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Professional judgements of risk and capacity in situations of self-neglect among older people

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ABSTRACT
Over the past 50 years, self-neglect among older people has been conceptualised in both social policy and the academy as a social problem which is defined in relation to medical illness and requires professional intervention. Few authors, however, have analysed the concept of self-neglect in relation to critical sociological theory. This is problematic because professional judgements, which provide the impetus for intervention, are inherently influenced by the social and cultural context. The purpose of this article is to use critical theory as a framework for interpreting the findings from a qualitative study which explored judgements in relation to older people in situations of self-neglect made by professionals. Two types of data were collected. There were 125 hours of observations at meetings and home assessments conducted by professionals associated with the *Community Options Programme* in Sydney, Australia, and 18 professionals who worked with self-neglecting older people in the community gave in-depth qualitative interviews. The findings show that professional judgements of self-neglect focus on risk and capacity, and that these perceptions influence when and how interventions occur. The assumptions upon which professional judgements are based are then further analysed in relation to critical theory.

KEY WORDS – self-neglect, risk, capacity, squalor, critical theory, qualitative research.

Introduction

Over the past 50 years, situations of self-neglect among older people have attracted increasing interest in both social policy and in academic writing. The interest in self-neglect originated in the United Kingdom (UK), where writers from a biomedical perspective studied individuals living in the community who deviated from societal standards of cleanliness and hygiene (MacMillan and Shaw 1966). They argued that, because individuals in

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their study had shared case characteristics such as domestic disorder, poor nutrition and 'difficult' personalities, self-neglect is a manifestation of a distinct medical syndrome. Empirical studies from the UK and Australia have since focused on identifying the illnesses that cause self-neglect, but the findings have so far been contradictory. For example, Radebaugh, Hooper and Gruenberg (1987) and Scallan *et al.* (2000) determined that most self-neglecting behaviours are largely unrelated to mental illness or other forms of cognitive impairment. In contrast, Snowdon (1987), Wrigley and Cooney (1992) and Halliday *et al.* (2000) found that the majority of self-neglecting behaviours could be attributed to mental illness, alcohol dependence, or other cognitive impairments.

Concern about self-neglect among older people emerged in the United States of America (USA) during the 1970s in parallel with the recognition of elder abuse as a hidden social problem (Bergeron and Gray 2003; Nerenberg 2000). In the USA, the term self-neglect is typically used in an all-encompassing manner to describe a person's failure to carry out vital self-care tasks, such as providing essential food for their self or maintaining a safe environment (Rathbone-McCuan and Bricker-Jenkins 1992). Self-neglect has been found to make up the majority of all elder abuse cases referred to Adult Protective Service organisations (Cyphers 1999; Dolon and Blakely 1989; Duke 1991; Teaster 2003).

As in the UK, American research has concentrated on determining the characteristics of people who self-neglect: studies have found that people who are described as self-neglecting are more likely than the general population to be over the age of 60 years, financially disadvantaged, socially isolated, and suffering from mental and physical impairments (Byers 1993; Cyphers 1999; Duke 1991; Gruman, Stern and Caro 1997; Longres 1994; Vinton 1992). It is interesting to note that self-neglect is not considered to be a type of elder abuse in the UK and Australia, because these countries have adopted the World Health Organisation's definition that elder abuse occurs within a relationship of trust (Biggs *et al.* 2009; Kurrle 1994). Furthermore, the argument first made by British researchers that self-neglect should be classified as a distinct medical syndrome has recently re-emerged in the USA (Pavlou and Lachs 2006; Pickens, Naik and Dyer 2006).

The overwhelming majority of the literature on self-neglect conceptualises the issue as a social problem that is defined in relation to medical illness and, therefore, requires professional intervention. As a consequence, legislation has been developed to address the problem of self-neglect in both the UK and the USA. In the UK, Section 47 of the *National Assistance Act 1948* can be used to justify coercive intervention when people are 'aged, infirm or physically incapacitated, living in insanitary

conditions … and are not receiving from other persons proper care and attention' (Nair and Mayberry 1995: 181). Although not often used, this statute can be applied to cases of extreme self-neglect (Shah 1995*b*). Each of the 50 states in the USA has developed different definitions of, and responses to, elder abuse: 42 states include self-neglect as a category of abuse, and professionals in 37 states are mandated to report self-neglecting clients to Adult Protective Services for assessment (American Bar Commission on Law and Aging 2005; Breaux and Hatch 2002).

It is disconcerting that, although mandatory interventions can occur in situations of self-neglect, there has been little sustained critique of the concept in relation to the cultural and social context in which judgements take place (Lauder 1999, 2005, 2006). Furthermore, the prominence of biomedical explanations in the literature obscures the influence of professional judgements in shaping understandings of and responses to self-neglect among older people. This article aims to address these issues by introducing critical theory as a tool to develop alternative ways of knowing, interpreting and understanding judgements that are made in situations of self-neglect. This framework is used to analyse findings from a qualitative study which critically explored judgements about self-neglect among older people made by 24 professionals in Sydney, Australia.

Introducing critical theory

Although most studies on self-neglect have not explicitly identified a theoretical framework (Lauder *et al.* 2009), it is clear that the majority are based on two assumptions, that self-neglect can be explained by a biological dysfunction, and that self-neglect is an objective and value-free category (Nettleton and Gustafsson 2002). Evidence for the first assumption can be found in the many articles that propose theories about the various physical and mental impairments that cause self-neglecting behaviour, as exemplified by the proposition that self-neglecting behaviour which cannot be explained by another illness is caused by a dysfunction of the frontal lobe (Orrell, Sahakian and Bergmann 1989; Snowdon, Shah and Halliday 2007). The belief that self-neglect is solely attributable to a biological dysfunction remains widespread even though limited empirical evidence supports the claim; the literature is self-referential and comprises more reviews and case studies than it does original research (Lauder 1999; Lauder *et al.* 2009). Consequently, a number of speculative theories and characteristics have been proposed as exploratory but are then repeated in the literature without reference to empirical evidence. For example, Clark, Mankikar and Gray (1975) suggested that self-neglecting behaviours are

caused by a personality disorder but, even though they offer no supporting empirical evidence, the assertion is re-stated in numerous reviews (Cole, Gillett and Fairburn 1992; O'Shea and Falvey 1997; Post 1983; Reyes-Ortiz 2001; Vostanis and Dean 1992).

The second assumption, or rather omission, in the extant literature is that self-neglect is an objective category that is unaffected by cultural norms surrounding cleanliness, hygiene and risk. For example, Snowdon, Shah and Halliday (2007: 48) argued that 'some people live in conditions so filthy and unhygienic that almost all observers, in whatever culture, would consider them unacceptable'. Other researchers have identified participants by employing a type case of self-neglect that was first developed by MacMillan and Shaw (1966: 1032): 'The usual picture is that of an old woman living alone … her garments and her house are filthy. She may be verminous and there may be faeces and pools of urine on the floor'. This case is both gendered and generalised and is clearly not an objective base upon which to build a sampling strategy.

Critical theorists have long taken issue with the over-reliance on biomedical explanations of ageing and argue that this continued emphasis ignores important social, environmental and structural influences on the experience of ageing (Phillipson and Baars 2007). For example, the prominence of objectivity in the biomedical discourse ignores the relational quality of human interactions and leaves the power relations between professional and client or patient unacknowledged (Estes, Biggs and Phillipson 2003; Powell and Biggs 2000). Drawing on Foucault, critical gerontologists have argued that the 'medical gaze' classifies and orders bodies in relation to an established norm, from which they determine what deficiencies need to be fixed, and further that in this way the body acts as a site of control, regulation and surveillance; a site upon which disciplinary power is enacted (Biggs and Powell 2001; Katz 1996; Powell and Biggs 2000).

This approach suggests that values espoused by the biomedical explanations of ageing become internalised by individuals, meaning that people exercise self-control in order to 'control the incidence of illness in their bodies' (Lupton 2003: 35). As a consequence, those who do not take responsibility for their health are blameworthy for the ensuing outcomes (Holstein and Minkler 2003). The self-surveillance that emerges from the internalisation of values around healthy or successful ageing was demonstrated in a study by Minichiello, Browne and Kendig (2000), which found that the older participants dissociated themselves from older people who they believed to be ageing negatively. Older people in the study associated receiving care from family with a loss of independence and, because of this, participants hid any signs of physical deterioration so

they could avoid accepting help from others (Minichiello, Browne and Kendig 2000).

Critical gerontologists have made important contributions to understanding how social policy and social structure impact on constructions of ageing, which has the potential to contribute to a deeper understanding of self-neglect among older people. This article aims to use critical theory to understand the assumptions that underpin professional judgements in situations of self-neglect. It will do this by going 'beyond everyday appearances and the unreflective acceptance of established positions' (Estes, Biggs and Phillipson 2003: 3).

Methodology

It is important to explore professional judgements because they influence how self-neglect is framed and provide the motivation for intervention. As little previous research has been conducted on professional judgements in situations of self-neglect among older people, qualitative methods were adopted because they allow for the analysis of individuals' interpretive frameworks and how people think and act in everyday life (Haimes 2002). Furthermore, qualitative research can provide rich data regarding the range of definitions and meanings assigned to situations of self-neglect, the locations at which dilemmas and decisions occur, and the wider socio-cultural frameworks shaping responses to these situations (Ezzy 2002). The findings presented in this paper are part of a larger study that explored professional ethical decision making in situations of self-neglect among older people. This research was given ethics approval by the Human Research Ethics Committee at the University of New South Wales.

The sample and data collection

A two-part methodology was chosen so that a diverse array of professional experiences and judgements in situations of self-neglect could be included. The first part involved the use of observational methods at a local community organisation to observe how self-neglect was addressed in an organisational context. The *Community Options Programme* (COPS) in Sydney was chosen as the case study site because it provides case management to older people living in the community who require more support than can be provided by mainstream home-care services. The programme employed a team which included one manager and five case managers or co-ordinators. Over five months, contact was made with this COPS team at least once a week. The team was observed in team

meetings, case-review meetings, and visits to clients' homes. In addition, organisational records about specific clients were reviewed, and formal interviews were conducted with each member of the COPS team. Over the five months, 125 contact hours were spent at the organisation.

The second step involved interviews with diverse professionals that become involved in situations of self-neglect and squalor in the community. Since the research focused on community-based interventions, the sample targeted the professionals that predominate in community work such as nursing, social work, welfare and rights advice. Twenty-eight organisations in Sydney that deal with situations of self-neglect and squalor among older people were identified through discussions prior to commencing the fieldwork; professionals in each of these organisations were then invited by letter to participate in the research. The participants were required to have current contact with situations of self-neglect or squalor in the community (one person was excluded as ineligible). The interview schedule was developed to collect basic socio-demographic information and work histories, and also covered how people defined self-neglect and squalor, the dilemmas that are faced in these situations, and how these dilemmas are resolved. Two pilot interviews were conducted after which the instrument was revised and simplified.

Eighteen professionals who worked with self-neglecting older people in the community were selected to participate in in-depth qualitative interviews. Each participant was interviewed once and the interviews lasted between one and two hours. The interviews were semi-structured with a core set of questions on ethical dilemmas and perceptions of self-neglect, but each participant also could address other topics that they believed relevant to the research aims. Two groups of professionals took part in this research. The first was composed of health professionals from Aged Care Assessment Teams (two participants), Mental Health Services (one), and Community Health (three). The second group focused on housing-related issues and included staff of: Local Area Councils (four participants), Departments of Housing (two) and Assistance for Care and Housing for the Aged (ACHA), a programme that aims to prevent older people becoming homeless (six).

The analysis

Data collection was handled as systematically as possible to minimise the complexity of integrating data from the two parts of the research. Notes from the observations and reviews of organisational records were recorded on a standard contact sheet, which is a way of recording information that encourages deeper analytical thinking (Silverman 2000). Each of the

formal interviews that were conducted with the COPS team and other professionals were recorded and transcribed. A journal was maintained to document thoughts, feelings and insights that developed throughout the data collection process. As the data were collected, the contact sheets and transcripts were imported into NVivo, which was used most intensively during the first stage of analysis, during which all relevant sentences and paragraphs were coded into initial categories and emerging themes were identified (Ezzy 2002).

This process of open coding was employed throughout and, as more data were collected, the original codes were changed and refined. After the initial codes were developed, all data were re-read and codes were reduced, combined and refined into increasingly central categories (Ezzy 2002). At this stage, the data from both parts of the research were constantly compared against each other in order to identify broad themes and categories across different sources of data (Bryman 2001; Hewett-Taylor 2001). Close attention was paid to inconsistencies and contradictory data, as negative cases are important for developing a more complete understanding (Rubin 2000; Seale and Silverman 1997). It was also at this point that analytic induction began, which involved connecting the emerging codes back to the literature (Pope, Ziebland and Mays 2000). In the final stage of the analysis, all transcripts, journal entries and other data were re-read, and the central story of the data was developed in relation to pre-existing theory.

Results

The judgements made by the participants in relation to self-neglecting older people focused on risk and people's capacity to make decisions and, as this section shows, these judgements impacted on when and how the professionals intervened in these situations. Before discussing each theme, however, it is first necessary to discuss how self-neglect was understood by the participants in the research. The term *self-neglect* was used by the participants to refer to situations that primarily involved personal neglect of self-care, such as the lack of health maintenance or personal cleanliness, while situations involving extreme environmental uncleanliness were labelled as *squalor*. While there was often some overlap between self-neglect and squalor, situations tended to be labelled by the behaviour that was considered to be most problematic. This distinction has been made by some Australian authors (Halliday *et al.* 2000; Shah 1995*a*, 1995*b*; Snowdon 1987; Snowdon, Shah and Halliday 2007), but is not apparent in the broader literature on self-neglect.

Risk

The distinction between *self-neglect* and *squalor* is important because professionals from health and other community organisations made different judgements about the level of risk present in the two situations. One view of risk was held by the six professionals who worked for health or mental health organisations. They believed that self-neglect, or a lack of self-care, was more likely to result in an acute risk than squalor. These participants associated self-neglect with poor nutrition, falls, visible sores, self-harm and psychosis, and felt that these risks warranted intervention. One nurse who worked in Aged Care stated that her top priority when examining older people is the maintenance of self-care:

> Physically are they eating and drinking, how much weight does it look like they've lost? Are they falling over? Have they got lesions on them that could be infected? All of those sort of acute things you'd be looking at.

The participants believed that risk can also be present in some situations of squalor, especially in situations where there is observable evidence of danger, such as open sores caused by infrequent bathing or burns from fires. A community Aged Care nurse spoke about how dirt could result in rashes, ulcers and scabs, and that infestations of bugs can lead to infection:

> I've seen people whose feet are so filthy in between their toes they can end up with ulcers and things like that. Same with people who are incontinent – especially if they are faecally incontinent and don't clean themselves properly – they can end up with rashes and infections and those sorts of things. Certainly if they end up with infestations of lice or scabies, things like that, they can end up with all sorts of rashes and hence infections.

These six professionals did not believe, however, that the risks in situations of squalor necessarily warranted professional intervention.

The second view of risk was voiced by the remaining 18 interviewees who worked at housing organisations and for COPS. They believed that, while both situations of self-neglect and squalor pose acute risks, situations of squalor pose the most danger to people and that this danger necessarily requires professional intervention. Their concerns about risks centred on those associated with vermin, fire and structural damage. The most common environmental risk that participants identified in situations of squalor was the presence of vermin in people's homes, which was associated with the generation of dangerous waste products and an increased risk of falling. A local council social worker shared a story of a woman who was living with hundreds of pigeons inside her home. She believed that the risk in this situation resulted from pigeon droppings: 'pigeon faeces carry a lot of bacteria that's quite harmful to humans. It can attack your lungs,

it can attack your eyesight, it can make you unwell, it can kill you, basically'.

Fire was the second most common risk associated with living in squalor. Central to this was the fear that squalor contributes to a raised risk of death when fire exits are blocked by the accumulation of rubbish. For example, the hallway of the home of an 85-year-old client of COPS was believed to be hazardous because, 'a refrigerator, a chest of drawers, an old cat-cage, flowerpots and a variety of papers and books block her way to the front door which is her only exit' (COPS case notes). The final area of risk related to the structural damage that can occur in situations of squalor. In a large city like Sydney, where few private residences are stand-alone homes, structural damage can also impact on others' living conditions. An ACHA welfare worker described a situation in which deficient home maintenance threatened the integrity of the home next door, 'it's a semi-detached [house]. The centre wall is an adjoining wall for both houses. And the state of his house – because the roof's falling in – is jeopardising the house next door'.

Neighbours shared the concerns about risk held by the housing and COPS professionals in situations of squalor. Almost all the participants gave accounts of people living next door to a person in squalor believing that they too were at risk from fire, vermin or structural damage. Neighbours were also displeased with the unpleasant impact that the squalor and associated smells had on their own living environments, and made complaints to the professionals involved in the research. In one situation, as a social worker related, neighbours complained because two women living in a house owned by the Department of Housing had been, 'throwing all the garbage into the front garden … there were animals and faeces everywhere'.

The primary difference between health professionals and the housing and COPS professionals was that the health professionals did not believe squalor *necessarily* to result in risk that requires professional intervention. Instead, their judgements about risk in situations of squalor were based on physical evidence that danger exists. For example, one participant was called to assess an older woman who had boxes stacked up to the ceiling in almost every room. Her house was considered to be a fire hazard by a social worker at the Department of Housing, but in the view of the health professional, the boxes did not constitute an acute fire risk:

> Some squalor is not dangerous … what is dangerous is someone who has highly flammable stuff and is neglectful – leaves the heater on, smokes in bed, or has a history of small fires. You have to take that into account. But that lady with the boxes to the ceiling has been living like that for 15 years. An accident might set that off but I don't think it will.

Perceptions of risk were heightened when people who were labelled as self-neglecting or living in squalor refused services. When confronted with a service refusal, participants had to make judgements around the extent to which people had the capacity to make decisions, which is discussed in the next section.

Capacity to make decisions

The professional's judgements about people's capacity to make decisions were influenced by their organisational background and their view of the level of risk that associated with self-neglect and squalor. One-half of the participants (the six who worked at health-care-focused organisations and six people from other community organisations) were cautious about making assumptions about the causes of situations of self-neglect and squalor without first conducting a formal health assessment. They recognised that self-neglect could be caused by a number of impairments, including dementia, delirium, psychosis, physical illness or dehydration. They were also careful not to assume that squalor is necessarily caused by mental illness or dementia, and also recognised that drug, alcohol and gambling problems, chronic disorganisation and mobility problems could also be contributing factors. Because of the multifaceted nature of these behaviours, these 12 professionals stressed the importance of thoroughly investigating possible causes of squalor and self-neglect before acting. For example, a community aged-care nurse commented on a woman whose:

> Mobility over the last six months or so really deteriorated and she had a fall two to three weeks before – that was really the beginning of her inability to do the washing and all of those things. But anyone else walking into the room would have just looked at it and said it was squalor.

If no such impairment exists, these participants believed that the self-neglect and squalor could be a lifestyle choice which, unless posing imminent harm to the person, must be respected. In contrast, the other 12 interviewees (all six COPS workers and six professionals from other community organisations) believed that some type of cognitive impairment or mental illness is present in most situations of squalor. An ACHA welfare worker said that. 'these people obviously have some type of dementia happening, or whether it be a mental illness or some voice in their heads telling them that they don't deserve to live'. Some participants were so certain that squalor is caused by mental illness that, when it was not diagnosed they were perplexed about how to proceed. A COPS co-ordinator participant spoke of an 84-year-old client living in squalor but without a mental illness or cognitive deficit. Because the client was intelligent and insightful, the professional found it difficult to intervene

because she could not 'pull the wool over her [the client's] eyes'. Another COPS co-ordinator felt strongly that it was sometimes more important to clean up in situations of squalor and to respect the client's decision to refuse services: 'I know that people should be able to live the way they want to. But to me, success is [making their] home liveable and [to arrange] someone … to keep an eye on them'. These participants also strongly believed that situations of squalor pose a risk to the person and to others, and so their judgements about capacity were connected to beliefs about danger in these situations.

Implications for professional action

Professional understandings of risk and capacity in situations of self-neglect and squalor impacted on whether the professionals thought it important to intervene and the extent to which they worked together to resolve difficult dilemmas that arose in these situations. The six health professionals, who prioritised the risks associated with self-neglect rather than squalor, believed it is important to intervene only in situations where a person was incapable of making decisions. As a result, the health professionals only became involved when the person clearly lacked decision-making capacity as a result of physical illness, mental illness or a cognitive impairment. The interviewees from community-based organisations and others in the community who were affected by squalor found this stance frustrating, particularly because health professionals hold the power to impose more restrictive interventions such as Community Treatment Orders. A community aged-care nurse reasoned that:

> You might get neighbours complaining because of smells or rats or whatever … so there can be quite a lot of pressure on the professionals on the Aged Care Assessment Team [because they're seen as] being the gatekeepers for permanent residential care for people. And so people can get very annoyed if you don't provide them with the outcome they want.

Most of the 18 participants who believed that risk is present in all situations of squalor believed that it creates an obligation upon them to intervene. For instance, a Department of Housing social worker interpreted the smell of urine inside a person's flat as a 'safety and health issue for you and your neighbours – you're in apartment block, this is a tenancy issue. It is not something that I can just ignore'. A Department of Housing social worker spoke of her duty to intervene in a situation of squalor even though the tenant had the capacity to make decisions:

> Somebody could be burnt to death in the building, so we are obligated to take some action. It's a catch-22 situation – we don't like doing it but it's something we

have to do because it's not just [the client's] house that's at risk – it's all the other people in the unit.

The dilemma most commonly raised by situations of squalor for these participants was *how* to intervene rather than *whether* to intervene. They expressed the desire to involve health professionals in these interventions, but their differing views about risk meant that community organisations were often left to address perceived risks without the assistance of health professionals.

Discussion

The findings have indicated that professional judgements in situations of self-neglect and squalor among older people centre upon risk and decision-making capacity, and that these judgements influence professional action. Perceptions of risk were influenced by the professionals' organisational context: those working at the health-focused organisations were the most concerned about risk resulting from self-neglect, whilst the participants who worked in housing and other community-based organisations were more focused on the risks associated with squalor. The prominence of concerns about risk, particularly in various situations of squalor, cannot be explained solely by objective approaches to risk; the minimal empirical data about the risks associated with self-neglect and squalor suggests that older adults are more at risk from self-neglecting behaviours, such as poor nutrition, than from major events such as fire damage (Tierney *et al.* 2004). Judgements about risk in situations of squalor made by participants at community organisations suggest that the experience of risk is both socially and culturally mediated, and that probabilistic understandings of risk are of limited use (Adam and Van Loon 2000; Clarke and Short 1993; Douglas 1992).

There are two possible reasons why risk was so prevalent in professional judgements of self-neglect and squalor. First, professional judgements about risk occur within a context of managerialism, in which organisations strive to improve the efficiency and effectiveness of service provision through the use of standardised assessment tools and quality management (Banks 2004; Barnes 1997). In this context, organisations have become increasingly focused on risk management. In Australia, for example, organisations manage risk to workers through stringent occupational health and safety regulations. These regulations had made the participants aware of the potential risks that are present in situations of squalor but had also limited the types of interventions that they believed that they could engage in. Some participants, for example, were not allowed to

enter the homes of people living in squalor because the uncleanliness was believed to pose a safety hazard.

The second reason that professional judgements emphasised risk is because self-neglect and squalor do not fit with existing cultural classifications, a point first made by Douglas (1966: 38–9), who examined attitudes to and practices around dirt. Wherever dirt appears, she argued, various systems of classification and ways of ordering behaviours exist. Dirt is therefore problematic not because of its intrinsic properties but because it conflicts with these classifications. This suggests that self-neglect and squalor are associated with risk not because of the probability that the behaviour will increase the risk of mortality, but because the behaviour does not fit with existing cultural classifications involving individual self-care and environmental cleanliness. Douglas and others believed that cultural classifications contribute to a moral narrative that allows judgements of people's behaviour (*cf.* Fine and Hallett 2003). In the USA and UK, for example, dirt has long been associated with a lack of purity, disorder and sin (Bushman and Bushman 1988), and transgressing the values of cleanliness and self-care can threaten a person's ability to get a job or to rent an apartment (Herskovits and Mitteness 1994).

The terms self-neglect and squalor-hoarding were clearly used by the participants in this research to describe behaviours that challenge cultural values of cleanliness and self-care. Home life, for example, results in organic and other waste, and so 'the tasks of homemaking are directed towards their containment and eradication' (Angus *et al.* 2005: 173). When these tasks are neglected, the inaction can be seen as challenging cultural values that encourage creating order in the environment and the personal responsibility to prevent disease through care of one's environment (Herskovits and Mitteness 1994). Individual responsibility to promote health outcomes is also encouraged in the broader policy context, as policies to address the ageing of the population, such as the Healthy Ageing Framework, stress individual control over lifestyle choices to prevent disability for as long as possible (Holstein and Minkler 2003). These values promote individual responsibility for achieving positive health outcomes; health becomes no longer a 'gift of God but rather the task and duty of the responsible citizen' (Beck-Gernsheim 2000: 124).

The participants went to great lengths not to blame individuals who self-neglected or lived in squalor for not conforming to conventional societal values. It is possible that this was because the professionals believed that neither self-neglect nor squalor are under the person's control. Previous research has shown that certain cues, such as a lack of cleanliness, self-care or a lack of social contact are often taken to signify a loss of control or a lack of coping with the ageing process (Åberg *et al.* 2004; Browne,

Dickson and van der Wal 2003; Seale 1996). In addition, some illnesses that are commonly experienced by older people, particularly those that affect cognitive status or impact on the control of urine or bowels, can suggest to professionals that people are experiencing diminished autonomy and lack of independence (Herskovits and Mitteness 1994; Lawton 1998; Twigg 2004). If this is the case, then the lack of self-care and cleanliness that is manifest in situations of older people's self-neglect raise questions for professionals working in the community about whether people are capable of making decisions about their care.

All the participants explicitly stated that medical assessments are necessary to determine whether people who are self-neglecting or living in squalor are legally incapable of making decisions. In this way, participant responses supported previous evidence that professionals base their determinations of decision-making capacity on objective notions of disability, functional capability and mental health status, rather than on subjective judgements related to the environment (Byers and Zeller 1995; Lauder *et al.* 2006). Yet, one-half of the participants assumed that a person must have some cognitive problem or mental illness to live in squalor and, in some cases, it was implied by professionals that people living in squalor have diminished capacity to make decisions. The assumption instigated action, as these 12 professionals believed it was important to intervene in all situations of squalor regardless of the person's medical capacity to make decisions. This raises questions about whether assuming the presence of a mental illness makes it more likely that professionals advocate an intervention, even if the behaviour is a lifestyle choice.

Conclusions

This article has introduced critical theory as a tool for understanding the cultural and social context in which judgements of self-neglect and squalor among older people take place. Analysis of the participants' responses shows that critical theory provides a useful lens for understanding why the concepts of risk and capacity are so prominent in judgements about older people who are self-neglecting or live in squalor. It also highlights how the lack of adherence to cultural norms that characterises these situations can raise questions about whether older people are capable of making decisions. In addition, this paper has moved beyond biomedical explanations of the causes of self-neglect, which are prominent in the extant literature, and provided a critical analysis of how situations of self-neglect among older people are assessed by professionals. Such analysis is important because it shows how judgements impact on intervention and

professional decision making. Critical theory has much to offer in challenging the assumptions upon which judgements about self-neglect and squalor among older people are based, and further analysis of the concepts of self-neglect and squalor is needed.

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