INTERVENTION: PROTECTION OR CONTROL?

It is a fine balance between respecting a client's autonomy and protecting them from severe self-neglect, say Joe Pidgeon and Peter Bates

Social workers and others are at times faced with severely neglectful home situations. For the worker involved such situations often bring into sharp focus issues of clients' rights, risk-taking and societal expectations of professional workers. Upholding the principle of a person's right to self-determination can at times be in conflict with what society regards as the legitimate protection of the weak and vulnerable, the age-old doctrine of *parens patriae* (the role of the state in protecting its vulnerable members). We must hold together self-determination, *parens patriae* and an awareness of the suffering and powerlessness that may attend vulnerability.

Severe self-neglect in people's homes also raises questions about the adequacy of support services, their flexibility and comprehensiveness, and the extent to which they should be pro-active in monitoring the situations of vulnerable people. It also brings into question the framework of legislation that hangs uncertainly around this area.

In our area of work with people who have enduring mental health problems, there are three main trends that might lead us to be aware of a rising incidence of self-neglect. It is paradoxical that these trends also offer great opportunities for improvement in the lives of our clients.

The first factor is the closure of long-stay psychiatric hospitals. It is important to recognise that this does not merely entail the movement of a good many people to alternative community settings; it also restricts the reverse movement of individuals into psychiatric hospitals for anything other than acute re-admissions. This raises the question of the kinds of supported accommodation that are being designed to replace the old long-stay hospitals.

> "We have to uphold the principle that people have a right to a self-determining lifestyle . . ."

The second trend relates to the application of normalisation theory in mental health work, a theory that is now widely espoused, if not acted upon, in many parts of the country. Personal dignity, privacy, autonomy and choice enlargement are key principles in normalisation thinking, and some people may choose to neglect themselves.

The greater number of our clients are single, and an increasing percentage are aspiring to an independent life in their own home. In such settings individuals may have to attend to a range of domestic, financial and personal tasks, perhaps with high levels of peripatetic support. However, unless these support services themselves become over-dominating, rigid and institutionalised, then no amount of good practice and flexible and imaginative resourcing is going to prevent the occasional recurrence of severe self-neglect.

Identifying need

The third trend is the implementation of effective case management systems, which will increase the perceived incidence of self-neglect. Where the community staff are effectively carrying out their task of support and monitoring, then incidences of harmful self-neglect will be more often identified. "Those arranging public services," to quote Sir Roy Griffiths, "must have systems which enable them to identify those who have need of care and support in the community" and "must assess those needs within the context of the individual's own situation".

Some of the difficult issues that arise over individual autonomy, legal and social rights and societal expectations are illustrated in the following biographies.

Mr B is in his middle 40s and has a long standing psychiatric diagnosis of obsessional personality disorder. He has a chequered history of psychiatric admissions and homelessness. We became involved at a point when Mr B was rehoused from a shelter through the Homeless Persons Act. Once in his new home he locked the door and for six weeks would not open it to anybody.

Was he legitimately exercising his right to be alone in his own house, celebrating the acquisition of a front door key? Or, alternatively, was he locked into a self-destructive state of mind — powerless and helpless? How was the balance between his rights to autonomy and his vulnerability to be assessed?

During this period Mr B had not claimed any benefits or paid any bills. He appeared not to be leaving the flat and we knew he had little food. With a chronic incontinence problem the floor and sofa (on which he chose to sleep) would be heavily soiled, as would his clothes. With an aversion to washing himself there was a possibility of recurrent, leg ulceration. On a number of occasions Mr B called out the GP and then refused him access, so the GP retaliated by taking him off his list.

What is the framework of legislation that we might have called upon, and what are its

limitations in these situations? An assessment under the Mental Health Act 1983 was an obvious starting place. The last time we had met Mr B our judgement did not indicate that a compulsory admission was appropriate. We could see him through the sitting room window, and he did not appear distressed in any way. One could apply to a Magistrates' Court for a Section 135 of the 1983 Mental Health Act allowing the police to forcibly gain access in order for an assessment to take place. Breaking a door down would be a highly symbolic assault upon Mr B, his rights and his sense of home. Could this be justified?

An alternative statutory instrument is Section 47 of the 1948 National Assistance Act and its 1951 Amendment, allowing compulsory removal to a place of safety if lives are at risk. The community physician did not think that Mr B met the criteria of Section 47, and considered it to be more appropriately dealt with under the Mental Health Act. One further area of legislation is provided by the Public Health Acts empowering intervention by environmental health departments. There are, for example, powers to enforce cleaning of faecal matter, urine-damaged property and rotting food; also powers to compel to bathe in order to disinfest. Such an approach might have eventually produced a Magistrates' Warrant to enter and clean up the flat at great financial cost to Mr B. But such a hit and run tactic deals only with the symptoms of self-neglect and does not address the cause.

If we had been allowed regular access we would have no alternative other than to help clean up, dispose of furniture and decontaminate. This, despite the lack of appropriate equipment, clothing and the poor economics of using the hours of such staff for duties of this kind; or we could have done nothing. In all areas we felt boxed in. The legislation we might have employed was of limited use or potentially very damaging to our clients' situations. The final outcome was that a social worker, who had known Mr B previously, spent over an hour shouting through the letterbox (and, incidentally, alerting all the neighbours to Mr B's predicament) and finally achieved access.

Next day Mr B was admitted to hospital, informally, for treatment for depression. He had his own idea of what we should have been protecting. He said at the time that he wished we had arranged for the police to break the door down.

Mismanagement

Our second biography involves gross financial mismanagement, which is a further aspect of personal neglect that raises tensions between the need to take control and client self-determination. Our enquiries with psychiatric hospital rehabilitation services that are deemed to be centres of excellence by the Department of Health show that it is exceptional for psychiatric hospital patient banks to offer out-patient banking, budgeting, or appointeeship/agency services. Yet numerous people want to leave hospital and live independently in the community, but continue to both want and need a financial management service.

If community-based staff are to take over where the hospital bank traditionally leaves off, then it is likely that financial management will become the most time-consuming activity in their programme. One alternative to be considered might be guardianship of the estate, via the Court of Protection. But this is available only to people with substantial capital and most of our clients have little or none.

The situation of Ms A illustrates some of the issues that arise when one considers intervention in the financial sphere. Living on her own she developed a delusional idea that she was incapable of accruing debt with the predictable result that multiple debts to fuel boards, housing and hire purchase companies threatened to engulf her. Neither the social worker nor the psychiatrist considered her compulsorily admissible, as the only danger

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arising from her delusions was a creeping destruction of domestic security. It had been shown over many years that this condition was not susceptible to medication.

After weeks of attempts to get at this impasse from other angles, it was finally decided to recommend an appointeeship to the Department of Social Security against Ms A's wishes and without her consent. This invasion of personal freedom, it should be said, is carried out without guidelines, review or appeal procedures. After a year the social worker was still managing most of the bills and issuing money to Ms A each fortnight. On one occasion recently the worker was a day late with her money, and the resulting stress led Ms A to set fire to her flat. She was initially placed in custody.

In these situations we are invariably faced with difficult decisions around the assessment of mental alertness, vulnerability and risk. We have to uphold the principle that people have a right to a self-determining lifestyle which may be risky, offensive to others and ultimately resulting in failure or breakdown. We also have to try to protect Mr B from harming himself when he is unable to help himself; to prevent Ms A from amassing hundreds of pounds of debt because of delusional thinking that puts her at risk of homelessness and worse.

While we are maintaining this fine balancing act we may well be fending off pressures from neighbours, family or even other agencies who are urging that "something be done". Sometimes these voices represent part of our own anxieties, and we begin to move from helping towards controlling. Taking control over another person's circumstances might be an expression of genuine concern; alternatively it might be an act emanating from our own need to blame someone, masking our own inability to provide appropriate help or to be seen to be doing something.

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