INTER-AGENCY SAFEGUARDING ADULTS GUIDANCE

Self-Neglect and Hoarding

Version Control
2.3

Teeswide Safeguarding Adults Board

CONTENTS

Revision Number	Date Approved by the Board	Change Record	Links to Other Policies	Review Date:
2.1	OLSG: Jan 19	Reviewed to strengthen risk escalation, include Duty to Refer	All other Teeswide Safeguarding Adults Policies	January 2021
2.2	OLSG: Jan 20	Reviewed to include reference to 'Team Around the Individual Panel'	All other Teeswide Safeguarding Adults Policies	January 2021
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In addition the following papers and procedures have been referred to:

- SCIE Report 69: Self-neglect policy and practice: building an evidence base for adult social care, published November 2014
- SCIE: Self-neglect policy and practice: key research messages, published March 2015
- SCIE: Self-neglect policy and practice: research messages for managers, published March 2015
- SCIE: Self-neglect policy and practice: research messages for practitioners, published March 2015
- SCIE: Adult Safeguarding: Sharing Information, published in January 2015
- Working with people who self-neglect, Research in Practice for Adults (RIPFA)
- Department of Health, Care Act 2014, Care and Support Statutory Guidance, updated October 2018
- Birmingham Safeguarding Adults Board Self-neglect Practice Guidance and Framework, May 2017
- KASiSB: Keeping Adults Safe in Shropshire, Guidance on Self-neglect, April 2016
- Self-neglect: the tension between human rights and duty of care, Community Care (November 2016), Rachel Carter.

1. INTRODUCTION

The aim of this guidance is to provide information and advice for people supporting adults with care and support needs who are at risk of harm as a result of self-neglect. This guidance seeks to support good practice in managing the balance between protecting adults from self-neglect and their right to self-determination to live their lives as they choose, and should be used in conjunction with the Teeswide Inter-Agency Safeguarding Adults Policy, Self-neglect and Hoarding and the Teeswide Inter-agency Safeguarding Adults Procedure https://www.tsab.org.uk/key-information/policies-strategies/.

This guidance relates only to adults. Where a child (a person under 18) is identified to be in a household where there is a concern about an adult self-neglecting, reference must be made to the Local Safeguarding Children Partnership procedures.

Everyone has a responsibility to take a 'Think Family' approach. 'Think Family' is an approach that requires all agencies to consider the needs of the whole family from working with individual members of it, making sure that support provided by children's, adults and family services is coordinated and takes account of how individual problems affect the whole family.

2. SELF-NEGLECT AND ADULT SAFEGUARDING

The DH Care and Support Statutory Guidance (Care Act 2014) states that 'self-neglect may not prompt a Section 42 enquiry' and that 'an assessment should be made on a case-by-case basis' with a decision on whether a response is required under safeguarding dependent upon the adult's ability to protect themselves by controlling their own behaviour.

An adult with possible care and support needs may choose to refuse to have an assessment. However, where the local authority identifies that an adult lacks mental capacity and that carrying out a needs assessment would be in the adult's best interests, the local authority is required to do so. This includes situations where the local authority identifies that an adult is experiencing, or is at risk of experiencing, abuse or neglect. Where the adult who is or is at risk of abuse or neglect has capacity and is still refusing an assessment, local authorities must undertake an assessment so far as possible and document this (Care Act 2014, Section 11).

a. Prevention

In the majority of self-neglect cases, early intervention and preventative actions will negate the need for safeguarding adult's procedures to be followed; and in this, the Care Act emphasises the importance of using local community support networks, and facilities provided by partner and voluntary organisations.

b. Mental Capacity Act

The Mental Capacity Act 2005 provides a statutory framework to promote decision-making for people who lack capacity to make decisions for themselves or who have capacity and want to make provision for when they may lack capacity in the future. It sets out who can make decisions, in what situations, and how they should go about this. It is designed to protect and restore control to those

vulnerable people who may lack capacity to make certain decisions due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol; and to support those who have capacity and choose to plan for their future.

c. Mental Capacity Act and Self-neglect

The Mental Capacity Act (2005) (MCA) is crucial in determining what action may or may not be taken in self-neglect cases.

All adults have a right to take risks and behave in a way that may be construed as self-neglectful if they have the capacity to do so, without interference from the state[1].

The MCA states that all workers have a duty to consider whether an adult who self-neglects has the mental capacity to understand the risks of the decisions they make and the impact these may have upon their safety and wellbeing, and the safety and wellbeing of others.

Mental capacity involves not only the ability to understand the consequences of a decision but also the ability to carry out the decision. Where decisional capacity is not accompanied by the adult's ability to carry out the decision, overall capacity is impaired and 'best interests' intervention by professionals to safeguard wellbeing maybe needed. Mental capacity assessments must be decision-specific and an apparent capacity to make simple decisions should not result in an assumption that the adult is able to make more complex decisions.

Where intervention may be required due to an adult's self-neglecting behaviour, any action proposed must be with the adult's consent where they are assessed as having mental capacity; unless there are wider public interest concerns. For example, other people may be at risk of harm or a crime has or may be committed. Examples of where other people may be at risk as a result of self-neglect include where there is a fire risk, where there are public health concerns such as infestation affecting other properties, and where there are risks to people visiting the property including professionals.

Where there is a concern of significant self-neglect one of the first considerations should be whether the adult has the mental capacity to understand the risks associated with their actions/lack of action. In accordance with the first principle of the MCA, an adult must be assumed to have capacity to make his or her own decisions unless it is proved otherwise. This means that it cannot be assumed that someone cannot make a decision for himself or herself just because they have a particular medical condition or disability. Moreover, in accordance with the third principle of the MCA, it is important to remember that people have the right to make decisions that others might think are unwise, and therefore in such situations should not automatically be labelled as lacking the capacity to make a decision.

Any capacity assessment carried out in relation to self-neglecting behaviour must be time specific and relate to a specific intervention or action. The professional responsible for undertaking the capacity assessment will be the person who is proposing the specific intervention or action, and is

[1] European Convention of Human Rights, Article 8

referred to as the 'decision-maker'. Although the decision-maker may need to seek support from other professionals in the multi-disciplinary team, they are responsible for making the final decision about a person's capacity.

If the person lacks capacity to consent to the specific action or intervention, then the decision maker must demonstrate that they have met the requirements of the best interests 'checklist.' In particularly challenging and complex cases it may be necessary for a referral to the Court of Protection to make the best interests decision.

Having mental capacity does not negate the need for action under safeguarding adults' procedures, particularly where the risk of harm is deemed to be serious or critical. Where professionals envisage serious or critical harm to a person and they have mental capacity, the duty of care extends to gathering all the necessary information to inform a thorough risk assessment and any subsequent actions, even without the consent of the individual. In such circumstances it may be determined that there are no legal powers to intervene in respect of the adult. However if the adult's decisions may impact negatively on other family members including children then a multi-agency decision should be made on the actions to be taken to reduce the risk to others. Practitioners will demonstrate that all risks, decisions and possible actions have been fully considered and documented on each of the individual's care record by all agencies involved.

More information about mental capacity can be found in the MCA Code of Practice at https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice

d. Making Safeguarding Personal (MSP)

The Care Act 2014, DH Care and Support Statutory Guidance 2017, describes six principles that underpin all safeguarding adult work and which should always inform the ways in which professionals and other staff work with adults.
In addition to these principles, Making Safeguarding Personal (MSP)[2] aims to ensure that the safeguarding process:

- is person-led and outcome-focussed
- enhances the individual's involvement, choice and control, and
- seeks to improve the quality of life, wellbeing and safety of the individual

3. LEARNING FROM SARS (SAFEGUARDING ADULTS REVIEWS)

The Care Act 2014, Section 44 requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review when an adult in its area, with care and support needs, dies **either** as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; **or** if an adult has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or

[2] Making Safeguarding Personal: Guide 2014, LGA ADASS

neglect. The Care Act also states that SABs 'are free to arrange a SAR in any other situations involving an adult in its area with needs for care and support.'

The Act further defines that 'something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.'

The findings from Safeguarding Adults Reviews involving cases of self-neglect have been examined and analysed over a number of years by various local authorities in order that lessons maybe learned and practice improved. The following is a summary of some of the findings:

- The importance of early information sharing in relation to previous or on-going concerns
- The importance of thorough and robust risk assessment and planning
- The importance of face-to-face reviews
- The need for a clear interface with safeguarding adults procedures
- The importance of effective collaboration between agencies
- The need for an increased understanding of the legislative options available to intervene in order to safeguard a person who is self-neglecting
- The importance of an understanding of, and the application of the Mental Capacity Act (2005)
- The importance of considering mental capacity where an individual refuses services to ensure that the individual understands the implications, and that this is documented. Services/support should be re-visited at regular intervals in the context that it may take time for an individual to be ready to accept support
- The need for practitioners and managers to challenge and reflect upon cases through the supervision process and training
- The need for robust guidance to assist practitioners in working in this complex area
- The need to ensure that assessment processes identify who carers are (and significant others) and how much care and/or support they are providing

4. LEGAL FRAMEWORK

The Legal Framework is set out in the Teeswide Inter-Agency Safeguarding Adults Policy Self-Neglect and Hoarding. Further detail of how legislation and guidance may be used can be seen in Appendix A.

5. WHAT IS SELF-NEGLECT?

Self-neglect is one of ten types (categories) of abuse and neglect set out in the DH's Care and Support Statutory Guidance, thereby linking self-neglect to statutory safeguarding duties. Self-neglect is described

as covering 'a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.[3]

This guidance supports engagement with adults who self-neglect through:

- Lack of self-care (e.g. neglecting personal care, hygiene and health; poor diet and nutrition) and/or,
- Lack of care of their domestic environment (e.g. neglecting home environment, hoarding and excessive clutter) and/or,
- Refusal of services that could mitigate the risk to safety and well-being (e.g. lack of engagement with health and/or social care staff and other services/agencies)

a. Hoarding Behaviour

Hoarding behaviour is considered to be a stand-alone mental disorder and is included in the Diagnostic and Statistical Manual of Mental Health Disorders (5th edition) published in 2013.[4] It can also be a symptom of other mental disorders. Hoarding is not a lifestyle choice and is distinct from the art of collecting. It is also different from people whose property is generally cluttered or 'messy'. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects, which are well in excess of their real value.

Anything can be hoarded, but items most commonly include:

- Clothes
- Newspapers, magazines and books
- Food and food containers
- Animals
- Medical equipment
- Collectables such as toys, video, DVDs and CDs.

Hoarding is recognised as a complex condition and it is likely that a range of agencies will come into contact with the same person over a period of time. It is also recognised that not all adults who hoard will be in receipt of support from statutory services such as Mental Health Services.

In cases where people are hoarding the Clutter Image Ratings should be used by professionals in order to get an accurate sense of the problem (in general, clutter that reaches the level of picture 4 or higher impinges enough on people's lives that they should be encouraged to get help for their hoarding problem). This should also be the trigger point for referral to the Cleveland Fire Brigade to undertake a home visit. Evidence of animal hoarding at any level should be reported to the RSPCA and the Animal Welfare Team in the Local Authority. The Clutter Image Ratings can be seen at appendix C, together with a list of questions which practitioners may find helpful when working with adults that self-neglect by hoarding.

[3] Department of Health, Care and Support Statutory Guidance

[4] American Psychiatric Association ISBN 978-58562-1

b. Substance Misuse and Self-neglect

The term ‘Drug and Alcohol misuse’ is defined as ‘drug and/or alcohol taking, which causes harm to the individual, their significant others or the wider community.’ The term drug refers to ‘psycho-active drugs including illicit drugs, ‘legal highs’ and prescribed and non- prescribed pharmaceutical preparations.’ The term misuse refers to the ‘illegal or illicit drug taking or alcohol consumption, which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence’.

Self-neglect may include situations where a person is suffering a significant impact on their wellbeing, but the cause of this is not directly a result of physical or mental impairment or illness, as it arises from acts of their own, such as drug and alcohol misuse and the chaotic lifestyle and risk taking behaviour associated with this. This can include:

- Attachment to their substance of choice and prioritising this above all else, impacting on their relationships with others
- Financial difficulties due to expenditure on drugs/alcohol resulting in debts and an inability to pay for food, utilities and other basic daily needs
- Risk of homelessness if unable to adhere to tenancy agreements
- Deterioration in physical and mental health
- Risk of overdose or risks associated with impure substances and variability of strength, if purchased ‘on the street’
- Risk of use of prescribed drugs by people they were not prescribed for, but sold on or swapped
- Risk of infection from injecting
- Risk of engaging in criminal activity to fund their lifestyle
- Exploitation by others, including sexual exploitation

Some people who misuse substances may have no diagnosable physical or mental impairment and no ‘appearance of need,’ but still present a significant risk to themselves and to their own wellbeing. In such cases, it is important to give advice and guidance or signpost to other services in accordance with the duty to promote wellbeing (Care Act 2014 and Making Safeguarding Personal).

c. Obesity and Self-neglect

The obese population in the United Kingdom is increasing and continues to be considerably over-represented in their use of health and social care services. Provision of care, support and the transfer and movement of obese patients presents a specific challenge, partly due to individual factors but also due to the lack of policies, space, equipment, adequate staff numbers and vehicles for safe care, treatment and transportation.

Whilst the interaction between obesity and self-neglect has not been directly researched, it is possible that some of the issues arising from obesity may impact on a person’s ability to care for

themselves, and on some of the underlying causes of disengagement from care and support services, eventually leading to concerns about self-neglect.

Key issues for practitioners in working with obese people

- Practitioners should consider any possible underlying causes, or disabilities, which may be interfering with the person's ability and/or choice to engage with care and support
- Co-operation, collaboration and communication between professionals that have knowledge and expertise in working with disability and those working in obesity can help lead to improved prevention, early detection, and treatment for people
- Practitioners/staff should be appropriately trained in the transfer and movement of obese people
- Health and social care providers need to identify and understand the barriers that people with disabilities and obesity may face in accessing health and preventative services, and make efforts to address them before assuming that the person is refusing support
- Health and social care providers need to make adjustments to policies, procedures, staff training and service delivery to ensure that services are easily and effectively accessed by people with disabilities and obesity. This needs to include addressing problems in understanding and communicating health needs, access to transport and buildings, and tackling discriminatory attitudes among health care staff and others, to ensure that people are offered the best possible opportunity of engaging with services
- Concerns about stigma, embarrassment, or worries that professionals may seek interventions that they are not ready to access, may mean that the person is able to engage in a conversation about a mental health or physical health problem when they do not feel able to talk about their obesity. Engaging the person to work on the problems they see as important is essential in developing a longer-term relationship
- There should be active support for obese people to live independent and healthy lives.

6. RISK FACTORS OF SELF-NEGLECT

Risk factors of self-neglect may include:

- Effects of advancing age
- Mental health problems
- Cognitive impairment
- Dementia
- Frontal lobe dysfunction
- Depression
- Long-term conditions
- Nutritional deficiency
- Alcohol and substance misuse
- Functional and social dependency
- Social isolation
- Delirium

- Obsessive Compulsive Disorder (OCD)

7. INDICATORS OF SELF-NEGLECT

The following are some of the indicators of self-neglect:

- Poor hygiene and dirty/inappropriate clothing
- Poor diet and nutrition leading to significant weight loss and/or other associated health issues
- Unmet medical/health needs (e.g. refusing insulin as treatment for diabetes or refusing treatment of leg ulcers) and lack of engagement with health and other services/agencies
- Alcohol/substance misuse
- Changes to behaviour and lifestyle from the person's norm
- Social isolation
- Situations where there is evidence that a child is suffering or is at risk of significant harm due to an adult self-neglecting
- Neglecting home environment (unsanitary, untidy or dirty conditions, poor maintenance etc.), which create a hazardous situation that could cause harm to the individual or others
- Hoarding items including an excessive attachment to possessions (people that hoard may hold an inappropriate emotional attachment to items)
- Keeping lots of pets that are poorly cared for
- Vermin
- Poor financial management (e.g. bills not being paid leading to utilities being cut off, unexplained money drawn from bank)
- Refusal of care services at home (recognising that this may also be due to a fear of cost etc.)
- Refusal of health assessments and interventions
- Leading what could be referred to as a 'chaotic' lifestyle (confusing with great disorder, erratic and/or self-sabotaging behaviour). Such people are sometimes described as 'chaotics.' It should be remembered however, that '**a *human being is a human being. Behaviours may be erratic, chaotic or self-sabotaging, but people still retain their human rights.'***[5]

8. FACTORS THAT MAY LEAD TO INDIVIDUALS BEING OVERLOOKED

Factors that could lead to individuals being overlooked may include:

- The perception that this is a 'lifestyle choice'
- Poor multi-agency working and lack of information sharing
- Lack of engagement from the individual or their family
- Challenges presented by the individual or family making it difficult for professionals to work with the individual to minimise risk

[5] Gardiner, L. (2014) Contribution by member of the Mental Capacity Act and Care Planning Advisory Group, SCIE The Mental Capacity Act (MCA) and Care Planning, October 2014

- A lack of understanding by carers of what their role involves leading to assumptions that support is being provided to an individual when it is not
- Less sensitivity to well known cases resulting in agencies/professionals minimising need and risk
- An individual with mental capacity making unwise decisions and withdrawing from agencies whilst continuing to be at risk of significant or serious harm
- Individuals with 'chaotic' (disorganised) lifestyles and multiple or competing needs
- Inconsistency in risk thresholds across agencies and teams together with a level of subjectivity in assessing risk

9. CAUSES OF SELF-NEGLECT

The causes or contributing factors, which may lead to or escalate self-neglect are many and varied but include:

- Physical or mental health decline of older people so that the person is no longer able to care for themselves or for their environment
- Isolation from family and friends resulting in loneliness and depression
- Mental illness in younger people such as depression or psychosis reducing the person's ability to care for themselves
- Fear and anxiety
- Issues of pride and refusal to accept help when ability to self-care is declining
- Alcohol or drug dependency/misuse
- People who have collected possessions, pets or items and who have become a hoarder and where the level of hoarding poses a serious risk to the person or neighbours (e.g. health, fire)
- Personal circumstances, family history and relationships
- Bereavement/traumatic event

10. ASSESSMENT OF THE DEGREE OF RISK

Responding to self-neglect will depend on the level of risk/harm that has been identified and it is therefore essential that a robust risk assessment is carried out when working with people that self-neglect.

This should include information on whether:

- The person is refusing medical treatment/medication
- The above is life-threatening
- There is adequate heating, sanitation and water in the home
- There are signs that the adult is malnourished
- Their environment is in a poor state of repair
- There is vermin, flies or the hoarding of pets
- There is evidence of hoarding or Obsessive Compulsive Disorder (OCD)
- There is a smell of gas

- There are concerns regarding the level of personal or environmental hygiene
- The adult is suffering from an untreated illness, injury or disease, or is depressed or physically unable to care for themselves
- There are associated risks to children in the home
- There have been any major losses or traumas in the adult's life

11. ESCALATION OF RISK/ TEAM AROUND THE INDIVIDUAL PANEL

It is considered best practice to set up a Team Around the Individual Panel to consider cases of individuals who remain at high risk of harm, despite the best efforts of individual professionals or agencies to intervene. The purpose of such panels is to facilitate, develop risk management plans, monitor and evaluate. The focus of the panel will be on addressing the risk to the adult and in doing this will also consider other persons affected, the panel will improve multi-agency communication, coordination and information sharing and provide support to practitioners and their managers in managing the risks involved in the most complex and challenging cases.

Any such panel should be specific to each local authority area and include representation from adult social care, housing and mental health services, as well as Cleveland Police and Cleveland Fire Brigade.

The aims of a Team Around the Individual Panel should be:

- To share information to identify, clarify and agree on risk management
- To promote the safety and wellbeing of adults at high risk of harm
- To provide a clear and comprehensive review of multi-agency risk assessments and management plans as part of Section 42 Safeguarding Adult Enquiries
- To discuss referrals and agree risk mitigation plans in each case
- To assign a lead organisation to coordinate multi-agency work and report back on progress
- For each organisation to provide advice where appropriate and to take responsibility for decision-making tasks associated with their particular role

Discussion of individuals should always include the options for promoting wellbeing, increasing safety and reducing risk with a view to developing a co-ordinated action plan.

12. INFORMATION SHARING

Sharing the right information, at the right time and with the right people is fundamental to good practice in working with people that self-neglect. The Care Act 2014 emphasises the need to empower people, to balance choice and control for individuals against preventing harm and reducing risk, and to respond proportionately to safeguarding concerns. In most situations this can only be done effectively by sharing information. Guidance on information sharing for practitioners and managers has been set out in the Teeswide Safeguarding Adults Board's Information Sharing Agreement https://www.tsab.org.uk/key-information/policies-strategies/ and all information shared should be strictly in accordance with the agreement.

The Teeswide Safeguarding Adults Board supports the concept of the **E**mpowering **C**ommunities **I**nclusion and **N**eighbourhood **M**anagement **S**ystem (ECINS) to facilitate the effective sharing of information. ECINS is an information sharing system that enables practitioners to create an environment where everyone knows what everyone else is doing. It enables practitioners to choose whom they share information with, securely and across multiple agencies by providing a central hub where practitioners can task and inform one another. It also brings together assessments and action plans in one place and significantly speeds up processes, enabling support to be quickly and effectively offered.

13. GOOD PRACTICE

a. Find out what the adult's views are and what they would like to happen

Time should be taken to build a relationship with the adult based on trust and co-operation. This is much more likely to facilitate an acceptance of help and support. Attempts at engagement may need to be repeated several times before an individual begins to respond and it is important not to sever contact with an individual who is displaying self-neglect/risk taking behavioural traits purely on the basis of refusal to engage with services or agencies regardless of capacity.

Details must be sought about what the adult at risks views are and what they would like to happen. Consideration should also be given to gathering the views of other people who are important in the adult's life, where consent to do so has been given.

In the event of a person lacking mental capacity, the views and wishes of the adult at risk (and their representatives) should be gathered as part of the best interest decision(s).

b. Find out if the adult at risk has mental capacity

A rigorous assessment of mental capacity should be undertaken including decisions in relation to accommodation (e.g. to remain at home), in relation to care and treatment (e.g. to refuse care, support or medical treatment) and/or in relation to keeping safe (e.g. to seek help/support). Mental capacity should be reassessed over time.

c. Take a creative and flexible approach

Professionals should think about different ways of engaging the adult in order to reduce the risks relating to self-neglect. This could involve thinking about who might be the best professional to get the best engagement with the person, or exploring different service options that may reduce risks.

d. Be persistent

The likelihood is that adults that self-neglect may refuse services or support when this is first offered. Professionals may, therefore, need repeatedly to try to work with a person to reduce risks. Non-engagement at first contact should not result in no further action being taken at a later date or

professionals not going back to the person and offering further help or support (particularly where risks may have changed or increased).

e. Work on a multi-agency basis

Work should be undertaken collaborate with other agencies, neighbours, friends and family networks and there should be effective coordination of any actions that need to be taken across all agencies by the key professional involved. Information about risk and actions should be shared with relevant agencies with the consent of the adult at risk.

f. Ensure that detailed and accurate recordings have been made

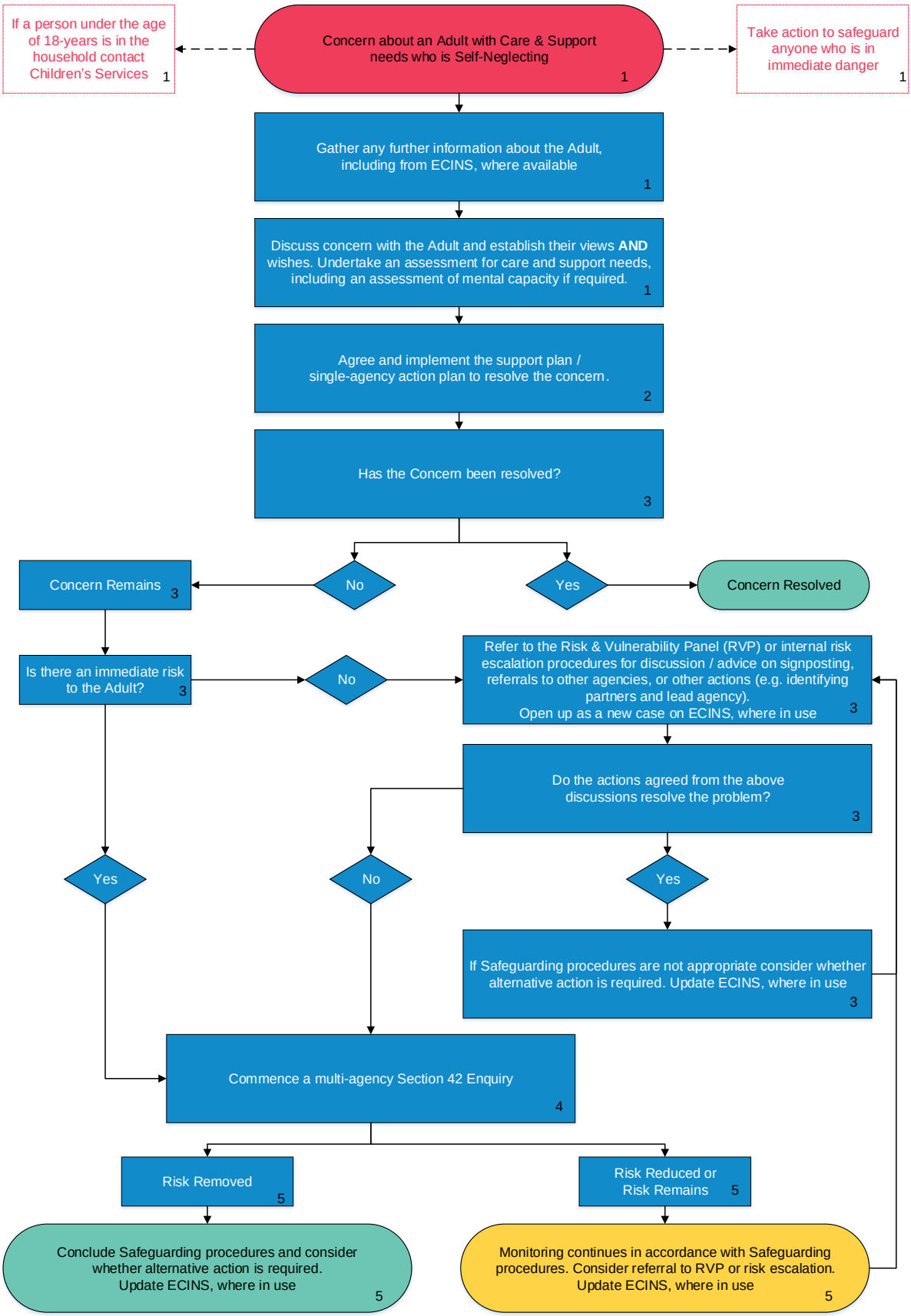
Factual, evidenced based recording should be made on a decision specific basis. This should include identification of risks and actions taken to manage or minimise risk and, where appropriate, a risk assessment and risk management document should be completed. Recording should fully evidence and support any decision making, and appropriate monitoring arrangements should be considered and implemented if necessary. This is particularly important where safeguarding adults procedures have not been used and therefore as a result, safeguarding adult's documentation has not have been completed.

g. Consider risks to others

Consideration must be given as to whether anyone else is at risk as a result of the adult's self-neglect. This may include children or other adults with care and support needs. Whilst actions may be limited in relation to the individual themselves, there may be a duty to take action to safeguard others. Should there be a concern that a self-neglecting parent may be neglecting children in their care, concerns should be reported to Children's' Social Care. Safeguarding and Promoting the Welfare of Adults and Children at Risk Guidance

14. RESPONDING TO CONCERNS ABOUT SELF-NEGLECT

Self-Neglect Guidance Flowchart



TEESWIDE SAFEGUARDING ADULTS MULTI-AGENCY SELF-NEGLECT GUIDANCE

FLOWCHART

In accordance with the Care Act 2014, safeguarding duties apply to an adult who:

- has needs for care and support (whether or not the local authority is meeting any of those needs) and;
- is experiencing, or at risk of abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

The adult experiencing, or at risk of abuse or neglect will be referred to as the ***adult*** throughout this flowchart

	Role	Responsibility	Maximum Timeframe
1	Concern about an ***adult*** with care and support needs self-neglecting:	Person raising the concern	
	• Take action to safeguard anyone in immediate danger as a result of self-neglect	Person raising the concern	Immediately
	• Contact Children's Services if a person under the age of 18 years is in the household	Person raising the concern	Immediately
	• Report the concern that an adult maybe at risk of self-neglect to Adult Social Care.	Person raising the concern	Immediately
	• Gather any further information about the adult including from ECINS if available, and record concerns that an adult maybe at risk of self-neglect	First point of contact, Adult Social Care (this may differ from authority to authority)	Immediately
	• If the ***adult*** is not known to Adult Services a referral should be made	As above	
	• If the ***adult*** is known to Adult Services discuss the concern with them and establish their views and wishes if appropriate	Adult Social Care Worker	If the situation is not urgent, time should be taken to build a relationship with the adult, based on trust and co-operation
	• Undertake an assessment of need for care and support (Care Act 2014, Section 9) including an assessment of mental capacity if required	Adult Social Care Worker	
	• Seek the ***adult's*** consent to share information		
	• Use the Safeguarding Adults Decision Support Guidance (SADSG) to assist in assessing the seriousness and level of risk associated with the concern*		Attempts at engagement may need to be repeated several times over a long period of time before the adult engages
	• In cases where people are hoarding use the Clutter Image Ratings in order to get an accurate sense of the problem (In general, clutter that reaches the level of picture 4 or higher impinges enough on people's lives that they should be encouraged to get help for their hoarding problem). This should also be the trigger point for the Cleveland Fire Brigade to undertake a visit		
	• In addition, for cases which reach Clutter Image Rating 4 and above, consideration should be given to referring to Environmental Health, particularly when the adult is not engaging with services or the condition of the property is affecting neighboring premises i.e. smells, vermin etc.		
	• Record risks and actions taken		
	*The SADSG is not intended to replace professional judgment and each case should be considered on its own merits. Any actions taken must be proportionate to the level of presenting risk or harm and be driven by		

	Role	Responsibility	Maximum Timeframe
	the desired outcomes of the ***adult*** or their representative		
2	Implement the Support Plan/Single Agency Action Plan • Review progress and evaluate the outcome • Review the views, wishes and desired outcomes of the ***adult*** • Set a date for a Review Meeting if needed • Decision made to conclude involvement if the concern is resolved	Adult Social Care Worker	1-2 weeks 3-6 months
3	Concern about the ***adult*** remains • In the case of immediate risk a Multi-agency Safeguarding Meeting should be convened • If no immediate risk refer to the Team around the Individual panel or internal risk escalation procedures for advice, signposting etc. • Continue gathering information and assessing risk • Record information on ECINS system if appropriate • Consider legal options • If the actions agreed at the RVP/ risk escalation process do not resolve the concern, decision made as to whether the Inter-agency Safeguarding Procedure is appropriate or whether more information is required • Safeguarding Adults Decision Support Guidance to be used to inform the decision making process • Consider alternative action if safeguarding procedures are not appropriate • Ensure that the views and wishes of the ***adult*** are taken into account • Determine who will undertake the initial enquiry (Care Act 2014, Section 42) if not the LA.	Designated Manager	In accordance with timescales set out in the TSAB Inter-agency Safeguarding Adults Procedure
4	Progress into Safeguarding Procedures • Further information gathered from identified sources in order to inform the decision as to whether to progress into safeguarding procedures • Seek or review the ***adult's*** views and wishes including their desired outcomes • Consider whether the ***adult*** requires an independent advocate to support them • Follow the Teeswide Inter-agency Safeguarding Adults Procedure • Where there is a child involved, a representative from children's services will be invited to the strategy meeting	Safeguarding partners; ***adult,*** their advocate, relative and carers	In accordance with timescales set out in the TSAB Inter-agency Safeguarding Adults Procedure
5	Arrange case progress review with relevant organisations/practitioners/relatives etc. • Review views, wishes and desired outcomes of the adult • Decision made to conclude Safeguarding Adults' Procedures or set a date for the next Multi-Agency Discussion / Meeting if needed • Outcome recorded and evaluated; establish whether the ***adult's*** desired outcomes have been met and to what extent • Update ECINS where available • Consider whether alternative action is required if safeguarding procedures have been concluded	Designated manager	

	Role	Responsibility	Maximum Timeframe
	• If the risk is reduced or remains monitoring to continue in accordance with the TSAB Safeguarding Adults Procedures • Consider referral to RVP • Update ECINS if available		

15. USEFUL SOURCES OF FURTHER INFORMATION

https://www.tsab.org.uk/key-information/prevention/self-neglect/

https://www.scie.org.uk/files/self-neglect/self-neglect-at-a-glance.pdf

Module Eight: Self-Neglect – Teeswide Safeguarding Adults Board

APPENDIX A - POSSIBLE LEGAL INTERVENTIONS

Agency	Legal Power and Action	Agency Circumstances requiring intervention
Environmental Health	**Power of entry/ Warrant (s.287 Public Health Act)** Gain entry for examination/ execution of necessary work required under Public Health Act Warrant allows entry by force if required.	Non-engagement of person. To gain entry for examination/execution of necessary work. Twenty-four hours' notice of the intended entry. Warrant applied for to magistrate's court following refusal of entry after twenty four hours. (All tenure including Leaseholders/Freeholders)
Environmental Health	**Enforcement Notice (s.83 PHA 1936)** Notice requires person served to comply. Failure to do so can lead to council carrying out requirements, at own expense; though can recover expenses that were reasonably incurred	Filthy or unwholesome condition of premises (articles requiring cleansing or destruction). (All tenure including Leaseholders/ Freeholders/Empty properties)
Police	**Power of Entry (S17 of Police and Criminal Evidence Act)** Person inside the property is not responding to outside contact and there is evidence of danger.	Information that someone was inside the premises was ill or injured and the Police would need to gain entry to save life and limb.
Police	**Policing and Crime Act 2017** Provides extension of powers **under sections 135 and 136 of the Mental Health Act 1983**, including removal of a person appearing to suffer from a mental disorder to a place of safety or if the person is already at a place of safety keep the person at that place or remove the person to another place of safety. * See Mental Health Service	If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control or for the protection of other persons. Before deciding to remove a person to, or to keep a person at, a place of safety under subsection (1), the constable must, if it is practicable to do so, consult— (a) a registered medical practitioner, (b) a registered nurse, (c) an approved mental health professional, or (d) a person of a description specified in regulations made by the Secretary of State."
Fire Service	**Powers of Entry Part 6 Section 44 The Fire and Rescue Services Act 2004** An employee of a fire and rescue authority who is authorised in writing by the authority for the purposes of this	This for the purpose of : • extinguishing or preventing the fire or protecting life or property; • rescuing people or protecting them from serious harm in a road traffic accident;

Agency	Legal Power and Action	Agency Circumstances requiring intervention
	section may do anything they reasonably believe to be necessary. **Emergency access can be gained by FRS to prevent a fire or other emergency**	• reacting in an emergency of another kind relating to the function of the fire and rescue authority; • preventing or limiting damage to property resulting from action taken. •
Housing	**Anti-Social Behaviour, Crime and Policing Act 2014** A civil injunction can be obtained from the County Court if the court is satisfied that the person against whom the injunction is sought has engaged or threatens to engage in anti-social behaviour, or if the court considers it just and convenient to grant the injunction for preventing the person from engaging in antisocial behaviour. **Homeless Reduction Act 2017: Duty to Refer:** The Act introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness/housing options teams.	Conduct by the tenant, which is capable of causing housing-related nuisance or annoyance to any person. "Housing-related" means directly or indirectly relating to the housing management functions of a housing provider or a local authority Where the adult is at risk of becoming homeless.
Animal Welfare Agencies such as RSPCA/ Local authority e.g. Animal Welfare or Environmental Health	**Animal Welfare Act 2006 Offences (Improvement notice)** Education for owner a preferred initial step, Improvement Notice issued and monitored. If not compliant can lead to a fine or **imprisonment**. Ability to seize and remove animal under Section 18 of the Act.	Cases of Animal mistreatment/ neglect. The Act makes it not only against the law to be cruel to an animal, but that a person must ensure that the welfare needs of the animals are met. See also: http://www.defra.gov.uk/wildlife - pets/.
Mental Health Service	**Mental Health Act 1983** **Section 135(1)** Provides for a police officer to enter a private premises, if need be by force, to search for and, if though fit, remove a person to a place of safety if certain grounds are met. An Approved Mental Health Professional (AMHP) and a doctor must accompany the police officer. NB. Place of Safety is usually the mental health unit, but can be the Emergency Department of a general hospital, or anywhere willing to act as such.	Evidence must be laid before a magistrate by an AMHP that there is reasonable cause to believe that a person is suffering from mental disorder, and is being • Ill-treated, or • Neglected, or • Being kept other than under proper control, or • If living alone is unable to care for self, and that the action is a proportionate response to the risks involved.
All	**Mental Capacity Act 2005** A decision can be made about what is in the best interests of a mentally incapacitated person by an appropriate	A person who lacks capacity to make decisions about their care and where they should live is refusing intervention and is at

Agency	Legal Power and Action	Agency Circumstances requiring intervention
	decision-maker under the MCA. It is important to follow the empowering principles of the Act and ensure that any actions taken are the less restrictive option available.	high risk of serious harm as a result,
Local Authority	**NB:** Where the decision is that the person needs to be deprived of their liberty in their best interests, a **Deprivation of Liberty Safeguards (DoLS)** authorisation will be required. In circumstances where a person is objecting to being removed from their home, or to any DoLS authorisation, referral to the **Court of Protection** may be needed and legal advice should be sought.	
Local Authority	**Care Act 2014** **Section 11** Provides for the Local Authority to carry out a needs assessment even if the adult refuses, when: a) the adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or (b) the adult is experiencing, or is at risk of, abuse or neglect.	

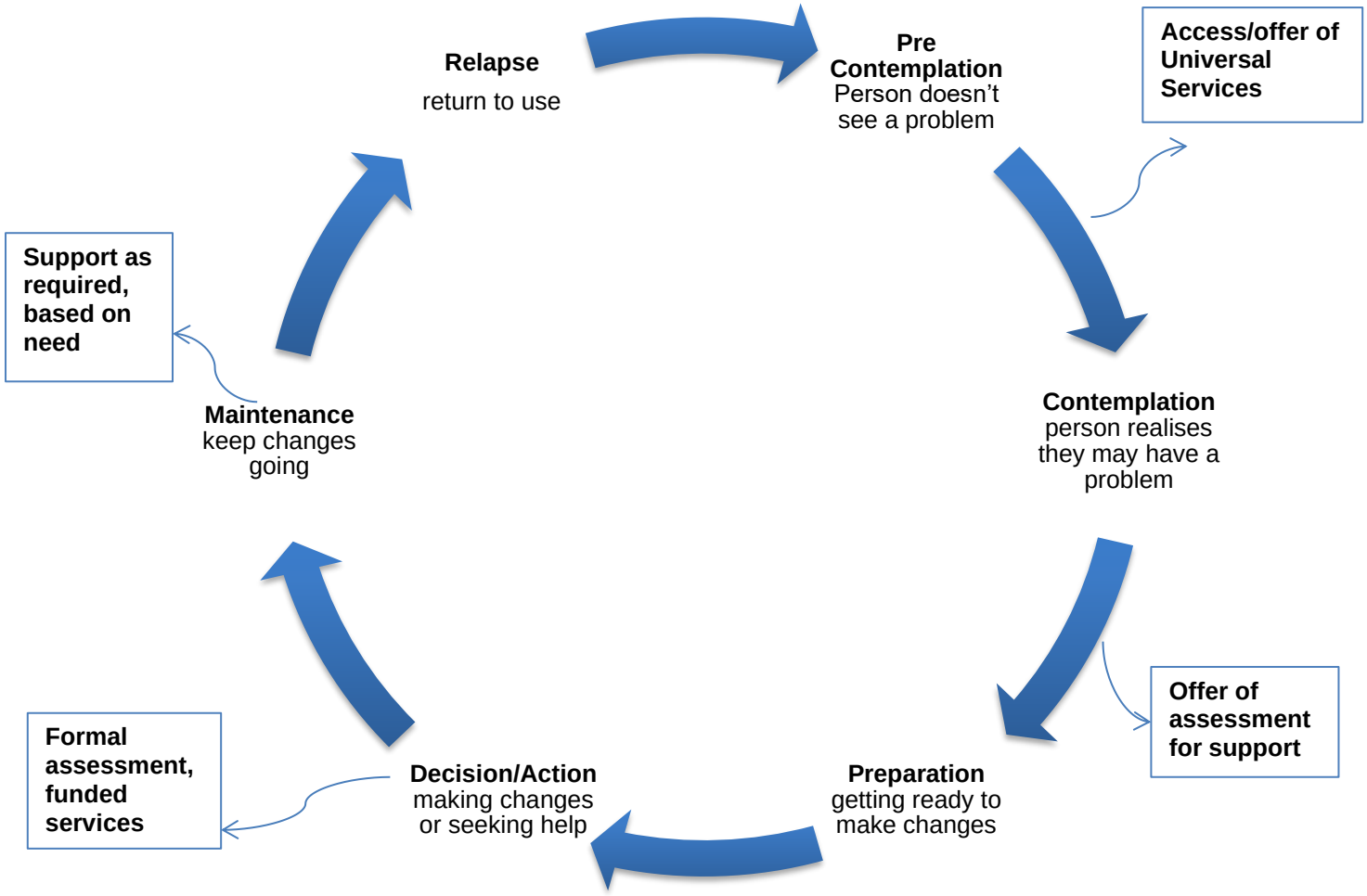
OTHER LEGAL CONSIDERATIONS:

Human Rights Act 1998: Public bodies have a positive obligation under the European Convention on Human Rights (ECHR, incorporated into the Human Rights Act 1998 in the UK) to protect the rights of the individual. In cases of self-neglect, articles 5 (right to liberty and security) and 8 (right to private and family life) of the ECHR are of particular importance.

These are not absolute rights, i.e. they can be overridden in certain circumstances. However, any infringement of these rights must be lawful and proportionate, which means that all interventions undertaken must take these rights into consideration. For example, any removal of a person from their home that does not follow a legal process (e.g. under the Mental Capacity or Mental Health Acts) is unlawful and would be challengeable in the Courts.

Inherent jurisdiction of the High Court: In extreme cases of self-neglect, where a person with capacity is at risk of serious harm or death and refuses all offers of support or interventions or is unduly influenced by someone else, taking the case to the High Court for a decision could be considered. The High Court has powers to intervene in such cases, although the presumption is always to protect the individual's human rights. Legal advice should be sought before taking this option.

APPENDIX B – CYCLE OF CHANGE



APPENDIX C –HOARDING AND CLUTTER IMAGE RATINGS

Guidance Questions for Practitioners

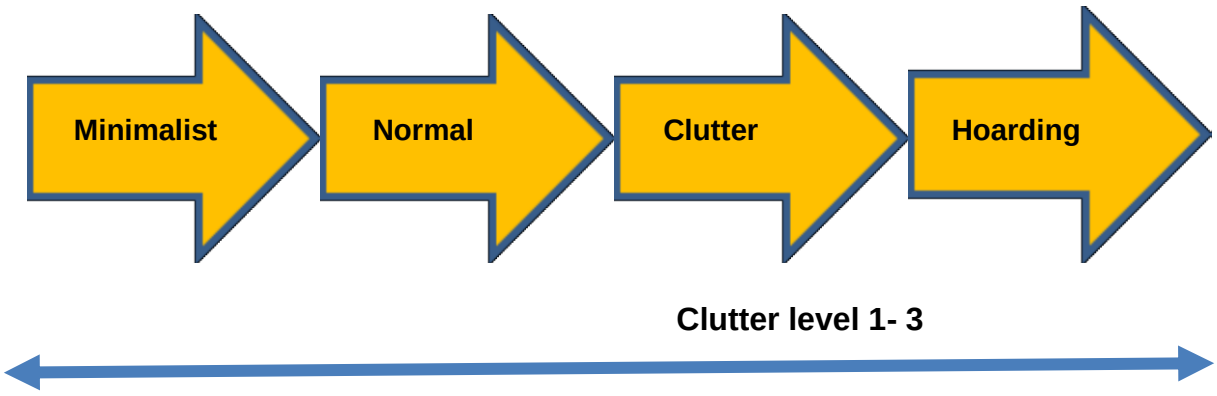
Listed below are examples of questions to ask where you are concerned about someone's safety in their own home, where you suspect a risk of self-neglect and hoarding.

Most adults with hoarding behaviour will be embarrassed about their surroundings and so the following questions should be adapted to suit the individual.

- how do you get in and out of your property? Do you feel safe living here?
- have you ever had an accident, slipped, tripped up or fallen? How did it happen?
- how have you made your home safer to prevent this (above) from happening again?
- how do you move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)?
- has a fire ever been started by accident?
- how do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested?

- do you ever use candles or an open flame to heat and light here or cook with camping gas?
- how do you manage to keep yourself warm, especially in the winter?
- when did you last go out in your garden? Do you feel safe to go out there?
- are you worried about other people getting into your garden to try and break-in? Has this ever happened?
- are you worried about mice, rats, foxes, or other pests? Do you leave food out for them?
- have you ever seen mice or rats in your home? Have they eaten any of your food or got upstairs and be nesting anywhere?
- can you prepare food, cook and wash up in your kitchen?
- do you use your fridge? May I have look in it? How do you keep things cold in the hot weather?
- how do you keep yourself clean? May I see your bathroom? Are you able to use your bathroom and use the toilet ok, have a wash, bath, and shower?
- can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)
- what do you do with your dirty washing?
- where do you sleep? Are you able to change your bed linen regularly? When did you last change them?
- how do you keep yourself warm at night? Have you got extra coverings to put on your bed if you are cold?
- Are there any broken windows in your home or any repairs that need to be done?
- because of the number of possessions you have, do you find it difficult to use some of your rooms? If so which ones?
- do you struggle with discarding things or to what extent do you have difficulty discarding (or recycling, selling, giving away) ordinary things that other people would get rid of?

CONTINUUM OF HOARDING BEHAVIOUR



Please use the clutter image rating below to assess what level the customer's hoarding problem is at:

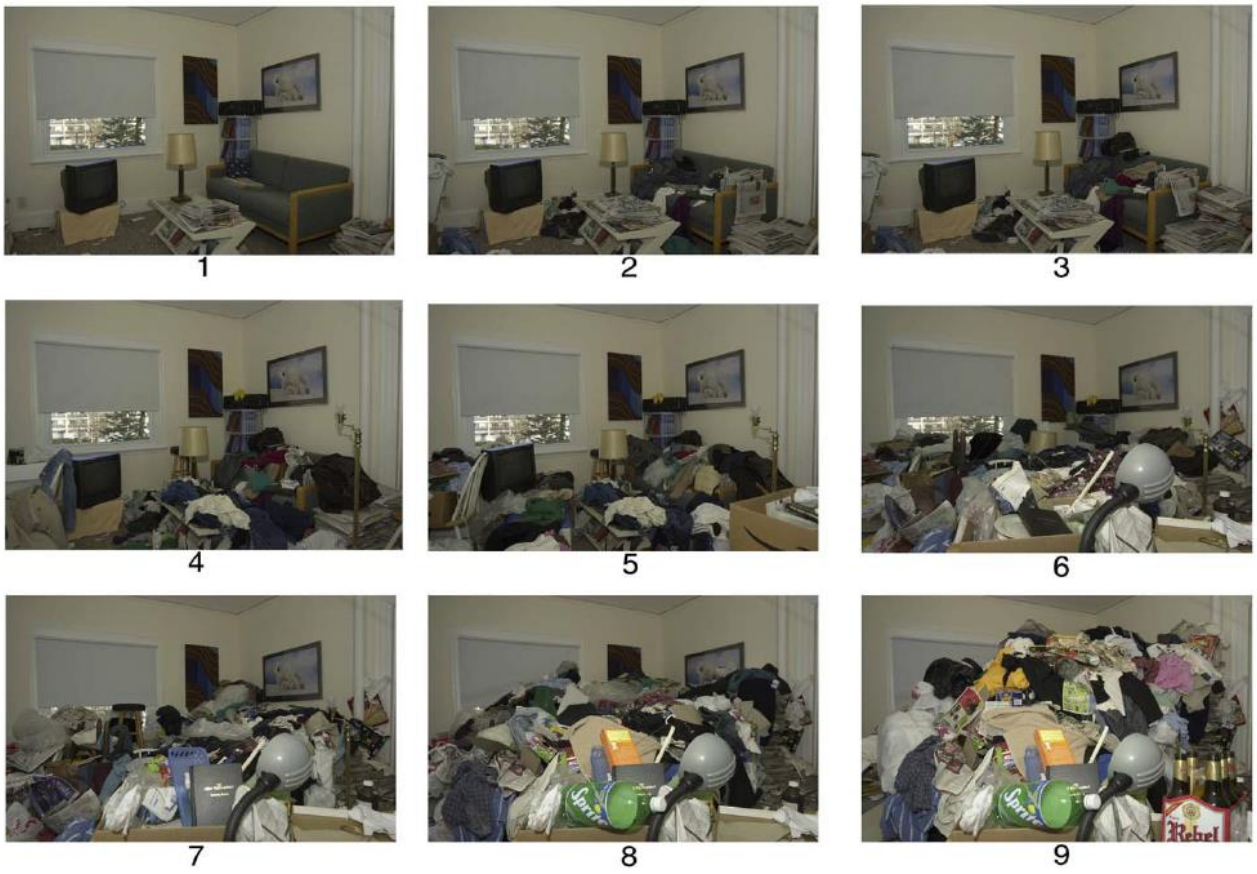
- Images 1-3 indicate level 1

- Images 4-6 indicate level 2
- Images 7-9 indicate level 3

Please note: the clutter images show hoarding of paper and household items, however, food waste, general rubbish, faeces, urine and vermin may also be present and this should be noted on the Hoarding Assessment Form.

CLUTTER IMAGE RATING SCALE - BEDROOM

CLUTTER IMAGE RATING SCALE – LIVING ROOM



CLUTTER IMAGE RATING SCALE - KITCHEN


1


2


3


4


5


6


7


8


9

Teeswide Safeguarding Adults Board

PRACTITIONER'S HOARDING ASSESSMENT

This assessment should be completed using the information you have gained using the Practitioner's Guidance Questions. Complete this review away from the client's property. Text boxes will expand to allow further text.

Date of Home Assessment				
Client's Name				
Client's Date of Birth				
Address				
Client's Contact Details				
Type of Dwelling				
Freeholder	Yes/No	Tenant - Name & Address of Landlord		
Household Members		Name	Relationship	DOB
Pets – indicate what pets and any concerns				
Agencies currently involved				
Non-Agency support currently in place				
Client's attitude toward hoarding				

Please Indicate if Present at the Property							
Structural Damage to Property	☐	Insect or Rodent Infestation	☐	Large Number of Animals	☐	Clutter Outside	☐
Rotten Food	☐	Animal Waste in House	☐	Concerns over Cleanliness of Property	☐	Visible Human Faeces	☐
Concerns of Self-Neglect	☐	Concerned for Children at the Property	☐	Concerned for Other Adults at the Property	☐		

Using the Clutter Image Scale, Please Score Each of the Rooms Below					
Bedroom 1		Bedroom 4		Separate Toilet	

Bedroom 2		Kitchen		Lounge	
Bedroom 3		Bathroom		Dining Room	

Provide a Description of the Hoarding Problem: (presence of human or animal waste, rodents or insects, rotting food, are utilities operational, structural damage, problems with blocked exits, are there combustibles, is there a fire risk? etc.)
Based on the information provided above, provide an overall clutter rating and level of risk below

Level 1 – Green	Level 2 – Orange	Level 3 – Red
Household environment is considered standard. No specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made subject to age and circumstances.	Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.	Household environment will require intervention with a collaborative multi agency approach with the involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents. Residents are often unaware of the implication of their hoarding actions and oblivious to the risk it poses.

Name of practitioner undertaking assessment	
Name of Organisation	
Contact Details	
Next Action to be Taken	
List Agencies Referred to with Dates and Contact Names	

APPENDIX D – CASE STUDIES

Elsie

An outline of Elsie's story was published in Community Care in September 2016
http://www.communitycare.co.uk/2016/09/28/self-neglect-someone-safeguard-elsies-story/

Mr M

Mr M, in his 70s, lives in an upper-floor council flat, and had hoarded over many years: his own possessions, items inherited from his family home, and materials he had collected from skips and building sites in case they came in useful. The material was piled from floor to ceiling in every room, and Mr M lived in a burrow tunnelled through the middle, with no lighting or heating, apart from a gas stove. Finally, after years of hiding in privacy, Mr M had realised that work being carried out on the building would lead to his living conditions being discovered. Mr M himself recounted how hard it had been for him to invite access to his home, how ashamed and scared he was, and how important his hoard was to him, having learnt as a child of the war never to waste anything.

Through working closely together, Mr M, his support worker and experienced contractors have been able gradually to remove from his flat a very large volume of hoarded material and bring improvements to his home environment. It has taken time and patience, courage and faith, and a strong relationship based on trust. The worker has not judged Mr M, and has worked at his pace, positively affirming his progress. Both Mr M and his support worker acknowledge his low self-esteem, and have connected with his doctor and mental health services. The worker has recognised the need to replace what Mr M is giving up, and has encouraged activities that reflect his interests. Mr M has valued the worker's honesty, kindness and sensitivity, his ability to listen and the respect and reciprocity within their relationship.

Ms J

Ms J is 69 and lives alone in a council tenancy. She is known to both Adult Social Care services and Mental Health services. She was admitted to hospital following a fall, which resulted in injury to her arm. She was reported to be under the influence of alcohol and to be covered in urine and faeces. Ms J discharged herself from hospital. The Police undertook a welfare call to Ms J and consequently made a referral to the local authority, reporting that she was still in the same condition as when she left hospital and that her home was dirty and soiled with evidence of lots of empty alcohol bottles and cans. Social workers from Adult Social Care visited Ms J. Ms J's ex-partner Mark had cleared the property and put the soiled bedding into the washing machine. Ms J's bed was very soiled and could not be totally cleaned. Mark said he had some money to buy a second hand bed but unfortunately the community resource was now closed. Mark was signposted to a new furniture service to buy a bed. He also picked up bedding from the food bank to have in reserve. Ms J did not want to attend formal services about her alcohol issues as she was too embarrassed and did not feel that there would be other people her age there. However she did consent to a referral to a floating support service. It was agreed that the floating support service would see Ms J every Wednesday morning and they would look at local groups to keep Ms J busy

during the day, as well as strategies to manage Ms J's alcohol use. It was agreed that the floating support service would update Adult Social Care on Ms J's progress.

Mr F

Mr F is 83 years old and has a medical condition that causes frequent bouts of diarrhoea. He has refused medical treatment for this but agreed to try and manage the side effects. However, Mr F is repeatedly admitted to hospital (26 occasions over a 28 month period) to treat dehydration and low potassium levels. Mr F would often discharge himself from hospital against medical advice.

Mr F receives four calls per day from a domiciliary care service to help with personal care, shopping and domestic tasks. However, he does not engage fully with the care package that has been arranged. He does not stop carers going into to his property but is very specific about what he will allow the carers to do.

An ambulance is often called when Mr F's condition deteriorates. Paramedics have submitted sixteen concerns in a 28-month period relating to Mr F living in squalid conditions and being emaciated. Concerns include: urine and faeces on furniture, walls and clothes; mouldy food; dirty incontinence pads in the bathroom; rubbish bags piled up; and an unsafe and unhygienic bathroom and kitchen.

Mr F's capacity has been assessed on numerous occasions in relation to decisions taken about his self-discharge from hospital against medical advice, and his refusal of care and help with domestic tasks that were included within his care plan. He is assessed as having mental capacity as he does not have an impairment of the mind or brain. Various professionals have repeatedly revisited the issue of his mental capacity given the seriousness of the concerns.

The case required multi-agency oversight and management via safeguarding adult's procedures to ensure that all possible options to reduce risks to Mr F had been explored. The social worker involved in the case identified that it took time (and creativity) to build up a relationship with Mr F and to gain his trust. The domiciliary care service regularly communicates with Adult Social Care about any difficulties they have in delivering his care and any deterioration in his condition. There are continued assessments of Mr F's capacity and in accordance with his wishes he continues to live at home.