

Logics of Appropriateness: Social Work Logics of Cooperative Practice in Self-Neglect

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Abstract

Working in a cooperative manner with other disciplines or agencies is often cited as an essential element of social work with adults who self-neglect (Barnett, 2018; Braye et al, 2011). Cooperative working is now a legal requirement for agencies involved in adult social care in England. However, little is known about how social workers engage cooperatively with other disciplines in practice. This study sets out to explore this issue, employing the ‘Logic of Appropriateness’ perspective (March and Olsen, 2013) to theorise the ways in which social workers talked about working with other disciplines in self-neglect casework. The article presents a qualitative study, which was undertaken through semi-structured interviews with 11 social workers in an urban, adult social care team in an English local authority. Thematic analysis was used to draw out four key logics used by the social workers — leadership, joint-working, conflict, and proxy — but also highlighted the ways in which social workers moved between different logics when talking about cooperative work and working with adults who self-neglect. The results highlight the complex dynamics of cooperation, and suggest that these

dynamics need to be understood in assessing the implementation of integrated policies for social care in this area.

Keywords: Self-neglect, Inter-disciplinary working, Cooperative working, Social work, Logic of Appropriateness

Introduction

In England, the Care Act, 2014 has provided a new framework for adult social care and this has had a range of implications for social work in situations of self-neglect. Under this Act, self-neglect has been re-conceptualised as a safeguarding category, whereas it was previously dealt with under an assessment of need. Interestingly, subsequent statutory guidance has modified self-neglect's status as a category of abuse, suggesting that it should only be subject to safeguarding enquiry on a case-by-case basis, if the person does not have the ability to protect themselves by 'controlling their behaviour' (Department of Health, 2018).

This ambivalent legal position further contributes to the fuzziness of the idea of self-neglect, such as limited prevalence data and the lack of an agreed definition or conceptual framework. There is some consensus, however, that the complex nature of self-neglect requires the input of a range of disciplines (Braye et al, 2011; Barnett, 2018). The Care Act reflects this approach in the requirement for cooperative practice (Section 6) across disciplines when working within adult social care. In this context, the aim of this article is to

examine social workers' accounts of cooperative practice with other disciplines when working in situations of self-neglect.

Cooperative working is often expressed in the specific ways that cooperation is sought. This might be working across agency boundaries (multi/inter-agency), working with different professionals (multi/inter-professional) or with practitioners who are not registered professionals (multi/inter-disciplinary). In the literature it is often unclear if the use of these different terms is significant or whether they are being used inter-changeably (D'Amour et al, 2005). In this article we have adopted the term 'cooperative practice' to reflect the language of the Care Act and will use the more inclusive 'inter-disciplinary' to reflect the range of practitioners involved.

Literature on cooperative practice frequently neglects how practitioners work in partnership with people who use services (and their carers) (D'Amour et al, 2005). In adult social care and safeguarding policy, such person-centred partnership is central to the work of practitioners (Department of Health, 2018; Lawson, 2018). Self-neglect is often identified by practitioners rather than service users, who may not agree with this label or experience practitioner judgements as stigmatising. This article's focus on inter-disciplinary cooperation rather than person-centred work is nonetheless important because inter-disciplinary work is often presented as an effective approach when working with service users who self-neglect (Barnett, 2018; Dahl et al, 2018). Despite the ambiguities of self-neglect, we know very little about how cooperative practice is seen on the ground, so it is important to examine how

the policy requirement for cooperation works, particularly from the perspective of social workers, who are key professionals in this area.

The goals and purposes of inter-disciplinary cooperation are difficult to pin down, often aspirational and open to differing interpretations (Cameron, 2016). The way that professionals approach cooperative work is increasingly characterised as 'means-ends' decision-making (Hammick et al, 2009), where cooperation is the means to achieve particular outcomes in casework. This instrumental approach is difficult to apply in a situation such as self-neglect, where there are disputes about the nature and definition of the problem and the ends aimed at (cure, maintenance, control, etc.) and where practitioners closely tie their work to rules and role. Furthermore, decisions in this area of practice often entail framing a situation as a particular type of problem, identifying one's role in dealing with it and recognising available and appropriate courses of action.

This approach to making decisions is captured by a 'Logic of Appropriateness' perspective (March and Olsen, 2013), which argues that people have a repertoire of roles and identities and these provide rules of appropriate behaviour in a situation: 'Following rules of a role or identity is a relatively complicated cognitive process involving thoughtful, reasoning behavior; but the processes of reasoning are not primarily connected to the anticipation of future consequences as they are in most contemporary conceptions of rationality.' (March and Olsen, 2013: 479).

After an appraisal of relevant literature on self-neglect and cooperative working we will outline the 'Logic of Appropriateness' perspective. The main body of the article will present a study of English local authority social workers' perceptions of cooperative practice across disciplines when working with people who self-neglect. The study aimed to delineate the range of logics with which social workers approach cooperative working. We argue that the 'Logic of Appropriateness' perspective provides insight into the dynamic nature of cooperation between practitioners in self-neglect casework.

Self-neglect and cooperative working

Self-neglect is a complex phenomenon and there is no consensus about what it entails (Anka et al, 2017; Braye et al, 2011). Dong (2017, p.949) use common characteristics to define self-neglect as a "refusal or failure to provide oneself with adequate care and protection in areas of food, water, clothing, hygiene, medication, living environments or safety precautions". However, this approach masks a number of ontological problems with the concept of self-neglect.

Prevalence studies are rare (Braye et al, 2011), so it is difficult to get a sense of the extent of self-neglect. In England, local authority data reveals that 154,700 safeguarding enquiries were concluded in England during 2017-18 and that 4.2% of these related to self-neglect (n=6,435) (Health and Social Care Information Centre, 2018). However, this was the first year that local authorities had to provide data on self-neglect. This number differs from a

USA study suggesting self-neglect is the main form of elder abuse reported, comprising 41.9% of elder abuse referrals (Teaster et al, 2006 cited in Dong, 2017). A small number of international studies reinforce the imprecise nature of estimating the prevalence of self-neglect. Day et al (2016) found that 142 per 100,000 people in Ireland were seen as self-neglecting, while Lauder and Roxburgh (2012) found that in Scotland, 157-211 people were identified as self-neglecting on GP caseloads. In South Korea, Lee and Kim (cited by Dong, 2017) suggest that 23% of older adults living alone experienced self-neglect. Dong (2017) also report that self-neglect is more prevalent in African American (21.7%) and Chinese (29.1%) households than White households (5.3%) in a range of Chicago-based studies. The divergence in prevalence rates identified in this small number of studies across different cultures reflects the difficult ontological issues involved in identifying hidden phenomena in vulnerable groups, with under-reporting and non-engagement common. This is further compounded by the lack of an agreed definition (Day et al, 2016).

Alternative ways to conceptualising self-neglect include normative approaches that take a neutral stance on the idea of failing to meet norms of basic care (Day et al, 2012) and approaches that place self-neglect within a medical frame (e.g.: dementia, mental health conditions, frailty) or see it in terms of behavioural problems (e.g. poor nutrition, non-compliance with medications, refusing support) (Lauder et al, 2009). A service user's choice to live with their own standard of self-care and their mental capacity to make such decisions are also often presented as 'pivots' in practitioner decision-making

(Braye et al, 2011). This is reflected in the Care Act statutory guidance, where a service user's ability to 'control their own behaviour' dictates whether social workers should see self-neglect as a safeguarding category (Department of Health, 2018). However, these ideas are also critiqued for privileging autonomy over other ethical principles (Scourfield, 2010).

The concept of self-neglect is also mired in problems of what are seen as its common characteristics. For example, some commentators seek to differentiate it from hoarding or squalor (McDermott, 2008) or talk about hoarding without reference to self-care (Bratiotis, 2012; Koenig et al, 2010). The term can also be used to describe those unwilling as well as those unable to self-care (Braye et al, 2017a). Further disputes emerge in relation to whether it is age-related. Self-neglect research often refers only to older people (e.g. Dong, 2017) while other literature acknowledges that it can occur at other stages across the lifespan (Lauder et al, 2009). National literatures provide no consensus on whether self-neglect should be treated as a safeguarding concern: UK (post-Care Act) and USA authors speak about it in these terms (e.g. Anka et al, 2017; Dong, 2017), while Australian authors and UK literature pre-dating the Care Act do not (e.g. McDermott, 2010; Braye et al, 2011). Furthermore, disputes about its meaning echo established professional positions. Medical or clinical approaches (e.g.: Fernandes de la Cruz et al, 2013), for instance, contrast with social constructionist approaches (e.g.: McDermott, 2010).

The recognition of self-neglect as a complex phenomenon to pin down (and respond to) has given rise to the view that work in this area has to draw on a range of perspectives from different disciplines (Barnett, 2018; Dahl et al, 2018). Braye et al (2017a) remind us that self-neglect is not the sole responsibility of adult social care and requires cooperation in information-sharing, assessment and decision-making. Several studies cite the emergence of inter-disciplinary hoarding task forces (Koenig et al, 2010; Brown and Pain, 2014). However, successive official reviews in England raise questions about the quality of cooperative working and point to problems of silo working, poor service coordination, role confusion and poor inter-disciplinary communication (Braye et al, 2015).

The Care Act, 2014, as noted above, now requires cooperative working to address self-neglect. However, there is often divergence between what policy says and the situation on the ground, which practitioners have to resolve in their practice (Evans, 2015). In this article we will explore this question from the perspective of social workers, the key professional group associated with local authorities' responsibility to work cooperatively.

Logics of Appropriateness

Practitioners can understand the same situation in quite different ways. They can, for instance, see different issues as key, conceive their own role very differently and see other actors as relevant, or not, to the task at hand (Evans and Hardy, 2010). In decision-making theory, the notion of logics of

appropriateness provides a convincing analysis of this phenomenon – particularly in situations where roles and rules are central to deciding how to act. The ‘Logic of Appropriateness’ approach is premised on the observation that people maintain a repertoire of roles and identities which encode appropriate behaviour to be deployed in different situations (March and Olsen, 2013). Encoded rules, for instance, identify the key elements that make sense of the situation, set out how to act (the appropriate role to adopt), what to expect of others and how to engage with them. Actors acquire these rules through a range of processes such as past experiences and socialisation into their profession. A particular rule is deployed in situations that look similar to settings where the rule has been effectively used before. This is the logic that underpins social interaction in day-to-day life and within social institutions.

However, there can be times where there is not a clear fit between a rule and a situation, or there are conflicting rules that seem to apply to a situation. This is often the case in new or changing contexts where ‘actors have problems in resolving ambiguities among alternative concepts of the self, accounts of the situation and prescriptions of appropriateness’ (March and Olsen, 2013; p. 482). For example, if the situation is too complex, it may be difficult to judge what works best. Here, there are multiple conceptions that actors are seeking to resolve in terms of an appropriate response in a given situation.

The Logic of Appropriateness perspective provides a critical lens through which to examine decision-making in cooperative practice. Its focus on practitioner roles is similar to ‘social identity’ theories relating to inter-group

relationships, such as Oliver's (2013) work on social work identity and boundary-spanning. D'Amour et al (2005) provide a comprehensive account of the theoretical ideas underpinning effective inter-disciplinary practice, including the idea that cooperation is a dynamic process. The Logic of Appropriateness perspective contributes to our understanding of this, revealing how logics reflect and can be influenced by a change of circumstances.

Given the ambiguities inherent in self-neglect and the ambivalent nature of the current policy response, the manner in which cooperation plays out on the ground needs further examination. We will now outline how a study on social workers' experiences of working with other disciplines to address self-neglect reflected a range of logics of cooperative practice.

Method

The aim of this study was to explore social workers' understanding and experiences of cooperative working in the area of self-neglect. The study is based on a theoretical sample of social workers from adult social care teams in a single local authority who had experience of working with self-neglect. A theoretical sample does not seek to draw conclusions about the views of a population but rather, looking at a case – cooperative practice and self-neglect – it explores perspectives and themes within a context that may help us understand what is happening in similar contexts (Ragin, 1987).

The sample consisted of eleven social workers from four adult social care teams working with adults aged 18 and over in a single English local authority and the participants were diverse in relation to length of time since qualification, gender, age and ethnic background. The data were collected through semi-structured interviews, which balanced the focus of understanding experiences and views of cooperative practice with flexibility to allow participants to contribute to the research agenda (May, 2011). Ethical approval was granted by the university research committee. Prior to interviewing, an information sheet was provided and informed consent was secured. Further opportunities to opt out were provided on the day of interviewing. On average, interviews lasted 50 minutes and were audio recorded, transcribed verbatim, anonymised and securely stored.

The analysis, drawing on an interpretivist epistemology, sought to identify participants' views of cooperative working, understanding of the social work role and the role of other disciplines, while also being alert both to emergent, unanticipated themes identified by participants and to our own theoretical preconceptions about the meaning of the data (Blaxter et al, 2010; Dey, 2004). The transcripts were analysed thematically, using line by line coding to draw out distinct features of the participant's logics (Gillham, 2005). The initial analysis was undertaken by the researcher who undertook the fieldwork and the codes were then reviewed by both researchers to review the fit of data and codes and interrogate our understanding of what has been 'discovered' (Dey, 2004, p.91).

Findings

The idea of cooperative work was threaded through most accounts of social work practice as a 'matter-of-fact' encounter, integral to working with people who self-neglect. However, the ways in which interviewees talked about interdisciplinary working, suggested at least four different logics of cooperative working: inter-connected assumptions about what is 'true, reasonable, natural, right and good' practice (March and Olsen, 2013, p.479). In this case, these assumptions relate to the proper roles social workers (and social services) and other practitioners (and their agencies) should fulfill and the proper purpose of working together in relation to self-neglect, which may change depending on situational factors.

The range of different services that participants referred to in the study, reflects the diversity of needs which might coincide with self-neglect, including health (GPs, community nurses, mental health services, substance misuse services, gerontology clinics for dementia or falls, paramedics, hospital staff and allied health disciplines, particularly occupational therapy), housing (tenancy support, housing repairs and landlords across the range of housing tenures), the voluntary and community care sector (care agencies, meals on wheels, day-centres, befriending services and age-specific national charities) as well as other services like the police, pest control and the fire services.

In the remainder of this section, we will outline how the four different logics were used by the participants to describe cooperative working – (i) the logic of

social work leadership where other practitioners' activity is seen as organised around the social work process, (ii) the logic of joint responsibility where other practitioners' work is seen as distinct and occurs in parallel to social work, (iii) the logic of conflict where other practitioners were perceived as working in adversarial ways, (iv) the logic of proxy, which allows for others to act on behalf of social work. We will then consider how these logics intersected and shifted depending on the situation in which cooperative working was sought, suggesting that static accounts of cooperative processes are likely to be inadequate to understanding the reality of dynamic day-to-day practice.

Logics of cooperative working

1. Logic of leadership: 'It's all a part of what we do'

Whilst the Care Act requires cooperation between services, statutory functions and duties such as safeguarding enquiries are normally led by social services. On the basis of leading these statutory processes, social workers described their work with holding an office with statutory responsibility for self-neglect, giving them a lead role amongst other professions.

'Once someone is admitted to hospital, you have this multi-disciplinary assessment but you must be assertive of your own assessment and recommendation anyway'
(SW4)

Within this logic of the primacy of social work,, other practitioners were described in auxiliary roles that were instrumental to the social work

intervention (rather than acknowledging these practitioners' own wider responsibilities). This was particularly evident in terms of describing other practitioners' instrumental value as conduits of information – referrers, information-providers and aides to the social work assessment.

'It's our responsibility to sort it out and assess what support is needed but OT reports are very helpful for pulling the information together...' (SW8)

This sense of other disciplines making secondary contributions to a process led by social workers also played out in accounts where social workers spoke about 'using' various other practitioners and agencies for information to contribute to the social work assessment.

'Has he got any other professional working with him to gather some information... You can use the GP for information about this man: does he have a formal diagnosis?' (SW1)

When the social work assessment was complete, other practitioners were cast in the role of assisting social workers to achieve social care outcomes. For example, environmental cleaning services, housing or tenancy management, pest control and animal welfare services were described as helpful to achieving the outcomes of a social work assessment rather than in the context of their own statutory responsibilities.

Social workers also spoke about the poor knowledge some other services seemed to have in relation to self-neglect and this meant that they needed to take more responsibility.

'It's a bit of a grey area. I don't think that a lot of professionals know their level of responsibility with self-neglect so its up to us to figure it out' (SW3)

Overall, from this perspective, cooperation was useful in achieving statutory social work aims and at times, this led to an instrumental view of other disciplines, rather than as practitioners in their own right.

2. Logic of joint responsibility: 'Not just a Social Services thing'

A different view was taken by those who subscribed to a logic of joint responsibility, where the work of other services and practitioners was seen as a parallel but separate process to social work. These accounts did not position social work as the primary profession in working with self-neglect but saw other agencies as having a distinct function and role, which was not just connected to liaison, communication and joint work with social services.

These social workers saw self-neglect as an intrinsically complex and multi-faceted problem, overlapping with a range of contributory issues. Frequently, they cited physical (frailty, mobility problems, poor overall health) and mental health (schizophrenia, dementia, depression, etc.) problems and substance misuse (particularly alcohol misuse) as areas that overlap with self-neglect. This prompted the importance of working together and participants discussed

working with a wide range of disciplines from different services. A sense of partnership and mutual support often characterised relationships with other practitioners when working with self-neglect.

‘It’s not just a social services thing, I think we also need to involve other agencies like housing, environmental health... the GP (and) mental health’ (SW4)

The idea that self-neglect is frequently identified in older adults’ lives was borne out through the range of gerontology and age-related services (falls clinics, dementia specialists, old age psychiatry) and frequently social workers would speak about the specialist contributions these services could make alongside social care input.

This theme also arose within inter-disciplinary settings, where the team served as a forum for different strands of work being brought together. Hospital based social workers saw themselves as partners in an inter-disciplinary team, but emphasised that each discipline had a unique contribution to working towards the safe discharge of people where there were concerns about self-neglect. The contribution of these disciplines was valued above purely assisting with the aims of the social work task.

‘We’re part of a multi-disciplinary team. We might suggest at the MDM meetings, should this person have investigations into dementia, should the psych liaison service come and have a chat and see if there is anything else there’ (SW2)

Sometimes this was discussed as part of a shared challenge in working with a difficult situation, but these accounts saw other disciplines as offering different skills and knowledge to the whole picture of what was going on for the service-user.

‘You get a different set of skills so the social worker will use different set of skills to the nurse and they are trained to pick up on other things’ (SW6)

Overall, this logic emphasised that social workers saw engagement with a network of other professionals and agencies – contributing distinct and valued specialities – in working with the multi-faceted phenomenon of self-neglect.

3. Logic of conflict: ‘I find them tricky’

This logic was used by social workers in situations where requests for, or expectations of, joint work were marked by conflict, challenge and adversarial responses. Conflict was attributed to differences in approach or values, rigid responses and a recognition of pressures within other organisations, and seemed to pick up on the idea that there is a lack of consensus around self-neglect amongst different disciplines (and their agencies), as discussed earlier.

In a number of instances, social workers saw their approach or their professional value base as intrinsically different to the approach of other practitioners. Often social workers spoke about their approach being

supportive and relationship-based in contrast with punitive approaches (e.g.: the police or housing) or episodic contact (e.g.: health or paramedics):

‘... the police referred him and they were saying no you can’t stay here and he was so angry, but I just thought, you know what, this is not the way and said to him I would come back the next day because I was trying to get a relationship going’ (SW1)

Frequently, social workers saw other practitioners using different thresholds, sometimes overstating concerns about self-neglect to engineer a rapid assessment, which was a source of frustration. Social workers saw their approach as person-centred and suggested that other disciplines’ paternalistic risk-aversion led to conflict in cooperative working:

‘The nurse thought I would be able to go in there, get everything done and that would be it. I had to explain that it’s her [the service user’s] property, she’s got capacity, she knows things are this way and she’s just not going to have any help so at a certain point there’s nothing more we can do’ (SW8)

These contrasting attitudes show how differing approaches and understandings of self-neglect led to challenge and difficulty in working together and to situations where social workers were subject to demands for action which they saw as inappropriate:

‘We often receive referrals saying “You need to clean her flat, she needs a blitz-clean, I want you to put in a care package”. We cannot force this lady to have services. She doesn’t want it and she has capacity’ (SW4)

Conflict also arose when social workers adopted the role of advocate in the face of what they saw as a lack of cooperation from other disciplines. Some social workers described difficulties related to rigid boundaries or inadequate systems for how agencies interact and cooperate – particularly medical services.

‘Mental health took the stance that... they would not re-assess him. We made this request three times. All we needed was for mental health to be more proactive’
(SW5)

This type of response was often associated with negative outcomes for service users and their rapid deterioration, to the frustration of social workers and this was sometimes couched in terms of heroic challenges to other disciplines’ apparent intransigence. However, some social workers understood this conflict in the context of cuts to the mental health services, rather than individual practitioner-level rigidity, while others spoke about how this difficulty related to local practice arrangements – often due to the absence of joint working protocols related to self-neglect or hoarding.

4. Logic of proxy: ‘Just so someone can keep an eye on the situation’

Having considered logics of social work leadership, joint responsibility and conflict, the final logic we will consider had a very different tone. Here social work was constructed as being outside day-to-day inter-disciplinary working. The social worker subcontracted – sometimes reluctantly – traditional social

work tasks to other agencies and practitioners, particularly those in the voluntary sector. In other words, the social workers assigned other practitioners to the role of proxy social worker.

A number of social workers emphasised the importance of relationship-based interventions to build trust with the service user. However, social workers appeared to see this as a role for other professionals, particularly those working in the voluntary sector:

‘Whereas I’d have some awkward conversation with him about why his trousers were down, the support worker basically said “Ah for God’s sake, man, look at your trousers down” and stuff like that in a jokey way... it’s really worked. It’s like speaking their language’ (SW2)

This is interesting in its positioning of social work in binary opposition with both the service user and the voluntary sector support staff, who *speak each other’s language*, and places social work at arm’s-length. This appears to mark a loss of professional territory for social work, which they related to policy changes and the context of austerity:

‘in the old days we were allowed to visit 5, 6, 7 times. These days it’s a ‘one-off’ visit. Very difficult due to the lack of resources... I do worry that we don’t spend enough time with our clients’ (SW6)

Social workers often talked about the need to involve other practitioners to fill this gap with a sense of regret:

'You just don't have time to work with them 'cos you don't have that time to really delve into it. You almost feel you uncover a problem and then you might be linking up with other professionals in the community to get it to a stable situation' (SW2)

At other times, such as when an initial offer of services was rejected but the risk remained high, continuing engagement with another practitioner was seen as a pragmatic response:

'We'd probably link him up with some voluntary sector agencies just so someone can keep an eye on the situation' (SW2)

Cooperation in this context was piecemeal, borne of necessity, often valued because it filled gaps that occurred in the context of limitations in contemporary adult social care roles. This logic was particularly used by social workers who were more experienced. It seemed to reflect an awareness of a more constrained role, for social work in the wake of policy shifts and the budget imperatives across contemporary adult social care.

Intersecting Logics

Social workers were not committed to one logic: rather the four logics seemed to constitute a repertoire with practitioners drawing on particular logics in certain situational contexts. These situations acted as pivots in terms of the logic used to describe cooperation. Here we will consider the ways in which these logics intersected and shifted.

The uni-directional and linear nature of referral to social care was picked up as a condition for a logic of social work leadership in the inter-disciplinary arena. However, factors such as 'inappropriate referrals' or service user needs being split according to silo-work thinking caused these social workers to shift to the second logic (where other disciplines were responsabilised). For example, social workers noted referrals from health, including at the point of hospital discharge, as a splitting of responsibility. In situations where service users had significant health needs, they argued that health services should not simply be referring the person for social work without continuing health input. Equally, where other practitioners wanted social workers to intervene because of subjective concerns about poor standards of hygiene, social workers used the logic of joint responsibility to resist and put back these concerns to the other discipline. This strategy was also deployed where social workers were undertaking work as a lead discipline but later realised that other skills or knowledge were required.

Conversely, social workers moved from a logic of joint responsibility to one of leadership in certain instances, for example, to assert their 'responsibilities' under the Care Act, 2014 within inter-disciplinary teams on hospital wards. This also happened where other disciplines, which had a contribution to make to meeting the service user's needs, sought to put forward different thresholds of intervention or argued for different approaches. Social workers in this instance commented that it may be best in this situation to 'get on' with the work alone because it felt like a path of least resistance.

For some respondents, the logic of joint responsibility could shift to a logic of conflict, particularly where power asymmetries existed. This was notable when working with clinical and health professionals or where there were inflexible or rigid organisational systems, such as mental health services not accepting direct referrals from social workers. Similarly, the logic of conflict could arise where social workers became frustrated with other practitioners' alternative constructions of self-neglect:

'I get very frustrated with people passing their own judgements about how people choose to live' (SW3)

The logic of conflict sometimes also shifted to one of shared responsibility, particularly when systems were responsive to the differences that existed between professions and acted to support these. Local protocols (hoarding protocols had been helpful in work with housing departments), inter-disciplinary training (with hospital staff) and commissioning decisions about the configuration and availability of core services (like 'blitz-cleaning' being brought in-house) helped to iron out such problems.

Situations 'parked' by a logic of proxy may elicit a move to a logic of leadership if the other agency reported the persons needs had changed or where another (often voluntary sector) service disagreed that the person could manage without social work input. However, in the context of austerity and cuts to the voluntary sector, the movement between these two logics often oscillated. Social workers would often deploy a logic of leadership to

assert the need for voluntary sector support where such a service was not available. In the face of funding cuts in local authorities cuts, many social workers reverted to a logic of proxy, arguing a lack of time or resource to effectively work in this way.

A 'Logic of Appropriateness' approach is helpful in theorising social workers' accounts of cooperation when encountering self-neglect and to capture the dynamic and situational nature of their thinking. Throughout these illustrations, there was clear evidence of social workers shifting from one logic to another based on situational factors. This seemed to reflect not only the recognition of new factors that drew forward a different logic from their repertoire but also the choice of logic itself as a strategy to control and direct the nature of cooperative working.

Discussion and Conclusion

Integrated, cooperative working is often constructed in adult social care policy and practice guidance as a neutral and common-sense activity (Department of Health, 2018; SCIE, 2018). The reality is, as one might expect, more complex, with cooperation taking many forms and meaning different things to different people (Thistlethwaite, 2013; Cameron, 2016). This article suggests that cooperation is a dynamic process, shifting according to situational demands. The 'Logic of Appropriateness' perspective helps to identify such shifting patterns and key dynamics of day-to-day cooperative practices.

The study demonstrates the contingent dimensions of rule-based action and that different decision environments informed the ways in which social workers engaged with rules. Certain factors, such as linear referral pathways, the requirement for multiple skill sets, the degree of conflict in the local inter-professional network or the presence of voluntary sector support all have an impact on the logic that social workers lean towards in self-neglect casework. This process shows social workers making choices about how to cooperate based on their understanding of inter-disciplinary networks in their area. The study also reveals social workers' accounts reflecting repertoires of roles that they might move between in any given situation. Such roles include a uni-professional leader, an actor within a network of responsibilised actors, an antagonist challenging or marshalling other practitioners in a network and a contractor of (professional) social work tasks, with situational factors prompting shifts in position.

The 'Logic of Appropriateness' offers two key insights into social work casework with people who self-neglect. Firstly, it foregrounds the uncertain nature of working with people who self-neglect, underpinned by imprecise policy and definitional blurring. Although collaboration is widely considered to be a marker of effectiveness in working with people who are identified as self-neglecting (Barnett, 2018; Braye et al, 2017a), the day-to-day activity of collaborating around self-neglect is more nuanced and situational, and the 'Logic of Appropriateness' approach helps to expose the different and intersecting ways that cooperation is discussed. Secondly, the perspective provides an ethical insight into social workers' approaches to cooperative

practice. Self-neglect is ethically complex: for instance, juggling principles of self-determination and protection from harm or an ethic of care (Braye et al, 2017b, McDermott, 2011). Social workers seemed to adopt various roles on the basis of fulfilling a purpose, whether that be to lead an inter-disciplinary network, to engage a wide array of skills from within the system, to challenge and advocate in the context of conflict, or to delegate to a service who can provide the services the person needs, particularly in the context of cuts within the local authority. Arguably, these diverse roles are selectively adopted within a complex ethical landscape and dependent on what the service user's situation demands.

We have used the 'Logic of Appropriateness' as a lens to look at how social work actors' approaches to cooperation are informed by their situated and contextualised roles (March and Olsen, 2013). However, in the contemporary world of personalised safeguarding in England and the 'Making Safeguarding Personal' policy (Lawson, 2017), we also have to recognise the world of the person who is the focus of concern, who may not even consider her/himself to be self-neglecting or understand the potentially normative cooperative efforts to resolve a situation they do not agree exists. Increasingly the literature calls for greater understanding of the meaning of the self-neglect for the person who is seen as self-neglecting (Braye et al, 2017a) rather than simply focusing on professional tasks and processes. However, this is not an either/or choice: these two areas for research should run together and inform each other. Furthermore, given the rapid roll-out of integration policies and services, despite uncertainty about the meaning of the key idea of self-neglect

at the heart of policy, it would be foolhardy not to examine how practitioners responsible for putting policy into practice make it work (Cameron, 2016).

This study shows how social workers have to negotiate the complexities of the policy of cooperation when engaged in casework with those who are experiencing self-neglect. A future research goal should be to understand more about how those labelled as experiencing self-neglect interpret cooperative practice between disciplines, whether they are included in the network of interested parties or spoken over by the various professionals in their lives — in short, how they are themselves participants in the networks that construct the services they receive (Evans, 2008). In this study of social work perspectives, it is also important to remember that other disciplines will have their own logics through which they see social work and wider cooperative actions. This has not been addressed in the current study but future research may be useful to draw out this idea further.

The findings of this study are also relevant and important in thinking about strategic decision-making in adult social care, particularly when we consider the priority given to cooperative practice in contemporary policy. Safeguarding Adults Boards, which hold responsibilities under the Care Act 2014 to oversee the professional activities concerning self-neglect casework, should take note of the messages from the logics. Of particular interest should be the circumstances that might help social workers shift from a logic of conflict to other logics, such as the availability of resources or procedures and protocols that facilitate joint-working. Even more importantly, it is crucial

for those responsible for strategic decisions in adult social care to understand the complex ways in which cooperative work is encountered on a day-to-day basis, in order to appreciate the complexity of such encounters when commissioning integrated responses.

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