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Social work practice with self-neglect and homelessness: Findings from vignette-based interviews

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Abstract

This article reports social workers' attitudes and approaches to working with people experiencing multiple exclusion homelessness (MEH) who self-neglect, and whether these people receive services, including safeguarding, differently from other populations. It draws on telephone interviews in 2020 with twenty-two social workers working with adults in a range of statutory local authority and National Health Service hospital roles in England. Interviews used two almost identical vignettes featuring self-neglect to prompt discussion and solicit experiences; one included homelessness and drug use to draw out any differences. Following transcription, interview data were analysed thematically. What emerged is a rich understanding of practice responses to self-neglect, but also uncertainties within contemporary social work: whether people who are homeless fall under the 'umbrella' of Adult Social Care and safeguarding; and whether self-neglect 'fits' under safeguarding. Additionally, participants described barriers to successful multi-agency support for people experiencing MEH, including stigma and exclusion from some statutory services. There was evidence that recent learning from Safeguarding Adults Reviews and local deaths has led to some examples of stronger multi-agency working in this context. The findings suggest

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more clarity is needed within the profession to ensure that people experiencing MEH benefit from strengthened social work input and safeguarding expertise.

Keywords: adult safeguarding, homelessness, multiple exclusion, self-neglect, social work

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Introduction

This article reports social workers' attitudes and approaches to practice with people experiencing multiple exclusion homelessness (MEH) who self-neglect, and whether they receive social care services, including adult safeguarding, differently from other populations. 'Self-neglect' is understood here as a lack of self-care to the extent that it threatens someone's safety, and can include the inability to avoid harm and reluctance to accept support (Department of Health and Social Care (DHSC), 2021).

We draw on a comparison of discussions of two fictional vignettes featuring people who self-neglect (see Box 1). One referred to the person as living with dementia whereas the second referred to a context of homelessness and drug use, which enabled the research team to explore differences in responses. These interviews are an early part of a three-year study of statutory safeguarding and local authority (LA) responses to self-neglect and homelessness, which was prompted by national

Box 1. Vignettes
Vignette A: Jane Smith has dementia. She lives in a privately rented ground-floor flat in a quiet residential area… *[insert TEXT]*
Vignette B: Jane Smith has a heroin and crack addiction. She has been homeless on and off for many years. She is currently living in temporary accommodation in a privately rented ground floor flat in a quiet residential area, but often sleeps rough because she prefers to be in the city centre… [*insert TEXT*]
(TEXT) Jane 'has a daughter with whom she no longer has any contact due to a family argument. Large amounts of personal items have accumulated inside the flat and backyard. Personal hygiene and self-neglect are an issue since the toilet appears blocked. Jane is throwing personal waste into the yard. There is no food in the fridge and Jane is very underweight. She has chronic obstructive pulmonary disease and continues to smoke heavily, which is thought to be a fire risk, in light of the accumulated possessions. She is anxious and depressed and refuses to go to the doctor to get her medication. A neighbour who occasionally says hello to Jane has raised concerns about her deteriorating health. Sometimes she does not see Jane for days but recently called an ambulance whose staff were forced to break down the door when Jane was seen collapsed on the floor. Jane spent a week in hospital undergoing assessments; the third time in hospital in the past year. Although the hospital social worker arranged help from a care agency, Jane will not allow anyone into her flat and refuses all offers of assistance.'

concerns, including the findings of Safeguarding Adults Reviews (SARs) into deaths of people who are homeless, and the lack of implementation of recommendations (Ministry of Housing, Communities and Local Government (MHCLG), 2018b). This article presents some of the questions and uncertainties that emerged from these interviews.

Background

Multiple exclusion homelessness: Definitions and responses

This article focuses on responses to self-neglect amongst adults experiencing MEH, a term which describes the experience of not only homelessness, but also other facets of social exclusion: experience of institutions (prison, LA (state) care, mental health/psychiatric care), substance misuse, or street culture activities (begging, survival shoplifting, sex work). Fitzpatrick *et al.*'s (2011) exploration of MEH found, in a survey, that 47 per cent of people who were homeless had experienced all of these and that most had experienced trauma or exclusion as a child. Recent estimates are that almost two-thirds of people sleeping rough in England have a drug or alcohol problem (MHCLG, 2020).

The notion of social exclusion, advanced by policymakers in England with the establishment of the Social Exclusion Unit (SEU) in 1997, attempts to address the 'joined-up' nature of problems (SEU, 1998). One of the Unit's first reports, *Rough Sleeping* (SEU, 1998), cast rough sleeping in social exclusion terms and sought to reduce numbers by two-thirds by 2002 (Mackie *et al.*, 2017). The present strategy (MHCLG, 2018b), now under the Department for Levelling Up, Housing and Communities, aimed to eliminate rough sleeping by 2027, a target brought forward to 2024 (Prime Minister's Office, 2019). The *Rough Sleeping Strategy* joined with the Care Act 2014 and the Homelessness Reduction Act 2017 in offering greater protection to those who are homeless. The 2017 Act placed new duties on some public bodies, such as local government and the National Health Service (NHS), with respect to people who are homeless or at risk of becoming so (MHCLG, 2018a). Eligibility for care and support changed under the Care Act 2014 to focus on eligible needs arising from physical or mental impairment or illness, and the statutory guidance states that substance misuse might be relevant to those needs (DHSC, 2021, para 6.104). Taken together, these policy shifts have been seen as helpful by including people experiencing MEH under the umbrella of care and support in England (Manthorpe *et al.*, 2015; Cornes *et al.*, 2016); this article offers social worker perspectives on MEH and its relationship with care and support, which have not always been heard (Manthorpe *et al.*, 2015).

Prior to the Care Act 2014, it was argued that housing support workers were filling a professional space left by a reduction in 'direct work' with adults by social workers (Cameron, 2010), and that homelessness and housing workers often felt isolated and out of their depth leading work with MEH (McDonagh, 2011). A review of homelessness and exclusion research found different services more likely to work in parallel, or, at worst, in conflict, rather than together on MEH (McDonagh, 2011). More recently, the government-commissioned programme by the Advisory Council on the Misuse of Drugs (2019) concluded that mainstream social care, health and some drug services do not meet the needs of people who are homeless, particularly rough sleepers, and proposed integrated health and social care approaches to recovery and housing, particularly for individuals with multi-faceted problems. New government proposals for health and social care integration, including local shared outcomes, accountability, records and pooled budgets (DHSC, 2022) echo calls from MEH practitioners and experts by experience within this study (Harris, 2022).

Ambiguities in self-neglect

The element of the Care Act 2014 of interest to this article and other commentators (Martineau *et al.*, 2019; Preston-Shoot, 2020, 2021) is one aspect of adult safeguarding practice—self-neglect—and its application in homelessness. Self-neglect was added to the safeguarding categories in the Care Act 2014 statutory guidance, and, in an analysis of SARs was the most commonly reported abuse or neglect (all SARs 2017–2019: Preston-Shoot *et al.*, 2020). An analysis of policy development on self-neglect (Martineau *et al.*, 2021) suggested ambiguity in national approaches, which may have translated into uncertainty within social work practice. Some SARs reported a lack of understanding that safeguarding may be required in cases which do not relate to a third party (e.g. Isle of Wight Safeguarding Adults Board, 2018).

Also documented are ethical difficulties associated with judgements of mental capacity and self-neglect. Self-neglect may arise as an effect of impaired capacity, but also features amongst people with capacity to make decisions. This presents practice challenges, weighing the obligation to promote well-being (Part 1, Care Act 2014), whilst observing principles that guard against welfare overreach and disrespect for individual autonomy (s.1, Mental Capacity Act 2005). Brown's (2011) evidence that decision-making is influenced by emotional factors is an important consideration in capacity assessments in the context of self-neglect, where past trauma may influence someone's decision-making more than their understanding of risks and consequences.

From its earliest showing in the literature, self-neglect has been understood as at least partly socially determined (e.g. Shaw and Macmillan on 'social breakdown', 1957; Gibbons *et al.*, 2006). There may be uncertainty about the degree that someone is excluded, or is excluding themselves, from social norms. Similarly, self-neglect is strongly associated with refusal of assistance—placing someone outside support structures. Again, to what degree this is an extension of someone's reluctance to look after themselves or a mismatch in their situation and the services offered is queried (Lauder *et al.*, 2009; Harris, 2022). Take-up of services and support is also shaped by encounters with professionals; in their international systematic review, Omerov *et al.* (2020) found that experiences of discrimination and stigmatisation negatively affect willingness to seek care, and the perceived and actual access to services.

The Care Act 2014 statutory guidance refers to self-neglect as covering 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings' (DHSC, 2021, para 14.17). The statutory guidance includes substance misuse as a potential element in the eligibility criteria for care and support (DHSC, 2021, para 6.104). It could be argued that the 2016 update to the guidance, by adding reference to the person's inability to 'control' their behaviour, also covers substance misuse as a potential safeguarding concern:

> An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support. (DHSC, 2021, para 14.17)

Without the recognition of self-neglect in cases involving substance use, many individuals experiencing MEH are unlikely to be considered for safeguarding.

Methods

This three-year study is identifying positive practices and areas for improvement in responses to self-neglect and homelessness. In addition to the interviews reported here, the study includes scoping reviews, fieldwork in three Safeguarding Adults Board (SAB) sites (six English LAs), including interviews with a wide range of professionals and people using services, economic modelling, and reflective practice and learning via Communities of Practice.

The interviews with social workers reported here were planned face-to-face, but with the advent of Covid-19 were re-scheduled by telephone and an additional question explored experiences of working under Covid-19 (Manthorpe *et al.*, 2021). This phase of the study received

ethical permissions (King's College London). All data collection materials were reviewed by an expert-by-experience and the safeguarding practitioner on the research team, which also includes social work, socio-legal and economics expertise. A wider stakeholder group advises the study.

Recruitment was undertaken by circulating an invitation via a national social work knowledge dissemination network. This did not mention homelessness but invited responses from social workers with an interest in self-neglect. Participants were selected from different adult social work roles and settings. The intended sample was twenty and we report on twenty-two interviews, including two pilots with participants with contrasting roles and seniority, as no changes were made to the interview schedule and vignettes. The sample size reflected the modest scale of this element of the study, prior to case study fieldwork, but was sufficient to offer rich and varied data to illuminate the subject. Participants were employed by ten LAs (local government bodies providing social services and safeguarding) and two NHS Hospital Trusts from diverse locations across London and predominantly southern England, and spanned inner city, suburban and rural localities. Most were working in specialist or generic adult services or multidisciplinary community teams; five were in NHS hospital teams. Six held manager roles. Details are summarised in Table 1.

Following informed consent, interviews were conducted by one researcher between August and October 2020. Interviews lasted thirty to sixty-five

Table 1. Participants' roles and locations ($n = 22$)

Role/team	LA/NHS Trust
Approved Mental Health Professional	LA1
Social Worker (SW), Homelessness Team	LA1
SW, Hospital Team	LA2
Manager, Mental Health	LA3
SW, Hospital Team	LA4
Manager, Community Team	LA5
SW, Locality Team	Trust 1
Manager, Disability Team	LA6
SW, Adult Team	LA7
SW, Reablement Team	LA5
SW, Adult Social Care	LA8
SW, Community Mental Health	Trust 2
SW, Hospital Team	LA6
SW, Locality Team	LA5
SW, Locality Team	LA8
Manager, Mental Health	LA9
Liaison & Diversion Practitioner	Trust 2
Senior Social Work Assistant, Locality Team	LA5
Manager, Specialist Team	LA4
SW, Assessment Team	LA10
Manager, Mental Health	LA2
SW, Hospital Team	LA1

minutes; all were audio-recorded and transcribed. The semi-structured interview guide explored one of two fictional vignettes (case studies), which were shared with the participant beforehand. Participants were alternately allocated one of the vignettes (see Box 1), which offered the same description of someone severely self-neglecting, with the distinction that in Vignette A the woman is living with dementia and in Vignette B she has a history of homelessness and drug use. Participants discussed one vignette and were asked their views on the Care Act 2014 and how—or if—it safeguards adults who self-neglect and are homeless. Vignettes prompt discussion about professional attitudes and practice approaches and solicit individuals' own experiences (Barter and Renold, 2000). The vignette was developed by the team to include severe self-neglect so discussion could focus on attitudes and responses, not debates about its presence.

The research team met regularly to discuss emerging findings, which informed the development of the coding framework (themes for the analysis). Interview data were read by a second researcher, to ensure familiarisation, entered into NVivo data analysis software, and analysed by two researchers, including the interviewer, using thematic analysis (Braun and Clarke, 2006), drawing on Framework Analysis principles (Gale *et al.*, 2013). Qualitative analysis is an iterative process where data collection is integral to the process, so the interviewer led the analysis. The framework was developed further during analysis and emerging themes coded inductively throughout. Team discussions ensured codes were consistent. Once data were coded, responses to each vignette were compared within individual themes. Findings are anonymised, with identifying features removed from quotations.

Findings

Participants were asked to talk through their approach to working with 'Jane' and commonalities and differences in responses to Vignettes A and B are reported here (and summarised in Supplementary Table S1). Findings are organised under two domains from the Local Government Association's *Adult Safeguarding and Homelessness 'Briefing on Positive Practice'* (Preston-Shoot, 2020) practice framework: 'Direct work with individuals' and 'Multi-agency and multi-disciplinary working'. (Other domains in this framework are beyond this article's focus.)

Direct work with Jane

Participants' descriptions of direct work that they would undertake with Jane included references to person-centred approaches and to mental

capacity, risk and needs assessments. We also report uncertainties about the relationship between homelessness and Adult Social Care and how this might affect practice.

Person-centred approaches

The strongest commonality amongst responses to the vignettes was the articulation of person-centred approaches. Almost all participants emphasised that their approach to self-neglect and service refusal would be relationship building, trying to establish rapport and trust, described as foundational to finding out who Jane is by establishing what is important to her. Practitioners emphasised the slow pace: going back regularly, not overwhelming her, showing you are not a threat. Only one participant mentioned exploring any past trauma with Jane A; this was raised more often for Jane B, where the presence of drugs and homelessness indicated a probable history of trauma and dysfunctional early relationships.

Participants acknowledged that a person-centred approach was not always easy and some felt not all colleagues would invest equally in the process. Again, this view was shared across vignettes:

> It would depend on professional to professional … I may want to pull out all the stops to try and engage with this lady and make small steps to manage some of the risks. 4A

> It takes a lot of energy and time and effort and interest in the person, and some people are really unpleasant and you don't want to spend time with them, but you have to because if you're not … who is going to do that? We all deserve that regard. 7B

For both Jane A and B, participants observed that current social work approaches were rarely configured for the long-term work that cases of self-neglect required.

Mental capacity

The second element emphasised by practitioners was exploring her decision-making capacity. Whilst there was variation in the approach—the pace, areas of capacity to assess, and whether they would undertake these or defer to a mental health practitioner—this did not relate to the two vignettes. Several participants expressed concern that professionals within and across services have different approaches and abilities to assess capacity:

> Self-neglect requires specialism … it's about how you do mental capacity assessments; they do very basic training, don't teach you how to dig deep so that you are able to access the complexities of the person;

> it's about the questions you ask, how you go about asking, the language you are using - a level of experience is required. 14A

There were mentions of moving to a best interests assessment if Jane A lacked capacity to make decisions about risks relating to her self-neglect, and some considered arranging a Mental Health Act assessment in case her condition called for compulsory hospital admission. With Jane B only one social worker suggested a Mental Health Act assessment to 'see what's going on'.

Risk

Discussion of risk featured strongly and unprompted; participants identified 'main' factors, discussed levels, and talked about assessing, reducing and managing risks. There was no discernible difference between the two vignettes, but some difference was evident between practitioners advocating a slightly more interventionist approach and those accepting some of the risks might be Jane's choice:

> . . .it's about trying to unpick what the risks are, what are the most risky bits and what are the bits that we can change, and are acceptable to Jane. 8A

Some highlighted additional risks relating to Jane B: using drugs safely, exploitation from people dealing drugs, engaging in sex work for drugs, and impacts on her mental capacity or health. Several expressed concerns that her drug use would prevent her from receiving a multi-agency response, explored below, but participants did not use stigmatising language when describing the risks nor did they dismiss her right to support.

Needs assessments

In their responses to both vignettes, participants described undertaking needs assessments (s.9 Care Act 2014) or trying to gather information for one. Several described eligibility for care and support under the Act (s.13) as open to interpretation and reported differing approaches within LAs, in particular in relation to homelessness:

> The Care Act is quite open to interpretation, yes, you've got the 'wellbeing' part of it, but I do still think it is open to interpretation to a degree, depending on which LA you work for. 12A

> The Care Act and homelessness . . . I don't know how it is put in there, or if it is there at all. 9B

As outlined, participants discussing Jane B had described how they would, in principle, take a person-centred approach to build rapport,

gauge risks and capacity to understand them, and assess needs and entitlement to support. However, as interviews progressed a divergence between approaches to Jane A and B became more noticeable when some participants reported uncertainty about whether someone who is homeless falls under the 'umbrella' of Adult Social Care. One perspective was that care and support needs might be missed:

> Homelessness isn't seen as part of the social care umbrella unfortunately … The conversations that I've been involved with are around 'Whose responsibility is he?' … Whatever social care needs they may have is very much the last thing on that list. 3B

A hospital-based social worker described a 'Homelessness Policy' to discharge patients to the LA Housing Department rather than fully assess needs. Another perspective was that Jane might be assessed, but if she was a street sleeper and drug user she would be unlikely to be offered social care. One described how Adult Social Care considered homelessness, substance misuse and mental health problems as other services' remit; this segmented approach was seen as less effective than a holistic approach:

> If this referral came in and they saw heroin and crack addiction, straight away they would say 'It's the Street Drugs and Alcohol Team', then they'll go on to the homelessness, 'It's not us, it's the Homeless Team', and then later: 'Oh, and she's in depression, it's not for us it's Mental Health' … years ago in the Community Mental Health Team one person would be working with Jane and deal with all these. 1B

In another LA a participant reported that safeguarding approaches to someone experiencing MEH tend not to be tenacious, in the knowledge that they will be referred on to homelessness services:

> When we make referrals for safeguarding, we quote the Care Act and we quote all the risks … nine times out of ten it comes back 'Not going to a Section 42 (enquiry), no real investigation', which is quite sad really because those individuals are really vulnerable …They have left that risk and not done anything because that person is 'difficult'. 17B

Some described barriers—structural-, policy- and resource-related—that they saw as preventing Adult Social Care responding to people who are homeless, which included being address rather than person-led; insufficient staff time and continuity, and, illustrated here, a 'primary need' approach to service allocation:

> Every time [he comes to hospital A&E someone does a safeguarding alert] … because he is a danger to himself - it is self-neglect … he has been in and out of hospital I think it was ten times … the outcome of the Adult Social Care assessment is that he's been referred to Housing … his 'primary' need. 18A

At times there was unquestioning acceptance of this approach, so if homelessness was a factor other potential concerns, such as care and support needs or safeguarding, were not addressed.

Multi-agency and multidisciplinary team around the person

Here we report participants' expectations of working across professional disciplines, and their experiences of similar cases. This included the strengths and limitations they described within local multi-agency working and whether this would take place within safeguarding. We also report broader uncertainties about working with self-neglect within safeguarding, and concerns about the exclusion of people experiencing MEH from other services due to stigma and inflexible service models. Examples were described of some LAs addressing these problems with new multidisciplinary responses to MEH.

Safeguarding: Everyone's business?

Participants consistently reported that they would explore whether any local services, including other LA departments, had information about Jane A/B or an established rapport. Frequently mentioned points of contact were Jane's GP and the hospital recently attended, followed by environmental health, fire services, mental health services, and community police and neighbourhood teams. With both vignettes, participants said they would refer to multi-agency forums because Jane was rejecting support, and occasionally this included safeguarding. Reports of the ease and effectiveness of multi-agency working varied. GPs were mentioned most as reluctant to share information and attend meetings, in person (pre-Covid-19) or online. Mental health services were described as 'stretched' or 'hard to engage'. Some reported feeling under-supported by other services when working with self-neglect:

> Adult Social Care sometimes seem to be the ones left holding the case … if someone doesn't consent to a service, quite often the Mental Health Team will just shut it down … We do try and manage the risk, even if someone is not consenting to support, we would do a lot of work behind the scenes … try and improve situations or share information. 8A

Because some multi-agency arrangements could seem to offer more scrutiny than support, a couple of participants described avoiding them:

> You can refer yourself to get support via the Risk Panel, I've done it twice, I'll never do it again … They just give you the information that they've got on their little laptop but there's no actual support … You

> come out of there with a list of actions that you as the worker then move on with … Actually, if I don't go down that avenue there's less people looking at me to see if I mess up. 3B

In contrast, successful multi-agency collaboration was reported by others in cases of self-neglect. This appeared to rely at times on good relationships at practitioner or manager level and some described efforts to build links, referring to 'lucky' or 'informal' rather than systematic successes:

> Health colleagues are just down the corridor … we've been quite lucky that we've actually built those networks and usually we can get everyone together … It's a commitment … otherwise it is very difficult. 16A

One described how 'hot desking' (having no set desk)—and presumably home working during the pandemic—disrupted those relationships and the value they brought to multi-agency interventions:

> Hot desking, it's really crap for creating and maintaining those links to do really good multi-agency practice. Before, you knew that 'Shelly' worked from the second floor, you'd pop down, you'd find Shelly and say 'I need you to help me out'. Now, I've no idea where Shelly is … those informal ways of pushing somebody to be seen, to get onto a panel, to be discussed. 3B

There were descriptions of the range of systems that did support effective multi-agency working:

> In terms of cooperation it's really variable … depends on how good the SAB is and how good the relationships are in other tiers… Other models have sprung up around risk management … if those sorts of things are in place and there's conversations between Operational Managers of different agencies then the cooperation works really well. 7B

Information sharing

The barrier to multi-agency working most often raised with Jane A/B was the complaint that information sharing could be complicated, not systematic: 'Nobody can see what each other is doing.' (21A).

This might be the only reason a case would progress under adult safeguarding rather than an alternative multi-agency risk-management route:

> Other agencies are more likely to share information with us if we say it's through Section 42 (enquiry), for example, Police or Housing or Mental Health. 8B

When to use adult safeguarding

When asked if a safeguarding referral would be appropriate, responses barely varied between Jane A and B. For some there was an unequivocal

need for safeguarding, for others there was no need with no 'perpetrator' (addressed below); for others, it was a necessary preliminary, but longer-term relationship-based work was required. Safeguarding was variously described as appropriate if Jane was found to lack capacity to make decisions around the risks, if the risks were severe, or if it took a long time to establish the rapport necessary to conduct an assessment and Jane was refusing assistance. If Jane could make decisions, it was more likely to be seen as routine Adult Social Care, still requiring multi-agency input. As mentioned, not everyone was confident about multi-agency working outside of safeguarding, so safeguarding was a lever for engagement, but others felt this was unnecessary. There were a few examples of using safeguarding for successful multi-agency working to address MEH:

> This homeless gentleman … we brought him in to safeguarding, we had a multi-agency meeting … Mental Health Services didn't want to touch him, but through safeguarding we managed to get him in, and eventually he was assessed. … I placed him in one care home and he caused havoc … Through the safeguarding process we managed to move him and get all the players to engage. 14A

Does self-neglect 'fit' safeguarding?

Some participants said that self-neglect never fits 'under' safeguarding:

> The perpetrator is the individual so what are you going to investigate? 9B

In contrast, another expressed concern about the lack of safeguarding responses to self-neglect, citing recommendations from SARs, and called for more awareness amongst practitioners:

> I really want self-neglect to be given some weight in terms of safeguarding … we would do full Care Act assessments for anyone that came in under the category of self-neglect; other areas … don't even understand that's it's a concern … When you look at [SARs]… there's never a person that's never been seen by anyone, and things often get missed. 21A

Another, with experience of leading safeguarding, challenged what they saw as narrow interpretations of 'care and support needs' under the Care Act 2014, which may exclude people without clear care needs from social care and safeguarding:

> The safeguarding process is very much based on that 'care and support need', which I don't necessarily think is a completely accurate reading of the Care Act … So, if you don't have a care and support need and you're homeless then that is seen as not Adult Social Care's issue, so the chances are you'll get referred to the Homelessness Outreach Team who will try and engage, but it's much more difficult for that multi-agency response … I think that's a problem … If 'Jane was an exceptionally

> abused child', it just changes, she hasn't got a care need but she's probably got a support need in there somewhere, and that's a lot more intangible … Adult Social Care would lose their minds around that I think because they already have an extensive workload. 6A

Exclusion from services

When describing the multi-agency approaches they would want to see, several participants observed that people using substances were less likely to receive support from other services. Many recognised that non-engagement with services—characteristic of self-neglect—could be a complex dance of unwillingness by both the individual and services. However, it was only within responses to Vignette B that some described how Jane could be excluded due to professional bias:

> They might just see her as like, 'This is just an absolute waste of money, she's a drug addict' … people may have their own biases … who 'deserves' to be helped and who doesn't.… If the culture of the organisation through the leadership is like this then that toxic behaviour filters down to the frontline … People become desensitised to stories like Jane so they just don't think there's any point. 19B

Specialist responses to homelessness and self-neglect: Breaking the cycle

Lack of specialist responses to MEH and the inflexibility of local service models were seen as contributing to a cycle of short-term contact with services followed by a return to homelessness: '…they're homeless again and there the cycle goes.' (4A).

This was raised by hospital social workers who expressed concern that limited specialist support created a 'revolving door' at hospital A&E. The lack of 'dual diagnosis' approaches to mental health and substance problems led to a stalemate:

> There is the age-old problem … you might have somebody again with a lot of trauma who is now substance misusing, they will have underlying mental health issues but they don't get into Mental Health Services until they can address their substance misuse … a Catch-22 situation. 6A

Some described how someone would often be housed, unsupported, in poor quality temporary accommodation, which led to a tenancy failure and a return to homelessness:

> I've got a case that's similar … my guy is currently in temporary accommodation … a really horrible place to live. Got drug and alcohol

> issues and he's schizophrenic but because he's temporary housed somewhere - that's it! … feels like the person's been dumped. 11B
>
> Social Care, they're very geared up that people are allowed to make unwise decisions … 'case closed' because they have capacity and they have a roof over their head … They could be entitled to [someone] to actually support them to start making changes in their life … They'll be kicked out again because there's no change, they're back on the street. V4A

However, participants working in LAs developing or commissioning responses to address gaps in support for MEH described new or strengthened multi-agency approaches using social work expertise developed from learning from local deaths and SARs:

> There's been a case of somebody who died within similar circumstances … that's why they formed this team … to support the person whether it's housing, it's personal care, it's support with drug and alcohol rehabilitation, people cannot just be left in the streets. V9B
>
> It's more joint working … the Homeless Team, they'll come to me with Jane's case and they go, 'Ok, so what do you think?' So, we'll have a discussion and then I will say 'Ok, let's go and see Jane' … before I take it to the next level. 1B
>
> They start to become a problem … it would come to Adult Social Care as safeguarding … they might seek to just pass it back to the Homelessness Outreach … My job is saying 'I think we should have a meeting about them' … somebody that you're concerned about who doesn't fit into safeguarding … there's nothing actually different in there, I don't think, but it just doesn't use the word 'safeguarding' … I looked at a couple of Serious Case Reviews from other areas and they had similar recommendations. V6A

These new specialist responses were positioned outside of adult safeguarding.

Limitations

The sample of interview participants was a convenience sample of social workers, almost all female, who responded to a request to contribute to research and saw themselves as having 'an interest in self-neglect'. This may limit the generalisability of the findings. Interviews took place during the Covid-19 pandemic; professional pressures were high, so interviews were kept relatively short and not face-to-face. The invitation targeted social workers, but in the interview one participant revealed that they were a non-qualified senior social work assistant; they were included as they described doing similar work to registered colleagues. Whilst there are concerns about whether participants' responses to vignettes reflect 'real world' conduct, or elicit idealised answers (Barter

and Renold, 2000), most, although not all, participants reflected on differences between their ideal responses and any limitations within their daily practice and the systems they work within. This meant that observations and concerns raised later in the interviews sometimes seemed to contradict earlier more idealised responses. Participants also shared their own experiences of working with self-neglect and homelessness, offering an additional dimension to responses to the vignette.

Discussion

Many social workers noted, unprompted, that Jane's situation was familiar, and that self-neglect was a regular feature of their practice. One finding from these interviews using vignettes was the similarity of the initial, strongly evidence-based practice responses to both Jane A and B's self-neglect: the need to be person-centred, to persevere to try to build a relationship in the face of rejection, appreciation of the complexities around mental capacity and risk, and the need for information sharing and a multidisciplinary approach (Braye *et al.*, 2014). Participants reflected that not all colleagues would invest equally in working in complex and potentially hostile situations, and having identified themselves as having 'an interest in self-neglect', some noted that they would be likely to take, or advise colleagues on, similar cases, having assumed (usually) informal roles as 'self-neglect' champions or practice leads, a role that could be supported and formalised.

There were non-judgmental views that Jane B might face additional risks related to her drug use, but also accounts of additional barriers to her receiving multi-agency support, including references to stigma and exclusion from services because drug or alcohol use was present, echoing what has been reported by people experiencing MEH (Mc Conalogue *et al.*, 2021), in a review of SARs featuring homelessness (Martineau *et al.*, 2019) and the wider research literature (see the systematic review by Omerov *et al.*, 2020). Discrimination faced by people experiencing homelessness has been characterised as 'legitimised' where the factors generating stigma, such as addiction, are judged by others to be 'controllable' (Johnstone *et al.*, 2015); our interview participants were not confident that all practitioners and services adequately overcome (un)conscious discriminatory attitudes towards MEH.

One structural barrier to support which was highlighted by these findings was practice approaches which prioritise one perceived 'primary' issue or service need—housing. This fails to address the complexity within MEH and denies the possible role of Social Care and safeguarding (as seen in SARs, for example, Isle of Wight SAB, 2018) by constraining inter-disciplinary approaches (Clements, 2020). For people who report childhood trauma, mental health problems, substance use and

homelessness, consideration of each of these as discrete 'issues' has been found to be unhelpful, even impossible, and creates frustration with services (Mc Conalogue *et al.*, 2021). Understanding of the complexity of MEH and the existing structural and attitudinal barriers to addressing it could be strengthened within both qualifying and post-qualifying training, within a focus on complex safeguarding and on Care Act and Mental Capacity Act assessments. Notably, some social workers raised concerns about the quality of mental capacity assessments, a concern that has emerged in another strand of this study (Harris, 2022) and in analyses of SARs featuring homelessness (Martineau *et al.*, 2019; Preston-Shoot *et al.*, 2020) but remains unexplored within research into homelessness.

Some social workers clearly saw MEH as simply outside the purview of Adult Social Care and safeguarding; others reported successful social work and multidisciplinary safeguarding responses to MEH; but some expressed frustration with barriers to someone like Jane B receiving the support that might benefit her: 'They have left that risk and not done anything.' A lack of systematic specialist provision for people facing complex problems has been described as the 'inverse care law', where those who most need support are at greatest risk of being unable to access it (Tudor Hart, 1971). Social workers interviewed prior to the Care Act 2014 reported how some people experiencing MEH might be marginalised by social services' inclusion (or exclusion) policies (Manthorpe *et al.*, 2015). Analogous practitioner concerns have been articulated recently within mental health services: that we can exclude people from services on the basis of complexity, thereby perpetuating an 'exclusion culture' (Beale, 2022). Whilst refusals of support by someone self-neglecting were familiar to our participants, there was also concern expressed by some about the failure of statutory services to offer flexible, specialised and multi-faceted support—the mismatch between someone's situation and needs and the services and approaches offered (Lauder *et al.*, 2009). This mismatch was described by our participants as contributing to a 'revolving door' of crisis contacts with emergency services but a long-term mistrust of, and frustration with, the services that might help to support some of the most socially excluded to reduce the risks they face and address their self-neglect.

Conclusion

These interviews with social workers evidence a rich understanding of person-centred practice responses to self-neglect, irrespective of whether homelessness and drug use featured, but what also emerged were questions and uncertainties within contemporary social work in England. These questions included whether people who are homeless fall under

the 'umbrella' of Adult Social Care and whether self-neglect, irrespective of the presence of homelessness, 'fits' adult safeguarding—reflecting, perhaps, the ambiguity in central policy-making that positioned it there. Additionally, not all concerns may be seen as safeguarding matters as the management of risk is core to all social work practice. However, more guidance would be useful within the profession to clarify the role and to strengthen the expertise of social work and safeguarding in supporting people experiencing MEH.

Of note was the reported learning from SARs and local deaths which has led to the strengthening of multidisciplinary working moving beyond a 'primary need' to work with the complexity of MEH, whether in multidisciplinary outreach teams or specialist risk management forums. Amongst the social workers interviewed here these approaches were the minority not the norm. NICE (2022) guidance calls for integrated responses to homelessness, endorsing a social work role in multidisciplinary outreach teams and a homelessness champion on SABs—proposals that align with recommendations from our study. Our findings also support approaches where Care Act, safeguarding and mental capacity assessments of people experiencing homelessness are carried out by practitioners with expertise in working with MEH.

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Supplementary material

Supplementary material is available at *British Journal of Social Work Journal* online.

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