4LSAB Multi-Agency Guidance on Responding to Self-Neglect

June 2024

1. Introduction

This guidance applies to adults who are self-neglecting. If the adult has caring responsibilities for a child, then child safeguarding procedures should be considered. Practitioners should always consider the whole family. Further information can be found in the 4LSAB Family Approach Toolkit.

Working with self neglect can be personally and professionally difficult. Practitioners should remember that it is not their individual responsibility to hold risk - it is the responsibility of agencies to do this and to support staff appropriately.

Any concerns for self-neglect should be reviewed against the three statutory criteria under section 42 of the Care Act 2014:

> (1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
>
> (a) has needs for care and support (whether or not the authority is meeting any of those needs),
>
> (b) is experiencing, or is at risk of, abuse or neglect, and
>
> (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

Professionals working with individuals experiencing or at risk of experiencing self-neglect must consider parts a and b above, and if they consider these criteria are met, submit a safeguarding referral to the Local Authority. The Local Authority will then consider parts a, b and c to determine if S42 criteria has been met for a safeguarding enquiry response to be initiated.

For further information on safeguarding concerns and when to make referrals for self-neglect, see the 4LSAB Safeguarding Concerns Guidance

If it is determined that the individual does not meet the 3 parts of the criteria, a response under a statutory adult safeguarding framework will not apply.

When the circumstances sit outside the statutory adult safeguarding framework,(i.e. an adult does not have care and support needs but is at risk of or experiencing self-neglect, or an adult has care and support needs but is able to protect themselves from self-neglect) the 4LSAB have a Multi-Agency Risk Management (MARM) Framework to facilitate multi-agency working and manage risks in the most effective way.

The MARM framework will be helpful in situations where there are concerns about self-neglect or hoarding and where usual responses by agencies or organisations are unable to mitigate against the risks and where the risks are unmanageable. Full details of the MARM process are found in the 4LSAB Multi-Agency Risk Management Framework

Throughout both processes, either a statutory safeguarding adults response, or Multi-Agency Risk Management process, the adult's views and wishes need to be central to the support and actions considered.

If there is professional disagreement about the appropriate framework to apply, or challenges around action or inaction by agencies, the 4LSAB Multi-Agency Safeguarding Adults Escalation Protocol should be referred to. It is important that the stages of this protocol are used, and to note that this is not a complaints process.

2. What is self-neglect?

The Care Act Guidance advises that 'self-neglect' covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding.

Partner agencies should consider the following indicators in relation to self-neglect:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

Agencies are required to think of these issues in a broad context – not just in terms of obvious manifestations such as hoarding. Self-neglect can happen anywhere - in the person's own home, or in settings such as residential care, supported living, or street homelessness.

It is also important to consider if the home is hoarded and the person is unable to reduce the items or if the home is cluttered due to moving to a smaller property, for example. Although a similar process may need to take place in relation to fire safety and reducing the items it is important to understand the individual's circumstances.

Self-neglect is not always immediately evident and professionals should be professionally curious. The extent of the self-neglect may only be identified through taking the time to build relationships and trust with the person.

Early intervention is the most effective means to avoid a harmful level of self-neglect.

3. Assessment of risks associated with self-neglect and consideration of vulnerability factors

This guidance recognises the interrelationship between financial, physical, mental, social, personal and environmental factors. There are a number of factors for consideration:

- Underlying poor mental health, which may include obsessive compulsive disorder or hoarding disorder
- Traumatic life changes, including bereavement
- Cognitive impairment
- Physical and nutritional deterioration.

- Health conditions such as diabetes, dementia, traumatic injury including spinal and brain injury - all of these may have an effect on the adult's abilities, energy levels, attention span, organisational skills or motivation
- Side effects of medication
- Poorly managed pain
- Personal beliefs and identity
- Mental capacity
- Neurodivergence, including autism
- Risks from alcohol or substance use
- Economic/financial issues including cost of living

A multi-disciplinary partnership approach can be most effective in gathering information regarding the extent of the risk and identifying an appropriate person or agency to take the lead in coordinating a person centred, outcome focused response. When engaging with the adult and considering the risks, consideration should be given to the following aspects of the adult's life:

- Presentations of self-neglect and the home situation
- The individual's perception of their situation
- Engagement in activities of daily living
- Functional and cognitive abilities of the person
- Family and social support networks, and the lack of these
- Underlying medical conditions
- Underlying mental health conditions
- Substance or alcohol use issues
- Environmental factors, including fire risks
- Home care and other services offered/in place and whether living conditions are preventing necessary care being provided.
- Environmental health monitoring.
- Money management and budgeting.
- Risks to others.
- Impact of self neglect on the rest of family
- Identifying and supporting any carers
- Engagement with services
- Any other indicators of abuse or neglect - for example financial abuse, or coercion/control by another person.

4. Intervention and management

In line with the 'Making Safeguarding Personal' principles of good practice, **the adult should be included and involved** in the assessment process and in developing a plan to reduce or eliminate identified risks. The person should be invited to attend any meetings and their views and wishes should be heard in relation to any findings or proposed actions.

Working with someone who is self-neglecting takes **patience and time** - it should be noted that short-term interventions are unlikely to be successful, and practitioners should be enabled to take a long-term approach. Building trust through regular, encouraging engagement and gentle persistence may help with progress, whereas

one-off interventions where the person does not have control (such as a deep-clean) are often deeply upsetting for the adult.

The Cycle of Change model can help when understanding the potential destructive behaviours witnessed in relation to self-neglect. It shows a variety of stages that someone can expect to go through when changing behaviour. Prochaska & DiClemente's model (1983) indicates that a person, at any given time during this process, is in a certain stage. This model applies to all types of change, whether it is trying to stop hoarding behaviours or controlling one's anger. See Appendix D for more information.

Professional curiosity is important at all times when working with someone who is self-neglecting. This means not taking things at face value, asking questions to understand why and how situations have developed, looking for evidence of what people tell you, and working effectively with other agencies. Further guidance can by found in the 7-minute Guide to Professional Curiosity.

Practitioners should take a **trauma-informed approach** to working with an adult who is self-neglecting, recognising that their self-neglect may be linked to past trauma (including trauma experienced in childhood) and working in a way that will prevent re-traumatisation. The five key principles of a trauma informed approach are: safety, trustworthiness, collaboration, empowerment and choice. See also the Short Guide to Trauma Informed Practice.

Types of intervention which may be useful in working with an adult who is self-neglecting include:

- Risk assessment - have effective, multi-agency approaches to assessing and monitoring risk, including using the MARM framework when appropriate
- Assessment of mental capacity
- Mental health assessment – it may, in a minority of cases, be appropriate to refer an individual for Mental Health Assessment
- Supporting the person to access other sources of support, such as provided by the voluntary sector
- Identifying and contacting family members who may be able to provide additional support, with the adult's consent
- Decluttering and cleaning services - offer practical help where a person cannot face the scale of the task but is willing to make progress. For further guidance see the 4LSAB Multi-Agency Hoarding Guidance
- Utilise local partners – those who may be able to help include the RSPCA/other animal charities, the fire service, environmental health, housing, voluntary organisations
- Occupational therapy assessment – physical limitations that result in self-neglect can be addressed
- Help with property management and repairs – people may benefit from help to arrange much needed maintenance to their home
- Support with money - such as benefits and budgeting
- Peer support – others who self-neglect may be able to assist with advice, understanding and insight

- Counselling and therapies – some individuals may be helped by counselling or other therapies. Cognitive behaviour therapy, for example, may help people with obsessive compulsive disorder, hoarding disorder or addictions

5. Key Agencies and their role

It is fundamental that a partnership approach is adopted when responding to, and managing self-neglect referrals and enquiries. Hence all organisations have a role in responding to these concerns; key in this are the roles briefly noted below. There is greater detail contained in the 4LSAB Multi-agency Guidance on Adult Safeguarding Roles and Responsibilities. The 4LSAB Multi-Agency Hoarding Guidance also lists the various legal powers that can be used by each agency.

Appendix B also lists sources of support.

Risk of Homelessness

The Local Authority Housing Department will be key partners. Where an adult is at risk of homelessness as a result of self-neglect or hoarding behaviour, the housing department will offer advice and assistance to individuals and practitioners to minimise any risk of homelessness. They can support adults who are street homeless and may be self-neglecting, or where their self-neglect is leading to a risk of eviction from their home. Early involvement from this team, particularly when considering alternative temporary or permanent accommodation options, is therefore essential. The 4LSAB Housing Practitioner Briefing on Homelessness gives greater detail.

Adult Social Care Department

Adult social care departments are responsible for an assessment of the adult's needs for care and support (section 9 of the Care Act) and also for assessing the support needs of carers (section 10 of the Care Act). Adult Social Care is also responsible for considering safeguarding referrals (section 42 of the Care Act). Where the adult is experiencing, or is at risk of, abuse or neglect, section 11 of the Care Act continues to place a duty for the local authority to carry out a needs assessment even when the adult does not consent.

Primary Health Services (GPs, Ambulance Service and District nurses)

The key role for Primary Health Services will be to identify concerns, take proportionate measures to support in mitigating risk as far as practically possible, support in making safeguarding personal and raise concerns in line with the Care Act (2014) and 4LSAB Multi-Agency Safeguarding Adults Policy and Guidance (July 2023) to the relevant Local Authority.

Primary Health Services will continue to meet need in accordance with their professional standard and duty of care, giving consideration of any need for onward referrals to other health professionals and services, such as Mental Health, Social Prescribers, H&IOWFRS and the third sector as required, while continuing to review and escalate any ongoing concerns.

Primary Health Services should work collaboratively with wider multi-agency partners to provide information to help support and inform the strategy discussions.

Fire and Rescue Services

When adults become vulnerable, they become vulnerable to fire. A high proportion of deaths or serious injuries from fires involve people with care and support needs or other vulnerabilities. Due to this Fire and Rescue Services being involved in multi-agency working and safeguarding processes is vital. Where properties are hoarded or cluttered this increases the risk for those occupying the address (and neighbouring properties) as well as the ability of emergency services to access the property.

Fire and Rescue Services have a responsibility to support other agencies to recognise, assess and manage fire risks for individuals. Fire and Rescue Services will assess risk through the home safety visit / safe and well visit programme: they can visit identified adults at risk and provide advice and equipment that is specific to the individual based on their needs, their behaviour and their home environment.

Access further information about referring for a Safe and Well visit.

6. Mental Capacity

The principles of the Mental Capacity Act 2005 should be applied where the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a specific decision at the time it needs to be made.

Although the Mental Capacity Act states that the person is not to be considered to lack capacity just because they may make decisions that others consider to be unwise, if the person is making unwise decisions, especially those that expose the person to risk, their mental capacity should be considered in more detail, and it may be appropriate to undertake a mental capacity assessment. It is not sufficient to assume such decisions are "lifestyle choices" without respectful challenge and exploration of the person's reasoning and background information.

Formal assessment of an individual's mental capacity which is decision and time specific should be recorded accurately.

Practitioners should also consider **executive capacity** when assessing mental capacity. Capacity involves not only weighing up information and being able to understand the consequences of decisions and actions ('decisional capacity'), but also the ability to implement those actions ('executive capacity'). It can be common to find that a person will say that they do something, or plan to do it, but it never happens - sometimes they never had an intention to carry it through, but in some cases there may be reasons why. If a person cannot understand that they are not carrying out the action from the decision, and there is evidence this happens repeatedly, it is likely that the person lacks capacity to make the decision. Practitioners need to avoid making assumptions about people making lifestyle choices without considering how mental health, addiction, brain injury or perhaps shame about their environment or circumstances may influence those 'choices'.

Where the adult declines support and they have been assessed as having the mental capacity to understand the consequences of such actions, this should be fully recorded. Practitioners should also include a record of the efforts and actions taken by all agencies involved to provide support and confirmation that they have considered alternative means to meet any duty of care owed to the person or others affected by the living conditions. There should be plans in place to monitor and review risks and reconsider actions should risks escalate. For cases where there is uncertainty about mental capacity a Court of Protection application should be considered.

7. Advocacy

The Care Act gives the Local Authority the duty of ensuring that an individual has independent advocacy to facilitate their involvement in their assessment, care planning, review and any safeguarding enquiry where they have 'substantial difficulty' participating. Sections 67 and 68 of the Care Act explain this requirement. This support is able to be provided by an "appropriate" person, who is not engaged with the Adult in a professional or paid capacity.

The Advocate has the responsibility of upholding the Best Interests of the Adult, assisting them to understand and exercise their rights and to challenge decisions they believe are inconsistent with local authority's duties to promote wellbeing.

Considering advocacy is important for any housing or legal decisions that may have an impact on the adult.

Information on advocacy for each area can be accessed here:

Hampshire: Voiceability
Portsmouth: South West Advocacy Network
Southampton: The Advocacy People
Isle of Wight: South West Advocacy Network

8. Further information

Further Information can be found here:
4LSAB Multi Agency Risk Assessment Framework (MARM)
4LSAB Multi-Agency Hoarding Protocol
4LSAB Multi-agency Fire Safety Framework
4LSAB Briefing on homelessness
SCIE resources on self-neglect
One Minute Guide to the Mental Capacity Act
Seven Minute Guide to Professional Curiosity

APPENDIX A: Good practice

Case Example from Hampshire County Council's Enhanced Support Project (ESP)

Context – Mr P a 64yr old gentleman who was living at home with his mother who passed away. It appears that he had unmet needs that his mother used to help with, and then he found himself alone.

Self-neglect. Details on referral received by GP: ‘I received a referral initially for bereavement counselling as P’s mum has passed away. I have been unable to get hold of P despite several attempts. I was informed by his Godmother (who contacted the surgery he won't answer the phone) I arranged a meeting via her at his mother’s bungalow after the funeral on 09/03/2023 and she would come with him. (P would not be attending the funeral apparently as he can't manage with grief). The Godmother has concerns as he possibly has slight learning disabilities? His mum used to do everything for him, washing clothes etc. He apparently won't let anyone into his flat, so no one knows how he is managing. He has a sister who I haven't contacted she is in contact with him but, apparently also not allowed into flat. The main concern is how he is managing day to day, is he able to look after himself as his mum did so much for him'.

Mr P was protected and supported by his mother and presents as a vulnerable gentleman. Home group provider for ESP reports that if you ask Mr P a question you only get 'one go as he retreats' and finds it very difficult to engage in conversation. Mr P reported to provider he was in a mess in his flat and it's 'barely inhabitable' but has not allowed his siblings (sister and brother) in the flat and has 'hidden himself away', there has been no fall out with his family, but Mr P doesn't like to share information and avoids questions and so it's difficult to determine what support he may need. Mr P had support around nutrition, washing and emotional support from his mum - the family have been in this situation for some time and are #finding it difficult to engage.

Outcomes/goals identified: reduce risk of self-neglect, improve living condition, improve social engagement.

In partnership with the provider for ESP it was established that Mr P could benefit from a strengths-based approach and would be able to do more to support himself if shown as recently his sister has taught him how to do washing independently.
The provider worked with P on a weekly basis to encourage him to adopt a healthy diet, facilitated a deep clean of his flat and promote its maintenance. They supported him to purchase a vacuum cleaner and demonstrated how this works step by step which has allowed him to carry out this task independently. The provider also replaced the fridge and cooker with new and obtained a washing machine (his first ever). All of which he has been taught to use and can complete these tasks.
In conjunction with his sister, we arranged for an autism assessment to be carried out, to obtain a formal diagnosis on the spectrum and put him in touch with social groups that may be of interest to him.

He has had his medication reviewed by his GP with the support of the provider making appointments and supporting him to attend.
Although after a hesitant start with ESP Mr P fully embraced the support provided through the project and has benefited from a consistent strength-based approach to enable him to maintain living independently in the community and utilise the facilities to do so.

Case Example from Solent NHS Trust

Individual lives in a four-bedroom semi-detached house. This was the family home which she moved into with her mother and lived there with grandparents as a young child. She inherited the property in her 20s after the loss of her grandparents and mother.

Individual first became known to adult mental health services following an acute onset of psychosis resulting in being detained under the Mental Health Act including Section 3 of the Mental Health Act for treatment.

Diagnosis: schizophrenia, Emotionally Unstable Personality Disorder, substance use.

Living In uninhabitable living conditions.

Hoarded and disorganised belongings throughout the property, no walk space available. Climbing over items just below ceiling height. Hoarded up to front door approx. 1.5 ft from front door.

Scored 9 on the clutter rating scale in most rooms.

Initial risks:

- Significantly poorly lit environment, using small battery powered lights.
- Rats and mice infestation.
- Risk of hoarded items collapsing.
- Possible structural risk due to weight of hoard upstairs.
- All windows closed, locked and unable to be opened due to lost keys.
- Unable to fully open front door significantly impeding entering and exiting the property.
- Fire risk and significant risk of fast spread of fire.
- Falls risk.
- Risk of injury whilst climbing over items.

Intervention:

- Initial involvement to build therapeutic relationship out of the home.
- Support patient to coffee shops and offer hot drinks and food.
- To get to know patient, their like, dislikes, interests, passions, difficulties, and obstacles.
- Built trust.
- Supported client to temporarily leave the property as a place of safety, including care home, and two supported living accommodations.
- Supported to engage in mental health treatments.

- Support with risk management including police.
- Over period of nine months agreed on a plan to re-organise belongings.
- 2 attempts with patient present – unsuccessful found incredibly distressing.
- Agreed on an informal contract outlining the exact plan.
- Used professional, kind, respectful and specific information.
- Client had knee height piles of wrapping and food wrappings. Allowed this to be discarded excluding anything that had handwritten notes on which got bagged up and placed in garage.
- Supported to have electrics checked by electrician.
- Blue Lamp Services to support with changing of locks on door and replacement keys.
- Fire services to support with smoke detection.
- Support for client to replace toaster, fridge, kettle, microwave and washing machine and bed for living room.
- Clearance company to remove all waste with Occupational Therapist being present to ensure contact was upheld throughout the process.
- Property deep cleaned throughout.
- At end of cleaning process accessible stairs, living room, hallways toilet and kitchen.
- Graded approach to returning home.
- Kept as many items as possible on display.
- Took photos and shared with patient of belongings.
- Patient purchased 20 storage boxes to help with the storing of items. Boxes labelled with inside items.
- Once home 2-3 visits provided to support with managing living room space and monitoring of risks.
- This has been safely maintained for past 1.5 years.

Key points

- Agree on respectful language to describe belongings.
- Patient invested in you as their practitioner.
- Demonstrate intention to be trustworthy.
- Do not impose your own values of living environments.
- TRUST and RESPECT essential to the process.
- Small pockets of function using smart goals to help work toward positive experiences.
- Building relations with charities to support the process of letting go of items.

Positive stories from practitioners

As part of a staff survey on self-neglect carried out by the Portsmouth Safeguarding Adults Board in 2024, practitioners were asked to share any positive stories that they had from their work with adults who self-neglect or hoard. 25 people shared their positive stories with the themes of:

- Supporting the adult to get a formal diagnosis
- Building a relationship with the adult over a period of time
- Working in a multi-agency way (eg involving Adult social care, Mental health services and voluntary sector)

- Securing more appropriate accommodation for the person (eg move to care home or sheltered accommodation)
- Advocating for the adult with health services
- Making appropriate referrals
- Securing support from specialist cleaning/decluttering services
- Getting advice from other services
- Mental capacity assessments
- Working with the person's family
- Addressing the root cause of the problem - eg loneliness
- Organising cleaning services

A selection of their examples are shared below:

'Working with ex-forces person who was very unkempt and was not washing or cleaning himself. His flat contained newspapers, old boxes, stale food. Discussed these issue and it was clear he had some mental health issues possible PTSD. On advocating for him at GP appointment a referral for a full MH assessment was done. This led to weeks of waiting and it was decided to go through a military charity and a full MH assessment was completed and severe PTSD diagnosed and a treatment plan was put in place. The flat was cleaned through the council and redecorated. New clothes were given to the person and a plan was put into place to assist him maintaining himself and flat. This took over 6 months with some relapse but eventually with support from myself and also Adult Service, MHT, and medication he was able to manage. On-going support was maintained for a period of 14 months and with careful guidance he did not return to his unkempt state or hoard. He now has employment and helping others through a similar journey as he went through.'

'Worked over some time to build trust with service user, identified that mum also had unmet care and support needs. joint working across ASC, LD, housing and fire service. After many discussions, I managed to get housing to commit to and fund a clean and deep clean. Mum and daughter were supported to create an action plan. Wider support service put in place, ie support worker.'

'Pt with early stages of frontotemporal dementia admitted into a nursing home declined to wash, change clothes or even take off his coat. Over weeks, built a relationship with him where he grew to trust me. Over those weeks showed him bathroom and eventually he agreed to allow me to help him to bathe BUT put back on his old clothes! I took him to the laundry room and said that perhaps next time we could put his clothes in and he could put on fresh ones. Uneasy with this, I suggested he could sit in laundry room with a cup of tea and could see his clothing at each stage of washing, drying and ironing doing what he could for himself with my support. We set aside Friday mornings for this. Eventually on a Friday, he would come to find me for his bath! It took MONTHS to get to that stage though and more time for him to allow other staff members to support him. They had to work alongside me for some time before he would trust them to help. A gentleman I will never forget and think of him with fondness as he taught me so much about how kindness, time, perseverance and thinking outside the box can lead. (there was some education of staff required who struggled with things such as Pts being in laundry room etc)'

APPENDIX B: Directory of Support

Below are links to some useful organisations which may be able to provide support.

- **Blue Lamp Trust -** a non-profit organisation dedicated to promoting and enhancing community safety
- **Hourglass -** charity dedicated to addressing the harm, abuse, and exploitation of older people
- **Hampshire and Isle of Wight Fire and Rescue Service** - information about how to access Safe and Well visits
- **Cinnamon Trust** - national charity for older people, the terminally ill and their pets
- **RSPCA** - animal welfare charity
- **AgeUK** - national charity for supporting older people
- **Age Concern Hampshire** - charity supporting older people in Hampshire
- **AgeUK Portsmouth** - charity supporting older people in Portsmouth
- **SSAFA**, the Armed Forces charity
- **Autism Hampshire** - charity providing information, support and services covering all areas
- **Herbert Protocol** - a form that carers, family or friends of a vulnerable person, or the person themselves can fill in. It contains a list of information to help the police if the person goes missing.
- **Domestic abuse services:**
    - Hampshire
    - Southampton
    - Portsmouth
    - Isle of Wight

Connect to Support Hampshire provides an extensive directory of services covering all areas.

Your **local Safeguarding Adults Board** will also provide details of local organisations and pathways:

- Hampshire SAB
- Southampton SAB
- Portsmouth SAB
- Isle of Wight SAB

APPENDIX C: Practical tips for engagement

Practitioners

- Time to build a relationship, to ‘find the person’, to understand the meaning of their self-neglect in the context of their life history.

- Collaborative work, multi-agency involvement and systems for securing it.

- Finding value in small achievements, recognising what is being given up.

- Engagement with manager and time to debrief so that you are in the best position to manage the case, recognising that working with self neglect can be emotionally difficult for professionals.

Service Users

- Practical input, household equipment (options for where to get these, charities, energy schemes), benefits, advocacy, possible re-housing options.

- Promoting choice where possible.

- Access to psychological and mental health services to tackle deep-rooted issues.

For additional information see the 4LSAB Multi-Agency Hoarding Guidance.

Top tips for conversation starters:

It can be daunting to start a conversation when the adult and or their home appears chaotic. As a professional it's important to go prepared, below are some conversation starters that may help. It's important you feel comfortable too and knowing what you can offer in terms of support, referrals and time can help this. Likewise, if you're going to need to take any sort of enforcement action, be clear what this is, what it will mean for the person and what will happen next. Debrief if you need to.

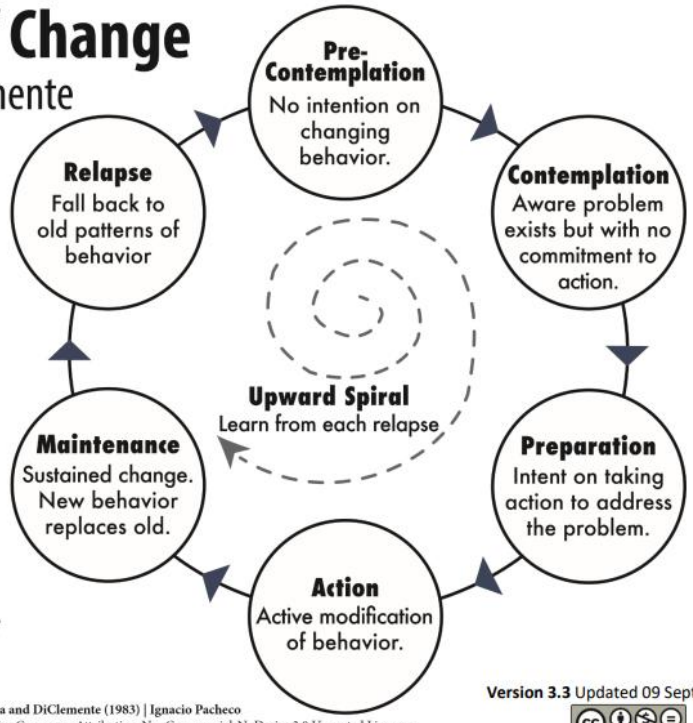
<table>
<tr><td>Ask the adult to tell you a story about them or their past, maybe something that still worries them or something they're proud of.</td><td>Take note of the objects around them such as photographs, jewellery, engage in conversations about specific items.</td><td>Find out what the adult wants help with, this may not be related to their self-neglect.</td></tr>
<tr><td>Ask about the adults past, and how this may trigger their behaviour in the present.</td><td>Have an open and honest conversation and ensure their response has been acknowledged.</td><td>Ask about the adults' networks, including friends and family. Ongoing support is key.</td></tr>
<tr><td>Set milestones keeping them small and timely. Ask for example what do you feel you can achieve in the coming week?</td><td>Ensure you display empathy. Acknowledge the fear many people feel when facing change.</td><td>Identify the strengths in the adult that you might highlight and have some ideas about how they might draw on these.</td></tr>
<tr><td>Ask 'what are your current concerns?'</td><td rowspan="2">Where you can, go at the person's own pace. Remember this maybe long entrenched behaviour so recognise this in your conversations.</td><td rowspan="2">Ensure you're in a location where the adult feels comfortable to talk, which may not always be at home initially.</td></tr>
<tr><td>Be professionally curious.</td></tr>
<tr><td>Be clear about what can happen next.</td><td>Ask them what they'd like to accomplish in the future, understand the adults wishes.</td><td>Ask them what we can work on together to achieve what you want from your life.</td></tr>
<tr><td>Be aware of your body language and facial expressions.</td><td>Encourage a deeper conversation, for example, 'what are the things working well in your life?'</td><td>Ask them 'What helps you when things get difficult?'</td></tr>
</table>

APPENDIX D

The Cycle of Change

Prochaska & DiClemente

- **Precontemplation:** A logical starting point for the model, where there is no intention of changing behavior; the person may be unaware that a problem exists
- **Contemplation:** The person becomes aware that there is a problem, but has made no commitment to change
- **Preparation:** The person is intent on taking action to correct the problem; usually requires buy-in from the client (i.e. the client is convinced that the change is good) and increased self-efficacy (i.e. the client believes s/he can make change)
- **Action:** The person is in active modification of behavior
- **Maintenance:** Sustained change occurs and new behavior(s) replaces old ones. Per this model, this stage is also transitional
- **Relapse:** The person falls back into old patterns of behavior
- **Upward Spiral:** Each time a person goes through the cycle, they learn from each relapse and (hopefully) grow stronger so that relapse is shorter or less devastating.



SOCIAL WORK TECH

The Cycle of Change
Adapted from a work by Prochaska and DiClemente (1983) | Ignacio Pacheco

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40