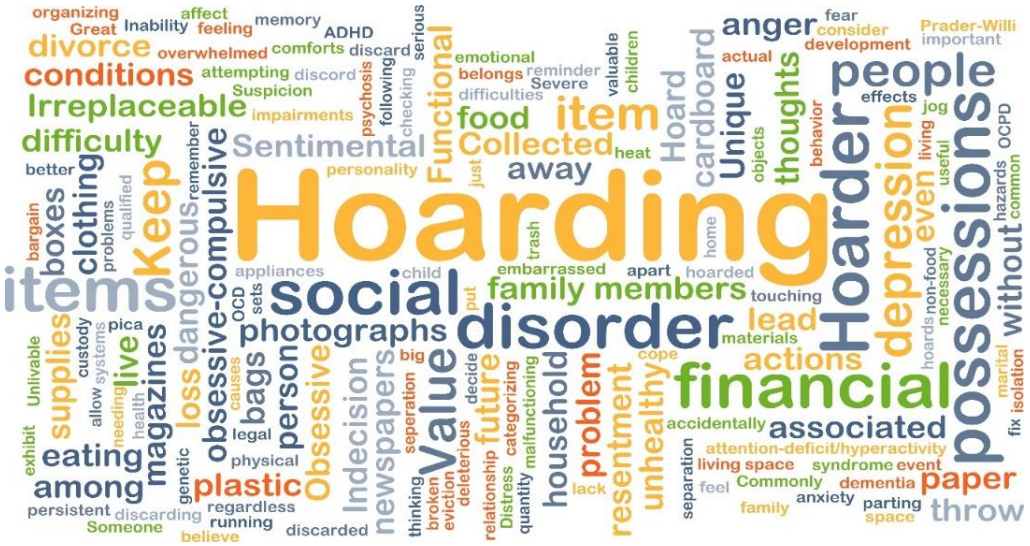
Self-Neglect & Hoarding

Toolkit for Practitioners

November 2024

Policy, Performance and Customer Care Team
Adult Social Care | Adults Directorate

Contents



Policy Summary

Document name	Self-Neglect & Hoarding Toolkit for Practitioners
Version	1.0
Publication date	December 2024
Review due date	December 2027
Approved by	SMT
Status	Mandatory (all named staff must adhere to guidance)
Author	Katy Rushworth, Safeguarding & Dignity Officer – Policy, Performance & Customer Care
Contributors	Katy Goodall, Interim Principal Manager – Integrated Adults Safeguarding Unit
Service area	Adult Social Care
Target audience	Adult Social Care and Health Partners
Distribution	Adult Social Care and Halton Safeguarding Adults Board Partner Agencies
Related document(s)	Self-Neglect Policy and Procedure 2024
Superseded document(s)	Self-Neglect & Hoarding Toolkit 2020
Equality Impact Assessment	Updated
If you require this policy or any associated documents in another format (e.g. other languages, easy-read or any other format), please email details of your requirements to: ascservicedevelopment@halton.gov.uk.	

Acknowledgements

This toolkit has been developed referencing various documents from the following authorities/organisations. We would like to acknowledge the use of these documents in the development of this toolkit. All information sources used have been clearly referenced throughout.

1. Purpose

The purpose of this toolkit is to develop practice guidance for a range of health and social care professionals to use, when supporting someone who is self-neglecting or hoarding. This toolkit can be used by any health or social care professional.

The Care Act 2014 clarified the relationship between self-neglect and safeguarding and made self-neglect a category of harm, about which the Local Authority has a duty to make enquiries and to assess need with the promotion of well-being at the heart.

In further clarification received from the Department of Health in June 2015, it states that self-neglect is the responsibility of safeguarding boards in terms of ensuring that policies and procedures underpin work around people who self-neglect, balancing self-determination, robust mental capacity assessment, consent and protection. It does not mean that each case of self-neglect must progress to a Section 42 enquiry, but that each case must receive an appropriate response.

Engaging with, assessing and providing support to such people can be complex and frustrating and often requires a clear understanding of the law, to ensure actions taken are defensible. Many dedicated, compassionate practitioners are left struggling with cases, feeling alone and isolated.

In 2011, the Law Commission undertook a series of scoping studies in adult social care. This identified a historic lack of understanding of self-neglect, resulting in inconsistent approaches to support and care. In an effort to address this, the Care Act statutory guidance 2014, formally recognises self-neglect as a category of abuse and neglect – and within that category identifies hoarding.

This means that the need locally for a consistent approach is key in ensuring that health and social care professionals work together, to ensure that people who self-neglect have the right support in a timely manner which is delivered in a proportionate and preventative way.

There are tensions between respect for autonomy and a perceived duty to preserve health and wellbeing."(SCIE 2011 ibid)

"Prevailing cultures of paternalism (in health) and risk-aversion (in social care)" (SCIE 2011)

People can tell us they will do that, but we don't test whether they can do it

We're not sure safeguarding is the right framework to use, though it does provide a framework in the absence of any other

It's just recorded that the person has capacity, not in relation to what, whereas we need to be more thorough and address every arena they're going to have to function in

The extent and severity of hoarding makes it clear that this can be a problematic condition from the standpoint of public health threat, costs to the public and even loss of life. Effective social and/or individual intervention for problematic hoarding is clearly needed. (Hoarding UK)

People who self-neglect don't want lots of people doing things for them, but support to get by…we're mindful that if we push people to do things they don't want to do we will get nowhere at all because they'll shut the door.

There is a bubble of people who think we really need this, but there are also groups who won't recognise that it has something to do with them; there will still be a gap, and we need to get that message out

2. Local Picture

In Halton, the number of safeguarding concerns raised over the last 4 years has fluctuated. In 2021/22 the increase in safeguarding concerns is thought to be attributed to the Covid-19 pandemic. The number of safeguarding concerns which have led to Section 42 enquiries has stayed relatively stable over the last 4 years, with the number of Section 42 enquiries relating to self-neglect increasing year on year.

Year	Number of Safeguarding Concerns Raised	Number of S.42 Enquiries	Number of S.42 Enquiries relating to Self-Neglect
2020/21	1098	336	7
2021/22	1220	366	10
2022/23	1096	436	11
2023/24	809	327	19

In 2016, Halton Borough Council launched its first Self-Neglect Policy. The policy was introduced to support with high risk cases and the Integrated Adults Safeguarding Unit (IASU) would determine those referrals that met the criteria for a S42 enquiry and will decide on an appropriate course of action for cases that do not meet the threshold for a S42 enquiry. However, we are aware that there is under reporting in relation to self-neglect in the borough and that more effective systems need to be put in place, in order to identify cases of self-neglect and respond to them in a more effective manner.

As stated above, self-neglect became a domain of abuse within the Care Act 2014. However, how self-neglect differs from other domains of abuse is, that there is no other person inflicting self-neglect on the individual in an abusive way – therefore, there is **no** alleged perpetrator only the individual themselves.

For social workers this provides a significant challenge in developing relationships that empower the individual, or safety plans, based upon what makes a person feel safe and well cared for, yet respect autonomous decision making.

It is important to explore the person's history; listen to the way they talk about their life; any difficulties and strategies they have developed for self-protection. By doing this, social workers and health professionals can begin assessing why the person self-neglects and begin to offer support in replacing attachment objects, with interaction and relationships with people and the community. Distress may have led people to seek comfort in having possession; when faced with isolation they may seek proximity to things they're attached to and when faced with chaos, may seek to preserve predictability.

Early relationships can have quite an effect on how a person perceived the world and may not recognise their self-neglect, they may even find comfort in their

situation. Deep-seated emotional issues, which have evolved as coping strategies cannot be undone in an instant.

Source: https://www.communitycare.co.uk/2016/08/22/hoarding-self-neglect-social-workers-need-know/

3. What is Self-Neglect?

Self-Neglect manifests itself in different ways. It might be that a person is physically or mentally unwell, or has a disorder and cannot meet their own care needs as a result. They may have suffered trauma or loss, or be receiving inappropriate support from a carer. The person may not recognise the level of self-neglect.

Self-neglect can occur as a result of dementia, brain damage, depression or psychotic disorders. It may be down to substance use, including misuse of prescribed medications.

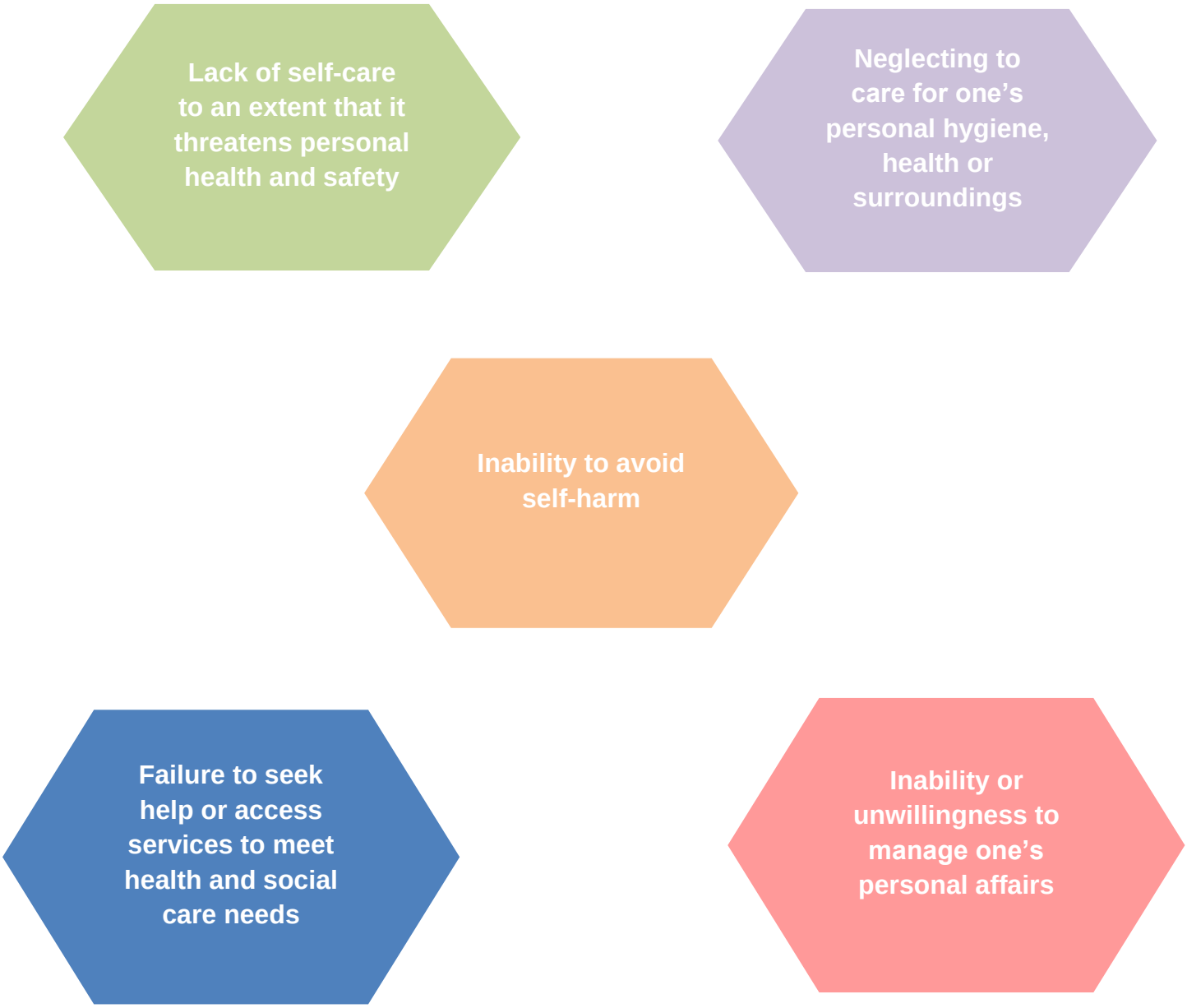
According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 2012, hoarding disorder is described as a pattern of compulsive behaviour, involving accumulating numerous possessions that are not really needed. This identifies those who severely self-neglect or hoard as in need of care and support, therefore, meeting the adult safeguarding criteria.

Symptoms of hoarding disorder can include emotional attachment and distress over parting with possessions, regardless of usefulness; allowing possessions to interfere with day to day life and relationships; and social isolation.

Often these attachments can begin with trauma and loss, parental attachment and control issues and information processing deficits. Often people who hoard suffer from anxiety.

Source: https://www.communitycare.co.uk/2016/08/22/hoarding-self-neglect-social-workers-need-know/

4. Types of Self-Neglect



Source: https://www.scie.org.uk/safeguarding/adults/introduction/types-and-indicators-of-abuse

5. Myth Busting

Myth	Truth
Removing clutter and property will remove the issue of hoarding	*Large scale removals without the person with hoarding behaviours permission do not work. Instead this is likely to have a long term negative impact on their mental health. The short-term quick fix approach also does not deal with core issues. Large scale clean-ups, even with the person's permission may not work*
Fires in hoarding properties will behave in the same way as they do anywhere else	*Fires were contained to the room of origin in 90% of all residential fires. In hoarding homes, however, that percentage dropped to 40% indicating that hoarded materials promote the spread of fire through a dwelling*
Hoarding only takes place in certain types of property	*Hoarding can be found in all property types. Hoarding in high rise premises pose very particular risks to the community and to fire fighters. Hoarding in privately owned residences creates some specific issues with regards to the application of legislation*
People with hoarding issues can't see all the stuff and dirt, they don't mind it	*People with hoarding behaviours can see the clutter but are able to mostly mentally block it out. This has been called clutter blindness, When a person does begin to recognise the problems, this can be a sign they are ready for change and help*
There is nothing we can do about it	*With the proper support, help and guidance, hoarding problems can be resolved*
People with hoarding issues love their belongings more than their family	*People with hoarding behaviours have a strong attachment to belongings for a range of reasons. This attachment is likely to be stronger than the average person's. The difficulty discarding is as a result of these complex issues, but does not reflect that the person's love*

	for those in their family is lesser. Simply that it is too difficult a process for the person to deal with
People with hoarding issues are just dirty and lazy. It's a "lifestyle" choice	*Usually just the opposite is true. In fact, people with hoarding behaviours have often undergone a traumatic experience and/or had a huge period of instability in their lives. Incorrect interventions can often cause further trauma because the relationship with the belongings acts as a coping mechanism, discarding this haphazardly often results in retriggering of the trauma and/or escalation of the behaviours*
All people with hoarding issues have Obsessive Compulsive Disorder (OCD)	*Hoarding Disorder has been classified by the American Diagnostic Statistical Manual (DSM) and is published in the International Classification of Diseases (ICD). A unique classification was seen to be necessary because interventions which have succeeded in OCD were not as effective treating hoarding behaviours*
People only hoard things at home	*Communal areas, gardens, storage spaces, friend's/neighbour/s homes and vehicles can also be used. There is legislation in place, in regard to all but storage spaces, which would mean that belongings which created unacceptable clutter could be in breach of a range of laws. Hoarding in offices and other business premises is not uncommon and can lead to blocked escape routes and increased risk of fire*
Evicting people with hoarding issues teaches them a lesson and stops them hoarding again	*Being evicted is a traumatic experience, and can create such anxiety for a person with hoarding issues that their tendency to hoard can increase. This too does not deal with the core issues. As such, it can be seen as simply shifting the problem*
People with hoarding issues don't like to talk about it	*There are currently support groups across the UK, although more support is needed*

All people with hoarding issues live in squalid conditions or own numerous pets or both	*Most people with hoarding issues do not live in unhygienic conditions, nor are they animal hoarders*
Every room in a hoarder's home is packed full of stuff	*People with hoarding tendencies may have parts of their home which are less cluttered, or live with people who aren't hoarders and who do what they can to keep parts of a home tidy*
People with hoarding tendencies are uneducated and have lower levels of intelligence	*Hoarding is found within all populations*
Everyone with lots of clutter is a hoarder	*Just because someone owns lots of stuff or lives in a cluttered home, doesn't necessarily mean they're a hoarder*
If people have capacity, then we can't do anything	*Although people have the right to make unwise decisions, capacity needs to be assessed regarding a time and decision specific decision, if there are concerns regarding the person's ability to make decisions for themselves, due to an underlying cognitive impairment. If a refusal to accept support and we know there are concerns regarding ongoing abuse or neglect, we have a duty to intervene*
Self-neglect is not a health issue, but a social care issue	*The impact on the person who is self-neglecting can be far and wide. This includes risk, covering health; fire; safety; personal care; carer breakdown; environmental and housing associated risks. In order to support the person who is self-neglecting, there needs to be shared accountability and multi-disciplinary team (MDT) working – working together in a preventative way*

Source: http://www.safeguardingpeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/hoarding/#Appendix_2_Hoarding_Myths_and_Truths

6. Do's and Don'ts

When Talking to Someone who Self-Neglects or Hoards PLEASE TRY TO:	
	Imagine yourself in that person's 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 clothing that is 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. 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 can 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

When Talking to Someone who Self-Neglects or Hoards **PLEASE DO NOT:**	
X	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
X	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"*
X	Let your non-verbal expression say what you are thinking. People who hoard are likely to notice non-verbal messages that convey judgement, like frowns or grimaces and may notice negative body language
X	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
X	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
X	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

Source: Safeguarding Adults Self-Neglect and Hoarding Toolkit. Some key tools and top tips for decision making and defensible recording in cases of self-neglect, Deborah Barnett, Care Knowledge - April 2019

7. Roles and Responsibilities

Service	*How they can support someone who is Self- Neglecting*
Clinical Psychology	*…can support people who self-neglect by developing psychological understanding of their situation and helping them find strategies to help manage their situation, including psychological therapy.*
Community Nurses	*…provide healthcare to people in their own homes. They will refer to other services, such as the continence or respiratory service, or for specialist equipment such as profiling beds.*
Environmental Health	*…aim reduce the risk to the self-neglecting person themselves, but also the wider community through practical direct work with the person, invoking any relevant legislation where necessary.*
Fire and Rescue Services	*…can provide fire safety advice and put practical measures in place to reduce the risk of a fire. They may refer on to other agencies for more support.*
General Practitioners (GP's)	*…can identify people who seem to be self-neglecting, provide support and advice and refer to other agencies such as mental health, to enable people to get support and assistance if required.*
Hospital Nurses	*…will identify patients who seems to be self-neglecting, support the patient and refer to other agencies to enable potential to gain help and support id required, within and following their stay in hospital*
Housing	*…can help people practically to support their tenancies if they are at risk of being evicted, due to problems with Self-Neglect and Hoarding. Housing will refer to other agencies if required.*
Advocacy	*…support the person to make their own decisions, ensure their views, wishes, feelings, beliefs and values are listened to, and may challenge decisions that they feel are not in the person's best interests.*
Occupational Therapists	*…work with individuals to identify any difficulties they experience in day to day living activities, finding ways to help individuals resolve them. They support independence where possible and safety within the community, to help build confidence and motivation.*
Paramedics	*..are called by the person or a third party caller due to medical concerns or health deterioration. They will deliver appropriate emergency treatment, assess mental capacity in relation to the health issues presented (particular around refusal to go to hospital) and refer on to other agencies with concerns.*
Physiotherapists	*…can help with treatment of injury, disease or disorders through physical methods and interventions. A Physio helps and guides patients, prescribes treatment and orders equipment. They can refer to other services if required.*

Police	*…can investigate and prosecute if there is a risk of wilful neglect, they can provide safeguarding to families and communities by sharing information, refer to specialist partner agencies and use force to gain entry/access of there are legal grounds to do so.*
Probation	*…will identify problems via home visits and provide regular monitoring. They may refer to social services, mental health, housing and health. They will complete risk assessments and risk management plans, making links to the risk of serious harm*
RSPCA/LA/Animal Welfare Services	*…investigate complaints of cruelty to and neglect to animals and offer support and advice*
Social Workers	*…will complete assessments by talking to and getting to know the person. They may establish their mental capacity to make a particular decision about their lives and consider all options available. They may put in support or care, or refer to other agencies. They may arrange multi-agency meetings and will rely on sign up from partner agencies regarding this. They can help with relationship building, communication skills and try to develop social networks for the person who is self-neglecting.*
Voluntary, Community and Faith Sector organisations	*…staff and volunteers can provide a whole range of social opportunities and support, to support people to connect with their peers and communities. This includes clubs, support groups, foodbanks and faith led support services. Staff and volunteers from this sector are a vital part of the formal and informal planned care and support for people who self-neglect.*
Mental Health Outreach Team	*…can provide specialist mental health related to support to people who self-neglect in their own homes. This includes practical support, active support and will aim to promote independence and choice, linking in with other services and sharing information.*
Red Cross	*…can provide short term support in the home for people after a hospital admittance following an accident, illness or during a personal crisis*
Hospital Discharge Social Care	*..can assess and plan care and support for people who are admitted to hospital, so that when the person is discharged, this is as safe a journey as possible for the person who is self-neglecting. This includes completing capacity and risk assessments, as well as information sharing with the wider MDT.*
Welfare Rights	*…can support the person who is self-neglecting to maximise their income, which may have a positive impact on their ability to self-care and emotional wellbeing.*
Drug and Alcohol Services	*…can provide support, advice, counselling and ensuring the person who is self-neglect access the appropriate level of health and social care support. This in addition to supporting*

	the person if they have a drug or alcohol problem, which may impact on their ability to self-care.
Reablement / Intermediate care	*…can support if someone is self-neglecting due to an acute problem, by providing short term support to re-enable and promote independence*

Source: **Adapted from Knowsley Safeguarding Adults Board – The Self-Neglect and Hoarding Toolkit 2023**

8. Hoarding and Diagnosis

There are several definitions of hoarding including:

Hoarding is the excessive collection and retention of any material to the point that is impedes day to day functioning

NHS England define hoarding as:

> "Excessively acquiring items that appear of little or no value and not being able to throw them away, resulting in unmanageable amounts of clutter"

This can be in the form of pathological hoarding or compulsive hoarding. The three main types of hoarding have been identified as:

- **Inanimate –** newspapers, books, magazines, food packaging and plastic bottles
- **Animals –** cannot offer the basic care to any pets they may own or have in their possession. Have a large number of animals, poor hygiene
- **Data –** data storage, large number of computers etc.

Context of Hoarding

Many people collect items at some point throughout their life, however, there remains a distinct difference between these people and those whom collecting various items becomes an unmanageable pattern of behaviour. Many people collect items such as books or stamps and this isn't considered a problem. The difference between a "hoard" and a "collection" is how these items are organised.

A collection is usually well ordered and the items are easily accessible. A hoard is usually very disorganised, takes up a lot of room and the items are largely inaccessible. 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 value.

Diagnosis of Hoarding

Hoarding is a disorder that may be present on its own or as a symptom of another disorder. Disorders most often associated with hoarding are obsessive-compulsive personality disorder (OCPD), obsessive-compulsive disorder (OCD), attention deficit/hyperactivity disorder (ADHD), anxiety and depression.

Hoarding disorders are now a recognised mental health condition. People with a hoarding disorder are challenging to engage, because many people who hoard frequently don't see it as a problem, or have little awareness of how it is impacting on their life or the lives of others. Many others do realise they do have a problem, but are reluctant to seek help because they feel extremely ashamed, humiliated or guilty about it.

It is vitally important when hoarding is discovered to encourage the individual who is hoarding to engage with housing and partner agencies, in order to have the best possible change of resolving the issue and getting the right support in place going forward. An individual's reluctance to engage and to seek help cannot only cause loneliness and mental health issues, but also pose a significant health and safety risk not only to themselves, but surrounding residents. Multi-agency approaches are often the most effective and long term support is recommended.

Characteristics of Hoarding

Characteristics of hoarding include, but are not limited to:

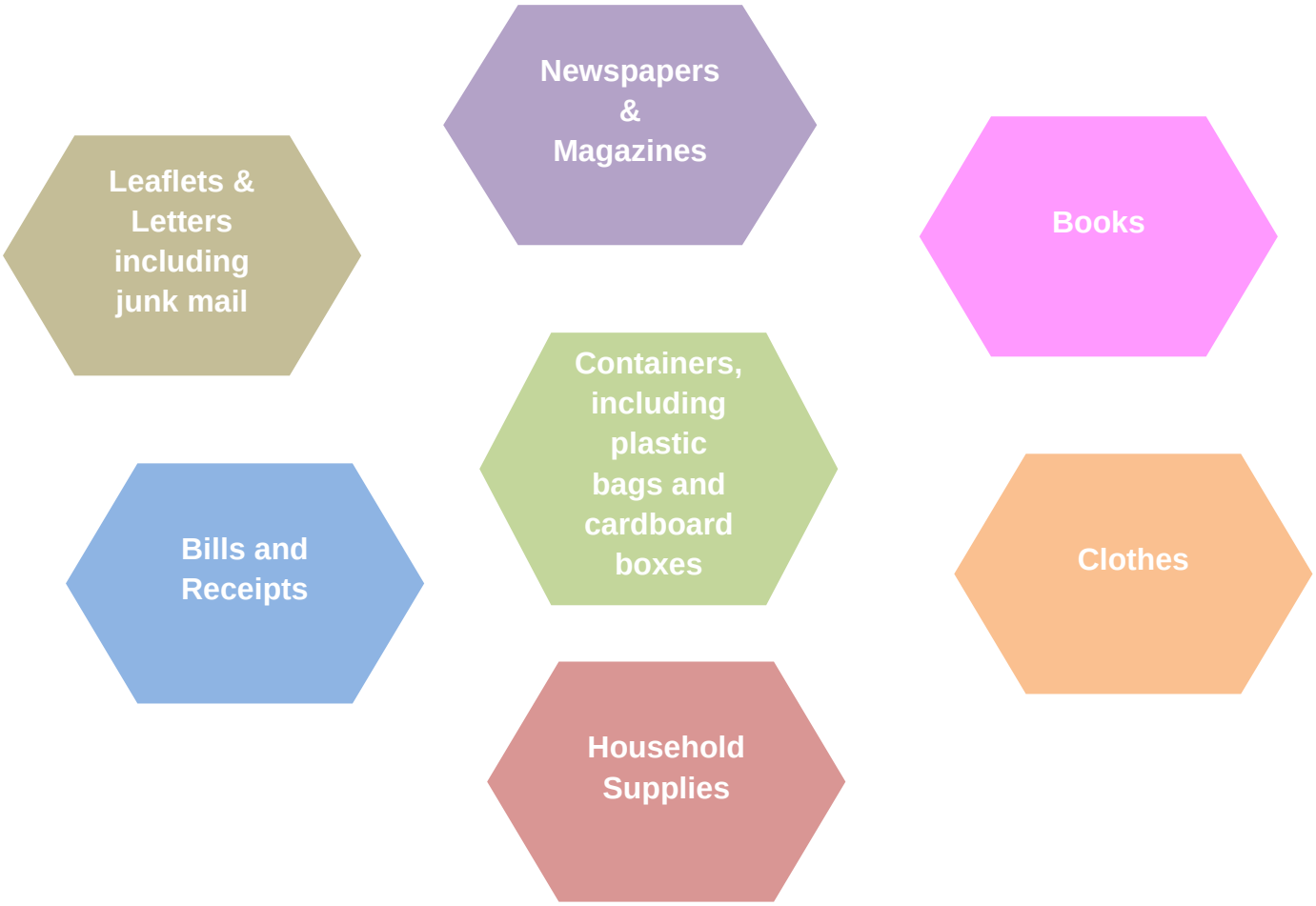
Characteristic	Description
Fear and Anxiety	Compulsive Hoarding may have started as a learnt behaviour or following a significant event such as bereavement. The person hoarding believes buying or saving things will relieve the anxiety and fear they feel. Any attempt to discard hoarded items can induce feelings varying from mild anxiety to a full panic attack with fear and anxiety
Extreme clutter throughout the homes living spaces	Hoarding behaviour may prevent several or all rooms within a property from being used for its intended purpose. An example of this could be severe clutter in the kitchen preventing any access to cooking facilities or items being stored on a bed that would prevent the tenant from using it for its sole purpose of sleeping

Inability to Discard Items	People who hoard may hold an inappropriate emotional attachment to items within their home
Long Term Behaviour Pattern	This behaviour pattern is one that is possibly developed over many years, or decades. This involves collecting and saving items within their home, with an inability to throw away items without experiencing fear and anxiety. This would also lead to the individual having difficulty permitting others to touch or move accumulated items
Indecisiveness	People who hoard struggle with the decision to discard items that are no longer necessary or of any use, which includes rubbish and general waste. This can also be linked to procrastination by the individual who is hoarding
Self-Care	A person who hoards may appear unkempt and dishevelled, due to lack of toileting or washing facilities in their home that are unavailable due to levels of hoarding within these rooms
Perfectionism	Perfectionism gets in the way of our priorities by causing us to focus on insignificant details instead of the big picture. This can lead to hoarders focusing on one thing while the general condition or their property deteriorates around them
Socially Isolated	People who hoard will typically alienate family and friends, fail to engage with supporting agencies and may be embarrassed to have visitors. This can involve refusing to have home visits from professionals in favour of office based appointments that may mask any issues with hoarding or the true scale of hoarding if previously known
Poor Insight	A person who hoards will typically see nothing wrong with their behaviour and the impact it has on them and others
Large number of pets	People who hoard may also have a large number of pets which can contribute to the level or hoarding as well as general untidiness within the home. This could also include animal hoarding. Animal hoarding refers to the compulsive need to collect and own animals for the sake of caring for them that results in accidental or unintentional abuse. Most animal hoarders fall victim to their good intentions and end up emotionally overwhelmed, socially isolated and alienated from family and friends. This can be a source of increased complaints from surrounding neighbours

Items people may hoard

Some people with a hoarding disorder will hoard a range of items, while others may just hoard certain types of objects.

Items that are often hoarded include:



Some people may hoard animals, which they may not be able to look after properly.

More recently, hoarding of data has become more common. This is where someone stores huge amounts of electronic data and emails that they are reluctant to delete.

How Hoarding Disorders can be treated

It is not easy to treat hoarding disorders, even when the person is prepared to seek help, but it can be overcome.

The main treatment is Cognitive Behavioural Therapy (CBT). Cognitive Behavioural Therapy is a type of therapy that aims to help you manage your problems by changing how you think (cognitive) and act (behaviour). It encourages you to talk about how you think about yourself, the world and other people, and how what you do affects your thoughts and feelings. The therapist will help the person to understand what makes it difficult to throw things away and the reasons why the clutter has built up. Regular sessions of CBT over a long period of time are usually necessary and will almost always need to include some home-based sessions, working directly on the clutter. This requires motivation, commitment and patience, as it can take many months to achieve the treatment goal. The goal to improve the person's decision-making and organisational skills, help them overcome urges to save and ultimately clear the clutter room by room. The therapist won't throw anything away but will help guide and encourage the person to do so. The therapist can also help the person to develop decision-making strategies, while identifying and challenging underlying beliefs that contribute to the hoarding problem. The person gradually becomes better at throwing things away, learning that nothing terrible happens when they do and becomes better at organising items they insist on keeping. At the end of the treatment, the person may not have cleared all their clutter, but they will have gained a better understanding of their problem. They will have a plan to help them contribute to build on their successes and avoid slipping back into their old ways.

Antidepressant medicines called Selective Serotonin Reuptake Inhibitors (SSRIs) have also been shown to help people with hoarding disorders.

Sources: https://www.nhs.uk/conditions/hoarding-disorder/

9. Legal Perspective

Legal Options in Regulation 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 proactively 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 outlines 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 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 legislative powers.

There may be circumstances in which a person's actions amount to anti-social behaviour 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 behaviour.

Environmental Health

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

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 Act 1990 provides the power to seek orders for repairs to privately owned dwellings and where necessary compulsory purchase orders.

Housing Act 2004 allows enforcement actions 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.

Prevention of Damage by Pests Act 1949 – under this act Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice.

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.

Landlords

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 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.

Mental Health Act 1983

Sections 2 and 3 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 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 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 outlined above (i.e. Schedule 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 us being ill-treated, neglected or kept otherwise than under proper control; or 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 up to 36 hours (it's usually 24 hours and in certain circumstances a Doctor can extend by 12 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, 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 of safety for up to 24 hours for the specified purposes, with the option to extend for 12 hours. The place of safety should 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 principle is that every action must be carried out in the best interests of the person concerned.

Where a person who is self-neglecting and/or living in squalor and 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 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 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 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.

Section 44 Mental Capacity Act 2005

Section 44 of the Mental Capacity Act created an offence of ill-treating or wilfully neglecting a person who lacks capacity, or whom the offender reasonably believes to lack capacity. The offence may only be committed by certain persons who have a caring or other specified responsibility for the person who lacks capacity. The penalties are, on summary, conviction up to 12 months imprisonment, a fine not exceeding the statutory maximum, or both, or on conviction on indictment of up to 5 years imprisonment or a fine, or both.

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 cases of self-neglect, 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 because of 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 resident 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 Service

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. The order applies to virtually all premises and covers nearly every type of building, structure and open space. For example, it applies to:

- Offices and shops
- Premises that provide care, including care homes and hospitals
- Community halls, places of worship and other community premises
- The shared areas of properties several households live in
- Pubs, clubs and restaurants
- Schools and sports centres
- Tents and marquees
- Hotels and hostels
- Factories and warehouses

It does **not** apply to:

- People's private homes, including individual flats in a block or house

Under the main rules of the Order, the owner/occupier must:

- Carry out a fire-risk assessment identifying any possible dangers and risks
- Consider who may be especially at risk
- Get rid of or reduce the risk from fire as far as is reasonably possible and provide general fire precautions to deal with any possible risk left
- Take other measures to make sure there is protection, if flammable or explosive materials are used or stored
- Create a plan to deal with any emergency and, in most cases, keep a record of your findings
- Review your findings where necessary

Under the Order, anyone who has control of premises or anyone who has a degree of control over certain areas or systems may be a "responsible person". Although in many premises, the responsible person will be obvious, there may be times when a number of people have some level of responsibility.

10. Capacity and Self-Neglect

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:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person it not to be treated as unable to make a decision unless all practical steps have been taken without success
- A person is not to be treated as unable to make a decision merely because h/she makes an unwise decision
- An act done or decision made, under the Act for, or on behalf of, a person who lacks capacity must be done, or made, in his/her best interests
- 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

Where a person's hoarding behaviour poses a serious risk to their health or safety, intervention will be required. With the exception of statutory requirements, any intervention or action proposed must be with the person's consent. In extreme cases of hoarding behaviour the very nature of the environment should lead professionals to question if the person has capacity to consent to the proposed action or intervention and trigger a capacity assessment.

This is confirmed by the Mental Capacity Act 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). 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 a 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 (please see Appendix 5). Due to the complexity of such cases, multi-agency meetings to coordinate 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 Disease 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. The executive functions are in 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 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 decisions. 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 the 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 Part 1. 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 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 include:

Housing:

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 a Court Appointed Deputyship or a Lasting Power of Attorney that specified 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

Occupational Therapy:

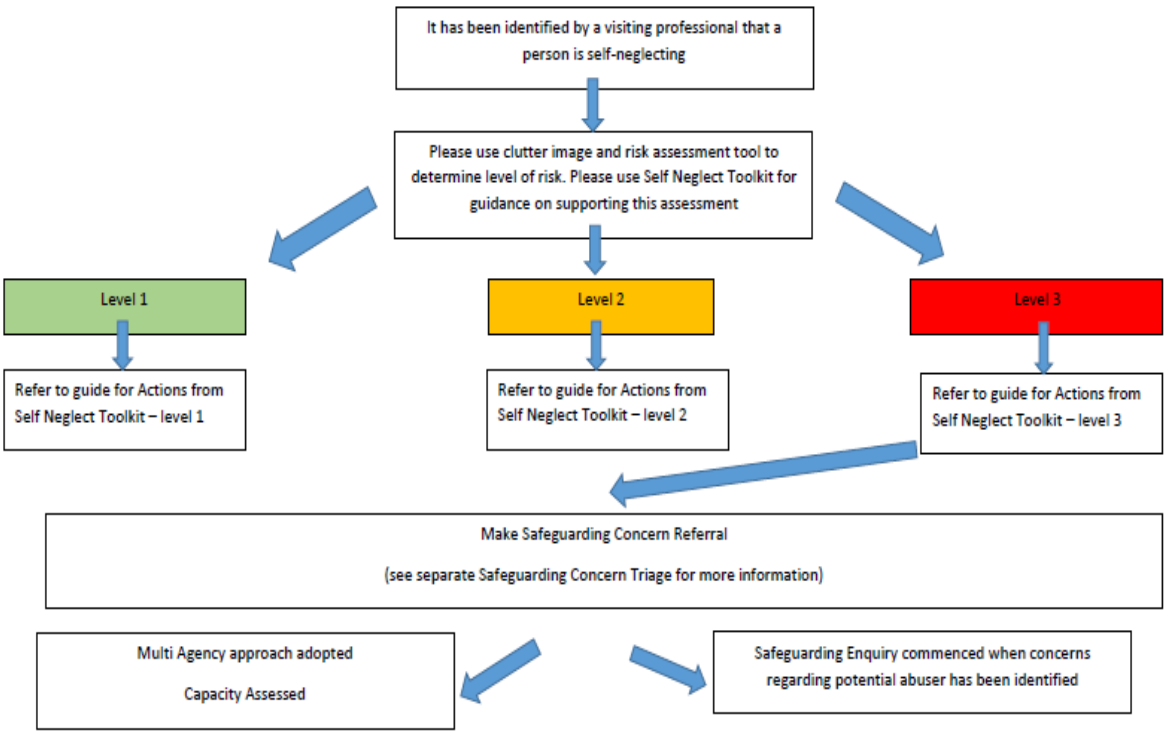
The Occupational Therapist (OT) understands the rehabilitative process/equipment required by the person to meet their needs. If the person does not appear to understand then the OT must assess the person's capacity to make a decision about the proposed equipment.

Examples of what to ask when assessing capacity

Domains of self-care and self-protection	Decisional capacity Appreciation of problems	Consequential problem solving	Executive capacity (verification of task performance)
Personal needs and hygiene: Bathing, dressing, toileting, and ambulation in home	Has it been difficult, or do you need assistance, to wash and dry your body or take a bath?	If you had trouble getting into the bathtub, how could you continue to bathe regularly without falling?	Physical examination of hair, skin, and nails. Gait evaluation and screening for balance problems and recent falls
Condition of home environment: Basic repairs/maintenance of living area and avoidance of safety risks	Do you have any trouble getting around your home due to clutter, furniture, or other items? It is important to make basic repairs to one's home; do any parts of your home need repairs?	What if your air conditioner [or heater] stopped working; how would you fix the problem?	Proxy reports of the home environment or a home safety evaluation performed by an occupational therapist or home health service.
Activities for independent living: Shopping and meal preparation, laundry and cleaning, using telephone, and transportation	Going to the store is important for buying food and clothing for everyday life. Do you have any problems going to the store regularly?	If you needed to call a friend [a cab or other service] to take you to the store, how would you do that?	Ask patient to use the clinic's phone and call a friend or other service to ask for a ride. [Patient should demonstrate all steps for making a call and getting information.]

Medical self-care: Medication adherence, wound care, and appropriate self-monitoring	People who forget to take their medications may end up having a worse health condition or need to see the doctor more often. Do you have problems remembering to take medications?	Consider if you had to have someone give your medications to you and watch you take them. How would this affect your everyday life	Ask patient to bring all medication bottles from home, even empty ones. Review medication fill and refill dates and pill counts, or have a home-health nurse do a home medication assessment
Financial affairs and estate: Managing check book, paying monthly bills, and entering binding contracts	What difficulties do you have paying your monthly bills on time? Who can assist you with paying your monthly bills or managing your finances	How could asking [cite individual] to help you with paying your bills be better than managing your monthly income and paying bills by yourself? Are there any reasons why asking [cite individual] to manage your income might not help or might make things worse for you?	Proxy reports of bank statements, uncollected debts, or bills. Can formally assess performance with routine financial tasks, such as 1- or 3-item transactions, including making changes or conducting a payment simulation using a check and register

11. Pathway to Self-Neglect – What to do next?



In terms of Adult Social Care and when to refer:

LEVEL 1 – information gathering and determine if person is known to adult social care. Request a reassessment or review of that persons care needs

LEVEL 2 -. Request a Social Care Assessment/Reassessment

LEVEL 3 – Safeguarding Concern to be raised.

12. When does a Section 42 Enquiry occur?

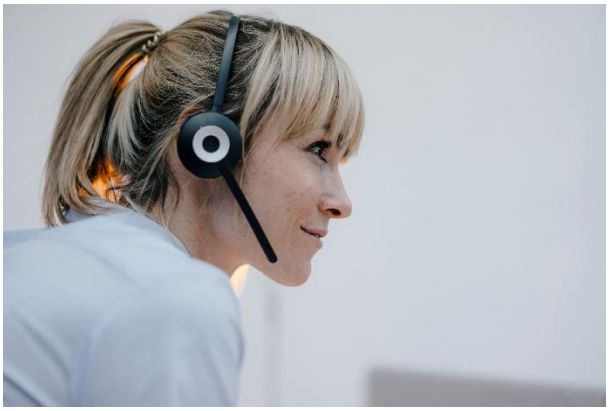
In most safeguarding issues, the Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. This enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

Cases of self-neglect may not prompt a Section 42 enquiry. We invariably judge these on a case-by-case basis. Whether or not a response is required 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.

It is key to establish a trusting relationship with a person who is engaging in self-neglect because restricting their autonomy can be harmful.

Source: https://www.anncrafttrust.org/what-is-self-neglect/



Safeguarding duties apply to:

- Any adult who has care and support needs (whether or not the local authority is meeting any of those needs); and
- Is experiencing, or at risk of abuse and neglect (including self-neglect); and
- As a result of those care and support needs is unable to protect themselves from either the risk or, the experience of, abuse and neglect

The duties apply equally whether a person lacks mental capacity or not. So while an individual's wishes and feelings are central to their care and support, agencies must share information with the local authority for initial enquiries to take place.

Enquiries must take place when the person has capacity and does not wish information to be shared, to ensure abuse and neglect is not affecting others, that a crime has not been committed, or that the person is making an autonomous decision and is not being coerced or harassed into that decision. Safeguarding duties have a legal effect in relation to many organisations and the local authority may request organisations to make further enquiries on their behalf.

Better to be Safe than Sorry

The updated Care Act guidance identified that not all cases of self-neglect need to go to Section 42 enquiry – perhaps the situation is not impacting on the person's wellbeing, does not impact on others, or is not a result of abuse or neglect.

It could be argued that someone hoarding is not going to share intimate details of themselves straight away. It can take time to develop trust and unless further enquiries are made (often requiring q multi-agency response to information gathering and capacity assessments) we may be leaving someone vulnerable and making assumptions that cannot be justified later.

The purpose of a safeguarding enquiry (Section 42 enquiry) is initially for the local authority to clarify matters and then decide on the course of action to:

Prevent abuse and neglect from occurring

Reduce the risk of abuse and neglect

Safeguard in a way that promotes physical and mental wellbeing

Promote choice, autonomy and control of decision making

Consider the individual's wishes, expectations, values and outcomes

Consider the risks to others

Consider any potential crime

Consider any issues of public interest

Provide information, support and guidance to individuals and organisations

Ensure the people can recognise abuse and neglect and then raise a concern

Prevent abuse/neglect from reoccurring

Fill in the gaps in knowledge

Coordinate approaches

Ensure that preventative measures are in place

Coordinate multi-agency assessments and responses

These responsibilities apply to people who hoard/self-neglect and whose health and wellbeing are at risk as a result. People may not engage with professionals, or be aware of the extent of their self-neglect.

For social workers and health professionals, this provides a significant challenge in developing relationships that empower the individual, or safety plans based upon what makes a person feel safe and well cared for, yet respect autonomous decision making, whilst juggling other duties and responsibilities.

It is important to explore with the person their history; listen to the way they talk about their life, difficulties and strategies for self-protection. By doing this, social workers can begin assessing why the person self-neglects and offer support in

replacing attachment to objects with interaction and relationships with people and the community. Distress may lead people to seek comfort in having possessions; when faced with isolation they may seek proximity to things they're attached to and when faced with chaos may seek to preserve predictability.

Early relationships can have quite an effect on how a person perceives the world and may not recognise their self-neglect and may even find comfort in the situation. Deep-seated emotional issues, which have evolved as coping strategies cannot be undone in an instant.

Source: https://www.communitycare.co.uk/2016/08/22/hoarding-self-neglect-social-workers-need-know/

Self-Neglect is challenging for practitioners due to:

- It's varied presentation, influenced by a complex mix of personal; mental; physical; social and environmental factors
- The high risk it poses, both to the individual and sometimes to others
- The possibility that adult social care intervention is not welcomed by the individual, making engagement difficult
- The challenges of assessing mental capacity
- Ethical dilemmas between respecting autonomy and fulfilling a duty of care
- Workflow systems that prioritise short-term task-focused involvement rather than long-term relationships with people
- The need for coordinated interventions from a range of agencies

Source: RIPFA Working with People who Self-Neglect Practice Tool, 2020

Understanding the Individual's Experience of Self-Neglect

There are some key areas for inquiry that will help in understanding the factors at work in any individual situation. What the practitioner needs to inquire into is as follows:

- What is the person's own view of the self-neglect?
- Is the self-neglect important to the person in some way?

- Is the self-neglect intentional, or an unintended consequence of something else?

- Is the self-neglect a recent change or a long standing pattern? Does the person have mental capacity in relation to specific decisions about self-care and/or acceptance of care and support?

- What strengths does the person have – what is he or she managing well and how might this be built on? What motivation for change does the person have?

- Have there been recent changes of experience, attitude or behaviour that might provide a window of opportunity for change?

- Are there links between the self-neglect and health or disability?

- Is alcohol consumption or substance misuse related to the self-neglect?

- How might the person's life history, family or social relations be interconnected with the self-neglect?

- Does the self-neglect play an important role as a coping mechanism? If so, is there anything else in the person's life that might play this role instead?

Source: RIPFA Working with People who Self-Neglect Practice Tool, 2020

13. Self-Neglect Pathway – A Guide for Adult Social Care

Visiting professional has identified through the assessment tool that the person self-neglecting meets Level 3 criteria using the self-neglect and hoarding toolkit

Action taken by the visiting professional, using guidance on actions from the toolkit

Safeguarding concern raised with the local authority

Triage of the safeguarding concern conducted by IASU to determine next steps:

Is a s42 enquiry required?

YES

- Third party involvement, i.e. neglect, exploitation, Domestic abuse.
- A history of self-neglect/non engagement.
- High risk of significant harm or death.
- The person lacks capacity around their care and support needs.
- The person has got social care needs that are not being met.

Considerations for s42 enquiry:

- Are there children at risk? (Refer to ICart)
- Formally assess and document capacity.
- Making Safeguarding Personal.
- Advocacy.
- Multi agency strategy discussion.
- MARAM – if person has capacity.
- LAP – if person lacks capacity.
- Consideration of S135 warrant by AMHP if person has a mental disorder to remove person to a place of safety

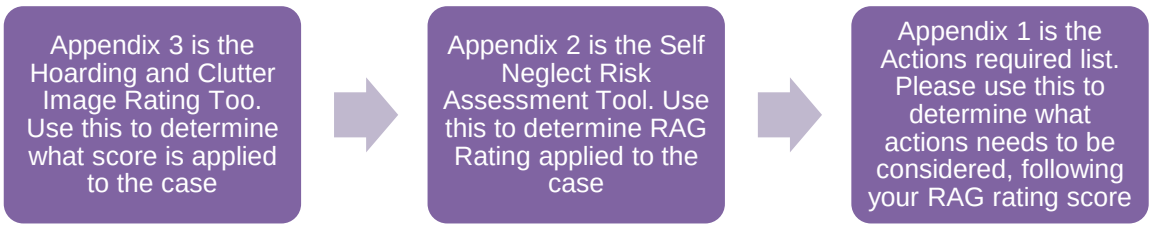
NO

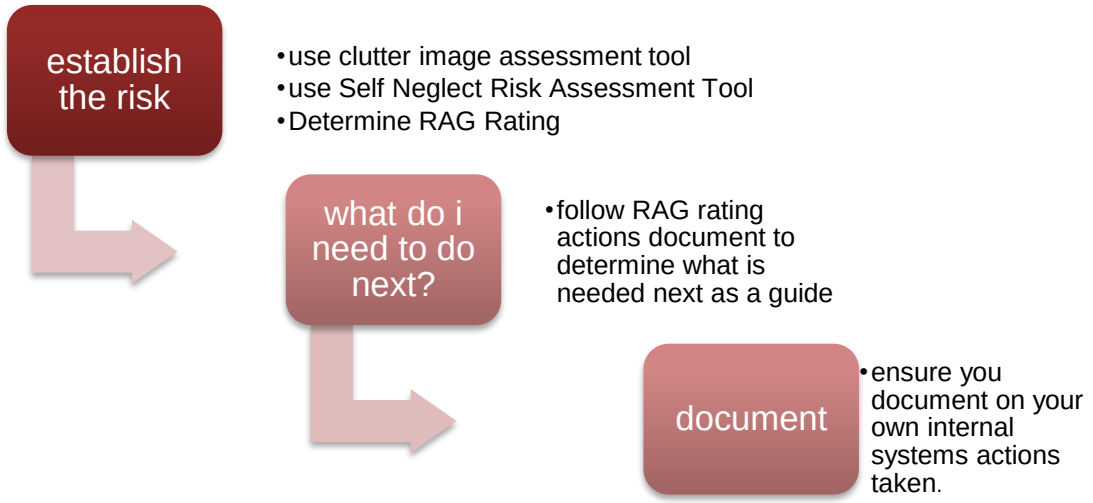
- No known history of self-neglect then may be proportionate to explore social care assessment initially.
- Person has capacity and is willing to engage with support.
- Referral to be made for a social care assessment.
- Ongoing attempts to build trusting relationship with person (Care management)

Considerations for intervention:

- Making Safeguarding Personal.
- Advocacy.
- Formally assess and document capacity.
- Risk assessment.
- Regular MDT meetings
- MARAM – if person has capacity
- LAP – if person lacks capacity.
- Consideration for s135 warrant by AMHP if person has a mental disorder to remove to a place of safety.
- Referral for s42 enquiry if risk increases with no positive intervention.

14. Risk Management – How to use the Clutter and Self-Neglect Risk Assessment





Rule of Thumb

Green

- Consider to refer to agencies
- Continue to support

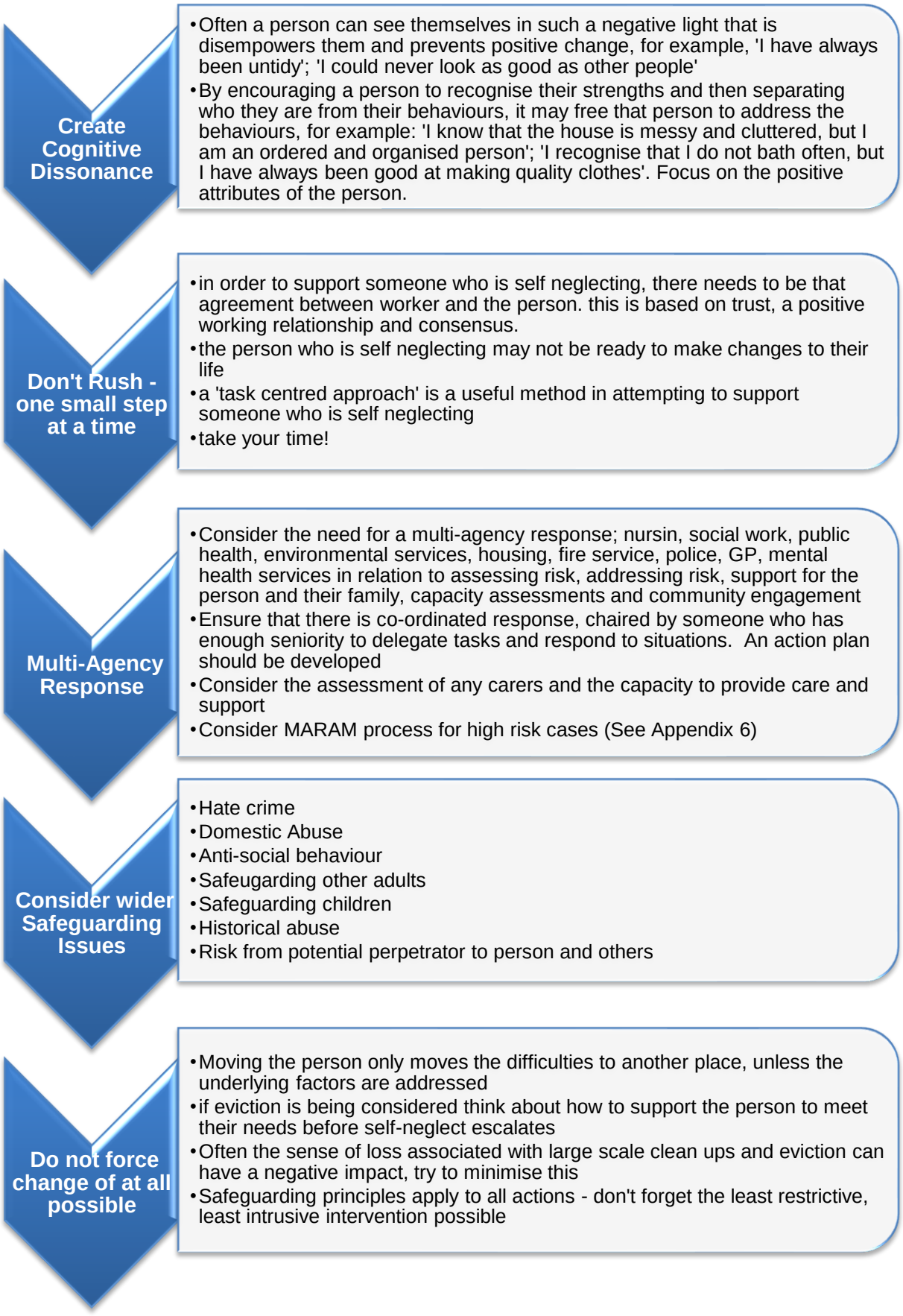
Amber

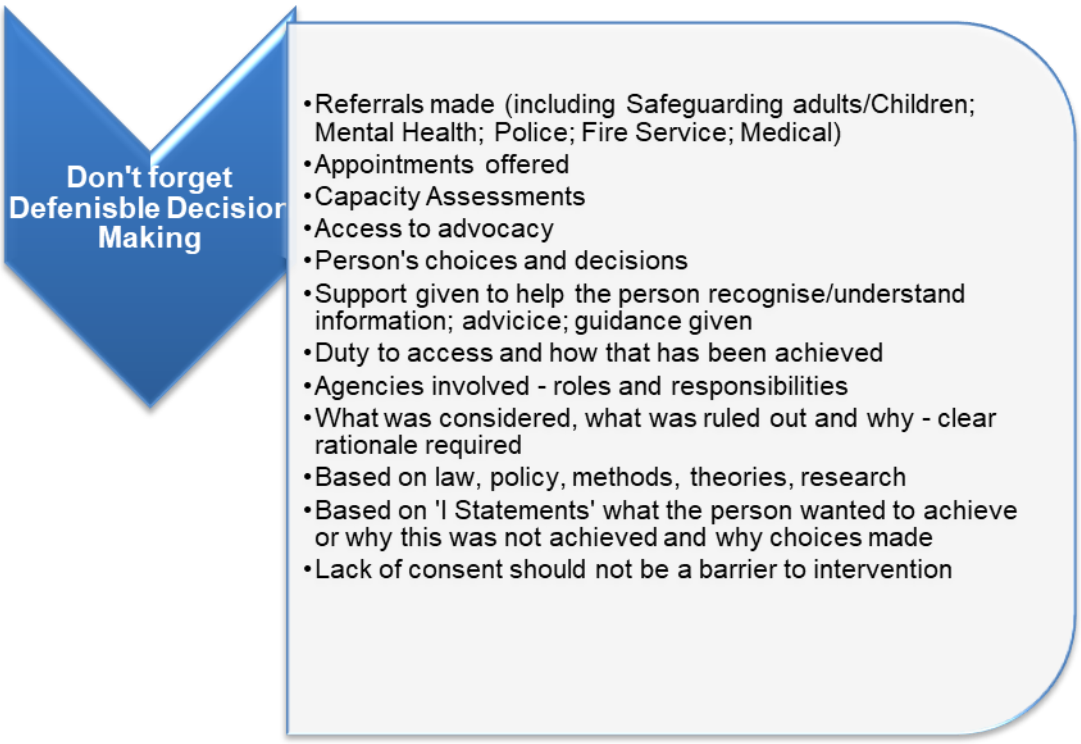
- Referral to adult social care for social care assessment/outcome focused review
- MDT approach to ensure information is pooled
- Risk Management Plans are clear and shared accountability evidenced

Red

- Ensure interim measures are initiated
- Safeguarding Referral to Adult Social Care required (also follow internal safeguarding processes)
- Attend strategy meeting held by adult social care
- Involvement in the Risk Management Plan are required

15. Top Tips


Create Cognitive Dissonance
•Often a person can see themselves in such a negative light that is 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.
Don't Rush - one small step at a time
•in order to support someone who is self neglecting, there needs to be that agreement between worker and the person. this is based on trust, a positive working relationship and consensus.
•the person who is self neglecting may not be ready to make changes to their life
•a 'task centred approach' is a useful method in attempting to support someone who is self neglecting
•take your time!
Multi-Agency Response
•Consider the need for a multi-agency response; nursin, social work, public health, environmental services, housing, fire service, police, GP, mental health services in relation to assessing risk, addressing risk, support for the person and their family, capacity assessments and community engagement
•Ensure that there is 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 to provide care and support
•Consider MARAM process for high risk cases (See Appendix 6)
Consider wider Safeguarding Issues
•Hate crime
•Domestic Abuse
•Anti-social behaviour
•Safeugarding other adults
•Safeguarding children
•Historical abuse
•Risk from potential perpetrator to person and others
Do not force change of 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



Practical Tasks

- **Risk Assessment –** have effective, multi-agency approaches to assessing and monitoring risk

- **Assess capacity –** ensure staff are competent in applying the Mental Capacity Act in cases of self-neglect

- **Mental Health Assessment –** it may, in a minority of cases, be appropriate to refer an individual for Mental Health Assessment

- **Sigpost –** with a multi-agency approach people can be signposted to effective resources of support

- **Contact family –** with the person's consent, try to engage family or friends to provide additional support

- **Decluttering and cleaning services –** where a person cannot face the scale of the task but is willing to make progress, offer to provide practical help

- **Utilise local partners –** those who may be able to provide practical help

- **Utilise local partners –** those who may be able to help include the RSPCA, the Fire Service, Environmental Health, Housing, Voluntary Organisations

- **Occupational Therapy Assessment –** physical limitations that result in self-neglect can be addressed

- **Help with property management and repairs –** people may benefit from help to arrange much needed maintenance to their home

- **Peer Support –** others who self-neglect may be able to assist with advice, understanding and insight

- **Counselling and Therapies –** some individuals may be helped by counselling or other therapies. Cognitive Behaviour Therapy, for example, may help people with obsessive compulsive disorder, hoarding disorder or addictions

Source: SCIE Self-Neglect at a glance, March 2024

16. Points of Contact

Logo	Team/Authority/Organisation	Address	Telephone Number	Email Address or Website
	Integrated Adults Safeguarding Unit, Halton Borough Council	Peel house Family Support Centre, Peelhouse Lane, Widnes, WA8 TJ	0151 511 8555	✉ adultsafeguarding@gov.uk
	Complex Care Widnes Team, Halton Borough Council	Municipal Building, Kingsway, Widnes, WA8 7QF	0151 511 6650	✉ Complexcare.widnes@halton.gov.uk
	Complex Care Runcorn Team, Halton Borough Council	Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD	0151 511 6655	✉ Complexcare.runcorn@halton.gov.uk
	Prevention & Wellbeing Service, Halton Borough Council	Municipal Building, Kingsway, Widnes, WA8 7QF	0151 511 7676	✉ IAT@halton.gov.uk

	Mental Health Team, Halton Borough Council	Brooker Centre, Hospital Way, Runcorn, WA7 2DA	01928 753968	✉ MHTR@halton.gov.uk
	Halton Borough Council Adult Social Care	Halton Direct Link, Runcorn Shopping City, Concourse Level, Rutland House, Runcorn, WA7 2ES Halton Direct Link, 7 Brook Street, Widnes, Cheshire. WA8 6NB	0151 907 8306	Halton Borough Council
	Emergency Duty Team, Halton Borough Council **(for social services and operates when day offices are closed)**	Municipal Building, Kingsway, Widnes, WA8 7QF	0345 050 0148	✉ EDT@halton.gov.uk **(any email should be accompanied by a phone call)**
	Bridgewater Community Healthcare NHS Foundation Trust	Spencer House, Dewhurst Road, Birchwood, Warrington, Cheshire, WA3 7PG		✉ bchft.adultsafeguarding@nhs.net Bridgewater Community Healthcare NHS Foundation Trust
	Halton Housing Trust	Halton Housing Trust, PO Box 576 Manchester M28 8HY	0303 333 0101	Halton Housing Trust
	Cheshire Police	Cheshire Constabulary, Public Protection Unit Runcorn Police Station, Halton Lea, Runcorn, WA7 2HG	Emergency: 999 Non-emergency 101	✉ vulnerability.hub@cheshire.police.uk Cheshire Police

	Cheshire Fire and Rescue	Cheshire Fire and Rescue Headquarters, Sadler Road, Winsford, CW7 2FQ	Emergency; 999 Headquarters: 01606 868 700	www.cheshirefire.gov.uk
	Cheshire & Merseyside Integrated Care Board	Runcorn Town Hall, Heath Road, Runcorn, WA7 5TD	01925 944443 (Halton General Enquiries)	Cheshire & Merseyside ICB
	Mersey Care NHS Foundation Trust	Anita Samuels Centre 4 Ellison Grove Huyton L36 9GA	0151 351 8484 (Safeguarding Duty Hub)	safeguarding.adults@merseycare.nhs.uk

Appendices

Appendix no. and file attachment	Name	Document
1	**Actions following determination of Risk**	Appendix 1 Actions following determinatic
2	**Self-Neglect & Hoarding Risk Assessment & Defensible Decision Making Tool**	Appendix 2 Self Neglect and Hoardinç
3	**Hoarding & Clutter Rating**	Appendix 3 Hoarding and Clutter Ratings.dc
4	**Learning Disability Keeping me Safe Risk Assessment**	Appendix 4 LD Keeping Me Safe Risk
5	**Best Interests Checklist**	Appendix 5 Best Interests Checklist.doc

Appendix no. and file attachment	Name	Document
6	**MARAM Guidance**	ASC Policy Library - Multi Agency Risk Assessment Policy (MARAM) - All Documents (sharepoint.com)