Sunderland Safeguarding Adults Board

Self-Neglect Practice Guidance

January 2017

Self-Neglect Quick Reference Flowchart

In all cases where there is a concern about self neglect:
(Note: the following list /sequence is not intended to be followed for all cases as some actions may not apply or may be completed at the same time)

- Find out the adult's views and what they want to happen
- Consider whether the individual is at risk and/or has care and support needs.
- Attempt to assess/manage any immediate risks
- Record risks and actions taken
- Consider/offer low level support/preventative interventions
- Consider (and assess where appropriate) mental capacity
- Identify key individuals and agencies involved
- Share information and work together
- Be flexible
- Be persistent

Assess level of harm or risk referring to the Sunderland Threshold Matrix Guidance and Sunderland Multi Agency Safeguarding Adults Procedures

Low-level harm or risk Tier 1 (see page 10)	**Significant / Very Significant harm or risk Tier 2 – 3** (see page 11)	**Critical harm or risk Tier 4** (see page 13)
Offer: • Advice, information, sign-posting. • Assessment/review of needs. • Preventative interventions • Provision of services. • If proposed actions manage risk – record actions/plan	• Decide if safeguarding adults • Consider referral to Police if offence committed Offer: • Advice, information, sign-posting • Assessment/review of needs • Provision of services • Strategy meeting or discussion may be held, or case will be referred to most appropriate agency for management	• Decide if safeguarding adults referral appropriate, though may not be managed under Section 42 enquiry process • Strategy meeting or discussion may be held, or case will be referred to most appropriate agency for management.

Always ensure you consider any risks to others, including children and other adults with care and support needs. If you are concerned about the welfare of a child, please contact Children's Safeguarding on 0191 520 5560 (available 8.30am to 5.15pm Monday - Thursday, 8.30am to 4.45pm Friday) or the Out of Hours Team on 0191 520 5552 (also available 24 hours Saturday and Sunday).

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1. Introduction

This aim of this document is to provide guidance for people supporting adults with care and support needs who are at risk of harm as a result of self-neglect.

Managing the balance between protecting adults from self-neglect and their right to self-determination is a challenge for professionals. The guidance aims to support good practice in this area.

2. The Care Act (2014)

Self-Neglect and Safeguarding Adults

The Safeguarding Adults element of the Care Act (2014) was implemented in April 2015 and brought about a number of changes which impact upon how self-neglect cases are dealt with.

Within the accompanying statutory guidance for the Care Act (2014), new categories of abuse were added, with "self-neglect" specifically included. As a result, self-neglect was incorporated as a form of abuse in local procedures. The statutory guidance's definition of self-neglect is as follows:

"Self-neglect – this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding".

The statutory guidance identifies that it can be difficult to assess self-neglect. Specifically, that it may be difficult to distinguish between whether a person is making a capacitated choice to live in a particular way (which may be described as an unwise choice or decision) or whether:

- The person lacks mental capacity to make the decision.
- There is a concern regarding the adult's ability to protect themselves by controlling their own behaviour

The Care Act's revised statutory guidance (2016) adds that:

"It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support".

Adult at Risk

A key change to how self-neglect is dealt with under the Safeguarding Adults Procedures is the definition of an adult at risk. The Care Act set out that to be considered as an adult at risk the individual:

"Has needs for care and support (whether or not the local authority is meeting any of those needs);

Is experiencing, or at risk of, abuse or neglect;

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 Care & Support Act revised guidance 2016).

Duty of Cooperation

The Care Act now makes integration, cooperation and partnership a legal requirement on local authorities and on all agencies involved in public care, including the NHS, independent or private sector organisations, housing and the Police. Cooperation with partners should enable earlier intervention which is recognised as an effective way to prevent, reduce or delay needs for care and support and safeguard adults at risk from abuse or neglect.

Wellbeing Principle

The Care Act places significant emphasis on the wellbeing principle with decisions being person-led and outcome-focused. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of an individual, including when carrying out safeguarding adults enquiries. The wellbeing principle will be an important consideration in responding to self-neglect cases. The definition of wellbeing as defined in the Care Act relates to the following areas:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life (including over care and support provided and the way it is provided);
- Social and economic wellbeing;
- Domestic, family and personal relationships;
- Participation in work, education, training or recreation;
- Suitability of living accommodation;
- The individual's contribution to society.

3. Definitions of Self-Neglect

Whilst there is currently no standard definition self-neglect, in addition to the Care Act (2014) definition above, three recognised forms of self-neglect include:

- Lack of self-care – this may involve neglecting personal hygiene, nutrition and hydration or health e.g. non-attendance at medical appointments.

- Lack of care of one's environment – this may result in unpleasant or dirty home conditions and an increased level of risk in the domestic environment such as health and safety and fire risks associated with hoarding.

- Refusal of services that could alleviate these issues, this may include the refusal of care services, treatment, assessments or intervention, which could potentially improve self-care or care of one's environment.

4. Understanding Self-Neglect

Indicators of Self-Neglect

- Neglecting personal hygiene impacting upon health.
- Neglecting home environment, with an impact upon health and wellbeing and public health issues. This may also lead to hazards in the home due to poor maintenance. Not disposing of refuse leading to infestations.
- Poor diet and nutrition leading to significant weight loss, significant weight gain/obesity or other associated health issues.
- Lack of engagement with health and other services/ agencies.
- Hoarding items – excessive attachment to possessions, people who hoard may hold an emotional attachment to items.
- Substance misuse.
- Large number of pets.

Factors that may lead to poor outcomes for individuals

- Value judgments around "lifestyle choice."
- Poor multiagency working and lack of appropriate information sharing.
- Lack of clarity on leadership and case management.
- Assumptions that support is being provided.
- Lack of engagement and challenges from the individual or family; creating barriers to engagement.
- Assumptions about caring roles within families including their capability to fulfill this role.
- A de-sensitisation to well known cases, resulting in minimisation of need and risk.
- Poor risk assessment or no risk assessment.
- Plans and engagement for outcomes being solely based upon mental capacity.
- Chaotic lifestyles and multiple or competing needs.
- Inconsistency in application of thresholds across agencies and teams.

Learning from Reviews Regarding Self Neglect

Findings from Serious Case Reviews (now termed Safeguarding Adult Reviews) identify the importance of the following:

- Early information sharing, in relation to previous or on-going concerns.
- Thorough and robust risk assessment and planning.

- Face-to-face reviews.
- A clear interface with safeguarding adults' procedures.
- Effective collaboration between agencies.
- Increased understanding of the legislative options available to intervene to support or safeguard a person who is self-neglecting.
- Application and understanding of the Mental Capacity Act (2005).
- Where an individual refuses services, ensure the individual is fully informed on options and risks and ensure mental capacity is considered.
- Clear and detailed documentation, including a decision making rationale.
- Re-visiting services and support at regular intervals: it may take time for an individual to be ready to accept some support.
- Management support for an approach which reflects the individuals pace and ongoing review/case management
- Practitioners and managers challenging and reflecting upon cases through the supervision process and training.
- Robust guidance to assist practitioners in working in this complex area.
- Assessment processes which identify who carers and significant others are utilising a "whole family approach"

5. Managing Self-Neglect

In the majority of self-neglect cases, early intervention and preventative actions can result in positive outcomes. Central to this is the need to understand the individual's wishes and needs. In the first instance health and social care staff will need to engage with individuals on issues of consent and desired outcomes. Consideration should also be given to gathering the views of other people who are important in the person's life, with their consent, or as part of the Best Interest framework.

In supporting individuals who self neglect, early intervention and prevention should be viewed as best practice as a means to support individuals. Professional judgment will need to remain person centered and responses should be proportionate to the level of risk. The professionals approach should be responsive to any changes in the individual's behavior or circumstances which are known to increase risk. The level of response could range from preventative intervention such as low level signposting and support to enable an individual to safeguard themselves through to use of statutory powers or duties.

Care Management, multiagency working and establishing relationships and trust can provide an effective framework to support person centered practice, and can be central to supporting individuals, offering lower level support. The Care Act emphasises the importance of using local community support networks and facilities provided by partner and voluntary organisations. Where preventative approaches and positive intervention have not been successful, or where at the point of referral the level of risk is considered to be significant or critical then referral into multi agency safeguarding may be appropriate.

The revised Care Act guidance 2016 clarifies the relationship to safeguarding procedures in that ordinarily it is not appropriate to initiate a Section 42 Enquiry under safeguarding procedures for people who are failing to care for themselves. Section 42 is aimed at those suffering abuse or neglect from a third party. Cases should be considered on an individual basis.

The Sunderland Safeguarding Adults Board Guidance to Interpreting the ADASS Threshold Matrix should be used to support decision making. In addition, the Social Care Institute for Excellence have published guidance on research into best practice on working with those who self neglect SCIE Guidance 69.

6. Mental Capacity

The Mental Capacity Act (2005) (MCA) is crucial to determining what action may or may not be taken in self-neglect cases. All adults have a right to take risks and behave in a way that may be construed as self-neglectful, if they have the capacity to do so without interference from the state.

Mental capacity is a complex attribute, involving not only the ability to understand the consequences of a decision but also the ability to carry out the decision. Where decisional capacity is not accompanied by the ability to carry out the decision, overall capacity is impaired and 'Best Interests' intervention by professionals to safeguard wellbeing may be legitimate. Mental capacity assessments must be decision-specific, apparent capacity to make simple decisions should not result in an assumption that the person is able to make more complex decisions.

Where it is felt intervention may be required due to a person's self-neglect behaviour, any action proposed must be with the person's consent where they are assessed as having mental capacity, unless there are wider public interest concerns, for example, other people may be at risk of harm or a crime has or may be committed. Examples where other people may be at risk as a result of self-neglect include where there is a fire risk or where there are public health concerns (e.g. infestation affecting other properties).

Where there is a concern around significant self-neglect (see section 7.2, page 11), one of the first considerations should be whether the person has mental capacity to understand the risks associated with their actions/lack of action. As per the first principle of the MCA, a person must be presumed to have capacity to make their own decisions. However, a prior presumption of mental capacity may be revisited in self-neglect cases. 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).

Any capacity assessment carried out in relation to self-neglect 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".

In self-neglect cases where there is a risk of significant harm (or higher), it is best practice to demonstrate your assessment (or presumption) of capacity using the MCA1form, and where a best interest decision is required using the MCA2 form.

In particularly challenging and complex cases, it may be necessary for a referral to the Court of Protection to make the best interests decision. Any referral to the Court of Protection should be considered in conjunction with legal advice. In self-neglect cases being managed under Safeguarding Adult Procedures the Local Authority will seek appropriate legal advice and would also administer the application to the Court.

If a person is assessed as having mental capacity this does not negate the need for action under safeguarding adults procedures, particularly where the risk of harm is deemed to be significant or critical. However the revised Care Act Guidance 2016 identifies that an assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour.

Where it is apparent to a professional that the threshold for significant/critical harm to a person has been met and they have mental capacity, duty of care extends to gathering all the available information to inform a thorough risk assessment and subsequent actions even without the consent of the individual. It may be determined that there are no legal powers to intervene, however it will be demonstrated that risks and possible actions have been fully considered where appropriate on a multi-agency basis. All assessment and actions should be recorded and detailed.

7. Guidance for Practitioners

Taking a creative and flexible approach

Engage the person in different ways appropriate to their needs and circumstances and being creative and flexible can have positive outcomes in terms of reducing risk around self neglect. This could involve thinking about who might be the best professional to get the best engagement with the person, or exploring different service options that may reduce risks.

Be patient

Because of the nature of self-neglect cases, the likelihood is that the person may refuse services or support when this is first offered. In conjunction with being flexible and creative, professionals may need to repeatedly try to work with a person to reduce risks. Non-engagement at first contact should not result in no further action being taken at a later date or professionals not going back to the person and offering

further help or support (particularly where risks may have changed or increased). Capacity to refuse services or support should not routinely be considered to be a barrier to further offers and reviews of engagement. It is not always necessary for this to be undertaken via a section 42 enquiry.

Work on a multi-agency basis

It is important to clarify and agree across all agencies the lead professional with oversight and coordination for each case and lines of communication. This should not be presumed and should be a proactive decision based upon key factors, for example; the person's current wishes; relationships and trust; known protective factors and levels of ongoing involvement or potential for involvement. There should be effective coordination of any actions that need to be taken across all agencies by the lead professional involved. Information about risk and actions should be shared with relevant agencies, in most circumstances with consent of the individual. Multi-agency action is not limited to that taken under safeguarding adults procedures.

Make thorough and accurate recordings

Identification of risks and actions taken to manage or minimise risk should be fully documented in professional notes and, where appropriate, a risk assessment and risk management document should be completed. Recording should fully evidence and support any decision making and appropriate monitoring arrangements should be considered and implemented if necessary. It is not always necessary for this to be undertaken via a section 42 enquiry.

Taking a proportionate approach

Responding to self-neglect will depend on the level of risk/harm posed to the individual and/or others and whether the adult is able to protect themselves and determine their own actions.

Professionals should refer to the Safeguarding Adults Guidance to Interpreting the ADASS Threshold Matrix which includes self-neglect, to identify the assessed level of risk based upon considerations about the vulnerability of the individual and the circumstances of the case.

- **Tier 1: Low Level Harm or Risk** - Identifiable risk factors that do not indicate imminent or significant harm to self or others
- **Tier 2 - 3 : Significant or Very Significant Harm or Risk** - Identifiable indicators of significant harm to self or others
- **Tier 4: Critical Harm or Risk** - Imminent risk of significant harm to self or others, where the impact on wellbeing would be critical.

7.1 Tier 1: Low Level Harm or Risk

This may include situations where existing information indicates that there are lower level risk factors present and that they are already being managed effectively by one or more practitioners. If a concern is identified as low level harm/risk, it is expected that the case is dealt with outside of safeguarding adults procedures and is managed by the most appropriate practitioner. Circumstances could include, but are not exclusive to:

- Reports that self-neglect is occurring or possible, but where the potential impact and consequence is not considered to be significant or immediate.
- Unwillingness to engage with services, accept assessments or offers of support and/ or intervention, but where available information suggests little risk of significant harm;
- Non-compliance with medication, which is unlikely to result in significant harm

Possible responses – Low Level Harm/Risk

Where presenting risks of self-neglect have been identified as low, the following actions should be considered by the most appropriate practitioner(s). An up-to-date assessment of the adult's needs should be obtained where applicable or where none exist, the need for appropriate assessments should be considered. Future monitoring should always consider risk and escalation to higher threshold tiers.

Information, advice; sign-posting

Examples include (but are not limited to):

- Information/advice about risks and what options there are for reducing risks;
- Promoting self-help (asking for help if needed; keeping appointments);
- Information/advice about health or care needs; financial information/advice;
- Sign-posting to universal services (e.g. GP, Fire Service, Leisure Services, and Libraries).

Assessment/Review and Services, Tenancy support; Floating support

Examples include (but are not limited to):

- Social care assessment/re-assessment/review; if a Social Care assessment or review is required referrals should be made by contacting Adult Social Care on 0191 520 5552 (including out of hours where there is an urgent social care need).
- Provision of social care services (long-term or short-term re-ablement) including direct payment/personal budget;
- Health assessment/re-assessment/review;
- Multi-Disciplinary meetings and Reviews
- Health treatment/intervention (including action/intervention under the Mental Health Act 1983);
- Fire alarm fitted, sprinkler system fitted; Change of accommodation.

Regular, low-level concerns can amount to a far higher level of concern which could, if the person is unable to protect themselves, then require further consideration and management under safeguarding adults procedures. This would include determining whether a section 42 enquiry is appropriate.

7.2 Tier 2 – 3: Significant or Very Significant Harm or Risk

This may include situations which indicate risk factors are present that place the

adult or others at risk of significant harm through self-neglect, but available information indicates that risk is not immediate and/or critical. This can include but may not be exclusive to:

Tier 2: Significant Harm or Risk

- Ongoing lack of care or behaviour which poses a risk to health and wellbeing
- Multiple reports of concerns of self-neglect from multiple agencies.
- Behaviour which poses a fire risk to self and others.
- Poor management of finances leading to risks to health, wellbeing or property;
- Unwillingness to engage with services, accept assessments or offers of support and/or intervention which has been offered. There should be recorded evidence of attempts made in respect of this.

Tier 3: Very Significant Harm or Risk

- Ongoing lack of care or behaviour to the extent that health and wellbeing deteriorate significantly e.g. pressure sores, wounds, dehydration, malnutrition, infection, refusal to take prescribed medication, lack of personal care, unsanitary/unhygienic lifestyle or living conditions, dietary disorder
- Unwillingness to engage with services, accept assessments or offers of support and/or intervention, and there are concerns about an individual's ability to care for themselves and their environment, or about their mental capacity.

Possible responses- Significant/Very Significant Level of Harm/Risk

Where presenting risks of self-neglect have been identified as significant or very significant using the thresholds, safeguarding adults procedures may be appropriate. A safeguarding adults referral should be made subject to the consent (or appropriate over-riding of consent) of the adult at risk. In assessing whether a referral is appropriate, consideration should be given as to the level of urgency and whether it is appropriate to arrange for a social work or another professional visit to check the welfare of the adult at risk. This will need to be arranged in addition to making a referral and the action taken to safeguard should be included on the referral form. This will include identifying whether multi-disciplinary team meetings or engagement with the individual is being successful in addressing the issues/reducing harm.

Safeguarding adults procedures can provide a more formal, multi-agency, framework for sharing information, assessing and managing risk. Where the threshold is deemed to be significant or very significant, whether a Section 42 enquiry is appropriate or whether measures being taken are sufficient would be considered when the referral is assessed. To enable this to happen the safeguarding adults referral should include specific consideration of:

- Whether the adult at risk is consenting to the safeguarding referral and or action under safeguarding adults procedures;
- Whether it is appropriate to override consent where consent has not been given;
- Whether the individual would be accepting of any other support/intervention outside of safeguarding adults procedures (refer to Section 5: Managing Self-

Neglect);

- The mental capacity of the adult at risk in relation to specific decisions;
- Involvement of the adult at risk (and/or their family/advocate/representative)
- A risk management/support plan, agreed in full consultation with the person at risk, identifying clear responsibilities for actions;
- A review of current arrangements for providing care and support. Does there need to be an assessment/re-assessment/review? This should include any informal carer arrangements;
- Options for encouraging engagement with the adult at risk (e.g. which professional is best placed to successfully engage? Who would the adult respond most positively to?);
- Any legal options available to safeguard the adult (see Appendix 1: Legal Options in relation to Self-Neglect). Legal advice should be sought;
- Whether there are any other people at risk (including children) and what action needs to be taken if this is case;
- A contingency plan, should the agreed Safeguarding Risk Management Plan fail;
- How agencies/professionals will keep in regular communication about any changes or significant events/incidents;
- Support for front-line staff delivering services to the individual (e.g. in responding to a refusal of services).

As with all safeguarding adults referrals, it is important that details of actions and decision-making are clearly recorded.

Where it is clear that this information needs to be ascertained/provided agencies may be requested to supply this. It will not always be the case that a meeting is convened to identify that this information is required.

7.3 Tier 4: Critical Harm or Risk

This includes the most serious and challenging presenting circumstances, including but not exclusive to:

- Complex and high level risk, including the potential for or possibility of death and/or serious injury because of the presenting risks and situation;
- A failure to seek/accept lifesaving services or medical care where required;
- Apparent lack of options available to protect the individual from risk/harm;
- Where the demands of managing the risk require significant commitment, professional/multi-agency involvement, coordination and resources;
- Possibility of heightened public awareness, scrutiny or media attention due to the high profile nature of the circumstances.
- Failure of multi-disciplinary team to effectively safeguard

Possible responses – Critical Level of Harm/Risk

Where presenting risks of self-neglect have been identified as critical, safeguarding adults procedures should be used and a safeguarding adults enquiry should be coordinated. Attempts should still be made to seek the adult at risk's consent for the safeguarding adults enquiry to take place, however where this is

not provided, consent should be overridden given the seriousness of the concerns. This is so that the concerns can be fully explored on a multi-agency basis and reassurance can be provided that all possible options to manage risk have been attempted.

8. Making a referral into safeguarding adults procedures

A Safeguarding Enquiry Referral Form (SERF) found on the Councils website safeguarding page http://www.sunderland.gov.uk/index.aspx?articleid=7644 can also be completed.

9. Ending Involvement

Ideally work will be carried out with individuals which will result in their situation being improved to a point where it is deemed to be safe enough, or their expressed outcomes have been achieved. This will be based on decisions made with the individuals themselves, their families/carers/advocate (if appropriate) and any agencies involved.

There may come a point at which all options have been exhausted, and no improvement has been established. In cases where a critical level of harm has been encountered and it has not been possible to reduce risks, supervision arrangements should be used to support staff who are delivering services/making decisions. Where appropriate further Senior Management advice should be sought.

Where safeguarding adults procedures have been used, shared decision making should be recorded via the multi-agency safeguarding procedures, including a decision to end involvement. Any ongoing monitoring or involvement can be conducted as part of core business for the professional involved, with the option of further safeguarding referrals considered where a change in circumstances warrants this.

Where safeguarding adults procedures have not been used because the tier is low, or there is a lack of consent, or work has been undertaken via another multi-agency framework, then any decision to end involvement should be communicated to all the other agencies/services involved. The decision-making rationale should be risk assessed and clearly recorded.

Appendix 1 – Legal Options in Relation to Self-Neglect

There are many legislative responsibilities placed on agencies to intervene in or be involved in some way with the care and welfare of adults who are believed to be vulnerable.

It is important that everyone involved thinks pro-actively and explores all potential options and wherever possible, the least restrictive option e.g. a move of the person permanently to smaller accommodation where they can cope better and retain their independence.

The following outline a summary of the powers and duties that may be relevant and applicable steps that can be taken in cases of dealing with persons who are self-neglecting and/or living in dirty and unpleasant conditions. The following is not necessarily an exhaustive list of all legislative powers that may be relevant in any particular case. Cases may involve use of a combination of the following exercise of legislative powers.

Environmental Health

Environmental Health Officers in the Local Authority have wide powers/duties to deal with waste and hazards. They will be key contributors to cross departmental meetings and planning, and in some cases e.g. where there are no mental health issues, no lack of capacity of the person concerned, and no other social care needs, then they may be the lead agency and act to address the physical environment.

Remedies available under the **Public Health Acts 1936 and 1961** include:

- power of entry/warrant to survey/examine (sections 239/240)
- power of entry/warrant for examination/execution of necessary work (section 287)
- Enforcement notices in relation to filthy/verminous premises (section 83) – applies to all tenure.

Remedies available under the **Environmental Protection Act 1990** include:

- Litter clearing notice where land open to air is defaced by refuse (section 92a)
- Abatement notice where any premise is in such a state as to be prejudicial to health or a nuisance (sections 79/80)

Other duties and powers exist as follows:

- **Town and Country Planning Acts** provide the power to seek orders for repairs to privately owned dwellings and where necessary compulsory purchase orders.
- The **Housing Act 2004** allow enforcement action where either a category 1 or category 2 hazard exists in any building or land posing a risk of harm to the health or safety of any actual or potential occupier or any dwelling or house in multiple occupation (HMO). Those powers range from serving an improvement notice, taking emergency remedial action, to the making of a demolition order.
- Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice under the **Prevention of Damage by Pests Act 1949.**

- The **Public Health (Control of Disease) Act 1984** Section 46 sets out restrictions in order to control the spread of disease, including use of infected premises, articles and actions that can be taken regarding infectious persons.

Housing – landlord powers
These powers could apply in Extra Care Sheltered Schemes, Independent Supported Living, private-rented or supported housing tenancies. It is likely that the housing provider will need to prove the tenant has mental capacity in relation to understanding their actions before legal action will be possible. If the tenant lacks capacity, the Mental Capacity Act 2005 should be used.

In extreme cases, a landlord can take action for possession of the property for breach of a person's tenancy agreement, where a tenant fails to comply with the obligation to maintain the property and its environment to a reasonable standard. This would be under either under Ground 1, Schedule 2 of the **Housing Act 1985** (secure tenancies) or Ground 12, Schedule 2 of the **Housing Act 1988** (assured tenancies).

The tenant is responsible for the behaviour of everyone who is authorised to enter the property.

There may also be circumstances in which a person's actions amount to anti-social behavior under the **Anti-Social Behaviour, Crime and Policing Act 2014**. Section 2(1)(c) of the Act introduces the concept of "housing related nuisance", so that a direct or indirect interference with housing management functions of a provider or local authority, such as preventing gas inspections, will be considered as anti-social behaviour. Injunctions, which compel someone to do or not do specific activities, may be obtained under Section 1 of the Act. They can be used to get the tenant to clear the property or provide access for contractors. To gain an injunction, the landlord must show that, on the balance of probabilities, the person is engaged or threatens to engage in antisocial behaviour, and that it is just and convenient to grant the injunction for the purpose of preventing an engagement in such behaviour. There are also powers which can be used to require a tenant to cooperate with a support service to address the underlying issues related to their behavior.

Mental Health Act 1983
Sections 2 and 3 of the Mental Health Act 1983
Where a person is suffering from a mental disorder (as defined under the Act) of such a degree, and it is considered necessary for the patient's health and safety or for the protection of others, they may be compulsorily admitted to hospital and detained there under Section 2 for assessment for 28 days. Section 3 enables such a patient to be compulsorily admitted for treatment.

Section 7 of the Mental Health Act 1983 – Guardianship
A Guardianship Order may be applied for where a person suffers from a mental disorder, the nature or degree of which warrants their reception into Guardianship (and it is necessary in the interests of the welfare of the patient or for the protection of other persons.) The person named as the Guardian may be either a local social services authority or any applicant.

A Guardianship Order confers upon the named Guardian the power to require the patient to reside at a place specified by them; the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training; and the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved mental health professional or other person so specified.

In all three cases outline above (i.e. Section 2, 3 and 7) there is a requirement that any application is made upon the recommendations of two registered medical practitioners.

Section 135 Mental Health Act 1983
Under Section 135, a Magistrate may issue a warrant where there may be reasonable cause to suspect that a person believed to be suffering from mental disorder, has or is being ill-treated, neglected or kept otherwise than under proper control; or is living alone unable to care for themselves. The warrant, if made, authorises any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove them to a place of safety.

Section 135 lasts 72 hours and is for the purpose of removing a person to a place of safety with a view to the making of an assessment regarding whether or not Section 2 or 3, or 7 of the Mental Health Act should be applied.

Section 136 Mental Health Act 1983
Section 136 allows police officers to remove adults who are believed to be "*suffering from mental disorder and in immediate need of care and control*" from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital.

Mental Capacity Act 2005
The powers to provide care to those who lack capacity are contained in the Mental Capacity Act 2005. Professionals must act in accordance with guidance given under the Mental Capacity Act Code of Practice when dealing with those who lack capacity and the overriding principal is that every action must is carried out in the best interests of the person concerned.

Where a person who is self-neglecting and/or living in squalor does not have the capacity to understand the likely consequences of refusing to cooperate with others and allow care to be given to them and/or clearing and cleaning of their property a best interest decision can be made to put in place arrangements for such matters to be addressed. A best interest decision should be taken formally with professionals involved and anyone with an interest in the person's welfare, such as members of the family.

The Mental Capacity Act 2005 provides that the taking of those steps needed to remove the risks and provide care will not be unlawful, provided that the taking of them does not involve using any methods of restriction that would deprive that person of their liberty. However where the action requires the removal of the person from their home then care needs to be taken to ensure that all steps taken are

compliant with the requirements of the Mental Capacity Act. Consideration needs to be given to whether or not any steps to be taken require a **Deprivation of Liberty Safeguards** application.

Where an individual resolutely refuses to any intervention, will not accept any amount of persuasion, and the use of restrictive methods not permitted under the Act are anticipated, it will be necessary to apply to the Court of Protection for an order authorising such protective measures. Any such applications would be made by the person's care manager who would need to seek legal advice and representation to make the application.

Emergency applications to the Court of Protection
You can apply to the Court of Protection to get an urgent or emergency court order in certain circumstances, e.g. a very serious situation when someone's life or welfare is at risk and a decision has to be made without delay. You won't get a court order unless the court decides it's a serious matter with an unavoidable time limit.

Where an emergency application is considered to be required, relevant legal advice must be sought.

Power of entry
The Police can gain entry to a property if they have information that a person inside the property was ill or injured with the purpose of saving life and limb. This is a power under Section 17 of the Police and Criminal Evidence Act 1984.

Inherent Jurisdiction
There have been cases where the Courts have exercised what is called the 'inherent jurisdiction' to provide a remedy where it has been persuaded that it is necessary, just and proportionate to do so, even though the person concerned has mental capacity.

In some self-neglect cases, there may be evidence of some undue influence from others who are preventing public authorities and agencies from engaging with the person concerned and thus preventing the person from addressing issues around self-neglect and their environment in a positive way.

Where there is evidence that someone who has capacity is not necessarily in a position to exercise their free will due to undue influence then it may be possible to obtain orders by way of injunctive relief that can remove those barriers to effective working. Where the person concerned has permitted another reside with them and that person is causing or contributing to the failure of the person to care for themselves or their environment, it may be possible to obtain an Order for their removal or restriction of their behaviours towards the person concerned.

In all such cases legal advice should be sought.

Animal welfare
The **Animal Welfare Act 2006** can be used in cases of animal mistreatment or neglect. The Act makes it against the law to be cruel to an animal and the owner must ensure the welfare needs of the animal are met. Powers range from providing

education to the owner, improvement notices, and fines through to imprisonment. The powers are usually enforced by the RSPCA, Environmental Health or DEFRA.

Fire

The fire brigade can serve a prohibition or restriction notice to an occupier or owner which will take immediate effect (under the **Regulatory Reform (Fire Safety) Order 2005**). This can apply to single private dwellings where the criteria of risk to relevant persons

Appendix 2 – Hoarding

Hoarding Disorder used to be considered a form of obsessive compulsive disorder (OCD). It is now considered a standalone mental disorder and is included in the 5th edition of the Diagnostic and Statistical Manual of Mental Health Disorders 2013. Hoarding can also be a symptom of other mental disorders. Hoarding Disorder is distinct from the act of collecting, and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects which are well in excess of their real value.

Hoarding does not favour a particular gender, age, ethnicity, socio-economic status, educational/occupational history or tenure type.

Anything can be hoarded, in various areas including the resident's property, garden or communal areas. Commonly hoarder items include but are not limited to:

- Clothes
- Newspapers, magazines or books
- Food and food containers
- Animals
- Medical equipment
- Collectibles such as toys, video, DVD, or CD's

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 (see page 25) and provide the information needed to alert other agencies.

Most clients with a hoarding problem will be embarrassed about their surroundings, so adapt the question to suit your customers.

- 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? Or got upstairs and 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 (or recycling, selling, giving away) ordinary things that other people would get rid of?

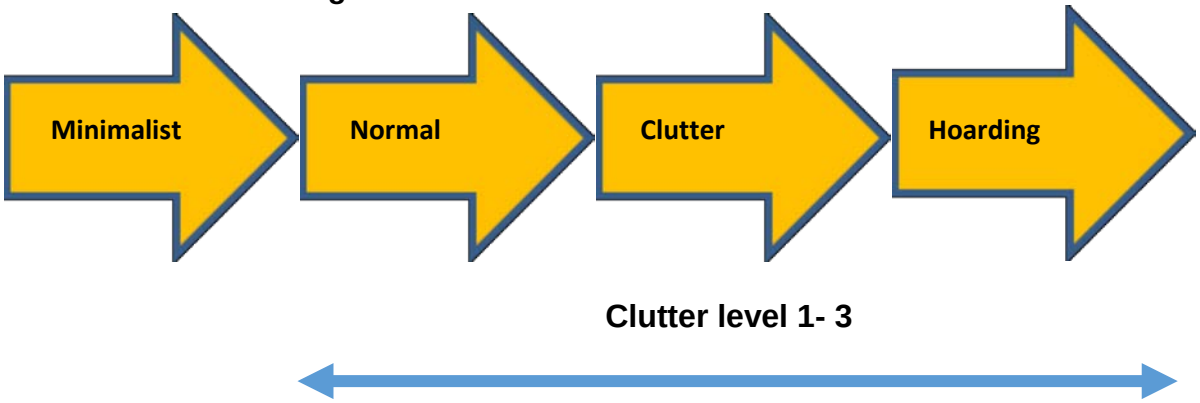
Multi-Agency Response

It is recognised that hoarding is a complex condition and that a variety of agencies will come into contact with the same person. It is also recognised that not all individuals will receive support from statutory services such as Mental Health.

Any professional working with individuals who may have or appear to a have a hoarding condition should ensure they complete the Practitioners Assessment and use the clutter image rating tool kit to decide what steps to take.

Evidence of animal hoarding at any level should be reported to the RSPCA.

Continuum of Hoarding Behaviour



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

Images 1-3 indicate level 1

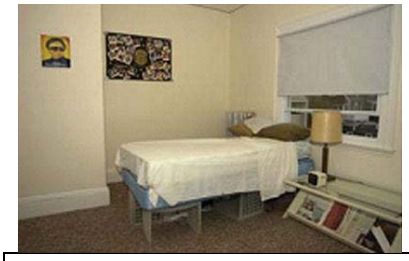
Images 4-6 indicate level 2

Images 7-9 indicate level 3

Then refer to clutter assessment tool to guide which details the appropriate action you should take. Record all actions undertaken in agency's recording system, detailing conversations with other professionals, actions taken and action yet to be taken.

Clutter Image Rating Scale[1] - Bedroom

Please select the photo that most accurately reflects the amount of clutter in the room

		
1	2	3
		
4	5	6
		
7	8	9

[1] The ratings are via The International OCD Foundation and were originally from a study by 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.

Clutter Image Rating Scale[2] - Lounge

Please select the photo that most accurately reflects the amount of clutter in the room

1

2

3

4

5

6

7

8

9

[2] The ratings are via The International OCD Foundation and were originally from a study by 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.

Clutter Image Rating Scale[3] – Kitchen

Please select the photo that most accurately reflects the amount of clutter in the room

1

2

3

4

5

6

7

8

9

[3] The ratings are via The International OCD Foundation and were originally from a study by 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.

Practitioner's Hoarding Assessment

This assessment should be completed using the information you have gained using the Practitioner's Guidance Questions. Complete this review away from the client's property and use the Clutter Image Rating Scale to inform your assessment. The Practitioner's Hoarding Assessment should be used to identify the level of hoarding and should be retained as a record of assessment. Text boxes will expand to allow further text.

Date of Home Assessment				
Client's Name				
Client's Date of Birth				
Address				
Client's Contact Details				
Type of Dwelling				
Freeholder	Yes/No	Tenant – Name & Address of Landlord		
Household Members		Name	Relationship	DOB
Pets – Indicate what pets and any concerns				
Agencies Currently Involved				
Non-Agency Support Currently in Place				
Client's Attitude Toward Hoarding				

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

Using the Clutter Image Scale Please Score Each of the Rooms Below					
Bedroom 1		Bedroom 4		Separate Toilet	
Bedroom 2		Kitchen		Lounge	
Bedroom 3		Bathroom		Dining Room	

Please provide a Description of the Hoarding Problem: (presence of human or animal waste, rodents or insects, rotting food, are utilities operational, structural damage, problems with blocked exits, are there combustibles, is there a fire risk? etc.)

Based on the information provided above, what level is your case graded?		
Level 1 - Green	Level 2 - Orange	Level 3 - Red

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

Appendix 3 – Case Studies

(Note: With thanks to Newcastle, North Tyneside & Northumberland for allowing reproduction of the case studies from their North of Tyne Self Neglect Guidance document).

Some case studies have been chosen to provide examples relating to self-neglect with varying levels of risk using the Safeguarding Adults Risk Threshold Tool:

Ms J - meets low level threshold

Ms J is 69 and lives alone in a Gentoo tenancy. She is known to adult social care and Mental Health services. She had a worker in mental health care coordination, until her case was closed in the last month.

She was admitted to hospital following a fall which resulted in injury to her arm. She was reported to be under the influence of alcohol was reported to be covered in urine and faeces.

Ms J self- discharged herself from hospital. The Police did a welfare call to Ms J and submitted an Adult Concern notification to the Local authority, reporting that she was still in the same condition as when she left Hospital and that her home was also dirty and soiled, with lots of empty alcohol bottles and cans.

Helen and Karen from the adult social care team visited Ms J. Ms J's ex-partner Mark had cleared the property and put the soiled bedding into the washing machine. Ms J's bed was very soiled and could not be totally cleaned. Mark said he had some money to buy a second hand bed, however the community resource he was to go to was now closed. Mark was signposted to a new furniture service to buy a bed. Helen also picked up bedding from a voluntary sector provider to have in reserve.

Ms J did not want to attend formal services about her alcohol issues as she was too embarrassed and did not feel that there would be other people her age there. She did agree to a referral to a home support service. It was agreed that the home support service would see Ms J every Wednesday morning and they would look at local groups to keep Ms J busy during the day as well as strategies to manage Ms J's alcohol use. It was agreed that the home support service would update Adult Social Care on Ms J's progress.

Elizabeth - meets low level threshold

Elizabeth is an 89 year old woman, with a physical disability, who normally resided with her sister in her owner occupied home. Elizabeth was referred to an advocacy service by a Community Psychiatric Nurse for advocacy support around writing a formal letter in relation to the clearance of her home. The sisters were placed in emergency accommodation following concerns from emergency services regarding their home environment, after being called to the house when Elizabeth suffered a fall. This was a situation commonly referred to as 'extreme hoarding'. Elizabeth and

her sister had agreed to their home being cleared, but items of furniture had been removed and disposed of without specific consent from Elizabeth or her sister.

In the first instance, advocate made enquiries with the local authority Adult Services Dept. and also the furniture Removals and Storage Company, to identify missing items. The advocate also supported Elizabeth to obtain a benefits check, following which a regular benefit has been paid to Elizabeth, to which she had been unaware of her entitlement.

The advocate continued to support Elizabeth, at meetings regarding her current placement and her expressed desire to return to home and in negotiations with Adult Services, around work that has been required on Elizabeth's home, to clear, clean, make safe and upgrade the utilities, fixtures and fittings. The house was finally ready for Elizabeth and her sister to return to after a year. Unfortunately her sister sadly passed away and Elizabeth decided that she would prefer to remain in residential care (fully funded due to her financial circumstances.)

The advocate continued to liaise with social work and health professionals in order to ensure the residential home was suitable for her needs on a permanent basis. Elizabeth expressed that she had been very grateful for the help she had received negotiating this difficult change in her life.

Mrs L - meets significant harm threshold

Mrs L was born in 1912, and lived in her owner occupied property with her husband; following the death of her husband (approx. 1993) she contacted adult social care several times for support.

Mrs L would ask for an assessment and would go through with the assessment and often accept services then would quickly disengage with services and take a dislike to care staff.

Mrs L's property was in a very unkempt state, she hoarded and her home was full to capacity with everything she declined to throw away. At one stage she refused to throw away left over food. She had always had dogs and she had two very large dogs who she adored.

The outside of her property was also unkempt, she put food down for birds and this attracted vermin. Her neighbours then became intolerant.

Involvement from Adult Social Care commenced in 2004. The property was not only unkempt it was unhygienic and becoming an environmental issue.

It soon became apparent that Mrs L would only accept support at her pace and often not at all. Visits would include supporting her to bag cardboard, newspapers at first and only if the Social Worker promised she would recycle. This may have seemed a small step but some headway was been made in at least making a clear pathway through her property.

The case was time consuming but she would not engage with an agency or a support worker.

Mrs L's health was deteriorating; she was getting frequent infections but did seek medical assistance.

A capacity assessment confirmed she did have capacity to understand the risk posed to her in relation to how she was living and the effect it had on her health.

Presenting Needs:

- Unkempt property/hoarding
- Isolation from her community
- Deteriorating health/personal care
- Environmental issues
- Disengaging with services including my intervention
- Suspiciousness
- Mrs L was diagnosed as having a personality disorder and Diogenes Syndrome (also known as Squalor Syndrome).

Having the diagnosis made it more understandable about how to continue to work with Mrs L.

The process of case management of Mrs L was lengthy and ongoing until she passed away aged 101. Mrs L continued living at home independently.

Robert – Meets Significant Harm Threshold

A safeguarding adults referral is made by the Police for Robert following a recent attendance at his property. The Police were called following concerns from neighbours.

Robert is 34 and known to misuse substances. He has a tenancy and a tenancy support worker. No formal mental capacity assessments have been undertaken, however the Police have found evidence that suggest Robert is abusing solvents which Police felt were affecting Robert's ability to make decisions.

When Police arrived at the property they heard a disturbance from within but Robert refused the Police entry and so forced entry was required. On entering the flat, Police found squalid conditions; numerous flies in the property; there was an old mattress in the middle of the living room floor and numerous empty bottles and cans of alcohol. Robert's bedroom was ankle deep in rubbish and the whole property smelt strongly of waste.

This was the fifth safeguarding referral in 9 months outlining similar concerns from a number of different agencies. Every previous concern has progressed to a section 42 enquiry. The Safeguarding Adults Plans centred around addressing the fire risk within Robert's property; attempting to engage Robert in drug and alcohol services;

continuing to attempt to engage Robert with his tenancy support worker; and ensuring regular communication between agencies.

Due to the frequency of referrals and the fact that the previous safeguarding adults plans do not appear to have resulted in any change in Robert's circumstances, it is decided that the case needs to progress and a multi-agency Strategy meeting held.

The Strategy Meeting ensured that all professionals involved with Robert were clear about his current situation and the level of risk. It was agreed that Mental Capacity Assessments needed to be undertaken in relation to Robert's ability to make decisions in relation to his accommodation (his tenancy was potentially at risk) and around his care and treatment. The Strategy Meeting discussed what had worked and what hadn't worked in the past in order to inform a safeguarding adults plan for the future (including contingency arrangements). The GP agreed to make a referral for a review of Robert's mental health. Legal Services were present at the meeting in order that the potential legal options could be explored.

It was also felt that this case would benefit from an evaluation of how successful the safeguarding adults plan had been. The concerns at this stage did not suggest that Robert was at serious risk of harm but it was acknowledged that there could be the potential for risks to escalate. If this was to be the case and there continued to be a lack of engagement with no legal options available, the case would be escalated to senior managers.

Mr F – Meets Critical Harm Threshold

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

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

An Ambulance is often called when Mr F's condition deteriorates. Paramedics have submitted 16 Adult Concerns in the 28 month period related to Mr F living in squalid conditions and being emaciated. Concerns include: urine and faeces on furniture, walls and clothes; mouldy food; dirty incontinence pads in bathroom; rubbish bags piled up; and unsafe and unhygienic bathroom and kitchen.

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

The case required multi-agency oversight and management via safeguarding adults procedures to ensure that all possible options to reduce risks to Mr F had been explored. The Social Worker involved in the case identified that it took time (and creativity) to build up a relationship with Mr F and to gain his trust. The domiciliary care service has to regularly communicate with Adult Social Care about any difficulties they have in delivering his care and any deterioration in his condition. There continued to be assessments of Mr F's capacity and the landlord considered taking action under the local Clean Homes Protocol (however the case was not felt to meet the threshold for action).

Appendix 4 – Useful Contacts (Refer to Sunderland Safeguarding Adult Procedures Section 11.1 (click on: Contents/Appendices/Contact Details in the Policies & Procedures section on www.sunderlandsab.org.uk)