ALCOHOL CHANGE UK

National Network of Safeguarding Adults Board Chairs

Working with people that practitioners find hard to engage

WORKING DRAFT | July 2026

Contents

Section 1 - Introduction

Why this briefing

This briefing aims to encourage and support frontline health and social care practitioners to work effectively with people who appear to struggle to engage with processes or systems that will benefit them. Engagement is viewed as a separate element within care, a necessary pre-condition for providing support. It argues that service providers need to have a specific focus on building engagement approaches and skills, just as much as on any other aspect of care.

Who this briefing is about

The majority of users of health and social care services are willing recipients of the care they are offered. However, for many, the struggle is to access services when they need them and in the way they want them.

Moreover, there is a group of people that services find difficult to engage. Examples are easy to find.

An alert 70-year-old man who is sitting in his own urine and faeces but refuses to let his carers change his continence pads and says "I can look after that" but who doesn't and ends up with grade 4 pressure sores which threaten to end his life.

A 58-year-old woman with mobility problems has allowed her nephew to come and live with her despite the fact that he is a heavy drinker with a history of abusing those around him. When workers visit neither of them will open the door.

The 54 year old man who is living in a house stuffed with hoarded newspapers, old magazines and boxed goods that he buys from television shopping channels but who refuses any help to de-clutter or manage his increasingly problematic spending.

This guide aims to support frontline workers to work most effectively with these and other individuals with similar presentations.

Who this briefing is for

This is a UK wide briefing which for frontline workers across health, social care, housing, criminal justice and related sectors. It will support them to recognise the need for engagement focused interventions and support them to identify potential approaches and techniques. It will also encourage service managers to support and encourage staff to use these approaches.

It was developed using material and input (including lived experience) from Wales, Scotland, England and Northern Ireland and is designed to be relevant to practitioners and managers in all four countries.

Definition

Engagement is a contested concept, widely used but rarely defined, incorrectly suggesting it is simple when it is complex and multi-faceted. Engagement is not an action, or a single activity, it is a process. It has the relationship between the service/practitioner and service user at its core. It comprises:

- Maintaining contact; and
- a working relationship built on trust and emotional safety; and
- a negotiated balancing of power between the service user and practitioner; and
- a shared sense between the service user and the practitioner that they are working towards goals and outcomes, at the pace the service user sets.

Engagement starts with maintaining **contact** but does not remain there: the establishing of contact between a service user and practitioner is insufficient to be classed as engagement, as it does not automatically denote that there is a working relationship.

For engagement to develop and be established, a **working relationship** is required between the service user and the practitioner in which the practitioner builds trust, enabling the service user to feel emotionally safe and share their concerns, challenges and strengths, wishes, feelings and desired outcomes.

'Engagement' in practice often either emphasises the responsibility of service users – who, e.g., must 'engage with services' – or focuses on the role of practitioners, who have a duty 'to engage' those individuals. In practice, responsibility is held by both service users and practitioners, but within that is the important recognition that practitioners hold more power in the relationship than service users and thus must take more of the responsibility for building engagement. In this context, the **balance of power** must be carefully attended to by the practitioner and negotiated with the service user to ensure they are working collaboratively while not demanding more of the service user than they can reasonably take on.

Finally, **goals and outcomes** are identified in the context of engagement, and engagement continues as a process enacted through the working relationship towards those outcomes, at the right pace for the service user.

Language

Practitioners must think carefully about the language they use when describing apparent 'engagement' and 'non-engagement'. As this briefing sets out, exploring the reasons behind lack of contact or involvement, identifying barriers and working to overcome them, are essential. A crucial first step is naming the situation accurately. 'Engagement' and 'non-engagement' and other similar labels are widely used to describe many different behaviours, from non-attendance at meetings or appointments, to intermittent contact that doesn't follow a service's own processes, to the explicit refusal by a service user to accept the service offered.[1]

The range of different behaviours and situations that can be captured under the umbrella of 'engagement' demand, therefore, that further explanation is provided. In other words, the label itself will always be insufficient to accurately represent what is happening and should never appear alone as a descriptor of, or label attached to, an individual service user. This also enables attention to be paid to systemic and structural issues that impact on engagement such as discrimination, capacity, disability, negative prior experiences of provision, poverty, and processes, rather than a narrow focus on the behaviours of the individual service user.

Language in use and responses to "did not attend" often betray an assumption that an individual is unwilling to engage when in fact they might be unable to do so. A key task is to use skills of compassionate enquiry to understand the backstory.

Principles

This approach is built on nine principles:

- Responses to people that services find difficult to engage should start with the recognition that there are things that we can do to help.

- We need to take every opportunity to engage apparently change resistant individuals and reduce the harms and risks involved.

- The response to such individuals should be non-discriminatory. These clients have an equal right to protection from harm as other groups. Services should not be denied or adjusted because of disapproval of their lifestyle or the workload they may require.

[1] This guidance addresses the engagement of individual service users with services; it is not concerned with the other main use of the term engagement, to describe community or wider user engagement, or co-production, in service-level decision-making, research or policy development.

- Agency management systems must support a positive and assertive approach to this group.

- The response to this group will need to be the responsibility of a range of specialist and non-specialist services, not just a single agency or worker.

- Ideally, the goal will be to work with people to bring them to the point at which they decide to engage or change; however, at some points the focus will need to be on managing risk and containing harm.

- Wherever possible actions and decisions should involve the person.

- No system of treatment and care can provide for every need. If gaps are being identified, especially consistent or serious gaps, staff should have mechanisms for recording and reporting these to those who commission services.

- When things go wrong staff and services should have the courage to review the human story and learn lessons for future practice. Responses will only improve through being open when things go wrong.

Section 2 - Why a focus on engagement?

Why this briefing? Lessons from serious case reviews

The Care Quality Commission's Special Review in to the care of Valdo Calocane in Nottingham has brought to the fore the importance of assertive engagement with individuals with complex needs (e.g. p.31). However, this is a theme that has been emerging repeatedly in Safeguarding Adult Reviews (SARs)[2] over the last decade.

The recent LGA/ADASS SAR analysis highlights poor responses to reluctance to engage in 38% of SARs analysed. It commented that: *Many SARs identified problems in how agencies had failed to engage individuals who may have been reluctant or unable to accept support. Lack of assertiveness or persistence on the part of practitioners was noted, with time not taken to build rapport that could generate trust. (Part 2 p.37)*

Individual SARs have made the same point. The Manchester SAB *Homelessness Thematic Review,* comments that: "*When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage".* The North Yorkshire Elaine SAR comments that: *'The impression is that agencies continued to attempt to engage with Elaine in the same way: making an appointment, turning up or calling and hoping she will accept contact this time. This seems to be a case of "professional optimism" triumphing over the need for a more "professionally curious" approach.*

[2]A system established under Section 44 of the Care Act 2014 to learn lessons for future practice from situations where people with care and support needs have suffered serious or irreparable harm.

A focus on engagement is vital to protect some of the most vulnerable individuals in society.

Why this briefing? The impact on resources

The need to ration services means that people who refuse a service are, to some extent, "welcome" because they release resources that can be used with other people. There is, therefore, a perverse incentive to allow people to pursue a self-destructive pathway: their disinterest allows others to receive a service.

However, it only takes a moment's reflection to recognise that this is a costly route. While not engaging with mainstream services, this group will be the frequent users of emergency and crisis services. The cost burden associated with failed appointments, repeated crises and harm to the community will be enormous. One individual with repeated ambulance and police call outs, occasional admissions to hospitals and arrests can cost tens of thousands if not hundreds of thousands of pounds each year.

Why this briefing? The legislative framework

The challenges of working with individuals that services find hard to engage is magnified by aspects of UK legislation.

For example, in England and Wales, The Mental Capacity Act 2005 recognises that: ...every adult has the right to make their own decisions (including unwise decisions) – unless there is proof that they lack the capacity to make that decision.[3] Therefore, people have the right to make choices about their life that other people feel are not in their best interests. The Care Act 2014 in England, the Social Services and Wellbeing Act 2014 in Wales and the Adult Support and Protection (Scotland) Act 2007 all emphasise the importance of personalisation - hearing and being led by the views of the person being cared for.

However, to what extent are the three people in the case studies above really making choices? The 70 year old man might have "had mental capacity" in terms of the English and Welsh legislation, but was still rejecting help in a manner that led to very serious harm. Was he really "making a choice" or was he embarrassed, ashamed and unwilling to be seen in soiled pants? Was it a "choice" or the pride of an older person? This example is based on real events and it is interesting to reflect that once he reached a crisis point and was rushed to hospital, he was grateful that people had finally taken action on his behalf.

This brief is designed to help professionals decide what alternative action can and should be taken in these challenging situations of apparent non-engagement.

[3] Mental Capacity Act 2005 Code of Practice (p.3)

Section 3 – The voices of individuals that services find difficult to engage

Evidence from SARs on Engagement

From the 652 SARs in the second national analysis (Preston-Shoot et al., 2024), a detailed qualitative analysis of 229 reviews was undertaken. 29% of these reviews found positive practice on making safeguarding personal, and 22% found that practice was characterised by perseverance. There were examples of practitioners building trusted, trauma-informed relationships, and of showing patience, persistence and tenacity in engaging with people who were reluctant to work with professionals. There were examples of personalised approaches to contact/meetings, home visits and other assertive outreach approaches.

By contrast, references to shortcomings on engagement were more commonly observed. 50% of these reviews commented on the lack of personalised approaches. There were specific instances of an absence of assertive outreach, of professional curiosity about apparent non-engagement, and of persistence. There were examples of involvement being closed down due to non-engagement without any exploration in a personalised way, and of individuals being signposted to service provision rather than taken and introduced with support. Some reviews commented on bias/negative attitudes as evidenced in language and labels in use, and on a deficit-based approach to practice – a low expectation of change. There was little evidence of consideration of the impact of protected characteristics on engagement, for example race or sexuality.

Engagement was also considered when reviews explored how services worked together. Here were examples of lack of information-sharing, for instance when services closed cases or when individuals moved across service borders. Decision-making on whether to refer a safeguarding concern or to open a safeguarding enquiry did not routinely recognise the potential significance of repeated patterns.

Engagement was also considered when reviews considered the organisational context for practice. Observed here were agencies and/or SABs that did not have policies on disengagement, and practitioners commenting on the impact of high workloads on the time available for complex and challenging scenarios. Some agencies were observed to lack or discourage flexibility in their expectations or approach to engagement.

SAR recommendations sometimes explicitly addressed engagement. In terms of direct practice, there were recommendations for working with families to identify approaches that might increase engagement and mitigate risk, and for ensuring that recording systems enabled identification of patterns of non-engagement.

In terms of organisational support for practice, there were recommendations for training to ensure that practitioners had both time and skills to persist with

engagement, and for the development of policies and guidance on clinical disengagement.

Practice, and supervision of practice needed to promote reflection on the concept of non-engagement with services and whether sufficient effort had been made to reach individuals and to compassionately enquire into their current and prior experiences of, and feelings toward services.

Case studies from serious case reviews/Adult Learning Reviews (in Scotland)

Nicola was a Scottish woman with a physical disability who lived with her daughter and her sister. She had carers going in to support her; however, they reported that the sister was difficult and aggressive. Ultimately, Nicola requested that the carers no longer attend, stating her sister was going to provide her care and her service was terminated, with no real assessment of the termination request and its implications. Sadly, Nicola was later murdered by her sister. There was concern that the request for termination of care services was really being manipulated by her sister and this was never explored at the time of the request.

Joe was an English man in his 50s who had a chronic alcohol dependency. This had caused life threatening health conditions and led to his marriage ending and losing contact with his two children. In the last days of his life, he was repeatedly found by professionals in a very self-neglected condition. This led to him being taken to Hospital but once in Hospital, despite needing life-saving interventions he would seek to self-discharge. On the final occasion he was assessed as having capacity to take that decision, went home and sadly died a few days later. Yet he had also constantly expressed to professionals his desire to reunite with his children, he would buy self-help books and expressed a desire to resolve his problems.

The voice of lived experience

Collating the human stories from people with lived experience reinforces the guidance given in this briefing regarding engagement. In summary form, people with lived experience emphasise the importance of:

- *Engagement* – recognise that people may be wary of professionals and services, possibly due to past experiences of institutions and the care system; appreciate that individuals may feel alone, fearful, helpless, confused, excluded, suicidal and depressed, unable to see a way out.
- *Professional curiosity* – "I was not asked 'why?'" There is always more to know. Experiences (traumas) had a "lasting effect on me." "Appreciate the beginning of the journey."
- *Partnership* – "work <u>with</u> me, involve me, and support me." "Keep in touch so that we know what is going on." Help with form filling, bank accounts and other practicalities.
- *Person-centred* – see the person and, where necessary, adapt our approach; "people did not see beyond the sleeping bag"; challenge misconceptions of people who are homeless and any evidence of assumptions (unconscious bias) that someone may be undeserving; there are multiple reasons behind why a person may become homeless.

- *Assessment* – what does this individual need? Do not assume or stereotype.
- *Language* – be careful and respectful about the language we use; words and phrases can betray assumptions. For example, who is not engaging? What does substance misuse imply?

Section 4 – An intersectional trauma informed approach to engagement

Introduction

While knowledge of trauma and its impact on those accessing social care services is not new, it is important to clarify what is meant by trauma, and importantly what is meant by taking a trauma informed approach to working with service users.

The four 'R's of a trauma-informed approach (SAMHSA, 2014[4]) are as follows:
"A program, organization, or system that is trauma-informed **realizes** the widespread impact of trauma and understands potential paths for recovery; **recognizes** the signs and symptoms of trauma in clients, families, staff, and others involved with the system; and **responds** by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively **resist re-traumatization**."

These are foundational, and essential for building trauma informed systems, not just practice. This matters when so many service users are trauma experienced, and within a system that has the capacity to heal, or harm. A trauma informed approach guides practitioners to build trusting, empathic, collaborative and culturally sensitive relationships with service users, regardless of whether trauma is known or not. Without realising the prevalence of trauma, recognising the impact it has on service users, responding appropriately and resisting re-traumatisation, we cannot deliver truly person-centred, holistic services for those who need them.

"Trauma matters. It shapes us. It happens all around us. It destroys some of us, and it is overcome by many of us. To ignore it is to ignore who we are in all our complexity." (Filson, 2016, quoted in Research in Practice, 2019[5])

A trauma informed approach is not 'one size fits all', and must be adapted to the individual experiences, presentations and needs of each service user. Their experience of trauma, and the impact it has had on them, will vary according to their history, context, and protected characteristics, with particular attention needed to how experiences of discrimination and oppression intersect for the individual. Within this person-centred approach, practitioners must also recognise that most trauma

[4] https://www.nctsn.org/sites/default/files/resources/resource-guide/samhsa_trauma.pdf [Accessed 26 March 2026]
[5] https://www.researchinpractice.org.uk/media/hj0k0021/ripfa_embedding_trauma-informed_approaches_frontline_briefing_web.pdf [Accessed 26 March 2026]

survivors have entrenched feelings of shame and guilt surrounding their experiences, their survival strategies, and behavioural responses[6]. This shame and guilt can prevent engagement with services.

The below sections set out the six principles of a trauma informed approach; these build on the four foundational 'R's above: safety; trustworthiness and transparency; collaboration and mutuality; empowerment, voice and choice; cultural, historical and gender issues; and peer support. These principles overlap and reinforce each other. A trauma informed approach is a relational, strengths-based approach that must be maintained throughout the time working with someone. It requires practitioners to undertake reflection and seek to understand how a service user's history and experiences shape their present behaviours and capacity to work with services. It sets out *how* we work with people, including when relationships can be challenging, and when enacting duties of care, protection and prevention might not align with the wishes of the individual service user.

TIA Principle: Safety

A trauma-informed approach attends to both the physical and psychological/emotional safety of those receiving services. This involves considering the setting in which the person receives the service, how practitioners interact with them, and who the service user is in the context of intersecting protected characteristics and experiences of discrimination and oppression. Feeling unsafe places service users in 'survival mode', which creates barriers for service users in trusting others and thus building working relationships, and barriers to engaging in information processing, reflection, problem solving and action setting. When safety has been established, it can be precarious in contexts of ongoing service provision and uncertainty or difficulties for the service user.

Building safety starts with practitioners recognising that they are working with service users who have developed – and embedded – survival strategies that can create challenges to the working relationship. This shift in perspective enables practitioners to work with the person in the context of these survival strategies, rather than seeing the behaviours as a problem to be solved or overcome for work to continue. Safety is built through the other principles outlined below, and through practitioners' honesty, openness, transparency, reliability, consistency, management of boundaries and expectations, and respect for the service user's lived experience, needs, challenges, and rights. Practitioners must be *reflexive* – identifying their own position, role, values, biases – and engage in *reflection* to challenge assumptions and bias about those they work with and find ways of overcoming the barriers created by trauma and its impacts.

TIA Principle: Collaboration and Mutuality

A trauma-informed approach recognises the importance of collaboration and mutuality when engaging with individuals, by consciously sharing power and working to reduce traditional hierarchies between professionals and those receiving support.

[6] As fn2.

Practitioners should recognise the lived experience of individuals as a form of expertise, valuing their knowledge of their own circumstances and working with them to shape decisions that affect their lives. Engagement should promote voice and choice, enabling individuals to participate meaningfully in planning and decision-making (see below). Rather than acting on behalf of individuals, professionals should adopt a dynamic approach that focuses on working *with* people, not *doing to* them. This collaborative practice should be underpinned by transparency, clear communication and the management of expectations, ensuring individuals understand processes, options and potential outcomes. For example, when developing a care plan, practitioners might invite individuals to articulate their goals and preferences, ensuring that their voice directly shapes the support provided. Similarly, in meetings or reviews, professionals can ask open questions like, "What would you like to see happen?" or "Are there aspects of your support you feel could be improved?" to centre the individual's perspective in decision-making.

TIA Principle: Empowerment, Voice and Choice

Approaches to service user engagement should prioritise empowerment, ensuring that individuals are supported to exercise autonomy and influence decisions that affect their lives. In line with the principles of the Care Act 2014, practitioners should recognise that individuals have the right to make their own decisions, including decisions that may appear unwise, and that these choices may be shaped by past experiences of trauma. Trauma can affect a person's ability to feel safe, trust professionals, or engage in reflective decision-making, with responses such as fight, flight or freeze influencing how individuals respond to support or intervention.

Practitioners should therefore recognise the potential challenges individuals may face in reclaiming their own sense of control, particularly where previous interactions with services may have resulted in disappointment, mistrust or a belief that support will fail them. Engagement should be underpinned by strengths-based conversations that recognise resilience and capability, while offering clear, meaningful options that enable genuine choice. This includes ensuring individuals have the opportunity to decline support or express needs for which provision may not currently be available, while working collaboratively to identify achievable options that do not set individuals up to fail.

TIA Principle: Trustworthiness and Transparency

Building trust with service users is essential to develop the working relationship and engagement. Transparency, honesty, openness and clarity must be embedded in every interaction, alongside explanations of systems, processes, and technical language (jargon) that are relevant to the service user. These might need to be repeated in a non-judgemental way for service users who may not be able to understand, or process the information, immediately. Consistency in processes is also part of building trust and practising transparency: where possible, ensuring the same practitioner works with the service user, and where this isn't possible, sharing information between practitioners to prevent the service user from having to repeat themselves.

Practising trustworthiness and transparency also aims to ensure there are no 'hidden agendas' or surprises for the service user during their contact with services. These might not be intentional but can significantly disrupt engagement through service users feeling betrayed or let down, threatening or removing any trust they had developed. When misunderstandings, miscommunications or unexpected events do occur, practitioners have an important role in repairing any damaged trust and relationships. This is done through acknowledgement of what has happened, validation of the service user's normal and understandable emotional response to it, followed by proactive efforts to regain trust.

TIA Principle: Cultural, historical and gender issues

The USA Substance Abuse and Mental Health Service Administration specifically lists 'cultural, historical and gender issues'; this can be extended to practitioners ensuring their practice is culturally sensitive, anti-racist, anti-oppressive, and inclusive, and recognises intersectionality by locating the service user in their history and context: "Intersectionality (Crenshaw, 1989) is a way of thinking about how the different dimensions of a person's life and identity can come together to produce unique experiences of discrimination and oppression. These dimensions may include class, race, gender, sexuality, disability or cultural heritage, along with other factors." (Research in Practice, 2024)[7]

Experiences of discrimination and stereotyping create barriers to engagement through damaging trust in institutions and practitioners. Many different and intersecting experiences of service users must be considered when applying this principle: racism, ableism, sexism, homophobia, transphobia, refugee/immigration discrimination, ageism, faith-based discrimination. Direct experiences of such discrimination must be considered, as well as more indirect discrimination created by assumptions, stereotyping and lack of visibility for minoritised communities that leads to system-created barriers to service access, and inequalities in outcomes. Other contextual factors relevant to understanding service users' engagement are deprivation, poverty, homelessness and insecure or otherwise problematic housing.

Reflexivity is essential for practitioners: reflecting on the relative positions of privilege / oppression that we all occupy, and how these present themselves through interactions with service users as well as the importance of challenging our own assumptions and bias, and attending to structural and systemic barriers to engagement.

TIA Principle: Peer Support

A trauma-informed approach recognises the value of peer support in promoting engagement, recovery and connection. Practitioners should consider the wider context of an individual's life, including the nature and quality of the support networks available

[7] https://www.researchinpractice.org.uk/adults/publications/2024/august/delivering-person-centred-care-for-the-uks-culturally-diverse-communities-frontline-briefing-2024/ [Accessed 26 March 2026]

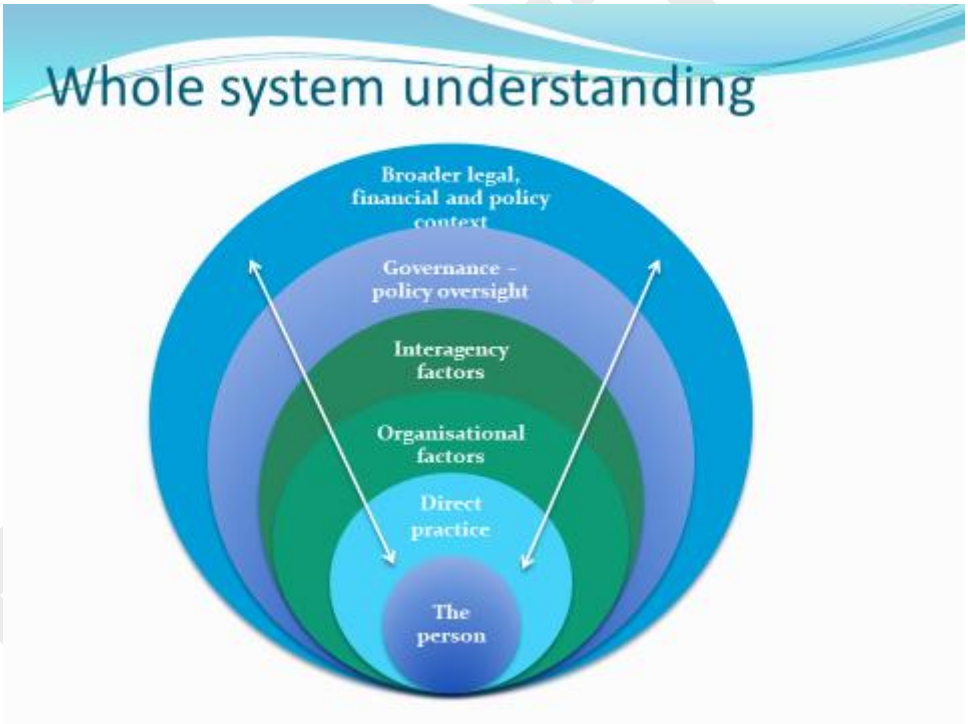
to them, and whether these relationships provide genuine encouragement and safety. Peer support may include survivor networks, lived-experience groups and community-based organisations that enable individuals to connect with others who share similar experiences. These spaces can play an important role in challenging feelings of guilt, shame and isolation that often arise following trauma, helping individuals to feel understood and less alone. Peer and community support can also support healing and act as a bridge to formal services, increasing confidence to engage with professionals where trust may previously have been limited. Where appropriate, practitioners should consider how connecting individuals with culturally relevant community groups or networks can strengthen identity, belonging and support, recognising the importance of cultural context in trauma recovery and engagement.

Section 5 - A Governance Framework

A Governance Framework

At the heart of the response to people that services find difficult to engage is an individual worker / client relationship: that is the subject of Section 6. However, that relationship has to sit within, and be supported by, a wider governance framework.

In the *second national analysis of safeguarding adult reviews* Professor Michael Preston-Shoot, Professor Suzy Braye and their colleagues identify five linked domains that cover adult social care practice. These are set out in the diagram below.



This framework describes a whole system approach. Action is not just the responsibility of the individual practitioner. Managers, agencies, local networks and national government all need to have a focus on improving engagement. The sections below reflect on actions to be taken under each of these headings.

Organisational factors

Internal agency procedures - Managers of all public-facing agencies need to be familiar with the frameworks in this briefing and be able to support their staff to work with people that they find hard to engage through:

- Endorsing positive approaches to this group in supervision

- Ensuring management of workloads enables time to be spent building trust
- Providing training and professional development opportunities to build relevant skills and to manage anxieties and uncertainties
- Challenging attitudes that perceive this group as "undeserving" or "making lifestyle choices".

An engagement friendly service? – Are relevant service managers considering whether their service is an engagement friendly service? Are location, accessibility, building style, staff manner and service operation conducive to individual engagement?

Baseline engagement interventions - Are workers routinely considering five options with all individuals?

- **Simple interventions** – Practitioners should ensure that they have raised concerns with the person and said something about the risks they are running. This follows a Making Every Contact Count approach. This should include offering to link them to other available support.
- **Enhanced and personalised feedback** – Has the practitioner given very specific feedback to the person about possible impacts (rather than generalised feedback about risks).
- **Positive encouragement** – Has the practitioner promoted self-belief and ensured the client understands they are always welcome to return if they do opt out or decline support.
- **Referral to services** – An attempt should be made to refer someone to another service that can help them. This should move beyond simply signposting
- **Engagement planning** – Do care plans routinely include an engagement plan: a plan of what will help to keep the person engaged in services and an agreement with the individual about what is to be done if they do disengage?

Training - do organisations and local networks have training / professional development opportunities to encourage and support the use of these approaches?

Inter-agency factors

Commissioning services - To have the greatest impact, commissioners and strategic leads need to commission and develop services that target individuals that services find hard to engage. These are likely to be persistent, assertive services built on relationship building, harm reduction and motivational interventions. In developing service specifications, commissioners must be careful not to chase the easy wins provided by prioritising work with people who are willing to engage and be prepared to support services to take time with individuals with complex needs.

Multi-agency management – There might be a need to develop structures or systems which facilitate the multi-agency responses to this group. This might involve:

- The development of a standing multi-agency group to respond to them; or
- The allocation of this task to an existing multi-agency group (e.g. a multi-agency safeguarding hub); or

- Having good systems which allow the swift convening of a multi-agency risk management meeting around a particular person.

Policy oversight

Oversight - The clients who are the focus of this guidance are likely to be of concern to multiple agencies. Therefore, there needs to be a local, senior, multi-agency forum where concerns about the management of these complex clients can be raised. This is likely to be the Safeguarding Adults Board, the Health and Wellbeing Board or Community Safety Partnership. This group should:

- Be a focus for the discussion of any problems;
- Be a point where practitioners and their managers can raise concerns about repeated or serious problems with the oversight group.

Broader legal, financial and policy considerations

Political – National governments need to:

- Consider whether key legislation, or its accompanying guidance, negatively Impacts on this group.
- Ensure national guidance and funding streams encompass and address the needs of people that services find hard to engage.

Section 6 – A framework for action

This section provides a framework for thinking through the steps that need to be taken when faced with an individual that services find difficult to engage.

This briefing is not primarily about motivational skills or counselling techniques. These clients will have very varied needs, barriers and motivations. It would be impossible to devise a single engagement or motivation technique which encompassed all or even most of them. Instead, this briefing offers a framework for thinking through the steps that need to be taken when faced with a hard to engage individual. This framework will point to other techniques that can be used, but its primary purpose is to set out a staged process to help workers consider whether they have done all they can to address these problems.

Other guidance documents that touch on engagement tend to look at themes such as hoarding, self-neglect or substance misuse. This looks at the key theme that unites them – the difficulty of working with someone who does not engage.

An engagement framework

- Identification of a possible need for an engagement-focused response
  ↓
- Does this person require a more intensive response?
  ↓
- If Yes: → Understanding and addressing barriers to engagement and change
  ↓
- Identifying options / techniques (e.g. motivational interventions, incentives, harm reduction, think family etc.)
  ↓
- Escalation – multi-agency management
  ➢
- Escalation - legal frameworks
  ↓
- Safely ceasing involvement
  ↓
- Learning lessons

The following sections explore each of these stages in more detail.

Cross-cutting - At each stage practitioners need to ensure that they are accurately and specifically recording the behaviours/situation that led to the person being deemed 'non-engaging'; and documenting the actions taken by practitioners to attempt to engage the person, and the success or otherwise of these.

Identification

The starting point - In most cases, this step will happen by default. The service will offer an appointment or develop a care plan, but the individual does not engage. They may simply not arrive for a follow-up appointment or dismiss offers of help. At this point practitioners need to consider whether this incident of non-engagement is an indication of a need for further action.

- Are practitioners routinely considering whether apparent non-engagement is a flag for further action?
- Are practitioners assuming that a person is unwilling to engage or thinking through barriers and obstacles to engagement?

A set of criteria for a more intensive response

Faced with someone whom they find difficult to engage practitioners and / or their agency may simply send a letter closing the case. In many cases, this may be appropriate, particularly if the *baseline engagement interventions* outlined on page x have been pursued. However, the appropriateness will depend on factors such as risk and vulnerability or impact on other services. The question is at what level of risk, vulnerability or impact is further intervention required?

- Have local commissioners, strategic leads, managers and indeed politicians agreed a clear set of criteria against which individuals can be assessed for further engagement.
- Is there a pattern or evidence of cumulative risk and what is the likelihood and significance of risks that might arise if further efforts to engage are not pursued?

Assessing whether someone meets the requirement for a more intensive response?

Practitioners will be supported by the development of a specific methodology or framework for identifying and flagging individuals. This will read across to the local criteria for further engagement and might follow the model of the DASH or DARA[8] that supports escalation in the domestic abuse sector. This process will be further supported by robust risk assessment systems and the use of professional curiosity and compassionate enquiry.

- Is there a methodology to support practitioners to identify and flag relevant individuals e.g. a jointly owned assessment / screening tool that helps practitioners identify and escalate these clients?

[8] DASH - Domestic Abuse, Stalking and 'Honour'- based abuse. The DASH risk checklist helps practitioners identify and understand the risk that victims of domestic abuse are facing.
DARA – Domestic Abuse Risk Assessment

- Are practitioners using professional curiosity in response to did not attend/was not brought/apparent non-engagement or service refusal? Do they consider and seek to explore what might lie behind this pattern? Are they asking the individual about their willingness and ability to engage and about physical and emotional barriers to engagement?

- Are practitioners undertaking a thorough assessment of risk based on client report but also other available risk information e.g. agencies, family and peers?

- Are agencies working together and sharing information to support the multi-agency identification of individuals that services find difficult to engage.

If the person does require an escalated response:

Understanding and addressing barriers to engagement and change

The first step will be to understand and assess barriers to engagement and change. These may be different from their risks and vulnerabilities. For example, the person may be at risk of abuse or exploitation, but the reason they cannot engage with those seeking to protect them is because of a pattern of acquired brain injury because of previous assaults.

- Has the practitioner attempted to understand why a person appears to refuse help or seems to struggle to engage with services? It is likely that specific reasons exist. There will be a backstory.

Identifying options / techniques

No single methodology will build engagement. Each person is different and every individual will be engaged by a unique set of approaches. The table below sets out key techniques that are likely to be effective.

• Outreach - Have you used assertive outreach as a means of building engagement, motivation, harm reduction?
• Relationship building – Are practitioners seeking to build relationships characterised by trust and continuity to promote engagement?
• Hearing the person's voice – People with lived experience sometimes comment that they were not asked why or stress "nothing about me without me."
• Time and persistence – Are practitioners taking the time required to build an engagement?

• Advocates / peer support – Will advocacy and peer support improve engagement?
• Harm reduction – Have you attempted to reduce the negative impacts of any behaviour even if these will not solve the central concern?
• Motivation – Have you considered strategies that will motivate the person to change? Are practitioners using Motivational Interviewing techniques?
• Think family – Are there family members or other social networks who require support? Are there family members who can support this process? Are there aspects of the family that are acting as a barrier to engagement?
• Incentives – Can incentives help to engage the person into care?

Multi-agency management

Ongoing challenges with engagement are likely to require referral for multi-agency management. Most local authority areas will have one or more multi-agency groups for complex cases. These will include statutory groups such as Multi-Agency Risk Assessment Conferences and Multi-Agency Public Protection Arrangements but also common standing groups such as Multi-Agency or Vulnerable Adult Risk Management groups or Multi-agency Safeguarding Hubs, Frequent Attenders and Blue Light groups. In addition, one-off meetings can be called, for example as part of a safeguarding process.

The key message is the benefits of multi-agency management in building engagement through information-sharing, building a team around the person approach and even simply helping locate individuals who have disengaged. However, this raises a number of questions for consideration:

- Are local practitioners aware of the range and purpose of local multi-agency meetings?

- Is a particular group offering a one-off discussion or longer-term oversight and which would most benefit the individual?

- Is there potential for escalation into a more senior, possibly chief executive level multi-agency group to which particularly entrenched cases can be referred for discussion?

Escalation to legal frameworks

In many cases it will be necessary to consider the use of key legal frameworks e.g. the Mental Capacity Act in England and Wales or the Adults with Incapacity (Scotland) Act 2000, the Mental Health Care and Treatment (Scotland) Act 2003, and the Adult Support and Protection (Scotland) Act 2007 in Scotland. This is not the place to discuss the specific use of these powers. Various governmental and other guidance documents are available.

This will probably be most effective if any action is taken in the light of discussion at the multi-agency framework outlined above.

- Can legal frameworks be used to address the problems posed by this individual?

Safely ceasing involvement

At the end of any process, it will be necessary to close cases and so to think about how to close the process. Again, this is likely to vary in individual situations but the following table sets out a number of issues to be considered.

• **Management oversight** – Have you ensured that the decision to close a case is discussed in supervision and agreed with your line manager? In particularly complex situations where there are concerns about the risks of a person not receiving ongoing support, has this been escalated to a relevant senior manager?
• **Rights to refuse support** – Are you confident that the person fully understands the risks of not receiving ongoing support? Is there any concern that the person's decision to end support is related to coercion or undue influence? If so, consider raising a safeguarding concern and/or seeking legal advice.
• **Mental capacity / mental health considerations** – Is there any reason to doubt the person's capacity to make decisions about their care and support needs and the risks in relation to ending services? Have you considered the person's executive capacity in relation to carrying out this decision? Does the person require an assessment/reassessment of their mental health needs?
• **Risk assessment –** Have you completed a comprehensive risk assessment, documenting any remaining risks, involvement of other agencies and mitigation / contingency measures?
• **A 'Team around the Person' approach** – Have you convened a multi-agency meeting to share information and a risk management plan? Which agencies

(such as GP or other health professionals) can remain involved in monitoring and making referrals back into services should risks escalate? Does the person have any family/friends/church or voluntary and community sector services involved who can support with monitoring?
• **Leaving the door open** – Are you confident that the person has all relevant and accessible information around how they can seek support from services again in the future?

Learning lessons

If the pathway does not lead to a successful outcome and possibly ends in tragedy, it will be necessary to consider whether this is an opportunity to learn lessons for future practice. This might be through an ad hoc in-house review, a formal serious incident review or referral for a formal review process e.g. a Safeguarding Adults Review (England), Adult Practice Review (Wales), Domestic Abuse Related Death Review (England and Wales), death of a homeless person review or Adult Support and Protection Learning Review or Domestic Homicide and Suicide Review (Scotland),

At a less critical level, individual workers, agencies and multi-agency groups might wish to routinely reflect on what enabled positive outcomes, where these have been achieved, and whether work to engage individuals highlights any particular gaps or blockages in care pathways or identifies any training needs. These should be escalated to managers and local commissioners or strategic leads.

- Have steps been taken to learn relevant lessons from the cases of individuals that service found difficult to engage?
- Are any systemic issues being fed back and escalated to relevant national agencies?

Section 7 - Recommendations for action

to be determined later

Appendix – Useful resources

To be complied later but to include resources already identified.

"The Keys to Engagement" (mental health)
"The Blue Light Project" (alcohol misuse) have addressed this issue with specific client groups and some
local areas e.g. Teeswide, Westminster,
Calderdale SAB Guidance for working with Non-Engaged Adults

Making Services Easier For People To Engage In | Teeswide Safeguarding Adults Board

Lewisham SAB -
guidance_on_improving_our_approach_to_adult_and_family_engagement.pdf

Supporting-care-package-engagement-for-adults-experiencing-multiple-disadvantage.pdf

Introduction to Missingness in Healthcare video from Professor Andrea Williamson (School of Health and Wellbeing) and the Missingness Project team

Opening Doors: Trauma-Informed Practice for the Workforce - This animation was developed by NHS Education for Scotland, in partnership with the Scottish Government. It is designed to be relevant to all workers within the Scottish workforce. It aims to support workers to know how to adapt the way they work to make a positive difference to people affected by trauma and adversity.