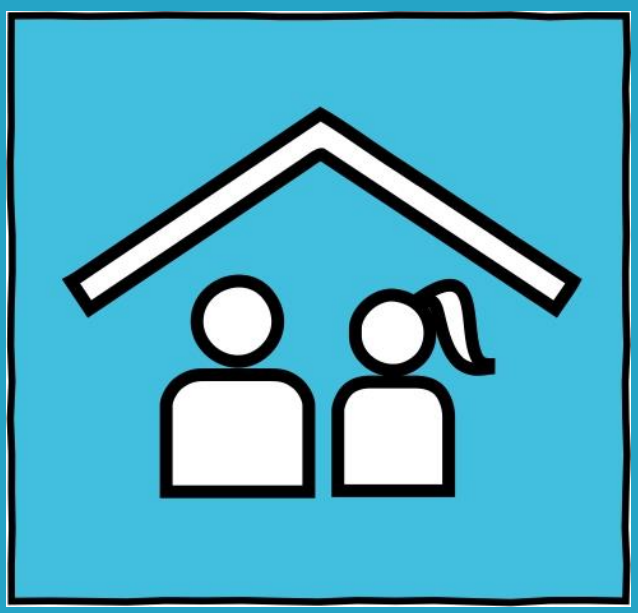
SUPPORTING CARE PACKAGE ENGAGEMENT FOR ADULTS EXPERIENCING MULTIPLE DISADVANTAGE



City of Westminster

Groundswell
Out of homelessness

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Introduction

This toolkit has been developed to support frontline workers, supported housing teams and social workers in understanding why individuals experiencing multiple disadvantage may not engage with their care package.

People facing overlapping challenges such as homelessness, substance use, mental ill health, trauma, and poverty often struggle to engage with traditional services. What may appear as resistance, avoidance, or "non-compliance" is often rooted in experiences of stigma, mistrust, and systems that don't reflect their needs or realities.

This resource offers practical guidance to help frontline workers better understand the barriers to engagement and to adapt practice in ways that build trust, promote choice, and support meaningful relationships. By working in a more flexible, trauma-informed and person-centred way, we can help reduce harm, improve outcomes, and ensure services are more accessible to those who need them most.

Why care packages may fail

People experiencing self-neglect or facing multiple disadvantages often find it difficult to engage with standard care packages. These difficulties are not due to a lack of need or interest in support, but are often the result of systemic, relational, and psychological barriers. Understanding these can help professionals take a more compassionate and flexible approach.

- **Lack of trust due to past trauma or stigma**
  Many individuals have experienced repeated rejection, neglect, or discrimination from institutions, services, or people in positions of authority. This can include traumatic encounters with the care system, healthcare, housing services, or the criminal justice system. As a result, they may be understandably cautious or mistrustful of professionals, especially those they don't know well.
- **Services that are too rigid to adapt to chaotic lifestyles**
  Traditional care models often rely on structure, punctuality, and routine. For someone whose life is affected by instability, homelessness, or daily survival pressures, this kind of rigid structure can feel unmanageable or irrelevant. If the service cannot flex around the person's reality, engagement is unlikely to be sustained.
- **Appointment-based care that doesn't fit the person's day-to-day reality**
  Expecting someone to attend regular appointments, especially in unfamiliar settings or with unfamiliar people, assumes a level of executive functioning, stability, and motivation that may not be present. Missed appointments are often seen as disengagement rather than signs that the approach is not working.
- **Mental health, substance use, or executive functioning challenges**
  Many people experiencing multiple disadvantage live with co-occurring mental health conditions, substance dependence, cognitive impairments, or brain injuries. These can affect memory, decision-making, concentration, communication and energy levels - making it hard to follow plans or routines, even when the person wants support.
- **Care plans designed without true co-production**
  When care plans are written *for* someone rather than *with* them, they are less likely to reflect that person's priorities, values, or capacity. If people don't recognise themselves in the care plan, or feel it was imposed on them, they are less likely to engage.
- **Care starting quickly, without time to build trust**
  Trust takes time, especially for people with trauma histories. Rushing into care delivery without relationship-building can feel intrusive or even threatening. When the focus is on tasks rather than connection, people may shut down or push away support.
- **Care delivered by strangers, or with constantly changing staff**
  Frequent staff changes or a lack of continuity can undermine any trust that is starting to form. People may become exhausted or disheartened by having to re-tell their story, explain their needs repeatedly, or start relationships from scratch each time a new worker appears.
- **The person's needs and wishes shifting over time**
  A person's priorities, needs, and emotional state may fluctuate due to external circumstances, internal challenges, or progress in recovery. A static care plan that isn't revisited or adapted over time may quickly become irrelevant or even counterproductive.

How can care services foster better engagement

Engaging individuals who experience multiple disadvantages or self-neglect requires a shift away from rigid, task-based models of care. Below are key principles and approaches that care providers can adopt to help build trust, promote safety, and support more consistent engagement.

1. Be Person-Led and Flexible

- Adapt the timing, frequency, and nature of support to match the individual's routine, preferences, and capacity. For example, someone may be more receptive to care in the afternoon rather than first thing in the morning, or they may respond better to practical help (like making a hot drink) before accepting personal care.
- If someone refuses daily support, don't interpret it as failure or shut the door entirely. Instead, scale the offer down, perhaps to once or twice a week, and agree a time that the person feels comfortable with. This maintains contact and preserves the relationship, offering a platform to build trust over time. Even limited engagement is better than none.
- Notice the person's communication preference and needs. For example, do they prefer to be addressed formally as Mr Smith, or simply John? Are they familiar with your accent and you theirs? Do you need to slow your rate of speech and give time for the person to process what you say? Can writing down important information help shared understanding?

2. Focus on Relationships First

- Trust is the foundation of care. Without it, even the most well-planned interventions may be rejected. Take time to build rapport through small, everyday interactions, sitting down for a chat, play cards or other games, watching 10 minutes of TV, or having a cup of tea together. Or it could be that taking care of a pet, fixing a TV, or sorting out what matters; do that first. Personal care may follow once trust is built.
- Encourage carers to take a person-centred approach, where the relationship itself is seen as central to the work, not just the completion of tasks. This helps the person feel valued, rather than managed or assessed.

3. Work Slowly, Celebrate Small Steps

- Recognise that progress might be subtle and gradual. For someone who is highly avoidant or mistrustful, simply opening the door, engaging in light conversation, or accepting a cup of tea may be significant steps.
- Avoid withdrawing care too quickly after a refusal or missed appointment. Continued gentle offers of support show reliability and care, both of which are essential for people who have experienced abandonment or neglect in the past.
- Remember, engagement may fluctuate, and take opportunities to be proactive where the person is ready and willing to engage

4. Use Familiar Faces

- Consistency is key. Whenever possible, ensure that a small, named group of carers support the individual, so they can become familiar with the faces and build a sense of safety and predictability.
- Weekends and cover shifts should also prioritise familiar staff, not just during core weekday visits. Avoiding a "revolving door" of unfamiliar workers can help reduce anxiety and improve trust.

- Introduce new staff gradually, ideally alongside someone the person already knows and trusts. This can help ease anxiety and build confidence in the new relationship.

5. Minimise Distress

- Stick to agreed visit times. People living with trauma, neurodiversity, or mental health challenges often rely on predictability. Arriving early or late can cause confusion, anxiety, and ultimately rejection of support.
- Simple courtesies matter. Always knock before entering, wait for a response, and introduce yourself clearly. For someone with a history of feeling unsafe, these small acts can be the difference between trust and disengagement.

6. Keep Shared Notes with Frontline Staff

- **Collaborate with housing support workers, outreach teams or keyworkers** to build a fuller picture of what works, and what doesn't, for the individual. Maintaining shared records (with the client's consent) helps ensure continuity and avoids duplication or missed opportunities. **Appendix 1 is an insight sharing form** that staff can fill out and include in the care package folder for your information.
- **Use shared logs to track patterns of engagement**, such as times of day the person is more open to support, or responses to particular staff. These details can guide how care is offered.
- **Document the client's own language and feedback**, for example, if someone says "they don't listen" or "too many people come round", this insight is vital for improving care delivery and reviewing the package. It may be helpful for you to use the client's choice of language when discussing things to support mutual understanding.
- Ensure all documentation is accurate, objective, and clearly distinguishes between fact and opinion.
- **Use shared records to celebrate small steps** (e.g. "opened the door today") and to monitor shifts in risk, routine, or willingness to engage, especially useful when care delivery is inconsistent or fluctuating.

Practical strategies for frontline workers to help engagement

Frontline staff often play a vital but sometimes overlooked role in helping people who are hard to engage with traditional services. Your consistent presence and deep understanding of the person can make a significant difference, often laying the groundwork for progress where other interventions have struggled.

You are often in a unique position to bridge the gap between individuals and formal care services. Through everyday contact, you can help reduce barriers to engagement, build trust, and provide vital context that enables more person-centred care. Here's how:

1. Bridge the Relationship

- Model engagement by being present during initial care visits. A familiar, trusted face can provide emotional reassurance and help reduce anxiety, especially for clients with a history of trauma or service avoidance.
- Create informal, low-pressure introductions. Where possible, introduce care staff during more relaxed moments, such as during a shared lunch, tea break, or casual chat, rather than in formal or

clinical settings. This humanises the interaction and helps shift the dynamic from “assessment” to “connection.”

- Support the transition between services. If a care package is starting or restarting, helping to prepare the individual in advance (e.g. explaining who will visit, when, and what to expect) can increase the likelihood of a positive first interaction.

2. Listen for What Matters

- Help the person explore what kind of support they actually want, or what’s currently getting in the way. This may be practical (e.g. "I don’t like early visits") or emotional (e.g. "I don’t trust strangers in my flat").
- Use motivational interviewing techniques to draw out the person’s own values and motivations. Simple, non-confrontational prompts like *“What’s not working for you?”* or *“If you could change one thing, what would it be?”* can lead to valuable insights and shape more effective care planning.
- Don’t dismiss small requests. If someone says they want a working TV or a quieter visitor, these may be entry points for trust-building and longer-term engagement.

3. Share your insights with carers

- Pass on what you know about the person’s routines, triggers, and preferences. As a frontline worker, you likely have a nuanced understanding of what times of day the person feels most settled, how they respond to visitors, or what topics they find distressing. This context can help care services approach more effectively. **Appendix 1 is an insight-sharing form** that staff can fill out to provide this information to care staff and include in the individual’s care folder.
- Offer insight into past patterns. For example, noting that the person has previously engaged better with female staff, prefers humour and light conversation, or becomes withdrawn after benefits reviews can all help social care tailor their approach. Include this information in Appendix 1.
- Advocate gently but firmly. You can help reframe “refusal” or “non-engagement” as communication, e.g., *“He’s not being difficult, he’s feeling overwhelmed when too many people turn up.”*
- Ensure all documentation is accurate, objective, and clearly distinguishes between fact and opinion.
- Document meaningful observations, not just outcomes. Note moments of connection (e.g., “opened the door today”), the person’s tone or body language, and reasons they give for declining support, these can all inform future engagement strategies.
- **Document the client’s own language and feedback**, for example, if someone says “they don’t listen” or “too many people come round”, this insight is vital for improving care delivery and reviewing the package. The client may use diplomatic shorthand for things that feel embarrassing for them, for example “down there” when they mean genitals. Mirror the language the client uses to respect their dignity as far as possible.
- Use records to spot patterns over time, even small changes in openness or routine can signal progress and should be shared with relevant teams.
- Reflect on your own responses. Use supervision or team debriefs to explore emotional reactions such as frustration, helplessness, or “stuckness”. Recognising unconscious bias or emotional fatigue is vital to maintaining a compassionate, person-centred approach.

Collaborative Case Management: Using MDTs, MCA, and Care Reviews

Effective support for individuals with complex needs often requires coordinated input from multiple professionals and agencies. Collaborative case management provides a structured framework to bring together practitioners, share information, and make joint decisions that prioritise the individual's well-being. By using **Multidisciplinary Team (MDT) meetings**, applying the **Mental Capacity Act (MCA)** when needed, and requesting **regular care reviews**, staff can ensure that care and support plans are responsive, consistent, and person-centred.

This approach helps avoid gaps or duplication in support, identifies who is best placed to lead on actions, and ensures that interventions are guided by what has worked previously while respecting the individual's choices and rights. Collaborative case management is most effective when it is proactive, clearly structured, and underpinned by trust, communication, and shared accountability across all agencies involved.

Multidisciplinary team (MDT) meetings

A multi-disciplinary case conference is an opportunity for a structured conversation about a person who has complex issues, potentially involving a range of practitioners associated with the person's care. Each practitioner brings his or her knowledge about the person/ or their area of specialist knowledge, to inform and jointly create an action plan to be co-ordinated by the key worker. Multi-disciplinary meetings work best when they are well structured, with a clear agenda and responsibilities.

Key points for effective MDTs:

- Don't assume someone else is dealing with the issue. Identify a lead practitioner to coordinate multi-agency working.
- The multi-disciplinary case conference toolkit can be downloaded here and the Information Sharing Agreement here.
- Utilise existing multi-agency forums such as the Monthly Enhanced Vulnerability Forum or other multi-agency risk meetings – see the Westminster MDT forums directory. These platforms provide a structured environment to share information, coordinate actions, and agree on a consistent support plan.
- Make sure to share detailed information about what interventions have already been tried, including what has been effective, even if only for a short time. Understanding what has worked can help guide future approaches.
- Identify and highlight which individuals or professionals have established trust and rapport with the person. This can be critical in engaging them and ensuring ongoing support.

Use the Mental Capacity Act

When engagement is inconsistent or decisions **appear unwise**, it is important to consider whether the Mental Capacity Act (MCA) applies.

- The MCA provides a framework for assessing whether a person has the capacity to make specific decisions at a particular time.
- Remember that capacity can fluctuate, and a person should always be supported to make their own choices wherever possible. If they are found to lack capacity, any decision made on their

behalf must be in their best interests and take into account their values, wishes, and past experiences. Using the MCA helps staff balance respect for autonomy with safeguarding duties. You can download a MCA screening tool to help you consider mental capacity here.

Request a care review

- When a care package or support plan is not meeting the individual's needs or appears to be failing, staff working closely with the person must take a proactive role in seeking a review.
- Supported housing staff and frontline workers should not hesitate to request a formal review of the care plan or package if concerns arise. This can help bring fresh eyes to the situation, reassess risks, and ensure that the support remains appropriate and effective.
- Regular reviews ensure that any changes in the person's circumstances or health needs are recognised early, and support is adapted accordingly. This approach reduces the risk of deterioration and promotes better outcomes for the individual.

Escalate persistent concerns

If support challenges continue and there is a **safeguarding concern**, it is important to act promptly and follow a clear escalation pathway:

- **Document your concerns**: Record what has been observed, what interventions have been tried, and the outcomes. Include dates, times, and any relevant context.
- **Notify your line manager or designated safeguarding lead:** Share all relevant information and discuss next steps.
- **Follow local safeguarding procedures**: Escalate to statutory services if the individual is at risk of harm, neglect, or abuse. Include contact details for relevant safeguarding teams.
- **Use multi-agency forums**: Bring the case to an MDT or safeguarding meeting if appropriate, to coordinate a structured response and ensure all agencies are informed.
- **Review and monitor**: Continue to monitor the situation closely, update records, and follow up on any actions agreed during escalation.

Looking after yourself

Supporting individuals who repeatedly resist help or disengage from services can be emotionally taxing and, at times, deeply frustrating. It's important to recognise that this work can have a personal impact and to take steps to care for your own wellbeing.

- **Acknowledge and normalise difficult emotions**
  It's completely normal to feel helpless, disheartened, or even angry at times. These are natural responses to working in high-pressure, emotionally demanding environments. Recognising these feelings without judgement is the first step towards managing them.
- **Draw on management support:** If you feel stuck, overwhelmed, or unsure how to proceed, involve your manager early. They can help you think through options, share responsibility for decisions, and provide guidance or escalation routes when cases become complex.
- **Make use of peer support:** Talking through challenges with colleagues can reduce isolation, normalise difficult feelings, and provide fresh perspectives. Sharing experiences helps build resilience and reminds staff they are not working alone.

- **Make use of reflective supervision** Regular reflective supervision provides a safe space to explore emotional responses, discuss complex cases, and think about different approaches. **Value your presence as part of the intervention**
  Even when it feels like you're "not getting anywhere," remember that your calm, consistent, and compassionate presence matters. For someone who has experienced trauma, instability, or neglect, being met with kindness and reliability can be profoundly healing, even if progress is slow or unseen.

Taking care of yourself is not an optional extra; it's essential to sustaining the work and providing safe, effective support to others.

Contact details for Westminster's social care teams

Concern	Contact details
Support for adults under the age of 65 with physical disabilities, and their carers Support for older people with physical disabilities or mental health problems, and their carers	**Adult Social Care Team** Information and advice/ referrals contact: 020 7641 2500 Email: adultsocialcare@westminster.gov.uk Website: https://www.peoplefirstinfo.org.uk/westminster-contact-details/ **South Westminster Care team managers** Gwyneth Pond (Mon-Weds) – 07817 054856 gpond@westminster.gov.uk Joanna Lui (Mon to Fri) – 07971 092091 jlui@westminster.gov.uk Ashley Cambridge – 07929 664076 acambridge@westminster.gov.uk **North Westminster Care team managers** Katie Taylor ktaylor@westminster.gov.uk 07971 026 899
Support for adults of all ages with physical health problems to regain their independence – it can be support for a few days or up to a maximum of 6 weeks e.g., when discharged from hospital or reduce admissions to hospital	**Community Independence Service -** this is a joint health and social care team *Referrals via Adult Social Care* OR via CNWL https://www.cnwl.nhs.uk/services/community-services/community-independence-service
If you have concerns that a vulnerable adult is being subjected to abuse or neglect	**Safeguarding Adults** To tell Westminster about any concerns you have (known as 'raising a Safeguarding Alert') you can contact them below, or fill out the alert form at this **page** (scroll down to 'Getting help from your council section'. **Safeguarding helpline:** 020 7641 2176 Tel: 020 7641 6000 (out-of-office-hours) Email: adultsocialcare@westminster.gov.uk
Support for adults with early signs of memory problems and their carers – joint health and social care team.	**The Westminster Memory Service** 42 Westbourne Park Road, London, W2 5PH Tel: 020 3317 3666 Email: wmsreferrals.cnwl@nhs.net
Support for adults with learning disabilities and their carers	**Westminster Learning Disability Partnership -** this is a joint health and social care team Address: 2nd Floor, 215 Lisson Grove London, NW8 8LW Tel: 0207 641 7411 Email: wldp@westminster.gov.uk

Appendix 1: Insight Sharing Form: Supporting Personalised Care

This plan has been developed for _____ (Service User name) and completed by _____ (Worker) On:_____ (Date)

1. What time of day is the person most settled? Are there routines that help them feel safe or calm?
2. Are there topics, actions, or situations that tend to upset or distress the person?
3. What does the person respond well to? E.g. Humour, tone of voice, familiar staff, quiet environments
4. Have they previously engaged better with certain types of staff or settings? What has helped or hindered this?
5. What matters most to the person? What breaks trust, and how can trust be reestablished?
Bottom line: Build trust first, be flexible, keep showing up — and share insights across teams so the person isn't lost between services. Recognise avoidance can be a survival strategy rooted in trauma, fear or shame — not just "being difficult."

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