the decision.

Assess capacity to avoid harm

Risk of harm may be reduced, and quality of life improve, by the cumulative benefit arising from separate interventions.

Also see your Non-Attendance Policy.

Medical Analgesia Psychotropics

Wellbeing Social interventions

Physical Appliances

Support with ADL

Other Housing, RSPCA etc

Medical

Wellbeing

Physical

Other

Interventions by local services

|  |  |  |
| --- | --- | --- |
| **Consider a multi-agency approach when**   1. Information sharing is needed 2. Universal services are struggling to manage risk 3. Person lacks capacity or their capacity fluctuates and decisions must be made in their best interests. **Follow the MCA**. 4. If you have held multi-agency meetings yet still feel that the person is at high and imminent risk from harm and appears to have capacity, then consult **the MSP Managing High Risk Together pathway**. |  | |
|  | Multi-agency  Approach |
|  |
| Safeguarding  Referral | |

**Raise a Safeguarding concern when:**

1. The person is at risk of abuse from others and

cannot protect themselves

1. A child or another adult at risk is living

in the household

1. Legal action may be required because of public
2. interest e.g. risk of fire
3. The person is at risk of harm from their self-neglect

**Raising your concern with the Contact Centre does not require consent –the person will be consulted with regarding any action they would like taken.**

-

**NHS Manchester CCG -** ‘Adapted from Northamptonshire CCG’s Flowchart’