SELF – NEGLECT AND HOARDING TOOLKIT

Some key tools and top tips for decision making and defensible recording in cases of self-neglect

Safeguarding Adults

Deborah Barnett
debbarnett27@outlook.com
07500448877

Forward

Sheila just wanted friends and a community, but no one wanted her. No one understood, or even tried to understand the turbulence of her life. She was an odd character my grandmother. I am not sure whether it was a cultural difference, a mental illness, a generational perspective, or maybe all these things that made her seem so different to me. I never knew her birthday, nor her age. I didn't know where she was brought up, or what her family were like. I piece together bits of information and try to create a picture of my family background, like a jigsaw puzzle, deeply frustrating with many pieces missing.

Sheila's history is of both Jewish and Gypsy traveler background and having lived through the war I suspect that she either didn't know her birthday, or was too afraid to give too many details to anyone. Sheila identified as 'a traveler' and lived in caravans and canal boats most of her life. My grandfather seems to have been very distantly related to Sheila's family, although there is even less detail about his family history. My grandfather spent the last of the war years working on the Burma Railway. Not long after the war my mother and her brother were born and Sheila left the travelling community to settle into a house with her family. Sheila had been ostracis
ed from many different communities in her life, always finding safety in the travelling community, however, when she moved into a house her own community rejected her.

When my mother was six and her brother four years old their father died of Tuberculosis, contracted during the war. Sheila couldn't cope with the isolation of a home life with two small children without the wider community and returned to travelling, making amends with old friends. Sheila was afraid to take her children out into what she perceived to be a dangerous world full of prejudice. My mother and her brother were left in the care of an elderly neighbour, who struggled to look after them. Eventually Dr Banardo's came to their rescue and my mother and her brother travelled to Northumberland to be raised in care. Their identity, place of belonging, religious and cultural background all changed overnight. Church of England became the religion that my mother was raised with and a community of children, ever changing, came and went in her life. My mother rarely saw Sheila throughout her childhood.

I was nine years old the first time that I met my grandmother. Sheila said that she was unwell and no longer welcome in her community, she needed her family. My mother found a house for her and supported her to move close to us. Sheila and my mother were never really close, but I was curious and would stop by her house most nights after school. It was a festinating and sometimes scary house, full of small china cups, crystal balls, tarot cards, lacy table cloths and pictures of Shirley Temple that Sheila had drawn herself. Sheila talked about old traditions and tales of travelers. The stories were not your average fairy tale type story, they were tragedies and tales with some moral attached which often went over my head. It was a cluttered, but organised house, crammed full of things to explore.

Sheila would play the accordion and even after she finished playing she would sit rocking in her chair. The tea spoons were made of real silver and she would polish

them endlessly. I arrived at her house one day to find a pony tied to the drain pipe. I couldn't tell you where it came from, or where it went, but it certainly looked strange in the middle of a terraced street. I think this was the point that Sheila's mental health began deteriorating, but it was difficult to tell eccentricity from mental ill health.

Sheila was telling me a tale of the waterways and seas one day when water started flooding down the stairs. I ran out of the house and home, convinced that it was invoked by the tales that she told. Sheila's house was flooded and much of her furniture destroyed, the bath had been left running. This was the final straw for Sheila and again she upped sticks and left saying that she was going back to travelling.
When I was 13 years old my mother received a phone call from the Police to say that her mother had been found dead in a squat. My mother and I travelled to what she called her home. The Police said that I was not allowed in as it would be too distressing, so I stood at the door looking in and waiting. Four or five cats ran out of the open door past me and the smell of cat urine was so strong I lifted the sleeve of my parker coat to my nose. It seemed like I could taste the urine from the air. I peered inside and saw dark unpainted walls, bare wires, newspapers and articles piled high. Post it notes covered every surface, reminding Sheila of daily tasks. I could see one arm chair piled high with china and silver objects all tarnished a nicotine brown. I couldn't see a bed, or anywhere to cook. My mother came out of the house crying, holding a mass of newspaper clippings. Sheila had repeatedly advertised for friends, but it seemed that no one had answered. The Police said that she had died of Bronchial Pneumonia, she had neglected herself and had not eaten, or cleaned up and had been very isolated.

Would a neighbour not have recognised her distress and seek help? Did they see her as the nuisance squatter who made a mess? Did no one want to find out about her, her history, her culture, and her tales? Could no one engage with her enough to just make a little difference?

Sheila would have rejected traditional Western Medicine in favour of herbal remedies picked from a garden, or river bank. Sheila wouldn't go to the doctors or Social Services herself, she didn't have a home address, or date of birth to register and if she wouldn't, or couldn't tell her family her details, then most certainly she wouldn't tell the Authorities. Someone trying to understand her would have assisted her to get a little help, as long as once that help was sought it respected her values, her traditions, her way of life and recognised the personal sacrifices and traumas that she had suffered to maintain her culture. It would take a lot not to judge her, if you didn't know her back ground. It would be easy to say that it was her choice to live that way.
It was clear that Sheila's mental health had suffered, however, no one considered whether she was able to make decisions or not. Sheila would have become agitated if things were imposed upon her, however, she was desperately lonely and just wanted someone to work with her, to help her in a way that was meaningful to her. The Police identified that Sheila had been smoking in the property and along with the vast quantities of newspaper and urine, this had posed a significant fire risk to others in the block. Neighbours had complained, but this merely meant that Sheila refused to leave the property, even for food, for fear that she would not be allowed back in.

We shouldn't be afraid to make a safeguarding referral and make enquiries about a

person. We should ensure that once that referral is received that the person is treated with dignity and respect. We should ensure that culture and background are part of the assessment and that we work with the person rather than against them. Even if a person has lost capacity to make decisions, we need to support them in the best way possible and ensure that the responses are proportionate to the risks (Least restrictive), whilst considering their identity. It would have been an easy answer to place Sheila in residential care before she died, but it wouldn't have been the right answer for her. Who would have thought to find her a caravan? It might have saved her life.

Have a look at the self-assessment and consider these issues:

- No one recognised Sheila's situation as self-neglect
- No one identified the need to safeguard her
- No one assessed her capacity to make decisions
- No one tried to engage with her
- No one talked to her about her cultural and religious beliefs
- No one understood her life story
- No one fully assessed her needs, or addressed her housing situation
- Sheila was regarded as strange, obstructive, eccentric and labelled as 'bad'
- No one identified her failing mental health, but neighbours called her 'mad'
- Eviction and clearance was on the cards, but she would resist that. Authorities had tried to do that to her all her life
- No one tried to engage her with a community, or made an effort to find out about her passion for drawing, painting, open spaces and music
- Sheila should have had human rights, but who would have considered the Human Rights of someone who is labelled as mad and bad?

It is the person's life story that allows us insight into why things occur, the narrative that they hold on their life. This is the key to opening a door to a different, less isolated world, just listening and engaging will have a profound effect.

Don't be afraid of safeguarding a person, don't be afraid of assessing needs. When you do infiltrate a very personal space, a life of potential loss and disappointment, make sure that you are sensitive, proportionate, compassionate and think outside of the box.

1. Introduction

This toolkit is intended to be person centred and solution focused, utilising outcome based models of practice to work with people who hoard and self-neglect. The toolkit is for multi-agency use and would be particularly useful for Housing providers, adult and children's social care, Health workers and other agencies working with those who may be at risk of Hoarding or Self Neglecting.

Self-neglect and compulsive hoarding are highly complex and require a collaborative and integrated approach. This toolkit aims to ensure that practitioners are equipped with methods of working with people in a manner that is meaningful, co-ordinated multi agency partnership working. The toolkit aims to facilitate positive and sustainable outcomes for people, by involving them in the process at all stages. The toolkit provides guidance, advice, process maps, assessments and methods of working that can be utilised and adapted by organisations to meet the needs of the individuals that they work with. All examples that are used for hoarding for example can be adapted for self-neglect too.

The toolkit includes reference to pieces of legislation that may be relevant to working with people who hoard and or self-neglect. See Mental Capacity Act and Environmental Health powers

This is a toolkit and therefore the appropriate tools should be selected using professional judgement about the suitability of the tool for the person and the benefits to them in practice.

2. Who would use the toolkit?

There is an expectation that everyone engages fully in partnership working to achieve the best outcome for the person who hoards or self neglects, while meeting the requirements and duties of individual agencies. It would be expected the Housing workers, domiciliary care providers, Health workers, GPs, Children and Adult Social Care workers, Mental Health workers would find this toolkit useful. It is important to highlight the need for Safeguarding Adults Boards to encourage the engagement of Psychology services in working with people who hoard or self-neglect. The reason for hoarding and self-neglecting is often a trauma, loss or bereavement. By dealing with these issues through therapeutic interventions addressing issues such as attachment, trauma, loss, bereavement, self-esteem and motivation and not discussing the hoarding or self-neglect until this therapeutic process has occurred we have found that people can become motivated to clear the clutter or stop self-neglecting. Hoarding Disorder is a diagnosable mental illness and as such should offer a pathway into mental health services via the GP.

3. The Care Act 2014, Hoarding and Self-Neglect

The Care Act 2014 identifies Self Neglect as a safeguarding responsibility and defines self-neglect as covering a wide range of behaviours such as neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. Falling under the safeguarding policies and procedures means that all safeguarding adults duties and responsibilities apply. Some cases of self-neglect may solely be due to disability or inability and therefore may not require further enquiries to be made, if an assessment and care and support plan would meet those needs.

4. Eligibility Criteria for Safeguarding

The 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 safeguarding duties have a legal effect in relation to organisations other than the local authority on for example the NHS and the Police. Safeguarding a person who hoards or self neglects requires an enquiry into the reasons behind a person's hoarding and self-neglect. Agencies have a duty to share information with the Local Authority for safeguarding purposes. The Local Authority have a duty to make enquiries, provide advice, guidance and signpost. In some cases safeguarding procedures will be invoked by the Local Authority. Information within this toolkit is designed to be used in conjunction with safeguarding adult's policies and procedures and therefore consistent with Care Act 2014 guidance.

5. Aims

This toolkit aims to guide the practitioner through decisions and considerations for safeguarding purposes when supporting someone who self neglects.

6. Objectives of the toolkit

The objectives of this toolkit are to promote:

Investigation, Enquiry and Information Sharing

- To explore the problems associated with Hoarding and Self-Neglect from different professional and community perspectives

Co-ordinated responses and identify support mechanisms

- To support a person who hoards or self-neglects in a structured and systematic way.
- To ensure consistent approaches that utilise the resources of all agencies to promote a persons wellbeing
- To clarify agency responsibility in relation to Hoarding and self-neglect

Reduced need for compulsory solutions

- To support a person as soon as possible to promote wellbeing and prevent the need for compulsory clearance, legal responses or imposed sanctions

Person Centred Solutions

- To ensure that there is a process for planning solutions, tailored to meet the needs of the person
- To co-ordinate responses of professional support, monitoring, repairs, temporary or permanent re-housing

Best Practice around the wellbeing of the person

- To understand the underlying factors of Hoarding and Self neglect
- To recognise sensitive and supportive approaches
- To improve knowledge of legal frameworks
- To ensure that the person has control of their own decision making and risks taken (Mental Capacity Act

7. Why do people self-neglect / hoard and what are the risks?

People may self-neglect, or hoard for a variety of reasons:

- Inability to maintain own self-care and household chores
- Parents who hoard and or/ childhood neglect
- The impact of abuse or neglect
- The impact of domestic abuse
- The impact of loss or bereavement
- The loss of a job, house or status
- The loss of a strongly held value system
- The loss of independence as a result of an accident, trauma, major ill health or frailty

These losses can cause a person to lose self-esteem, feel less valued, experience a lack of power and control over their own life and people may feel upset, or ascribe negative characteristics to themselves such as guilt, lack of capability and shame.

People can lose trust in other people as a result of these losses and withdraw from personal human engagement. Sometimes attachments that were once formed with people are developed with objects, because objects can not hurt your feelings, do not leave you and there is more personal control over objects. Sometimes these same attachments are developed with animals. The objects can form a sense of security and form structure to a person's day.

When feeling such loss, the person seeks to control the anxiety and distress in a number of ways:

- Collecting things
- Maintaining control over things
- Seeking brief comfort and escape through use of alcohol or drugs
- Considering use in things and or recycling things to demonstrate positive contribution
- Self-harm or personal neglect
- Considering beauty in things when others do not
- Sentimental attachment and the need to preserve memories
- The joy of acquisition creates new purpose
- Rejection of traditional western medicine in favour of other cultural, herbal or environmentally / animal friendly options.

These coping mechanisms can become the cause of the problem, as excessive accumulation presents difficulty in managing daily tasks, exacerbating the personal lack of self-esteem by feelings of being unable to achieve that which others achieve regularly. Guilt, shame and self-deprecation increases and debilitate the person.

The impact of the trauma, or loss also has an effect on the person. Responses to trauma are often interpreted in the area of the brain used in high stress situations and utilise primitive responses; Fight, flight, freeze, flop. The person can resist intervention fighting to preserve personal autonomy, they can hide from others and feel like they are constantly running away from the intrusion of others, they can freeze and become unable to confront tasks that are required to maintain wellbeing or they can flop and become passive, feeling exhausted by the daily tasks to be achieved.

The same area of the brain used in response to trauma and loss does not have order, chronology or the ability to structure and plan things. The chronological memory is affected and the person's ability to plan and maintain order and cleanliness is damaged. The person is in a perpetual state of readiness in a crisis situation and the brain has not informed the person that the event is over because there is no time context within this area of our brain function. Instead this area of the brain focuses on the senses, preparing to respond to the crisis. What visual stimulus is there, what sounds can be heard, what is available for use as a tool, what can I prepare myself with in order that this does not happen again? Interestingly these aspects of sensory response equate to the qualities that people who hoard describe in the value of their goods.

People who self-neglect and refuse care, services and treatment are essentially self-harming. Refusing essential services will eventually result in discomfort and pain. Self-harm is described as a coping mechanism for those hoping to deal with the anxiety and overwhelming distress of loss, abuse, or neglect.

Social isolation and self-neglect are a toxic mix and will only result in increasing deterioration to physical and mental wellbeing. Added to the risk to personal wellbeing is:

- Fire risk
- Falls risk
- The risk from poor housing structures and lack of repairs
- Goods falling
- Nutritional risks
- Risk from insanitary conditions
- Risk to others

Without sensitive and lawful intervention, over a prolonged period of time there is a definite possibility that these behaviours will result in the death of the person concerned. The behaviours represent a continuum of deterioration towards a fatal final outcome and all public sector services have a duty to do everything that is within their lawful capability, to support the person in a manner that is appropriate and proportionate to their needs, to prevent this potential. In complex physical and emotional situations the prevention of deterioration can require greater resources and the partnership support of a number of agencies, willing and able to offer their services, without judgement or discrimination. The barriers presented as a result of the person's mechanisms to try and cope with the emotional turmoil experienced, should not be removed without consideration of what would support the person in the absence of current coping mechanisms. This requires comprehensive multi-agency assessment, early development of rapport and support to engage in gainful activities with others who have similar interests within the community. The person will need to develop self-worth through active and rewarding participation with others. Positive feedback is essential to provide direction, identity and belonging, qualities often described as missing by people who have suffered loss, bereavement, trauma, abuse or neglect.

Clearing clutter will only make things worse and the person is highly likely to begin collecting again, only this time feeling more powerless and less in control. The person may also be more suspicious of services and more likely to resist support.

8. Hoarding and Clutter Rating

Determining the level of hoarding and the person's responses to the collection of clutter can be a valuable tool to begin discussion regarding the risks. The clutter rating tool has been adapted for this purpose and to determine when consideration for safeguarding is required.

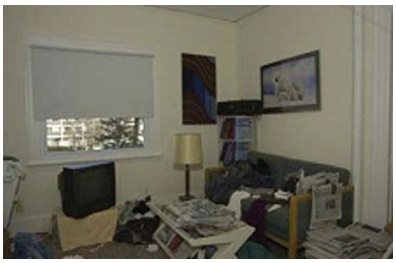
Adapted from Frost, RO, Steketee G, Tolin DF, Renaud S. Development and validation of the Clutter Image Rating. Journal of Psychopathology and Behavioral Assessment. 2008;32:401–417

Level 1



1	2	3

Low level clutter – Develop a rapport with the person concerned. Consider the person's ability to understand the tenancy agreement. Support person to engage with topics of interest and meet with others who have similar interest in local community - develop relationships.


1	2	3



Level 1 ***Clutter image rating 1 - 3***	Household environment is considered standard. No specialised assistance is needed.
1. Property structure, services & garden area	• All entrances and exits, stairways, roof space and windows accessible. • Smoke alarms fitted and functional or referrals made to fire brigade to visit and install. • All services functional and maintained in good working order. • Garden is accessible, tidy and maintained
2. Household Functions	• No excessive clutter, all rooms can be safely used for their intended purpose. • All rooms are rated 0-3 on the Clutter Rating Scale • No additional unused household appliances appear in unusual locations around the property • Property is maintained within terms of any lease or tenancy agreements where appropriate. • Property is not at risk of action by Environmental Health.
3. Health and Safety	• Property is clean with no odours, (pet or other) • No rotting food • No concerning use of candles • No concern over flies • Residents managing personal care • No writing on the walls • Quantities of medication are within appropriate limits, in date and stored appropriately.
4. Safeguard of Children & Family members	• No Concerns for household members
5. Animals and Pests	• Any pets at the property are well cared for • No pests or infestations at the property
6. Personal Protective Equipment (PPE)	• No PPE required • No visit in pairs required.

Level 2



4	5	6

Moderate clutter – Make a safeguarding referral. Identify most suitable person to engage with the person. Enquiries to consider why and when this began, capacity of person to make each relevant decision including capacity to understand tenancy agreement. Multi-agency response may be headed by the most suitable agency. Risk assessment required and work with the person concerned at their pace. Do not discuss removing any goods until rapport developed and full assessment of the person's needs, values and wishes conducted. Safeguarding duties and responsibilities apply.



4	5	6



Level 2 ***Clutter Image Rating 4 – 6***	**Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.**
1. Property structure, services & garden area	• Only major exit is blocked • Only one of the services is not fully functional • Concern that services are not well maintained • Smoke alarms are not installed or not functioning • Garden is not accessible due to clutter, or is not maintained • Evidence of indoor items stored outside • Evidence of light structural damage including damp • Interior doors missing or blocked open
2. Household Functions	• Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose. • Clutter is causing congestion between the rooms and entrances. • Room(s) score between 4-5 on the clutter scale. • Inconsistent levels of housekeeping throughout the property • Some household appliances are not functioning properly and there may be additional units in unusual places. • Property is not maintained within terms of lease or tenancy agreement where applicable. • Evidence of outdoor items being stored inside
3. Health and Safety	• Kitchen and bathroom are not kept clean • Offensive odour in the property • Resident is not maintaining safe cooking environment • Some concern with the quantity of medication, or its storage or expiry dates. • No rotting food • No concerning use of candles • Resident trying to manage personal care but struggling • No writing on the walls
4. Safeguard of Children & Family members	• Hoarding on clutter scale 4 -7 doesn't automatically constitute a Safeguarding Alert. • Please note all additional concerns for householders • Properties with children or vulnerable residents with additional support needs may trigger a Safeguarding Alert under a different risk.
5. Animals and Pests	• Pets at the property are not well cared for • Resident is not unable to control the animals • Animal's living area is not maintained and smells • Animals appear to be under nourished or over fed • Sound of mice heard at the property. • Spider webs in house • Light insect infestation (bed bugs, lice, fleas, cockroaches, ants, etc.)
6. Personal Protective Equipment (PPE)	• Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent. • PPE required.

Level 3



7	8	9

High level clutter – A safeguarding referral will be required. Where there is a risk to the persons physical and mental wellbeing safeguarding processes should be followed and a full multi-agency meeting held to plan the enquiry and assessment process.



7	8	9



Level 3 Clutter image rating 7 - 9	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 referral due to the significant risk to health of the householders, surrounding properties and residents.
1. Property structure, services & garden area	• Limited access to the property due to extreme clutter • Evidence may be seen of extreme clutter seen at windows • Evidence may be seen of extreme clutter outside the property • Garden not accessible and extensively overgrown • Services not connected or not functioning properly • Smoke alarms not fitted or not functioning • Property lacks ventilation due to clutter • Evidence of structural damage or outstanding repairs including damp • Interior doors missing or blocked open • Evidence of indoor items stored outside
2. Household Functions	• Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose. • Room(s) scores 7 - 9 on the clutter image scale • Rooms not used for intended purposes or very limited • Beds inaccessible or unusable due to clutter or infestation • Entrances, hallways and stairs blocked or difficult to pass • Toilets, sinks not functioning or not in use • Resident at risk due to living environment • Household appliances are not functioning or inaccessible • Resident has no safe cooking environment • Resident is using candles • Evidence of outdoor clutter being stored indoors. • No evidence of housekeeping being undertaken • Broken household items not discarded e.g. broken glass or plates • Concern for declining mental health • Property is not maintained within terms of lease or tenancy agreement where applicable • Property is at risk of notice being served by Environmental Health
3. Health and Safety	• Human urine and or excrement may be present • Excessive odour in the property, may also be evident from the outside • Rotting food may be present • Evidence may be seen of unclean, unused and or buried plates & dishes. • Broken household items not discarded e.g. broken glass or plates • Inappropriate quantities or storage of medication. • Pungent odour can be smelt inside the property and possibly from outside. • Concern with the integrity of the electrics • Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics. • Concern for declining mental health
4. Safeguard of Children & Family members	• Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert. • Please note all additional concerns for householders
5. Animals and Pests	• Animals at the property at risk due the level of clutter in the property • Resident may not able to control the animals at the property

	• Animal's living area is not maintained and smells • Animals appear to be under nourished or over fed • Hoarding of animals at the property • Heavy insect infestation (bed bugs, lice, fleas, cockroaches, ants, silverfish, etc.) • Visible rodent infestation
6. Personal Protective Equipment (PPE)	• May be required

9. 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?

The information gained from these questions will inform a Hoarding Assessment and provide the information needed to alert other agencies. Many people with a hoarding problem will be embarrassed about their surroundings, so adapt the question to suit your people.

- 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 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 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 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 in to your garden to try and break-in? Has this ever happened?
- Are you worried about mice, rats or 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? Could they be nesting anywhere?
- Can you prepare food, cook and wash up in your kitchen?
- Do you use your fridge? Can I have look in it? How do you keep things cold in the hot weather?
- How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Have a wash, bath? 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? 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, recycling, selling or giving away

10. Guidance on recording against the Risk Assessment Tools (See Tools after guidance)

The Risk Assessment Tool and Self-Neglect Assessment Tools are to be used as a guide or check list to determine the level of risk. The first assessment tool should be used in relation to forms of abuse perpetrated against the victim. The second risk assessment tool determines the level and risks posed by self-neglect.

Even if the risk is determined as low on the assessment, you can still raise an Alert and record a rationale if you have concerns. State what action you have taken to prevent deterioration of wellbeing for the person and prevent abuse from occurring.

In looking at the factors of abuse begin at the red column and work backwards. This will ensure that you are considering the level of investigation required and preserving any evidence for a potential police investigation.

If you are going to make a referral for Adult Protection Procedures to be invoked record the situation against the Risk Assessment Tool to provide a rationale. Any disagreement can be settled by a conversation about where professionals feel risk fits within the factors of the tool.

If a person does not consent, a referral can still be made where there is reasonable suspicion of a potential crime, risks to others, coercion or harassment of the person, or when it is in the public interest to do so. If a person lacks capacity to consent, a capacity assessment must be completed by the most relevant person and a Best Interests Decision made regarding the referral. The enquiry process will explore all these factors and determine safeguarding outcomes. It is part of the duties of the Local Authority to make these enquiries or cause others to make enquiries. Once the referral is made then the autonomous decision making of the person and proportionate responses with the least intrusion will be considered, however, no person has the right to impose risk or harm, or commit a crime against others and those who are requiring Mental Health Act assessments or are intimidated or coerced by domestic abuse situations are not in a position to provide consent.

Depending on the assessed level of risk, the needs of the person and the complexity of the situation, safeguarding responses may be:

- Low level advice, guidance or signposting.
- There may be an assessment of need required and a Social Worker allocated to conduct this.
- There may be aids and adaptations required and an OT allocated to assess and meet need
- The Local Authority may determine another agency better equipped to lead the enquiry, for example if Housing or Nursing services have been involved with the person over a long period of time and understand the person and situation better, they may in a better position to convene and chair multi-agency safeguarding arrangements, with support, oversight and guidance from the Local Authority
- The Local Authority may make multi-agency safeguarding arrangements

In using this guidance the eligibility criteria for safeguarding must be considered. The person should be aware of all parties involved and offered the opportunity to be fully involved, unless it would be unsafe to do so.

9 Factors

Risk Assessment Tool for Defensible Decision Making

1. Forms of abuse / neglect	Low risk		Moderate	High	Critical	Guidance (Defensible Decision Making -Please record a rationale against all 9 factors)
Physical						• Refer to the table overleaf. Types and Seriousness of Abuse. Look at the relevant categories of abuse and use your knowledge of the case and your professional judgement to gauge the seriousness of concern. • Low level incidents (column 1 & 2 overleaf) may be reported to the Local Authority as an Alert. Advice and guidance will be offered and potentially safeguarding actions requests monitored. Some cases will result in a S42 enquiry, others could be dealt with via staff training/supervision, care management and/or complaints procedures. Professional abuse can occur in relation to any of the categories listed left. **All cases of Female Genital Mutilation, Honour Based Crime, Sexual Exploitation, Forced Marriage, Grooming for terrorist activities, should be reported to the police and adult safeguarding immediately. See specific tool for Self Neglect. Domestic Abuse should also be considered in relation to safeguarding adults.** **This tool does not replace professional judgement not aim to set a rigid threshold for intervention. Note professional decision making reflects the fact that the type & seriousness of abuse may fall within the low risk category, other factors may make the issue more serious and therefore warrant progression via safeguarding procedures. All 9 factors are to be considered and recorded against. This should be used as a risk assessment tool rather than a screening tool. See eligibility for safeguarding.**
Sexual / Exploitation						
Psychological						
Financial						
Neglect						
Self-Neglect	See Specific Threshold Tool					
Organisational						
Discriminatory (hate / mate crime)						
Modern slavery						
Domestic Abuse						
Terrorist Activity						
2.The vulnerability of the victim	**Less vulnerable**		**More vulnerable**			• Can the adult protect themselves, and do they have the communication skills to raise an alert? • Does the person lack mental capacity? • Is the person dependent on the alleged perpetrator?
3.Patterns of abuse	Isolated incident		Recent abuse		Repeated abuse	Determine if the abuse is/was: • A one off incident? • A recent incident in an ongoing relationship? • A repeated abuse that has gone on for a length of time?
4.Impact of abuse on victims	Low impact				Seriously affected	• Impact of abuse does not necessarily correspond to the extent of the abuse • Sometimes serious acts can be withstood by an individual who has plenty of support; whereas even minor abuse can be devastating if perpetrated by someone who the person trusts or is the only source of support.
5.Impact on others	No one else affected		Others indirectly affected		Others directly affected	Other people may be affected by the abuse of another adult. Determine if: • No one else involved or witnessing the abuse? • Relatives or other residents/service users are distressed or affected by the abuse? • Other people are intimidated and/or their environment affected?
6.Intent of alleged perpetrator	Not intended				Deliberate/ Targeted	Determine if the abuse is/was: • Unintentional or ill informed? • Violent/serious unprofessional response to difficulties in caring? • Planned and deliberately malicious? ***The act/omission doesn't have to be intentional to meet safeguarding criteria**
7.Illegality of actions	Bad practice but not illegal		Criminal act		Serious criminal act	Seek advice if you are unsure if a crime has been committed. Try to determine: • Poor or bad practice (but not illegal)? • Whether it may be against the law? • If it is clearly a crime?
8.Risk of repeated abuse on victim		Unlikely to recur	Possible to recur	Likely to recur		Is the abuse: • Unlikely to happen again? • Less likely with significant changes e.g. training, supervision, respite, support • Very likely even if changes are made and/or more support provided?
9.Risk of repeated abuse on others	Others not at risk		Possibly at risk	Others at risk	Others at serious risk	Are others (adults and/or children) at risk of being abused: • Very unlikely? • Less likely if significant changes are made? • This perpetrator/setting represents a threat to other vulnerable adults or children?

Types of Abuse and Seriousness	These cases may be referred where the person has care and support needs and cannot protect themselves from abuse or neglect as a result of their care and support needs.		**The examples below are likely to indicate the need for a referral for formal procedures. If there is any immediate danger to an individual evident, call 999 straight away.**		
Level of Risk	**Minimal Risk**	**Low Risk**	**Moderate**	**High**	**Critical**
Physical	• Staff error causing no/little harm e.g. friction mark on skin due to ill-fitting hoist sling • Minor events that still meet criteria for 'incident reporting' accidents **Medication** • Adult does not receive prescribed medication (missed/wrong dose) on one occasion – no harm occurs	• Isolated incident involving service on service user • Inexplicable marking found on one occasion • Minor event where users lack capacity **Medication** • Recurring missed medication or administration errors that cause no harm	• Inexplicable marking or lesions, cuts or grip marks on a number of occasions • Accumulations of minor incidents **Medication**. • Recurring missed medication or errors that affect more than one adult and/or result in harm • Potential serious consequences	• Inappropriate restraint • Withholding of food, drinks or aids to independence • Inexplicable fractures/injuries • Assault **Medication** • Deliberate maladministration of medications • Convert administration without proper medical authorisation	• Grievous bodily harm/assault with a weapon leading to irreversible damage or death **Medication** • Pattern of recurring errors or an incident of deliberate maladministration that results in ill-health or death
Sexual / Exploitation	• Isolated incident of teasing or low-level unwanted sexualised attention (verbal or touching) directed at one adult by another whether or not capacity exists	• Minimal verbal sexualised teasing or banter	• Recurring sexualised touching or isolated/recurring masturbation without valid consent • Voyeurism without consent • Being subject to indecent exposure	• Attempted penetration by any means (whether or not it occurs within a relationship) without valid consent • Being made to look at pornographic material against will/where valid consent cannot be given	• Sex in a relationship characterised by authority inequality or exploitation e.g. staff and service user • Sex without valid consent (rape)
Psychological	• Isolated incident where adult is spoken to in a rude or other inappropriate way – respect is undetermined but no or little distress caused	• Occasional taunts or verbal outburst • Withholding of information to disempower	• Treatment that undermines dignity and esteem • Denying or failing to recognise adult's choice or opinion • Frequent verbal outbursts or harassment	• Humiliation • Emotional blackmail e.g. threats or abandonment/harm • Frequent and frightening verbal outbursts	• Denial of basic human rights/civil liberties, over-riding advance directive, forced marriage • Prolonged intimidation • Vicious/personalised verbal attacks
Financial	• Staff personally benefit from users funds e.g. accrue 'reward' points on their own store loyalty cards when shopping • Money not recorded safely and properly • Non-payment of care fees	• Adult not routinely involved in decisions about how their money is spent or kept safe – capacity in this respect is not properly considered	• Adult's monies kept in a joint bank account – unclear arrangements for equitable sharing of interest • Adult denied access to his/her own funds or possessions	• Misuse/misappropriation of property or possessions of benefits by a person in a position of trust or control • Personal finance removed from adult's control	• Fraud/exploitation relating to benefits, income, property or will • Theft
Neglect	• Isolated missed home care visit where no harm occurs • Adult is not assisted with a meal/drink on one occasion and no harm occurs • Adult not bathed as often as would like – possible complaint	• Inadequacies in care provision that lead to discomfort or inconvenience- no significant harm occurs e.g. being left wet occasionally • Not having access to aids to independence	• Recurrent missed home care visits where risk of harm escalates, or one miss where harm occurs • Hospital discharge without adequate planning and harm occurs	• Ongoing lack of care to the extent that health and wellbeing deteriorate significantly e.g. pressure wounds, dehydration, malnutrition, loss of independence/confidence	• Failure to arrange access to lifesaving services or medical care • Failure to intervene in dangerous situations where the adult lacks the capacity to assess risk
Organisational (any one or combination of the other forms of abuse)	• Lack of stimulation/opportunities for people to engage in social and leisure activities • Service users not given sufficient voice or involve in the running of the service	• Denial of individuality and opportunities for service user to make informed choice and take responsible risks • Care-planning documentation not person-centred	• Rigid/inflexible routines • Service user's dignity is undetermined e.g. lack of privacy during support with intimate care needs, sharing under-clothing	• Bad practice not being reported and going unchecked • Unsafe and unhygienic living environments	• Staff misusing their position of power over service users • Over-medication and/or inappropriate restraint used to manage behaviour • Widespread consistent ill-treatment
Discriminatory (Including hate / mate crime)	• Isolated incident of teasing motivated by prejudicial attitudes towards an adult's individual differences	• Isolated incident of care planning that fails to address an adult's specific diversity	• Inequitable access to service provision as a result of a diversity issue	• Being refused access to essential services • Denial of civil liberties e.g. voting, making a complaint • Humiliation or threats on a regular basis	• Hate crime resulting in injury/emergency medical treatment/fear for life

		• associated needs for a short period • Occasional taunts	• Recurring failure to meet specific care/support needs associated with diversity	• Recurring taunts	• Hate crime resulting in serious injury or attempted murder/honour-based violence •
Modern slavery	• All concerns of modern slavery or human trafficking are deemed to be of significant critical level		• Limited freedom of movement • Being forced to work with little or no payment • Limited or no access to medical / dental care	• Limited access to food or shelter • Regularly moved to avoid detection • No access or no passport or ID documentation	• Sexual exploitation / prostitution • Starvation • Organ harvesting • Imprisonment or unlawful detention • Forced marriage
Domestic Abuse (Please use the SafeLives DASH Risk Checklist to determine level of risk)	• Isolated one off incident consistent with other above categories (White column) within a family or with a current or past partner	• Occasional incidents (Blue Column) within a family or with a current or past partner	• Controlling behaviour • Limited access to medical and dental care • Limited access to funds • Power and control issues within relationship	• Accumulations of minor incidents, marks bruising or lesions • Frequent verbal / physical outbursts • No access / control over finances • Stalking • Relationship characterised by imbalance of power • Threatening or harming animals	• Pregnancy increases threat • Sex without consent • Forced marriage • Female genital mutilation • Honour based violence • Attempts to strangle, choke or suffocate
Terrorist Activity	• All concerns of grooming / activities for any form of extremist group should be reported immediately to the police and adult safeguarding. This could include extreme right wing activities, extreme animal rights activists or grooming for religious or cultural reasons.		• Changes in types of friends • Online activities that cause concern that person is changing views • Changes in mood or behaviour that may indicate change of perspective about religious or political ideology towards an extremist group	• Engaging with extremist demonstrations • Radicalisation • Advocating violence, threat of violence, or use of force to achieve goals on behalf of suspected terrorist organisation • Providing financial or material support to suspected terrorist organisation • Attempting to recruit people on behalf of suspected terrorist organisation	• Family ties or other close associations to known or suspected terrorist organisations • Statements that laws or perspectives of the country are destroying or suppressing people • Browsing or publicising on internet extremist perspectives • Statements or threats to kill or harm on behalf of potential terrorist organisations
If there are children within the household, or present at the time of the incident please consider contacting the Local Authority Children's Services regarding your concerns					

Self-Neglect and Hoarding Risk Assessment and Defensible Decision Making Tool

1. The vulnerability of the person	Less vulnerable	More Vulnerable		• Does the person have capacity to make decisions with regard to care provision / housing etc? • Does the person have a diagnosed mental illness? • Does the person have support from family or friends? • Are friends / family obstructive to services? • Does the person accept care and treatment?
2. Forms of Self-Neglect and Hoarding	Low risk	Moderate	High / Critical	• Refer to the tables following. Types and Seriousness of Hoarding and self-neglect. Look at the relevant categories of hoarding and self-neglect and use your knowledge of the case and your professional judgement to identify the seriousness of concern. • Incidents that might fall outside invoked Adult Protection procedures (Low Risk) could potentially be addressed via preventative measures such as engaging with the person, developing a rapport, supporting the person to address concerns, getting the person to engage with community activities and develop / repair relationships, access to health care and counselling (Do not under estimate the value of community engagement) • If a Social Worker or nurse is involved in the care of the person, report concerns to them as part of preventative measures in addition to the safeguarding referral.
Self Neglect				
Hoarding Property				
Hoarding household functions				
Hoarding Health and safety				
Hoarding Safeguarding				
3. Level of self-neglect / hoarding (See clutter rating scale for Hoarding)	Low risk	Moderate risk	High risk	Determine if the hoarding / self-neglect is: • A fire risk? • Impacting on the person's wellbeing (Care Act 2014 definition)? • Preventing access to emergency services? • Affecting the person's ability to cook, clean and general hygiene? • Creating limited access to main areas of the house? • Is the person at increased risk of falls?

4. Background to hoarding self-neglect	**Low impact**		**Seriously affected**	• Does the person have a disability that means that they cannot care for themselves? • Does the person have mental health issues and to what extent? • Has this been a long standing problem? • Does the person engage with services, support and guidance offered? • Are there social isolation issues? • When did self-neglect first begin? • What does the person want to happen?
5. Impact on others	**No one else affected**	**Others indirectly affected**	**Others directly affected**	Others may be affected by the self-neglect or hoarding. Determine if: • Are there other vulnerable people (Children or adults) within the house affected by the persons hoarding / self-neglect? • Does the hoarding / self-neglect prevent the person from seeing family and friends? • Are there animals within the property that are not being appropriately cared for?
6. Reasonable suspicion of abuse	**No suspicion**	**Indicators present**	**Reasonable suspicion**	Determine if there is reason to suspect: • That the hoarding self-neglect is an indicator that the person may be being abused • The person may be targeted for abuse from local people • That a crime may be taking place • That the person is being neglected by someone else • That safeguarding is required for additional safeguarding reasons *Follow your safeguarding policies and procedures
7. Legal frameworks	**No current legal issues**	**Some minor legal issues not currently impacting**	**Serious legal issues**	Try to determine whether: • The person is at risk of eviction, fines, non-payment issues • There is an environmental risk that requires action – Public health issues • There are safeguarding and animal welfare issues • Fire risks that are a danger to others • Are there risks to others such as other adults or children?

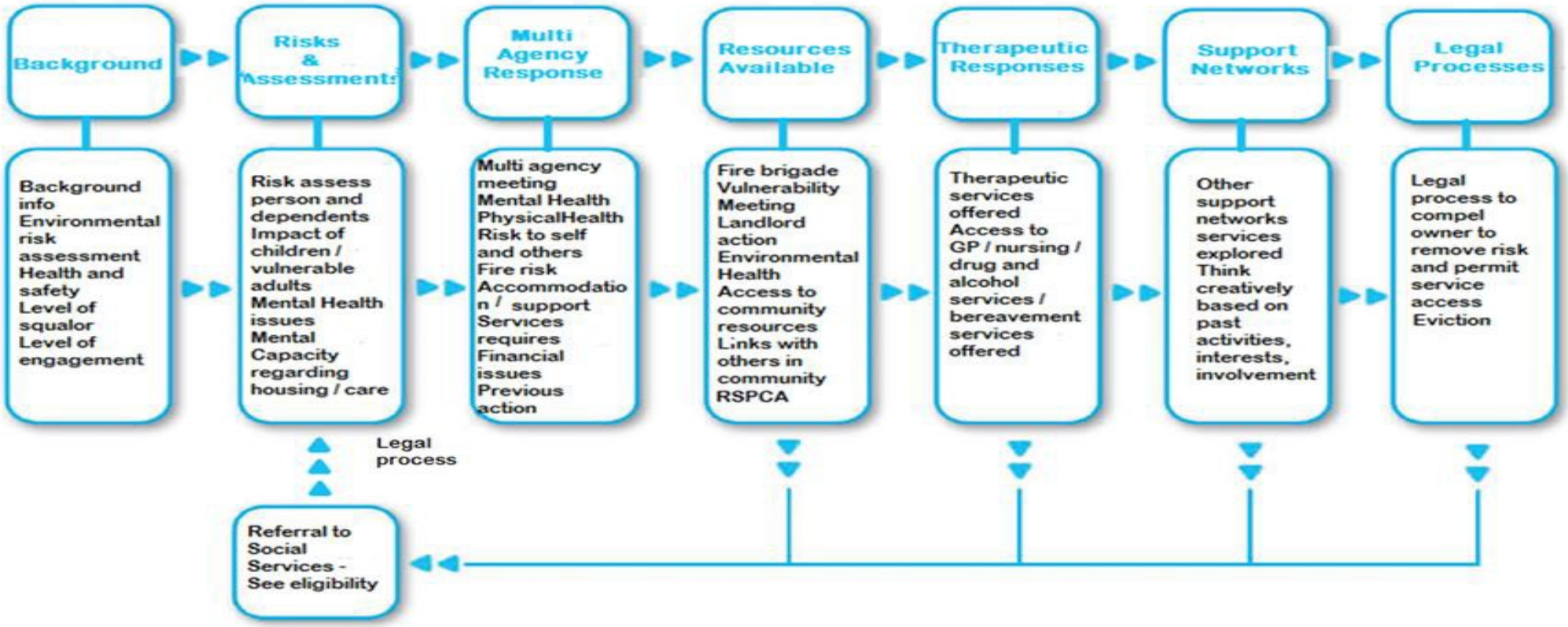
Types of Abuse and Seriousness	These cases may be referred where the person has care and support needs and cannot protect themselves from abuse or neglect, as a result of their care and support needs.	The examples below are likely to indicate the need for a referral for formal safeguarding procedures. If there is any immediate danger to an individual evident, call 999 straight away for ambulance, fire or police intervention. Following your referral an enquiry will take place to explore whether there are any issues of historical or current abuse / neglect impacting upon the person, determine a persons capacity to make each decision, to rule out anyone else who may be affected by the circumstances and to identify whether there are any potential Mental Health issues that need addressing. The safeguarding team may do this or they may advise individuals of actions and feedback required, or they may ask the most appropriate agency to conduct a multi agency meeting to achieve positive outcomes, have oversight of this and provide guidance.	
Level of Risk	**Minimal Risk**	**Moderate**	**High / Critical**
Self-Neglect	• Person is accepting support and services • Health care is being addressed • Person is not losing weight • Person accessing services to improve wellbeing • There are no carer issues • Person has access to social and community activities • Person is able to contribute to daily living activities • Personal hygiene is good	• Access to support services is limited • Health care and attendance at appointments is sporadic • Person is of low weight • Persons wellbeing is partially affected • Person has limited social interaction • Carers are not present or prevent intervention • Person has limited access to social or community activities • Persons ability to contribute toward daily living activities is affected • Personal hygiene is becoming an issue	• The person refuses to engage with necessary services • Health care is poor and there is deterioration in health • Weight is reducing • Wellbeing is affected on a daily basis • Person is isolated from family and friends • Care is prevented or refused • The person does not engage with social or community activities • The person does not manage daily living activities • Hygiene is poor and causing skin problems • Aids and adaptations refused or not accessed
Hoarding Property	• All entrances and exits, stairways, roof space and windows accessible. • Smoke alarms fitted and functional or referrals made to fire brigade to visit and install. • All services functional and maintained in good working order. • Garden is accessible, tidy and maintained	• Only major exit is blocked • Only one of the services is not fully functional • Concern that services are not well maintained • Smoke alarms are not installed or not functioning • Garden is not accessible due to clutter, or is not maintained • Evidence of indoor items stored outside • Evidence of light structural damage including damp • Interior doors missing or blocked open	• Limited access to the property due to extreme clutter • Evidence may be seen of extreme clutter seen at windows • Evidence may be seen of extreme clutter outside the property • Garden not accessible and extensively overgrown • Services not connected or not functioning properly • Smoke alarms not fitted or not functioning • Property lacks ventilation due to clutter • Evidence of structural damage or outstanding repairs including damp • Interior doors missing or blocked open • Evidence of indoor items stored outside

Hoarding – Household functions	• No excessive clutter, all rooms can be safely used for their intended purpose. • All rooms are rated 0-3 on the Clutter Rating Scale • No additional unused household appliances appear in unusual locations around the property • Property is maintained within terms of any lease or tenancy agreements where appropriate. • Property is not at risk of action by Environmental Health.	• Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose. • Clutter is causing congestion between the rooms and entrances. • Room(s) score between 4-5 on the clutter scale. • Inconsistent levels of housekeeping throughout the property • Some household appliances are not functioning properly and there may be additional units in unusual places. • Property is not maintained within terms of lease or tenancy agreement where applicable. • Evidence of outdoor items being stored inside	• Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose. • Room(s) scores 7 - 9 on the clutter image scale and not used for intended purpose • Beds inaccessible or unusable due to clutter or infestation • Entrances, hallways and stairs blocked or difficult to pass • Toilets, sinks not functioning or not in use • Resident at risk due to living environment • Household appliances are not functioning or inaccessible and no safe cooking environment • Resident is using candles • Evidence of outdoor clutter being stored indoors. • No evidence of housekeeping being undertaken • Broken household items not discarded e.g. broken glass or plates • Concern for declining mental health • Property is not maintained within terms of lease or tenancy agreement where applicable and is at risk of notice being served by Environmental Health
Hoarding – Health and Safety	• Property is clean with no odours, (pet or other) • No rotting food • No concerning use of candles • No concern over flies • Residents managing personal care • No writing on the walls • Quantities of medication are within appropriate limits, in date and stored appropriately. • Personal protective equipment is not required	• Kitchen and bathroom are not kept clean • Offensive odour in the property • Resident is not maintaining safe cooking environment • Some concern with the quantity of medication, or its storage or expiry dates. • No rotting food • No concerning use of candles • Resident trying to manage personal care but struggling • No writing on the walls • Light insect infestation (bed bugs, lice, fleas, cockroaches, ants, etc.) • Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent. • Personal Protective Equipment required.	• Human urine and or excrement may be present • Excessive odour in the property, may also be evident from the outside • Rotting food may be present • Evidence may be seen of unclean, unused and or buried plates & dishes. • Broken household items not discarded e.g. broken glass or plates • Inappropriate quantities or storage of medication. • Pungent odour can be smelt inside the property and possibly from outside. • Concern with the integrity of the electrics • Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics. • Concern for declining mental health • Heavy insect infestation (bed bugs, lice, fleas, cockroaches, ants, silverfish, etc.) Visible rodent infestation

Hoarding – Safeguarding of Children, family members and / or animals	• No Concerns for household members	• Hoarding on clutter scale 4 -7 make a safeguarding Alert, enquiries need to take place • Please note all additional concerns for householders • Properties with children or vulnerable residents with additional support needs may trigger a Safeguarding Alert	• Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert. • Please note all additional concerns for householders
RESPONSIBILITY	**All workers to engage with the person, develop a rapport, supporting the person to address concerns, getting the person to engage with community activities and develop / repair relationships, access to health care and counselling, improve wellbeing – Preventative measures**	**Workers to follow the processes identified by local procedures for Safeguarding and use resources in the toolkit. Consult with Local Authority Safeguarding Adults for advice and guidance. Inform Social Worker or Nurse if involved with person.**	**Referral to Social Services Safeguarding Adults and follow Local Authority Safeguarding Procedures. Use resources in the toolkit**

Please remember that safeguarding is everyone's business. For cases of self-neglect / hoarding a multi-agency response is required even if your Local Authority Safeguarding Team decide that they are not going to invoke safeguarding procedures. Remember that the Mental Capacity Act requires agencies to determine whether the person has the capacity to consent to actions, tenancies, repairs, services, assessments etc. It is likely that a number of agencies will be required to conduct capacity assessments, or support someone to undertake capacity assessments with the person self-neglecting. Other forms of abuse or neglect must be ruled out. See the 'Ten Steps' and assessment processes.

Self Neglect and Hoarding - A Journey of Support



We have an obligation to ensure the safety of others. This may mean that planning is not just about the individual with whom we are working and therefore may have limitations or restrictions on their choice. Some examples of this may be where there is a fire risk, safeguarding concerns for children or other vulnerable adults, where there is reasonable suspicion of a crime, risks to animals, public health issues. We must record referrals that we have made. In addition to this the person may not have choice when their mental wellbeing is significantly affected and they require detention under the Mental Health Act, for their own safety and wellbeing and that of others. After all other considerations have been made we must differentiate between the persons own autonomous decision making where they have the capacity and ability to make a decision, even if we consider this to be an unwise decision and that where we must assess capacity and make Best Interest decisions under the Mental Capacity Act. If a person has capacity and is considered to be making an unwise decision, this does not mean that we should disengage with the person. We should record information and advice given, attempts at assessment and dates for review. The following form enables us record in a way that is defensible.

STAGE 1 (Raise a Safeguarding Alert with Local Authority and seek advice / guidance)

Risks to others must be a consideration – referrals must be made to protect others, with responses proportionate to the risk presented.

Is there a potential risk to others? (Consider safeguarding adults who may have care / support needs and children)
Is there a potential risk from others?
Is there a potential risk to animals?
Is there a potential fire risk?
Is there a potential public health risk as a result of vermin / flies / other?
Is there potential coercion / harassment affecting the decision making?
Is there a potential crime?

Inform the person that you must report :	Record that you have assessed risks to others and safeguarding issues. Move on to stage 2	Other info to consider: Insight, access to person, support networks
• safeguarding issues, ☐ • to the fire service, ☐ • to environmental health ☐ • to RSPCA ☐ • to police ☐ • other ☐		

Date discussed	Provide reasons for referrals, document discussion below. Move on to stage 2	Who did you report to? outcome	Action to be taken /
Document discussion			

STAGE 2

Is a multi-agency meeting required? Are there a number of capacity assessments that may require particular expertise, or issues / risks / tasks that require sharing?

Does the person have Mental Health problems that may require a referral to the Mental Health Team?
YES
Record action taken:

NO
Move on to next question

Does the person **have capacity** with regard to: *Please list each financial, care, treatment, safeguarding, housing etc decision assessed and state whether the person is capacitated(Use MCA assessment). Record information, advice, guidance given, get the person to sign and continue monitoring.*	Does the person **lack capacity** with regard to: *Please list each aspect; Finance, care, treatment, safeguarding, housing etc decision assessed and state if the person is not capacitated. Do MCA assessment, consult, get advocate, make best interest decision.*
Capacity can be assumed unless there is reason to assess. A person self-neglecting would be reason enough to warrant assessing their capacity to make each relevant decision. Each agency is responsible for their own capacity assessments. Where the person is limiting agencies access, each agency will be responsible for writing a list of questions for the professional able to gain access to ask in an effort to determine whether the person has capacity to make that decision.	**You must make the distinction between:** **The persons thought out, autonomous, capacitated decision making (Their responsibility to act or not, even when considered an unwise decision)** **and** **A person who does not have capacity and your responsibility to act or establish appropriate, proportionate, least restrictive support in the persons best interests (Defensible Decision Making)**

Finance	For example: 1. Paying bills – X has capacity to make decisions with regard to bill paying. X receives x benefits to cover payments. Payment not made. Supported to access Citizens Advice and given leaflets about managing bills. Informed X that they could be evicted for not paying rent. X signed or

Finance	
Personal hygiene	
Care provision	
Medical treatment	
Safeguarding	
Housing (Tenancy and repairs)	
Aids & Adaptations	
Assistive technology	
Other	

NOTE: If a person has capacity to make an autonomous decision, even if it appears unwise, then you do not have their consent to provide, care, treatment services. You can share information without consent where there may be a crime, risks to others or they are being coerced / harassed into making that decision. If you consider the person to lack capacity to make a decision then the person who needs consent to provide the care, treatment or service must undertake a capacity assessment (MCA) and make a best interest decision that is the least restrictive option.

If you are concerned that the persons self-neglecting behaviors may lead to their death then a sensitive assessment will need to determine whether this is an autonomous and capacitated decision made by the person to self-neglect in an effort to die. These concerns may need to be escalated to legal services and / or the court of protection to utilise the inherent jurisdiction of the court where grief or trauma is thought to be significantly impacting on their self-worth and psychological thought processes.

11. Mental Capacity

The Mental Capacity Act 2005 provides a statutory framework for people who lack capacity to make decisions for themselves. The act has 5 statutory principles and these are the values which underpin the legal requirements of the act. They are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practical steps have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this act for or on behalf of a person who lacks capacity must be done, or made in his or her best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

When a person's hoarding behaviour poses a serious risk to their health and safety, intervention will be required. With the exception of statutory requirements, any intervention, or action proposed must be with the customer's consent. In extreme cases of hoarding behaviour, the very nature of the environment *should* lead professionals to question whether the customer has capacity to consent to the proposed action or intervention and trigger a capacity assessment. This is confirmed by The MCA code of practice which states that one of the reasons why people may question a person's capacity to make a specific decision is "the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision" (4.35 MCA Code of Practice, P. 52). Arguably, extreme hoarding behaviour meets this criterion and an assessment should take place. Consideration must be given where there is dialogue, or situations that suggest a person's capacity to make decision with regard to their place of residence or care provision may be in doubt.

Any capacity assessment carried out in relation to self-neglect / hoarding 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 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". Due to the complexity of such cases, multi-agency meetings to coordinate capacity assessments may be required. Where the person denies access to professionals the person who has developed a rapport with the person self-neglecting will need to be supported by the relevant agencies to conduct capacity assessments.

In particularly challenging and complex cases, it may be necessary for the local authority to refer to the Court of Protection to make the best interests decision. Any referral to the Court of Protection should be discussed with legal services and the relevant service manager.

What is the difference between competency and capacity and why is this important when working with people who self-neglect and / or hoard?

Competency

To be competent means that the overall function of the brain is working effectively to enable a person to make choices, decisions and carry out functions. Often the mini mental state test is used to assess competency. In many people who have for example Dementia, Parkinson's or Huntington's disease the first aspect of brain function affected is the executive function and unfortunately this is not tested very effectively using the mini mental state test.

Executive Function

The executive function of the brain is a set of cognitive or understanding / processing skills that are needed to plan, order, construct and monitor information to set goals or tasks. Executive function deficits can lead to problems in safety, routine behaviours, voluntary movements and emotional wellbeing – all associated with self-neglect and hoarding behaviours. The executive functions are the first to be affected when someone has for example Dementia.

Capacity

Capacity is decision making ability and a person may have quite a lack of competency, but be able to make a specific decision. The decision making ability means that a person must be able to link the functional demands- the ability to undertake the tasks, the ability to weigh up the risks and the ability to process the information and maintain the information to make the decision. In some way shape or form the person has to be able to let the person assessing them know that they are doing this. Many competent people make what others would consider to be bad decisions, but are not prevented from taking risks and making bad decision. This is not a sign that a person lacks capacity to make the decision, just that they have weighed everything up, considered the factors and determined that for them this would be what they wanted. The main issue in the evaluation of decision-making capacity is the process of making the decision, and not the decision itself.

Why do I need to know this?

This is important because the first test of the capacity assessment states is there an impairment of the brain function or mind? Someone who hoards or self neglects can take huge risks with their own health and often professionals assess the person as having capacity, as they are deemed competent. The person is therefore deemed to not meet criteria for a capacity assessment and is said to be making poor decisions that are autonomous and therefore they are able to make this choice without professional intervention. If you are concerned then an assessment of the executive functions of the mind would support the capacity assessment in the functional aspect (Part 1).

The second part of the test should be directly related to the first part. This means that a person can only be said to lack capacity if the reason for the inability e.g to understand the decision to be made, weigh up the risks and positives of a situation, retain and communicate the decision, directly links to the functional aspect of the test or the impairment of the brain function or mind. If the first element of the test is not accurately assessed then this creates difficulty in understanding whether the person can undertake these decision making skills.

Decisions should not be broad decisions about care, services or treatment, they should be specific to a course of action. If a practitioner requires the consent, agreement, signature or understanding of the individual, then they should determine the capacity of the person to consent to that action using the assessment process defined in the Mental Capacity Act (2005). This may be for tenancy, individual treatment options, aspects of care offered, equipment required, access to services, information sharing or any intervention. If you understand the course of action being proposed and offered to the person, then you will be the person required to assess the individual's capacity to consent to the proposed care, service or treatment. If there is only one agency able to gain access to the person, all agencies are responsible for developing questions for that agency to ask to determine their capacity as well as is practicably possible.

Some examples may be:

Housing – The housing officer understands the tenancy agreement, therefore they will be the appropriate person to determine whether the person understands the tenancy agreement. The Housing Officer will need to conduct (And record) a capacity assessment where there is doubt about the person's ability to provide consent. If the person is deemed to lack capacity to make that decision a 'Best Interest' decision must be made. A third party cannot sign a tenancy agreement on behalf of another person unless they have Court Appointed Deputyship or a Lasting Power of Attorney that specifies such actions under 'Finance'

Health – If a health professional is proposing a course of treatment, medication or intervention, they understand the intervention proposed, therefore they are the person to determine whether the person self-neglecting understands the intervention. If the Health professional doubts the person's ability to understand they must conduct (And record) a capacity assessment. If the person is deemed to lack capacity to make that decision a 'Best Interest' decision must be made. A third party cannot give consent on behalf of another person unless they have Court Appointed Deputyship or a Lasting Power of Attorney that specifies such actions under 'Welfare'

Occupational Therapy – The Occupational therapist (OT) understands the rehabilitative process / equipment required by the person to meet their needs. If the person does not appear to understand then the (OT) must assess the persons capacity to make a decision about the proposed equipment.

Capacity Assessment

1

Is there an impairment or disturbance of the functioning of brain or mind? (Permanent or temporary?

NO

The person has capacity to make their own decisions including unwise decisions (Remember 10 steps)

Yes

Functional Test

2

With all possible help given the person is able to understand the information relevant to the decision

Yes / No

&

Are they able to retain the information long enough to make the decision?

Yes / No

&

Are they able to weigh up the information, consequences, risks pro's con's to make the decision?

Yes / No

&

Are they able to communicate their decision in some way?

Yes / No

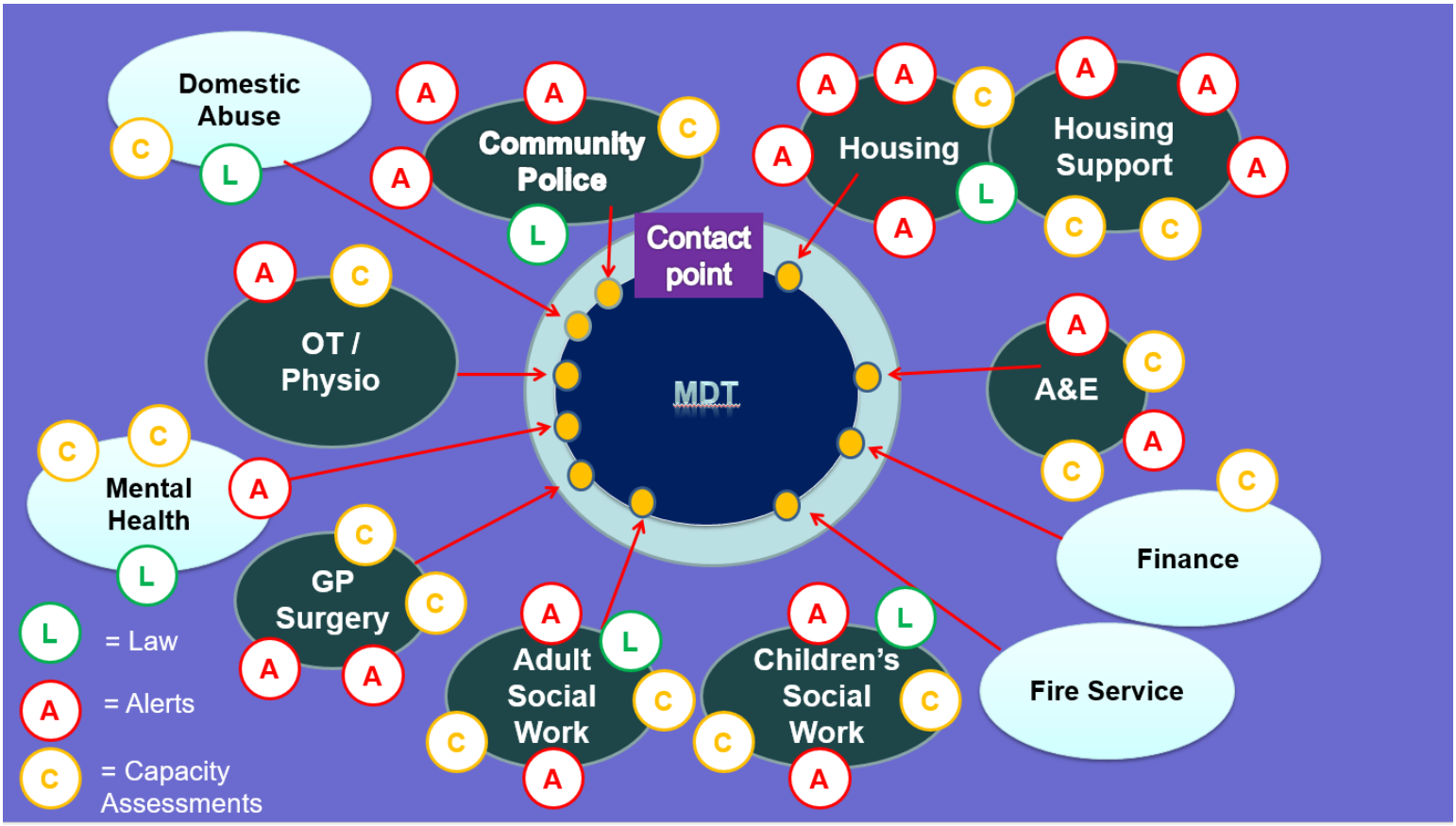
Yes

If the answer to <u>all four questions</u> in the functional test is <u>YES</u> the person has capacity to make that decision – record capacity assessment, information and advice given and the persons chosen action

No

If the answer to <u>any one of the four questions</u> is <u>NO</u> then the person lacks capacity to make that particular decision

In a severe case of self-neglect there may be a number of agencies involved with the person / persons concerned. The safeguarding enquiry will not only require the coordination of risks to the person and others, depicted by the red 'A' sign for 'Alerts, but must also coordinate the required capacity assessments, depicted by the yellow 'C' signs.



12. Information Sharing

Information sharing will also have to be coordinated. Who will share information with the person self-neglecting, how will information be shared. Consider accessibility and the persons ability to access services and how appointments should be offered to the person. Methods of communication will also need to be coordinated, it is important that the person feels supported and not overwhelmed by the safeguarding process. The person's autonomous decision making (Where capacitated) will be central to this process. All decisions directly relating to the individual wishes, values and expectations will be made by the person concerned when they are capacitated. Your duty of care means that you must respect the autonomy of the person including the ability to make unwise decisions. The person has a right to private life that means autonomous decision making without the intrusion, or disproportionate intervention of professionals. When a person is deemed as lacking capacity to make a decision, then the least intrusive, least restrictive and most proportionate intervention should be considered with an emphasis on the wishes and values of the person.

In addition to the coordination of responses to risks, capacity assessments, comprehensive assessment, and information sharing, multiple agencies may have legislation that conflicts with each other. A Human Rights based approach considering all articles is required to coordinate legislative responses across the agencies.

Human Rights Most Relevant to Self-Neglect

Article 2
Right to Life

Article 3
Right not to be tortured or treated in an inhumane or degrading way

Article 4
No slavery or forced labour

Article 5
Right to Liberty

Article 7
No punishment without Law
All are equal before the law and are entitled without any discrimination to equal protection of the law. All are entitled to equal protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.

Article 8
Right to Respect for Private and Family Life

Article 9
Right to freedom of thought, conscience and religion

Article 14
Right not to be discriminated against in relation to any of the Human Rights listed here

Article 1, Protocol 1
Right to peaceful enjoyment of possessions

During the thematic review of the Safeguarding Adults Reviews conducted in cases of self-neglect a pattern was identified that suggested many Human Rights were violated including the right to Private life (Which includes the right to make autonomous decisions if capacitated to do so). Access to civil or criminal justice is rarely if ever identified as part of the lessons learned, however, reflecting on Lady Hales words in the Cheshire West case, 'If it is a violation of my rights then it is a violation of a disabled persons rights'. I am sure that should I be subject to criminal activity I would have access to criminal justice and if I had my Human Rights violated I would seek at the very least civil redress, to prevent this from happening to others. All are entitled to equal protection of the Law. Use of Human Rights places the person central to the decision making and ensures that single agency legislation is compatible with the rights of the person.

9 Golden Rules

1. **Remember that the Data Protection Act is not a barrier to sharing information** but provides a framework to ensure that personal information about living persons is shared appropriately

2. **If there are concerns that a child or an adult at risk of abuse or neglect, then it is your legal duty to share information** with the local authority for investigation purposes. If the adult has capacity to make informed decisions about their welfare and safety and they do not want action taken, this does not preclude the sharing of information with relevant colleagues. This is to enable professionals to assess the risk of harm to the person and others (Including potential crimes) and be confident that the adult is not being unduly influenced, coerced or intimidated and is aware of all the options. It is good practice to inform the adult that this is happening unless doing so would increase risk of harm.

3. **Be open and honest** with the person (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

4. **Seek advice** if you are in any doubt, without disclosing the identity of the person where possible.

5. **Share with consent where appropriate** and, where possible, respect the wishes of those who do not consent to share confidential information. You should go ahead and share information without consent if, in your judgement, that lack of consent can be overridden in the public interest, eg safeguarding adults or children at risk. Your judgement will be based on reasonable suspicion that abuse has occurred.

6. **Consider safety and well-being:** Base your information sharing decisions on considerations of the safety and well-being of the person and others who may be affected by their actions.

7. **Necessary, proportionate, relevant, accurate, timely and secure:** Ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those people who need to have it, is accurate and up-to-date, is shared in a timely fashion, and is shared securely.

8. **Keep a record** of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

9. **Never assume that someone else will pass on the information:** If you have concerns about the safety and wellbeing of a person and believe that they are suffering or likely to suffer abuse, share information with the local authority and the police

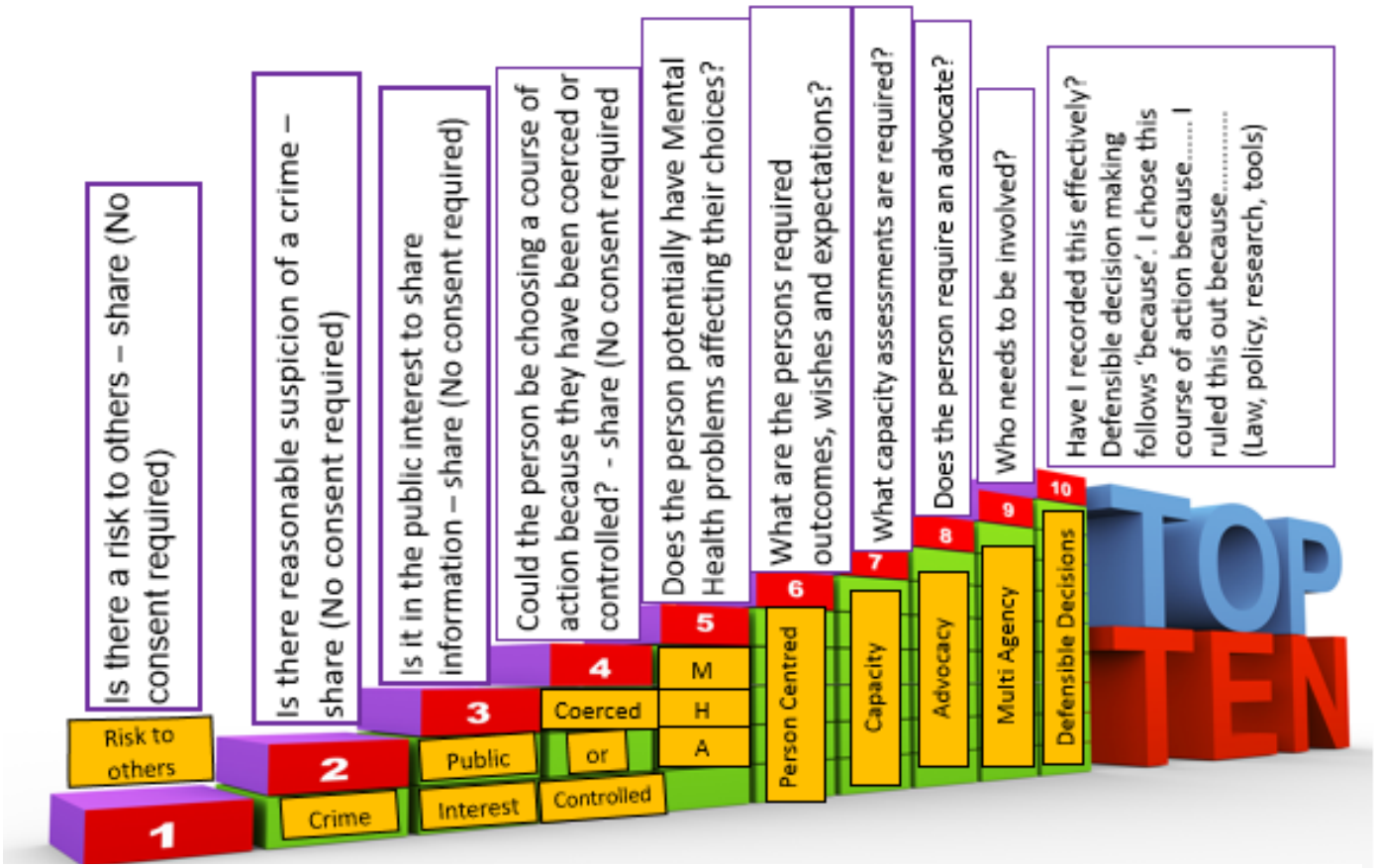
The
Care Act 2014 states that information sharing should be consistent with the principles set out in the Caldicott Review published 2013 entitled, "Information to share ornot to share: the information governance review" ensuring that:

Information will only be shared on a 'need to know' basis when it is in the interests of the adult;

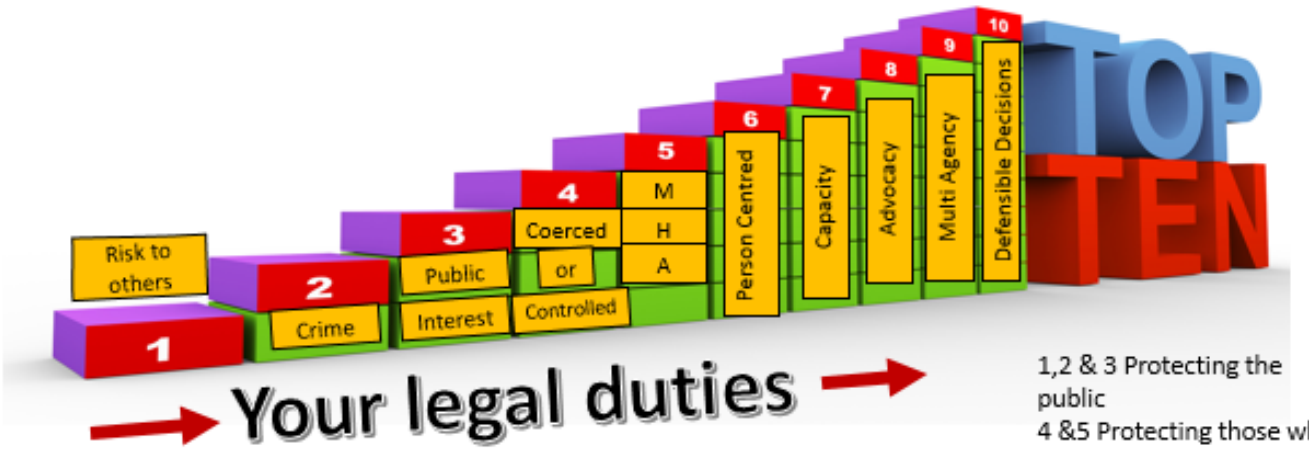
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.
- Where an adult has refused to consent to information being disclosed for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (See 9 Golden Rules) and wherever possible the Caldicott Guardian should be involved.
- Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework
- Principles of confidentiality designed to safeguard and promote the interests of an adult should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the welfare of an adult. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of the adult then a duty arises to make full disclosure in the public interest.

The decisions about what information is shared and with who will be taken on a case by-case basis. Whether information is shared and with or without the adult at risk's consent. The information shared should be:

- Necessary for the purpose for which it is being shared.
- Shared only with those who have a need for it.
- Be accurate and up to date.
- Be shared in a timely fashion.
- Be shared accurately.
- Be recorded proportionately demonstrating why a course of action was chosen – I did this se……
- **Ten Steps to Information Sharing and Decision Making**



Where a person is deemed to have capacity to make a decision, but does not consent to a safeguarding referral it may still be necessary to make a referral to the Local Authority in order that the S42 Care Act (2014) enquiry can consider the risk to others, potential crime, public interest issues, potential domestic abuse and coercive or intimidating behaviours, the mental health of the person and the capacity of the person to make all relevant decisions. The safeguarding responses must consider and respect autonomous decisions made by the person about their own care and the balance of risks presented by any response. Only relevant information should be shared with relevant people.



1,2 & 3 Protecting the public
4 &5 Protecting those who can not consent
6,7,8,9 Supporting and protecting the individual
10. Protecting ourselves

13. Practical Application

In assessing and working with a person who hoards we may need to consider whether a referral for diagnosis is required. Following the DMS-5 diagnostic criteria a structured interview process was developed (Nordsletten et al., 2013). The principles of diagnosis were further explored using scaling as a method of assessment in assisting the person who hoards to self-reflect. (Steketee and Frost, n.d.)

To consider whether someone has a hoarding disorder we may need to consider their **ability to discard things and the impact this has on them emotionally**. This might include their ability to throw things away, give things away, sell things or recycle things. It is useful to know how a person feels about getting rid of things and the level of distress that this causes the person. This would help determine whether there may be further Psychological assessments required or whether the clutter has another attributable reason. It may be useful to use a scaling system of 0-10 to establish the level of distress a person feels when discarding or being asked to discard objects. 0 = little or no distress, 10 = severe distress and anxiety.

The impact of the clutter on the person How does the person feel obtaining the items (The positive aspects). How would they feel if asked to stop **acquiring** the objects (Again you can use scaling to determine how they feel about this). How does the person feel about the clutter, how do they feel about others seeing the clutter and how does this affect them on a daily basis? Please refer to the clutter rating scale and ask the person to identify the image that most reflects the relevant rooms of the house, or complete this yourself if the person is not able to. Some people may not have insight into the level of distress caused by the clutter, or removal of objects. This may have to be sensitively tested in a hypothetical situation.

When hoarding behaviours began. If the hoarding has been problematic for a relatively short period of time, is there a reason why the person has so much clutter. Consider things such as a recent house move, inheritance, or other circumstances which might explain the clutter.

What kinds of things they hoard and what do they find most difficult to discard? There are usually themes and patterns to the persons collecting that are not instantly recognisable. It is helpful to explore this in some detail with the person to establish their themes e,g, animal hoarding, newspapers and books, food and food products, bric-a-brac, humorous items etc. It is useful to look at the differences between hoarding behaviours and collecting behaviours to determine this.

Does the person intentionally save the items? Does the person intentionally and actively seek to collect items or do they passively allow the items to accumulate? This helps in determining whether the person has a hoarding disorder.

Can rooms be used for their intended purpose? It is useful to decide how well each of the main living spaces can be accessed and utilised. It may be helpful to ask the person how they feel about each room of the house including, hallways, garages and loft areas. You might find it helpful to use a rating scale of 0 – 10 with 0 being I can easily use and access all the facilities in this room and 10 being I cannot access this room and safely use the facilities. Has anyone recently helped the person to remove any items and if so what, how and what volume? This helps to judge whether the situation would usually be worse.

Does the person have difficulty sorting objects, or identifying appropriate places? How would the person feel about organising a small area. Is the person able to identify a specific purpose for the object or are there multiple reasons for keeping the object?

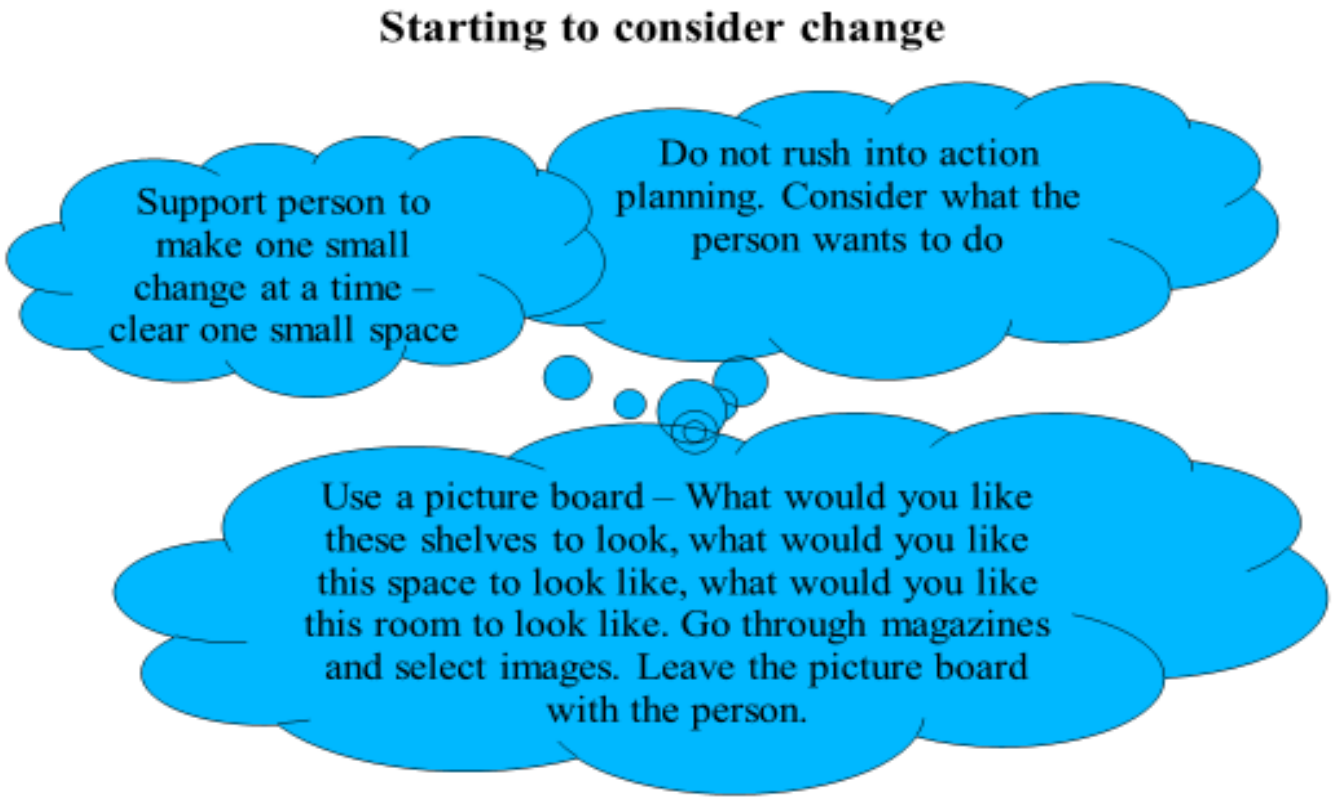
Is the person's ability to function socially and occupationally affected?

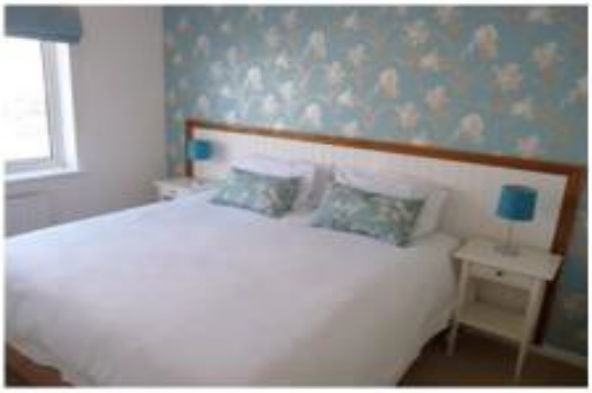
Some people who hoard can interact well with others outside the home environment and their friends and colleagues may be unaware of the difficulties they face at home. Family member perspectives can be useful. It is also very useful to determine to roles that family members play i.e do they live with the person, do they regard themselves as a carer for the person.

That hoarding is not associated with an inability to complete the tasks such as a learning disability, physical disability, Autistic Spectrum Disorder or other Psychiatric problem. If a person is hoarding because they cannot physically achieve the task, or because their Mental Health condition prevents them from achieving the task and they have little or no emotional connection to the items and therefore could discard the items without distress, a referral to the Local Authority will be required. This could be a safeguarding referral that would most likely result in a Social Work assessment to determine how these needs can be met

14. Beginning the Process of Change

Picture and story boards are a good way to engage a person. Ask the person where they would like to start organizing. It may be a shelf area or a table top. Begin small and in a place that the person feels would benefit them. Ask the person to find pictures or images of what they would like that space to look like. Get the person to establish small targets. Support sorting and organization of goods with positive reinforcement.





Keeping up the change

Monitor small steps and celebrate each success. Do not emphasise negatives of previous behaviour

Don't feel like it is your responsibility, do not take charge or control. Do not get too enthusiastic and push the person before they have moved on themselves. Do support them to access counselling or therapeutic services

Continue to explore and work to remove barriers

·Remember that the person may have times where they feel like change is impossible or that they can not manage the change

The Do's and Don'ts

When talking to someone who hoards DO NOT:	
	**Use judgmental language.** Like anyone else, individuals who hoard will not be receptive to negative comments about the state of their home or their character (e.g. "What a mess!" "What kind of person lives like this?") Imagine your own response if someone came into your home and spoke in this manner, especially if you already felt ashamed.
	**Use words that devalue or negatively judge possessions.** People who hoard are often aware that others do not view their possessions and homes as they do. They often react strongly to words that reference their possessions negatively, like "trash", "garbage" and "junk".
	**Let your non-verbal expression say what you're thinking.** People who hoard are likely to notice non- verbal messages that convey judgment, like frowns or grimaces and may notice negative body language.
	**Make suggestions about the person's belongings.** Even well-intentioned suggestions about discarding items are usually not well received by those hoarding. You must work at the pace of the person concerned
	**Try to persuade or argue with the person.** Efforts to persuade individuals to make a change in their home or behaviour often have the opposite effect – the person actually talks themselves into keeping the items.
	**Touch the person's belongings without explicit permission.** Those who hoard often have strong feelings and beliefs about their possessions and often find it upsetting when another person touches their things. Anyone visiting the home of someone with hoarding should only touch the person's belongings if they have the person's explicit permission

When talking to someone who hoards DO:	
	**Imagine yourself in that persons shoes.** How would you want others to talk to you to help you manage your anger, frustration, resentment, and embarrassment?
	**Match the person's language.** Listen for the individual's manner of referring to his/her possessions (e.g. "my things", "my collections") and use the same language (i.e. "your things", "your collections").
	**Use encouraging language.** In communicating with people who hoard about the consequences of hoarding, use language that reduces defensiveness and increases motivation to solve the problem (e.g. "I see that you have a pathway from your front door to your living room. That's great that you've kept things out of the way so that you don't slip or fall. I can see that you can walk through here pretty well by turning sideways. The thing is that somebody else that might need to come into your home, like a fire fighter or an emergency responder, would have a pretty difficult time getting through here. They have equipment they're usually carrying and fire fighters have protective clothes that are bulky. It's important to have a pathway that is wide enough so that they could get through to help you or anyone else who needed it. In fact, the safety law states that [insert wording about exits/ways out must be clear], so this is one important change that has to be made in your home".
	**Highlight strengths.** All people have strengths, positive aspects of themselves, their behaviour, or even their homes. A visitor's ability to notice these strengths helps forge a good relationship and paves the way for resolving the hoarding problem (e.g. "I see that you can easily access your bathroom sink and shower," "What a beautiful painting!", "I can see how much you care about your cat.")
	**Focus the intervention initially on safety and organisation of possessions and later work on discarding.** Discussion of the fate of the person's possessions will be necessary at some point, but it is preferable for this discussion to follow work on safety and organisation.

15. Why do Agencies Struggle in Cases of Self-Neglect

Key Factor	Impacting Issues	Potential Responses / Outcomes	Potential Solutions
Recognising and Reporting Self - Neglect	• No clear safeguarding procedures on self-neglect • No clear definition of when to refer to safeguarding and when to manage as a single agency • Inconsistent definitions of self-neglect • No clear models of intervention • No clear risk assessment tools • No specific training in self –neglect across all agencies	• Differing responses • Single agency left with complex case • No safeguarding procedures and multi-agency co-ordination • Inconsistencies in referrals to safeguarding • Defensive rather than solution focused practice	• Clear procedures on for safeguarding in cases of self-neglect • A Care Act based definition of self-neglect across all procedures • A specified model for intervention • Tools to assess the level of risk • Specific multi-agency training • Practice that works on the strengths of the individual and solutions rather than defensive practice
Recognising safeguarding as a response that addresses victim, perpetrator, family and community issues	• No recognition of the risks to others • No identification of the impact of behaviours on others e.g neighbours, family and carers	• Complaints criminalise or impose penalties on the person self-neglecting exacerbating their difficulties • Family and support withdraw • Stress of carers is not supported	• Earlier multi agency response • Co-ordinated responses with a key identified agency • Early rapport development with individual and family / carers

	• No carers assessments • Not recognising other forms of abuse such as mate crime, financial abuse and anti-social behavior	• Perpetrator risks are not investigated and addressed (Financial abuse, anti-social behavior of others, mate crime, physical and sexual abuse, neglect from carers)	• Address issues impacting on others via relavant legal frameworks • Safeguarding enquiries explore this issues
Recognising the need for S42 enquiries in cases of self-neglect	• Reluctance to make appropriate enquiries • Lack of understanding about S42 enquiries • Lack of understanding with regard to a person's consent for safeguarding • Lack of understanding about the various potential responses to a S42 enquiry	• Local Authorities wait until self-neglect escalates to a severe situation before intervening – often this is too late • Some Local Authorities think that there must be consent for safeguarding – in cases of self-neglect the enquiry should be to determine capacity and consent. This results in the Local Authority withdrawing support at a critical time of intervention • Some Local Authorities feel that if safeguarding procedures are invoked that they need to be the key enquirer, or person to chair the safeguarding meeting and therefore do not invoke procedures early enough. There may be better placed agencies to manage the safeguarding issues	• Lower level reporting of self neglect (3-6 on clutter rating scale) • Clear training on when consent is not required for safeguarding purposes • Multi agency training in chairing safeguarding meetings in cases of self-neglect • Single point of contact trained and qualified to effectively triage safeguarding cases including cases of self-neglect

		with advice and guidance from the Local Authority, maintaining compliance with safeguarding duties and responsibilities.	
Lack of understanding of the need to report 'Reasonable Suspicion of Abuse / Neglect'	• Agencies feel the need to investigate and therefore potentially destroy police evidence • Late police reporting • Inconsistent communication with Police • Accumulating risk is not identified	• Evidence is not preserved • Procedures are invoked at too late a stage to make a difference • Additional abuse and neglect is not explored • Carers who may be obstructive or disengage from care are not made aware of the potential consequences of their actions	• Multi-agency enquiry / investigation training relating to 'Police Powers of Arrest' and why this links with the safeguarding process • Training explores accumulating risk and preservation of evidence • Policies and procedures clearly state that we do not need to know that abuse / neglect has occurred but only need reasonable suspicion.
Misunderstanding capacity and consent	• Individual agencies do not accept responsibility for capacity assessments and are not made accountable for capacity assessments • Capacity assessments are not coordinated	• Capacity and consent is not assessed, recognised or recorded and potential responses to support the individual are missed • S42 enquiries do not explore the need to coordinate capacity assessments alongside risks • Advocacy and support is not considered	• The Safeguarding Adults Board to audit multi-agency capacity assessment standards • Multi-agency training in who does capacity assessments, when they are required, how to record capacity assessments and the consequences of not doing a capacity assessment

		• May violate the rights of the individual, or the rights of others to remain safe from harm • The person is assumed to have capacity when there are things that may indicate otherwise	• Enquiries consider social isolation, appropriate advocacy and a coordination of capacity assessments at an earlier stage of intervention • Inherent Jurisdiction of the Court should be identified in Policies and Procedures as a consideration
Holistic Assessment	• Assessments are not conducted appropriately • Misunderstanding the requirement to assess when someone may lack capacity to make certain decisions and if there are safeguarding concerns • Lack of follow up in Mental Health Act procedures / Assessments under S117 • Lack of cultural and religious beliefs idetified	• The reasons for self-neglect are not identified and if appropriate supported • A clear holistic assessment across all agencies is not conducted • Risk assessments are not consistent • Risk management plans are not identified within appropriate legal frameworks • Support plans are from a single agency rather than a coordinated approach • There is no clear escalation process to manage sprialingrisk • Services present barrier to access without having a clear picture of the risks	• Safeguarding training that includes the duty to assess if there is reason to suspect that the person may lack capacity to consent to assessment • Training that includes the duty to assess where there is reasonable suspicion of abuse or neglect irrespective of whether the person engages • Policies and Procedures that reflect the above duties and maintaining contact with someone who self-neglects • A clear process of identifying and responding to people subject to S117 aftercare

		• People disengage and services lose touch with them and their escalating risks • Models and methods of assessment with someone who is self-neglecting are not clearly identified. • Outcomes focus on clearing the clutter or healing the person before engaging with the person and their perspectives	• Training in models of assessment - Assessment needs to explore potential mental disorder, trauma and trauma response, historical issues impacting on the person, social networks, physical health and nutritional requirements, personal philosophies and the identity of the person beyond what is observed and utilise cognitive and solution focused assessment alongside risk management approaches. • Executive Strategy Meetings or Executive Risk Assessment Meetings should cover multiple abuse or serious risk of harm to an individual with an overarching strategic response that supports individual operational responses. • Procedures should specify that clearing the clutter or focusing on the self neglect does not work and only

			exacerbates the difficulties. A rapport must be developed before any removal of goods unless there is an imminent risk to others
Information Sharing	• Information is not shared with relevant agencies • Perceived barriers to information sharing • Lack of understanding of Caldicott Principles of information sharing	• Agencies do not share relevant information as they fear it may be wrong to do so • Lack of recognition of duties under the Care Act to share information • Lack of understanding regarding the need to share information with the Police and when to share information with the Police • Barriers to gaining a clear picture of abuse and neglect	• Clear information sharing procedures that explicitly detail responsibilities in relation to safeguarding • Safeguarding training includes information sharing procedures • GP and other Health professionals have access to information even if not in attendance at meetings. Housing are made aware of key issues even if not in attendance at meetings and Police where appropriate.
Pathways Between Services	• No clear pathways when multiple low level disabilities / mental health issues / substance misuse / previously 'Looked After' child.	• Someone who has multiple low level disabilities can be very vulnerable, but prevented from accessing Social Work Services • Key agencies do not know how, or are not able to support	• Multiple risks are assessed holistically and an agency made accountable for this assessment • Clear procedures for access to mental Health and

	• Access and engagement of Mental health services • Access and engagement of Substance Misuse services • Access to services for people who have Autistic Spectrum Disorders • Potential Domestic Abuse not identified	referrals to Mental Health services • Agencies send letters to people to offer appointments when the person is not able or not capable of responding to a letter and the case is closed in some of the most high risk cases • Disputes between services about whether the person meets their particular criteria for intervention, disregarding the safeguarding eligibility criteria • Unclear accountability	Substance Misuse services – accountability and follow up • Face to face or telephone contact to ensure that the person has equitable access to services, where there has been no response to an appointment and risks of abuse / neglect identified. • Multi-agency safeguarding training identifies clear pathways for support • Safeguarding training addresses the need for domestic abuse to be identified and considered in relation presenting situation
Multi Agency Response	• An early multi-agency response is not instigated	• Issues of capacity and consent are unclear leading to little or no positive intervention or person centred work, other than leaving the person to their own devices. • Capacity assessments are not coordinated • A key person to have oversight of the process is not identified • There is no one allocated who can develop a rapport with the	• The Local Authority do not need to manage all elements of the Safeguarding Process – they can have oversight and provide advice and guidance to others, when they are more appropriate to make enquiries or chair a multi-agency meeting. Policies and Procedures should reflect this

		individual and involve them in the process • Historical abuse, trauma and neglect, or patterns of behavior are not explored • Potential crime is not investigated • Coercive and controlling behaviours of others and the impact of this on the person is not explored • Carers needs / assessments are not identified • The persons Mental Wellbeing is not considered and referred appropriately • Preventative fire prevention is not considered • Risks to others are not considered • Support and advocacy for the individual is not considered • Therapeutic intervention is not considered • A single agency is left struggling to understand how to support the person and address risk	• Training in chairing safeguarding meetings and multi-agency responses should be offered to managers within all relevant agencies • All agencies need to be made accountable for safeguarding in cases of self-neglect and this should be address via Policies and procedures and monitored via the Safeguarding Adults Board processes. • Examples of good multi-agency working should be shared and positive lessons learned from the experience.

Communication	• Systems prevent barriers to communication • Assessments and support plans do not include the interventions from other professionals • A key person to coordinate the assessment and support planning is not identified • Communication breaks down between agencies • Agencies use differing and sometimes conflicting approaches	• CPA and Safeguarding have competing outcomes • Too many meetings for an individual who may be unwilling to engage • There is no one person to contact to share information • Agencies disagree at critical points of care when they could be discussed and conflict resolved earlier • IT dependent services identify systems as a barrier to communication without considering other methods • A clear picture of risk is not identified	• IT systems are not a barrier to communication. Staff should be encouraged to pick up the phone or go out to speak to each other. • Policies and Procedures should reflect Care Act requirements for assessment and communication • Training in Care Act responsibilities: Maintaining wellbeing, preventing or delaying the need for services, community engagement, coordinated responses etc
Non compliance	• Agencies withdraw from people who are obstructive or do not comply • The reasons for a persons resistance are not explored and clarified	• The underlying issues affecting the person is not fully assessed • The person has unrealistic perspectives and perceives that things can be imposed • The person is not made aware of their rights and their responsibilities in a clear manner	• Training in motivational interviewing techniques to help a person begin contemplating their current situation and the incongruence with the desired outcomes

	• People who may have a need for services are not aware of their rights to personalised services. They are not made aware that safeguarding is not imposing something (Unless there is a crime or risk to others) but supporting the wishes, values, expectations and outcomes the person requires. • Labels are ascribed to a person due to noncompliance or behavioural responses	• Services focus on the needs of the individual and do not offer an opportunity to consider themselves, others whom their actions impact upon • Attention of the professional is diverted to those cases where they feel they can do something and risks escalate, the persons emotions are not considered and rapport is broken	• Support to assist the person engage in their local community resources – Care Act responses identified in training • Circles of Support identified around the person – Procedures to identify this • Key person identified to engage with the person self-neglecting • Earlier intervention via a coordinated approach • Beware of labelling people as Anti-social, criminal or a nuisance without exploring the reasons behind these behaviours. – Safeguarding training to address this.
Management and Oversight	• Workload management • Resource allocation • Inconsistent perspectives • Supervision inconsistent	• Time to engage and assess is not created • Appropriate resources and services are not mapped within the local area • Managers have a different perspective to practitioners	• Clear direction is given in policies and procedures • Supervision identifies cases of self-neglect and explores case load pressure • Managers to attend self-neglect training – more consistent responses

	• Caseload consideration	• Competing case load responsibilities are not discussed	• Services are identified to support work with people who self-neglect
Knowledge and the Legal Framework	• Agencies do not have a clear knowledge and understanding of the relevant legal frameworks • Agencies are not aware of the Powers and Duties of the other agencies.	• Assumptions are made about the role or ability of other agencies to intervene. • Potential interventions are not explored or are missed • Recording does not reflect practice and is not justifiable or defensible.	• Policies and Procedures reflect the legal frameworks available in cases of self-neglect • Multi-agency meetings / responses are developed to extract information from all professionals • Information is made available to all partner agencies

After conducting a thematic review of Safeguarding Adults Review, Domestic Homicide Reviews and Mental Health Homicide Reviews covering the past five years Key themes began to emerge. These themes have been collated into a self-assessment document. Beginning with the question in the yellow section and reflecting upon the work that you are doing with the person self-neglecting consider the question. You can use the blue column as guidance and the green column to consider the potential barriers and the efforts to break down these barriers.

This tool may also prove useful for those conducting Safeguarding Adults Reviews.

Self-Neglect – Self Assessment Tool

Guidance	Criteria	Barriers
1. Identifying Self-Neglect		
Self-neglect covers a wide range of behaviours including: • Neglecting to care for personal hygiene • Neglecting to care for health • Neglecting to care for surroundings • And behaviours such as hoarding **A safeguarding referral should be made in cases of self-neglect where the 3 part test is met:** • the person has needs for care and support • is experiencing or at risk of abuse or neglect (Including self-neglect) • And as a result of those care and support needs is unable to protect themselves from either risk of, or the experience of abuse and neglect **You do not need consent to make a safeguarding referral:** • Checking out the persons consent is part of Local Authority S42 duties, therefore a referral can be made without consent • Enquiries can be made about the issues affecting the person / others, including whether the person consents or not • If they do not consent this simply means that the Local Authority does not have their cooperation, but does not prevent agencies from taking any steps that they can.	**Self-Neglect has been appropriately identified and a safeguarding referral has been made to the Local Authority.** (See Ten Steps, Clutter rating scale guidance, Risk Assessment Tool and safeguarding referral procedures)	**Barriers can include**: • Not recognising or identifying the issue as self-neglect or neglect • Not recognising appropriate threshold criteria for safeguarding or applying additional thresholds • Where a person's self-neglect is impacting on their emotional or physical wellbeing, then it is no longer questionable whether they have needs for care and support – they meet the three part test. • You do not need consent to make a safeguarding referral to the Local Authority. Lack of consent for safeguarding purposes should not be a barrier.

The purpose of the enquiry is to establish a person's capacity to make certain decisions, determine the level of risk to the person and others, coordinate personalised responses to abuse and neglect and to explore potential crime.		
2. Section 42 Enquiries		
The purpose of an enquiry is to: • Get a picture of the abuse / neglect / self-neglect • Make sure that the person is safe (Consider MCA and personalised response) • Consider capacity assessments required and by whom, • Rule out additional or historical abuse / neglect, • Explore potential crime • Identify any coercive or controlling behaviours • Explore any mental health / substance misuse concerns • Consider risks to others • Determine the care and support needs of the individual • Consider advocacy and methods of communication • Determine whether a multi-agency response is required **The Local Authority must have oversight of safeguarding procedures, but can request another agency to make enquiries on their behalf, or chair multi-agency meetings for safeguarding purposes. Information and outcomes must be shared with the Local Authority.** **The benefit of invoking safeguarding procedures (Risk assessment and clutter rating scale 4-6) is:** Safeguarding duties and responsibilities apply: • Duty to share information for enquiry purposes	**Have S42 enquiries been implemented appropriately?** (See Clutter rating scale guidance (Where there are issues with hoarding), Risk Assessment Tool and safeguarding referral procedures)	**Barriers can include:** • Lack of understanding about what a S42 enquiry is • Reluctance to coordinate a multi-agency response to prevent further neglect / self-neglect • A lack of confidence in coordinating, delegating and utilising all partnership agencies to make enquiries and respond to abuse or neglect • Local Authority doesn't just have oversight but wants to maintain control, rather than a multi-agency response, or is overwhelmed with safeguarding referrals and refers back to single agency to deal with case without multi-agency support or coordination

• Duty to cooperate with the Local Authority and the Local Authority to cooperate with other agencies for safeguarding purposes • Duty to assess where there is an identified need • Duty to determine consent • Duty to provide appropriate advocacy • Duty to assess carers needs **In most cases where hoarding reaches scales 7-9 on the clutter rating scale, or self-neglect is having a significant impact on the persons physical or emotional wellbeing, the Local Authority will make safeguarding arrangements, unless there is an agency more appropriate to do so. In cases where there is a potential crime Police will lead the investigation process.**		
3. Risk to Others		
Risks to others can include: • Fire risk • Rats, vermin, flies • Faecal matter, vomit, or other bodily fluids • Toxic substances • Open wires, unsafe gas, structural issues • Oxygen tanks where someone smokes, or other medical equipment • Drugs paraphernalia (Uses needles, spoons, knives) • Weapons • People using the property who may target other vulnerable people • Anti-social behaviour	**Has the risk to others been considered? Is the response proportionate to the risk?**	**Barriers can include:** • A strong focus on individual rights and needs without consideration of the needs and rights of others to be safe • Not reporting, or poor response to potentially criminal activity. • Over reaction to risk e.g fire risk does not require a whole house clearance, there are many more less intrusive responses.

• People who may have needs for care and support also residing at the property • Children residing or spending time at the property • Animals at the property		• Other forms of abuse are explored without consideration of self-neglect
4. Risk Assessment		
Risk assessments should include: • Historical abuse and past knowledge of the person • Previous safeguarding referrals • Cumulative risk • The vulnerability of the person (Capacity, mental ill health, physical disability, learning disability, autistic spectrum disorder, age and frailty of the person, social isolation and support the person has, acceptance of care and support, insight the person has into their problems and difficulties) • Type and seriousness of self-neglect / hoarding • Level of self-neglect / hoarding (Clutter rating scale) • Background to self-neglect / hoarding (Does the person have a disability / mental health problems that prevent self-care, has this been a long standing problem – when did it begin and was there a trigger, does the person engage with services and was there a time when this was different, is social isolation a concern) • Impact on others • Reasonable suspicion of abuse (Could self-neglect be an indicator of abuse / neglect, is the person targeted for abuse / anti-social behaviour / mate crime, is the person neglected by someone responsible for their care) • Legal frameworks (Is the person at risk of eviction, are there pressing environmental concerns or public health	**Has the appropriate risk assessment been completed?** (See Clutter rating scale guidance, Risk Assessment Tool and safeguarding procedures) **Has the reason for the refusal of care, services or treatment been explored in relation to risk?**	**Barriers include**: • Services identifying risk but not identifying the risk management plan • Services recognising level of risk but not implementing defensible decision making e.g evidence of capacity assessments and outcomes, use of Human Rights Act, recognition of someone being deprived of their liberty in the community • Cases being closed with escalating risks identified • Is the person being moved from service to service without a safeguarding oversight and coordination of services?

concerns, debt issues that may lead to prosecution, other criminal convictions, child protection proceedings) • Is there anyone obstructing or preventing work with the person (Family members, other persons at the property)		
5. Carers Assessment		
Carers assessments to consider: • Carers needs in continuing to support the person • Capacity issues relating to carer and ability to provide care • People residing at the property who may not consider themselves carers, but may still have a duty to care • Obstructive or aggressive carers / family members **Note: If there is an identified carer, then this may be a case of neglect rather than self-neglect. Wilful neglect is a potential crime.**	**Have carers needs been considered and a carers assessment completed?** **Have carers been identified on care and support plans where they are meeting an identified need of the person for whom they care?** **Are carers aware of their duties and responsibilities / potential consequences?**	**Barrier include**: • Carers not identifying as carers • Carers not being identified on care and support plan as meeting as need • Not recognising carers who self-neglect – eligible for safeguarding
6. Mental Health and Substance Misuse		
In assessing mental health and substance misuse consider: • Does the person require mental health assessment • Has a referral been made • Are there barriers to assessment • Does the person misuse substances • Would they engage with substance misuse services • The impact of substance misuse on physical and mental wellbeing / daily functioning and increased risks • Assessment including that of executive functions of the brain	**Have referrals for Mental Health and Substance Misuse Services been considered and recorded?** **Have all legal duties under Mental Health Act been considered?** (S117 aftercare, community treatment orders, guardianships etc) **IS CPA well-coordinated with safeguarding responses?**	**Barriers can include**: • Sending appointment letters to someone who is not engaging (Not appropriate form of communication). • Maintaining that someone with agoraphobia needs to attend a clinic appointment (Not accessible to the person) • Unclear pathways between services

When someone self-neglects there may be a range of Psychological issues impacting on them, for example attachment issues, issues of neglect in childhood, executive function difficulties, trauma and loss issues, agoraphobia. Mental Health Services should consider access to Psychology support even if there is not a defined medical treatment route. Access should be defined as accessible to the person ie someone with agoraphobia is not going to make it to a clinic appointment and someone self-neglecting is unlikely to respond to appointment letters.		• Case closure – no risk / capacity assessments
7. Capacity and Consent		
You assume capacity unless there is reason to believe otherwise, you should consider: The MCA code of practice states that one of the reasons why people may question a person's capacity to make a specific decision is "the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision" (4.35 MCA Code of Practice, P. 52). Arguably, extreme self-neglect or hoarding behaviour meets this criterion and assessments should take place. **In determining who assesses capacity, or who is accountable for assessing capacity you should consider:** • If you are the person who requires consent, agreement, understanding or a signature from the person self-neglecting for a proposed treatment, care provision, course of action or tenancy agreement / compliance, then you need to assess whether the person is capable of consenting by undertaking a capacity assessment. • Any capacity assessment carried out in relation to self-neglect 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	**Are all relevant capacity assessments up to date and recorded within one support plan for monitoring?** **List capacity assessments required e.g.** • Tenancy agreement • Tenancy support • Tenancy review • Medication offered • Treatment offered • Safeguarding referral • Assessment and support planning • Services offered (Identified individually) • Finance • Aids and adaptations	**Barriers include**: • Capacity assessments being too generic, not issue specific enough and not undertaken by the appropriate agency • The person / agency requiring consent to provide an aspect of care, a treatment or a service has not taken responsibility for that capacity assessment • Lack of understanding where a person has capacity and is making an unwise decision – entitled to do this (Consider 10 steps) • Confusion about what 'Duty of Care' means. A duty of care does not mean that we

intervention or action (Wherever possible), and is referred to as the 'decision-maker'. • 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 • When the person is assessed as lacking capacity the decision maker is responsible for the 'Best Interests decision' • If the person is deemed to have capacity, this should be clearly recorded along with the things that the person did / said that made the decision maker think that the person had capacity and the information and advice given. • If the person self-neglecting is refusing to engage with certain professionals anyone who has access and has developed a rapport with the person self-neglecting should be supported by the actual decision maker to carry out the capacity assessment and best interest decision. **Safeguarding Principles should be considered throughout all safeguarding interventions, including capacity assessments:** ➢ Empower the person to understand and make decisions ➢ Establish their desired expectations and outcomes ➢ Take action before harm occurs and prevent further abuse / neglect ➢ Proportionate responses that are least intrusive and in the persons best interests ➢ Consider support / advocacy and identify someone to help the person engage in the process / provide feedback to the person ➢ Solve difficulties by working together across agencies ➢ Utilise community resources ➢ Agencies to be accountable for their actions, knowledge, application of legal frameworks (Including the ability to conduct capacity assessments and record appropriately)	**Are proportionate and least restrictive interventions being considered?** **Where a person lacks capacity to make a decision are we balancing their rights, wishes and expectations with the actual level of risk, or are we being too risk averse?**	prevent risk and protect the person no matter what. It means respecting the wishes, expectations, values and outcomes of a capacitated individual, including their right to make what others might consider 'unwise decisions'. If the person has capacity to make a particular decision and this is not criminal, or posing a risk to others, they are not being coerced or intimidated into making this decision and they are not detainable under the Mental Health Act we have no right to intervene in that decision, but can offer support advice, guidance, therapy to enable to person to understand more and hopefully reconsider their decision. • Lack of defensible recording when a person has capacity and their decision could have a significant impact on wellbeing

➢ The person self-neglecting understands the roles of all agencies involved in their care and support **List all the aspects of care, treatment, service provision or intervention that requires the persons consent. Identify the person / agency that requires consent as the 'decision maker'. Safeguarding plans to detail the capacity assessments required and the person / agency responsible with timescales for completion and follow up monitoring. Once the capacity assessments are complete then agencies are looking to see whether there may be a change in the person's ability to consent.**		• Lack of coordination of capacity assessments in the safeguarding process • Lack of access to the person – record what is known and share knowledge across agencies to consider to best knowledge each decision. • Mini Mental State Tests and Diagnostic Tests being used instead of a capacity assessment
8. Advocacy and Representation		
The Local Authority has a duty to arrange for an independent advocate to be available to represent and support the person self-neglecting, to facilitate their involvement in the process. This duty applies when the person has substantial difficulty in being involved in any part of the safeguarding process. Substantial difficulty is defined as the person having difficulty to: • Understand the relevant information • Retain that information • Use or weigh up that information • Communicate their views, wishes and feelings **This duty does not apply if the Local Authority are satisfied that there is a person who** • Would be an appropriate person to represent and support the person to facilitate their involvement (Friend or family member who is not part of any safeguarding procedures	**Does the person have suitable representation and support?**	**Barriers include**: • Lack of understanding regarding Local Authority duties to find advocacy where a person has 'Substantial difficulties' being involved in the process • Utilising family members where they have a vested interest or may be implicated in the safeguarding issues

and does not have a vested interest in any potential outcomes) • Who is not engaged in providing care or treatment for the person in a professional capacity • Where the person has capacity and is competent to consent to consent to a course of action		
9. Multi-agency Response		
Multi agency response to consider: • Capacity issues in relation to a range of matters affecting the person and who should / can do them • To rule out additional or historical abuse or neglect • To explore potential crime, • To identify any coercive or controlling behaviours affecting the person, • To examine the persons mental health and how this may be affecting them, • To explore any risks to others, • To determine support needs of the individual including appropriate advocacy **Earlier intervention assists in developing a rapport, access to community, circles of support around the person, solution focussed / strength based rather than risk management processes. In multi-agency meetings consider:** • Police led enquiries coordinated alongside any required assessment processes • In criminal cases – the preservation of evidence • Referrals to necessary services • Involvement of services not already involved eg domestic abuse, substance misuse, mental health services, fire	**Has a Multi-agency response been coordinated early enough to prevent the deterioration of physical and mental wellbeing?** **Has a key person been identified to liaise with the person self-neglecting?**	**Barriers include**: • The person being passed between agencies without oversight or coordination • Where there are issues of severe neglect short term intervention services are not appropriate e.g Case being held solely with the GP, Single Point of Access or Duty Team • Lack of consistency – Developing a rapport with the person is of prime importance. An agency, or if possible person should be identified as the key agency to undertake the long term work • Barriers in sharing information, coordinating approaches, access to

service, anti-social behaviour services, MAPPA, MARAC, SARC, public health etc. • Coordination of assessment methodology • Therapeutic assessment and intervention processes • Who leads on information sharing, communication and involvement of the person self-neglecting • Coordination of capacity assessments • Identify gaps in knowledge and who will find this information • The whole family approach – others at risk, support offered • Animal welfare • Perpetrator risks / vulnerabilities / support and who will provide feedback • Barriers and how these will be overcome • All aspects of the risk assessment		appropriate support and not ensuring that the duty to cooperate with the Local Authority and the Local Authority to cooperate with other agencies – When meeting a number of barriers from a particular organisation in trying to prevent abuse and neglect from occurring or protect someone from abuse, or neglect concerns should be escalated. Board members should be supportive and offer advice and guidance to ensure that safeguarding duties are being met within their organisation.
10. Comprehensive and Holistic Assessment		
Where a person self-neglecting refuses an assessment S11 of the Care Act identifies that when a person refuses an assessment the Local Authority have a duty to carry out that assessment when: • The person lacks capacity to refuse that assessment and carrying out the assessment is in the persons best interests (Must be recorded) • The person is experiencing, or at risk of, abuse or neglect **When assessing someone who self-neglects, do not assume that this is a lifestyle choice**. Ask the 'miracle question' 'If you were to wake up tomorrow and your house was miraculously changed into	**Has a comprehensive and holistic assessment of need been conducted with or without the consent of the individual where self-neglect is impacting upon physical and mental wellbeing?** **Is there a duty to assess?** **Have non-commissioned services, other agencies, carers, friends and other parties meeting an identified need for the individual all been recorded as**	• Overly simplistic assessment that does not consider why a person is self-neglecting, how the self-neglect began and what the person gains from the self-neglect • Some cultures believe in alternative medicines and therapies, rejecting Western Medicine. Where a person

the type of house you would like to be living in, what would it look like, what would you see, what would you be doing, what would be different?' or If you were to wake up tomorrow morning and you did not feel so low in mood what would you be doing, what would things look like, what would be different?' **Has the assessment covered enough detail to understand the reasons for self-neglect, when self-neglect began, any triggers, loss bereavement, abuse. The goals of the person and any barriers.** **History of neglect, family contact, family relationships, motivation. See assessment information.**	**meeting that need on the care and support plan?** **Have all parties been informed of their duties, responsibilities and need to inform should needs change?** **Have culture, values and religious beliefs been explored with the person?**	has capacity to make decisions about medical intervention and treatment and has differing cultural beliefs from traditional Western medical perspectives, this needs to be explored thoroughly and support plans established in a culturally sensitive manner. • Family members, friends and non-commissioned services meeting the needs of the individual are not identified on the care and support plan – Ensure that if a person or organisation agree to meet a need that they understand accountability for meeting that need
11. Compliance and insight		
When someone is not accepting of services explore the reasons why. What prevents the person from accepting support? **Consider:** • Harm minimisation – what can be achieved and how much will this lessen the risks? • Has there been a negative experience of services? • How can negative experiences be changed: be prompt, remain engaged, be on time, communicate in ways that the	**Is the person accepting of care, support and services?** **Is there a plan to maintain engagement / contact?** **Does the person have insight into their behaviours?**	• Recognition of loss and grief – this is not merely about bereavement and can include, for example, loss of childhood through neglect, loss of mobility or ability, loss of independence in older

person can respond, do not send letters if this is inappropriate to the needs of the person, do not impose actions if at all possible, work with the person and their time scales, no clear ups before other issues explore and any clearing at the pace of the person (Dependent upon risks to others). • Is there someone who has a relationship with the person and are they willing / able to support services in providing care / support • Can a rapport be developed with someone • Look for solutions to this barrier **Consider the process of change (Kubler-Ross). If a person is in denial, angry or resistive, this is part of the change process and you can support the person to move on. Consider Motivational Interviewing techniques and the process of moving someone from pre-contemplative to contemplative (Prochaska and DiClemente)**	**Has potential loss, trauma and grief been considered in the widest context and how can the person be supported through this?**	persons, loss of confidence as a result of abuse. • Not recognising the process of change – If you are suggesting change then a person may experience a range of emotions and anxieties about leaving something that they feel safe with behind – Do not suggest taking something away from the person without exploring what they gain from it and how they feel this emotion can be replaced
12. Imposed Sanctions, Compliance or Penalties		
A person is unlikely to change when power and control is removed from them. In some cases sanctions must be imposed and the effects of these must be considered by professionals intervening. Consider: • Eviction notices • Child protection proceedings • Imposed housing sanctions • Criminal proceedings • Debt and debt recovery • Other	**Are there any legal considerations or imposed compliance considerations and have these been clearly recorded?**	• Lack of capacity assessments – Sanctions cannot be imposed upon someone who did not understand the requirements in the first place, unless there is a risk to others or criminal proceedings.

13. Information Sharing

Relevant information can be shared with relevant agencies without consent when: • There is reasonable suspicion of risk to others • There is reasonable suspicion of crime • There is reasonable suspicion of public interest issues • There is reasonable suspicion of coercive and controlling behaviours / domestic abuse • There is reason to believe that the person may need assessment under the Mental Health Act **Confidentiality must not be confused with secrecy.** **It is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly those situations where vulnerable people may be at risk.**	**Is information being shared across all agencies to prevent deterioration of physical and mental wellbeing and safeguard the person?**	• The Data Protection Act is not a barrier, it supports this form of information sharing

14. Personalised Safeguarding

Personalised safeguarding means that when a person has capacity to make a decision they are entitled to make an unwise decision, consider: • Capacity assessments and whether the person is making a capacitated decision (Assessed and recorded as such) and; • This is not impacting adversely on anyone else and; • The reasoning behind this decision has been explored and; • Information and advice has been offered in a format that the person understands (Recorded) **Where a person lacks capacity to make a decision are we sure**	**After risk to others, potential crime, public interest issues, coercive and controlling behaviours have been ruled out is there evidence of person centred care and support planning?** **Have the wishes, views and values of the person and their expectations / outcomes been identified and recorded?** **Has the reason why a person is refusing treatment, care and support been explored?**	• Lack of understanding of the Mental Capacity Act • Anxiety about unwise decisions • A feeling that we are in trouble if we do not protect people when they are making capacitated, unwise decisions – We are not the decision maker, they are and are responsible for their decisions

that the course of action is the least restrictive possible and in the best interests of the person. Remember: • A safe but miserable life is no life at all • We do not have to eliminate all risks, just minimise risk to the person as far as is comfortable for them • Get multi-agency support, senior management support, legal support or support from the Court of Protection if the situation is proving problematic **We should explore the reasons why a person is refusing care, support or treatment**. This needs to include possible correlation with past caring responsibilities and let downs, cultural issues, the interface with professionals in the past. We should not make assumptions based on our own culture and values e.g. If a person has strong beliefs about non-traditional forms of medicine is this impacting upon their acceptance of traditional Western Medicine?	**Have cultural, ethnic, religious and personal perspectives in relation to care, services or treatment been explored?** **Have capacity assessments been conducted in relation to each treatment decision?** **Has the persons relationship, cultures and values been assessed alongside family and community cultures and values?**	and the consequences, but we must demonstrate why we think that this is a capacitated decision (Info advice offered and the persons reasoning)
15. Management Support and Response		
When there are barriers from agencies, barriers from the person themselves, barriers in knowledge of legislation and potential responses and barriers in cooperation, and a person's physical and mental wellbeing is deteriorating, this implies that current interventions are not working and the barriers are too significant for practitioners to manage alone, even across agencies. **It is helpful to have a layer of safeguarding sitting between Safeguarding multi-agency response and Safeguarding Adult Review. This may be called an Executive Strategy / Executive Safeguarding / Overarching Strategy. This may be chaired by a Senior Manager within the Local Authority who can look at the strategic elements of the safeguarding process to support the**	**Are escalating risks taken seriously and addressed at the appropriate level of managements / intervention?** **Is there clarity regarding when to escalate concerns and to whom?**	• No clear escalation process in safeguarding where is person is continuing to deteriorate as a result of self-neglect

removal of any barriers, feed the outcomes and actions down to operational staff and up to the Safeguarding Adults Board for action. Individual safeguarding meetings will still be held looking at the needs of the individual or persons involved and feed information back to the Senior Manager.		
Defensible Decision Making		
Defensible or justifiable decision making follows the word 'because': • I chose this course of action because…… • I ruled this out because……. **And following 'because' should be recorded:** • The legislation used to make the decision • In absence of legislation use policy, model, method, theory or research that informed the decision • This should be balanced with what the person did or said that made you think this was an appropriate course of action, or not • Alongside attempts to enable the person to understand consequences, pro's, cons, risks, alternative options and information and advice given **Intervention should be justified in recording logs:** • Who is intervening • What is the purpose of the intervention • What actions were taken • What were the outcomes of the action **If a professional is struggling to identify outcomes from intervention they need to raise this during supervision and consider:** • Why am I going around in circles with this case?	**Is my recording defensible (or justifiable) rather than defensive (Offering reasons for failure)?**	• Professionals stating 'I did this in my head' – A major barrier to defensible decision making. We need to see your justification for actions taken, in other words demonstrate what you considered and why it was appropriate, what you ruled out and why.

• What might possible solutions be? • Who do I need to help me with these solutions? • Is the mental and physical wellbeing of this person significantly deteriorating and does this need escalating? **A summary of work, progress, barriers and how those barriers have been addressed can support defensible decision making. Consider including:** • Referrals made • Appointments offered • Information and advice given • Capacity assessments • Access to advocacy • Persons wishes, choices, expectations and outcomes • Support given to help the person recognise / understand • Duty to assess and how this has been achieved • What was considered, what was ruled out and why • Legal frameworks used • Models, methods, theory and research used in practice • 'I statements' of the person or indicative responses		
Other		
Practitioners to consider the barriers and explore in supervision the possible solutions to barriers. Ensure that intervention is not overly intrusive and involves the person as far as is possible. Consider the emotional impact of any decision and whether this may have a negative or positive impact.	**Are we trying to impose large scale clear ups, and sanctions that are neither cost effective, nor support the person?**	• Services imposing control with no recognised benefits.

If a person has an emotional attachment to their actions or hoarded items then removing the items will only serve to increase the sense of loss and powerlessness. It will exacerbate the problem, not remove it. The wellbeing of others must be factored in but if we can achieve this working with the person, rather than against them it will more likely be sustainable. The cost of clear ups to the Local Authority is substantial and the problem will only begin again elsewhere and with less positive intervention. **Have we considered ethics in decision making. Non Maleficence (No harm) – we cannot impose something that we know could be harmful to the person or contribute toward their death.**		

Safeguarding Principles are applied:

Empower – Part of the safeguarding plan needs to consider how the person will be empowered during the process:

- Outcomes and expectations of the person
- Equitable access to services including the Criminal Justice Service where there is crime committed against the person
- The prevention of oppression and discrimination and consideration of cultural or religious beliefs impacting on the persons decision making
- Strength focused intervention that seeks to place the person as the expert in their own wellbeing
- The person is well informed about any safeguarding process and the roles of persons involved in support.
- There is an assumption that the person has capacity to consent to interventions. Where there is reason to believe that an individual may not have capacity to consent, this will be assessed by the person requiring consent (Or relevant person). Any capacity assessment will be recorded and any decision made will be proportionate and least restrictive, ensuring that the person has a safer, but also happier life with their own best interests central to decision making.
- Access to advocacy
- The expectations, wishes, values and outcomes expressed by the person will be central to any action or intervention.
- The Human Rights of any individual will be maintained
- Information will be shared in line with Caldicott Principles and any Information Sharing Agreement. We cannot assure absolute confidentiality, where there is reasonable suspicion of a crime, a potential risk to others or matters of public interest, information may have to be shared. If a person has potentially been coerced or intimidated into making a decision then information may need to be shared. Where a person's mental ill health may require assessment under the Mental Health Act relevant information may need to be shared with relevant people. The duty of candour means that we should be open with people about when and how information will be shared.

Prevention – Part of the safeguarding plan needs to consider how we support the person to prevent neglect / self-neglect:

- For people to be supported to recognise and report abuse in a manner that they can understand
- The need to inform people of their rights to be free from abuse and supported to exercise these rights, including access to advocacy
- Recognition of what good care and positive, equitable care practice looks like across agencies
- Consideration of ethics: Beneficence, non-maleficence, justice and autonomy
- Dignity, compassion and respect in care provision
- Identify least restrictive interventions and how to reduce restrictions
- Recognise the difference between a restriction, restraint and a deprivation of a person's liberty
- Anti-discriminatory, anti-oppressive practice
- Recognition of culture, religion and personal values in assessment and planning
- Understanding the Mental Capacity Act and how its principles apply in practice across all agencies
- The links between commissioning and provider services and the need for consistent and coordinated care planning and review
- Holistic assessment, care and support planning that is coordinated and specific to the needs of the individual, family and in the context of the community in which the person lives
- The whole family approach to care and support. Carers assessments that identify and address carers needs, comprehension, communication skills, memory, risk factors and ability to meet the identified needs of the person that they are caring for
- Risk assessment processes that are not risk averse
- Recognition of abuse and neglect including self-neglect at an early stage
- Recognition of strong leadership and management
- Recognition of potential domestic abuse
- Agencies not working in silos

Protection– Part of the safeguarding plan needs to consider how we protect a person from neglect either with their consent, or where incapacitated in their best interests:

- Eligibility criteria and who can be safeguarded (3 part eligibility test for safeguarding – do not need to be eligible for Local Authority services)
- Recognising and reporting forms of abuse / neglect (Including self-neglect)
- Recognising indicators of abuse and neglect / self-neglect and when to report
- How to report abuse / neglect (Including self-neglect) and the appropriate response to the reporting of abuse neglect / self-neglect
- Safeguarding multi-agency response to define the remit of the enquiry. We can make a referral without the persons consent and can consider safeguarding issues regarding potential perpetrators, risks to others, whether the person is making autonomous decisions or whether they lack capacity to make certain decisions, whether they have significant mental health problems or whether they are in a situation where they may be coerced or intimidated into making a decision. We cannot respond or take any action in relation to the person where they do not consent or they lack capacity and it is not in their best interests to take that action, but we must rule out all of these considerations as part of the enquiry process
- S42 enquiries conducted to determine capacity to make decisions e.g understand tenancy or housing repairs, make decisions about medication or treatment, make financial decisions, or decisions about specific aspects of care and support.
- S42 enquiries to consider the risk to others, children or other vulnerable people
- S42 enquiries to consider coordination of assessments that include when a person began self-neglecting and why
- S42 enquiries to consider service or professional barriers and engage in appropriate support at strategic level where necessary to break down barriers to effectively safeguard.
- S42 enquiries to consider the human rights of the individual and support access to civil or criminal justice to protect them and others
- S42 enquiries to consider any conflicting aspects of protection across agencies
- Safeguarding is everyone's business – roles and responsibilities of agencies defined as part of the safeguarding plan and with the person concerned
  Safeguarding process identifies a risk assessment process and how ongoing risk assessment will be conducted across all agencies
- Information sharing and confidentiality do not present barriers

Proportionate responses –

- The least intrusive and restrictive response appropriate to the risk presented
- Examine whether safeguarding practice is overly paternalistic / maternalistic, or risk averse
- Justification of actions taken
- Record what has been considered, ruled out and why
- A balance of Beneficence (The doing of good; active kindness; caring), Non-maleficence (Doing no harm; cannot inflict harm on others, Justice (Being fair, moral and equitable) and Autonomy (Freedom from external control and influence; independence)
- Understanding of capacity and consent
- How to apply the principles of the Mental Capacity Act in practice
- How to support someone to understand and make an informed decision
- How to balance 'Best Interest Decisions'
- What an unwise decision is
- Recognition of 'Reasonable Suspicion' of abuse / neglect / crime and responses proportionate to the potential risk
- Recognising Human Rights

Partnership– Part of the safeguarding plan needs to consider how we work in partnership across agencies including Substance Misuse and Mental Health Services where someone is self-neglecting

- The need to work across a variety of partners working within the communities
- Ensuring that local solutions are found within the persons chosen community where possible, to support the person to maintain contact with people, community resources and facilities
- Reducing isolation through partnership work
- Partners take responsibility and are accountable for decision making in safeguarding
- The role of the Safeguarding Adults Board in supporting partnership work – If there is a significant capacity assessment required, or a number of capacity assessments required and a partner agency is refusing to conduct the capacity assessments requested, stating that they do not do capacity assessments this becomes a safeguarding concern. If the whole agency rather than an individual is refusing to conduct capacity assessments then this becomes organisational abuse when it is possible that the agency regularly works with people who may not be capable of making autonomous, capacitated decisions about their care, services or treatments. The people who use the service are entitled to have a capacity assessment conducted, an advocate where appropriate and a best interest decision that is least restrictive recorded. It is a violation of the persons right to private life if this is not recorded and justified. Where numerous people who may not be able to make capacitated decisions are getting care, services or treatment without the application of the Mental Capacity Act principles and assessment in practice then this will need the support of training, the support of the Safeguarding Adults Board and monitoring by relevant services including the Care Quality Commission to ensure that practice is compliant with legislation and rights are not being violated. Local Authority employees should not be conducting capacity assessments about subject matter that they know little about, unless the person self-neglecting is preventing access to that particular agency and the agency concerned provides questions, support and guidance on how to conduct the capacity assessment. A recent example: An elderly lady diagnosed with Dementia was refusing chemotherapy treatment. The consultant was not sure whether the lady was able to make this decision and asked the Social Worker to conduct the capacity assessment. I later asked the Social Worker what they knew about Chemotherapy and they replied nothing. I am not sure how the Social Worker could justify the outcome of their assessment. If the Social Worker did not understand Chemotherapy, then how could they determine whether the woman understood Chemotherapy? This placed the consultant at risk because they needed consent for the treatment or to ensure that the lady was capable of understanding enough to decline the treatment. The Social Worker was at risk because they were making big decisions about treatment that they knew nothing about and could be violating the elderly ladies right to make autonomous decisions.
- The role of the Local Authority and the roles and responsibilities of agencies involved in safeguarding is understood
- Shared values and a culture that promotes safeguarding across all service areas.
- Breaking down barriers to prevent and delay the need for services – partnership recognition of early intervention
- Community members are supported to detect and report abuse and neglect / self-neglect
- The need for a collective understanding of safeguarding partnership work in relation to legislation and Safeguarding Adults Board policies and procedures

Accountability– Part of the safeguarding plan needs to consider how we maintain the relevant agencies accountability throughout the safeguarding process. Actions and outcomes are recorded and reviewed. To consider:

- Informed, transparent practice and decision making with clearly recorded discussion and conflict
- Effective partnership governance in safeguarding
- Partnership accountability for recognising and determining capacity and consent in safeguarding practice
- Accountability for sharing of information – information sharing agreement / protocol for safeguarding
- Accountability in recognising the Human Rights of an individual and preventing oppression and discrimination
- Supporting partner agencies to break down barriers in access to services where a person is in need of safeguarding
- When to escalate concerns
- The role of the Court of Protection
- Wider partnerships such as Multi Agency Public Protection Arrangements, Multi Agency Risk Assessment Conferences, Sexual Abuse Referral Centres, Hate and Mate Crime Initiatives, Counter Terrorism reporting, and the interface between these services where other forms of abuse have been identified in addition to self-neglect or resulting in self-neglect
- Reporting accountability e.g Deprivation of Liberty Safeguards, Care Quality Commission, Disclosure and Barring Service, Commissioning, Trading Standards, Fraud
- Working to support clear care and support planning in one holistic plan
- A lead person is identified and maintained to coo

16. Ten Top Tips

1. Develop a rapport

- Get to know the person, develop a rapport and find out about their life from childhood, things that affected them and when the self-neglect began
- Discover if there has been a time when things were different – what happened and how did this occur?
- Do not discuss change until the person is ready to change.
- The earlier the intervention the easier it is for the person to consider change

2. Work, Activities and Education

- Find activities, work or education that the person enjoyed doing and try to help them to engage in community activities.
- Getting out and meeting other people may help the person to reflect on their own situation. It may identify a structure for their day / week.
- Meeting people and being valued by others may help in reducing the impact of trauma, loss, bereavement, abuse or neglect

3. Self-Esteem

- Understand what feelings the person has about themselves, their house and why things are the way that they are.
- Why the person is so attached to the current situation and if they were no longer in the situation, what would replace those feelings?

4. Strengths Based Approach

- Use a strengths based approach to determine the positive things that a person has in their life or can achieve for themselves and how they would like to manage risk.
- Capacity and consent issues recorded effectively
- Use scaling questions – On a scale of 0-10 how do you feel about……..

5. Consider Methods of Motivation and Communication

- Part of the **change process** is to have **doubt, upset, anger, resentment and finally acceptance**. Plan how you can manage these changes and encourage the person to engage with appropriate counselling or **therapeutic support**.
- A person may well relapse, you can help the person to start the process over again with plenty of encouragement. Consider times when you have tried to change a behaviour or give something up, it often takes a few attempts.
- Use the miracle question

6. Create Cognitive Dissonance

- Often a person can see themselves in such a negative light that it disempowers them and prevents positive change, for example, 'I have always been untidy; I could never look as good as other people'.
- By encouraging a person to **recognise their strengths** and then separating who they are from their behaviours, it may free that person to address the behaviours, for example, 'I know that the house is messy and cluttered, but I am an ordered and organised person; I recognise that I do not bath often, but I have always been good at making quality clothes'. Focus on the positive attributes of the person.

7. Don't Rush – One small step at a time

Take one small step at a time with lots of encouragement

- Work together to identify the key issues in relation to safety and wellbeing.
- Work on making the person / property safe.
- Support the person in identifying what is important to them and what they would like to sort out first.
- Lots of positive reinforcement is required.

8. Multi-Agency Response

- Consider the need for a multi-agency response; nursing, social work, public health, environmental services, housing, fire service, police, GP, mental health services in relation to assessing risk, preventing risk, addressing risk, support for the person and their family, capacity assessments and community engagement. Coordinated responses with Psychology leading all intervention methodology and safeguarding coordinated via the Local Authority will be the best support for the person to address past trauma and contemplate change.

- Ensure that there is a co-ordinated response, chaired by someone who has enough seniority to delegate tasks and respond to situations. An action plan should be developed

- Consider the assessment of any carers and the capacity of carers to provide care and support

9. Consider Wider Safeguarding Issues

Consider wider safeguarding issues such as:

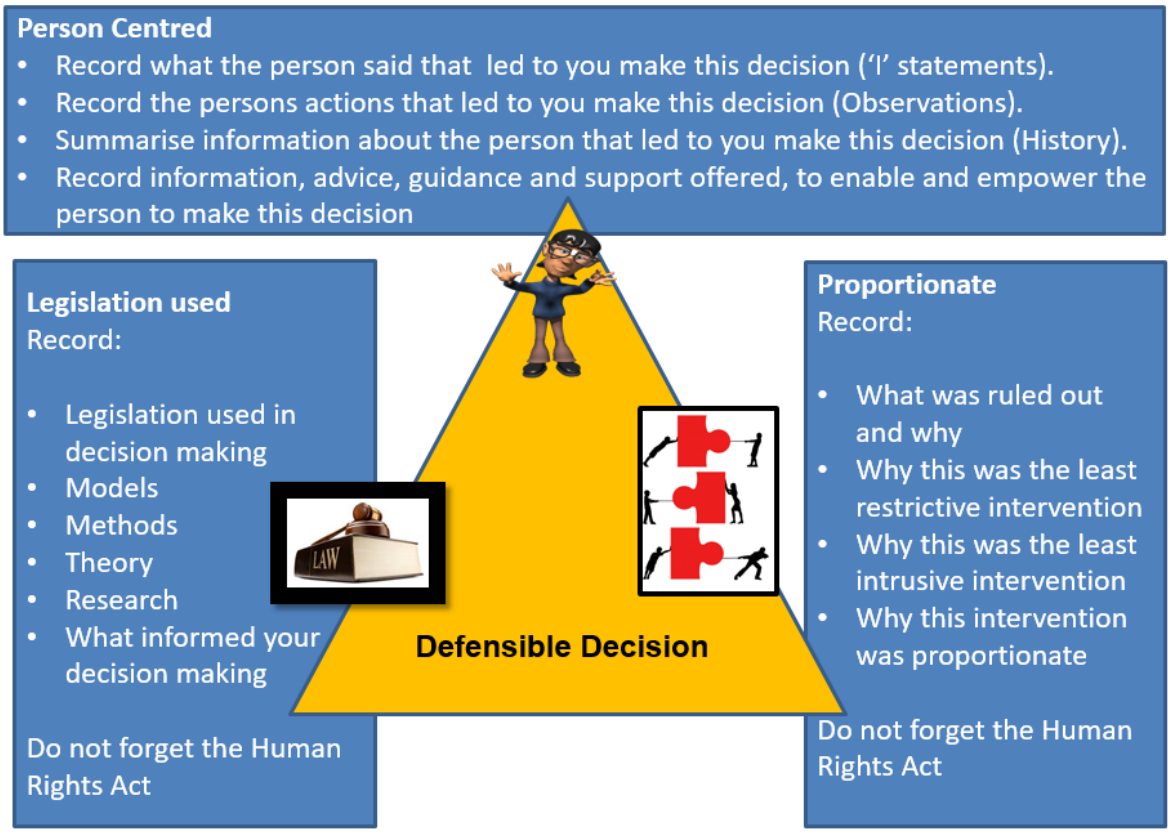
- hate crime,
- domestic abuse,
- anti-social behaviour,
- safeguarding other adults,
- safeguarding children,
- historical abuse,
- risk from potential perpetrator to person and others

10. Do not Force Change if at all Possible

- Moving the person only moves the difficulties to another place, unless the underlying factors are addressed.
- If eviction is being considered think about how to support the person to meet their needs before self-neglect escalates.
- Often the sense of loss associated with large scale clean ups and eviction can have a negative impact, try to minimise this
- Safeguarding principles apply to all actions – don't forget the least restrictive, least intrusive intervention possible

Do Not Forget Defensible Decision Making

- Referrals made (Including safeguarding adults / children, Mental Health, Police, Fire Service, Medical)
- Appointments offered
- Capacity assessments
- Access to advocacy
- Persons choices and decisions
- Support given to help the person recognise / understand (Information, advice and guidance given)
- Duty to assess and how that has been achieved
- Agencies involved – roles and responsibilities
- What was considered, what ruled out and why
- Based on Law, Policy, methods, models, theories, research
- Based on 'I statements' what the person wanted to achieve, or why this was not achieved and why choices made



Tools and resources within this toolkit have been collected and adapted from a number of sources including Murton SAB, Durham SAB, Fire Service, Livin (Housing Durham) and resources from Steketee G & Frost R. These tools are intended to support practice consistentwith the Care Act, but should not replace professional judgement.

Self-Neglect Training and Consultancy Work

- **If you would like further training on self-neglect please get in touch**
- **Training can be single or multi-agency**
- **It is helpful to complete training in the Mental Capacity Act prior to attending the self-neglect training. T-ASC can provide Mental Capacity Act Training too**
- **If you require a consultant to discuss issues of safeguarding and self-neglect within your Local Authority it would be great to hear from you**
- **If you require a Safeguarding Adults Review relating to self-neglect I am interested in being commissioned for any part of**

the process. Please forward Terms of Reference (No confidential information)

Deborah Barnett

T-ASC (Training, Advice, Solutions and Consultancy)

debbarnett27@outlook.com

07500448877

0191 6703848