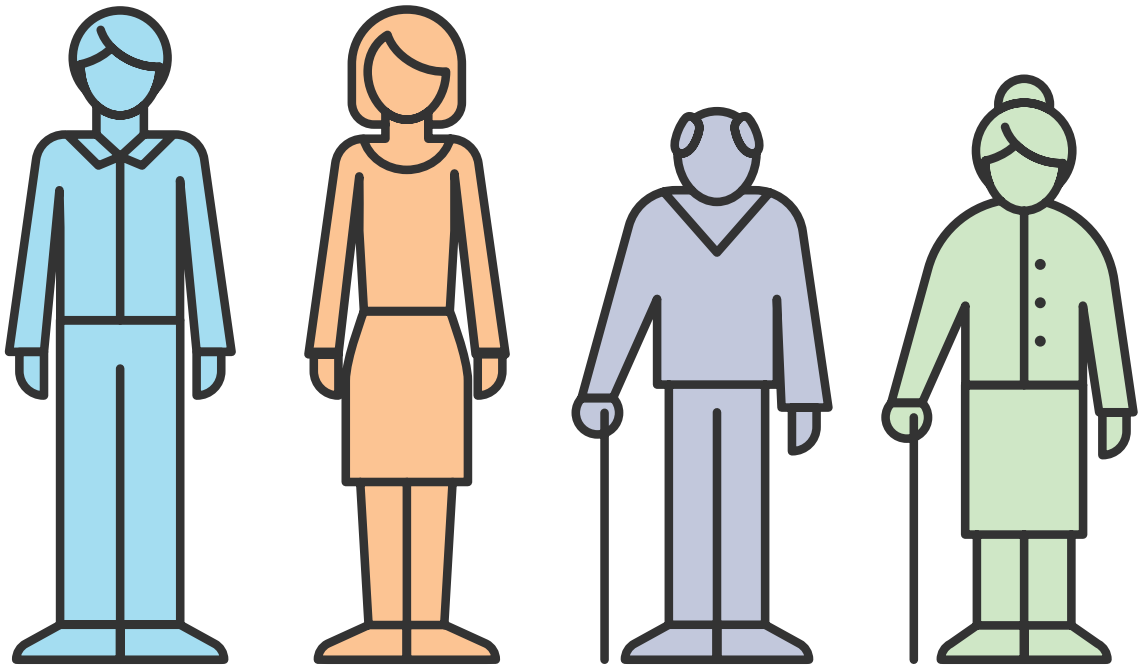
CITY OF YORK Safeguarding Adults

City of York and North Yorkshire Multi-Agency Practice Guidance:

Working with Adults who Self Neglect



All Together Safer: All Together Better

North Yorkshire Safeguarding Adults Board

Contents

Date of Next Review: **November 2023**

1. Scope of this Practice Guidance

This document outlines Practice Guidance for dealing with issues and concerns of self-neglect in relation to adults with care and support needs (See Appendix A: Glossary of Terms).

The Guidance should be read alongside the Joint area Multi-Agency Safeguarding Adults Policy and Procedures (West Yorkshire, North Yorkshire and City of York).

The Guidance is underpinned by a commitment to Safeguarding Adults and to the promotion of Human Rights. The 6 Safeguarding Principles outlined in the Care Act 2014 Guidance should drive all work with people in situations of self-neglect.

This document has been produced to ensure a consistent, proportionate and multi-agency approach to the protection of individuals who may be at significant risk (or placing others at significant risk; see Appendix A) from 'unwise' decisions in relation to self-neglect. It applies only to situations where the person has mental capacity to understand the potential consequences of their behaviour, and has not engaged with statutory agencies. Where the person lacks capacity, the best interests' process should be used.

This Guidance does not include issues of risk associated with deliberate self-harm, or neglect by others. If you are aware of deliberate self-harm, you may wish to consider informing the person's GP. If harm appears to have occurred due to an act of neglect or inaction by another individual or service, a Safeguarding Adults Concern should be raised with Adult Social Care in York and in North Yorkshire.

This Guidance is underpinned by an understanding that agencies will share information with each other to prevent or reduce risk as per the Data Protection Act 2018, The Care Act 2014, and existing local information sharing agreements.

The Guidance is supported by Self-Neglect training which can be accessed through the Workforce Development Unit. All agency personnel take responsibility for attending this.

This document has been jointly produced and adopted by North Yorkshire County Council and City of York Council together with partners of the North Yorkshire Safeguarding Adults Board and York Safeguarding Adults Board.

For any queries on this guidance please contact:

North Yorkshire Safeguarding Adults Board: nysab@northyorks.gov.uk

York Safeguarding Adults Board: https://www.safeguardingadultsyork.org.uk/the-board/feedback/

If you are concerned about an Adult at risk of abuse or neglect you should contact the following:

North Yorkshire - 01609 780 780

City of York

- **01904 555111** (office hours) or fax **01904 554055**
- Hearing impaired customers can use the text facility **07534 437804**
- Out of hours: **01609 780780**

In an emergency, contact the police, tel: 999.
If the person is not in immediate danger, contact the police, tel: 101.

2. Risk Factors

- Significant harm to adults at risk.
- Legal liability on organisations for acts of commission or omission.

3. Related Policies /Procedures

- Joint Multi-Agency Safeguarding Adults Policy and Procedures, West Yorkshire, North Yorkshire and City of York
- City of York and North Yorkshire Joint Hoarding Procedure

4. Personnel

The Guidance applies to all personnel in organisations with a duty of care towards potentially vulnerable adults.

5. What is Self-Neglect?

There is no single operational definition of self-neglect. The Department of Health (2016), defines it as, '… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

Skills for Care provided a framework for research into self-neglect identifying three distinct areas that are characteristic of self-neglect:

- Lack of self-care - this includes neglect of one's personal hygiene, nutrition and hydration, or health, to an extent that may endanger safety or wellbeing;
- Lack of care of one's environment - this includes situations that may lead to domestic squalor or elevated levels of risk in the domestic environment (e.g. health or fire risks caused by hoarding);
- Refusal of assistance that might alleviate these issues. This might include, for example, refusal of care services in either their home or a care environment or of health assessments or interventions, even if previously agreed, which could potentially improve self-care or care of one's environment.

There are many indicators of self-neglect, which are useful for professionals to look out for (please see Appendix B)

There are various reasons why people self-neglect. Some people have insight into their behaviour, while others do not. It can occur as a result of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment or through personal choice. It can be triggered by trauma and significant life events. Self-neglect is an issue that affects people from all backgrounds.

Section 2.6 Joint Area Multi Agency Safeguarding Adults Policy and Procedures (West Yorkshire, North Yorkshire and City of York).

6. Hoarding

If a person exhibits hoarding behaviours, this does not automatically constitute self-neglect, or a safeguarding concern. However, if we associate hoarding with the acquisition of items, and an associated inability to discard things that have little or no value (in the opinions of others); to the point where it interferes with use of living space or activities of daily living; then consideration of this Guidance may be useful to prevent a person coming to harm, or harming others. For further information on Hoarding please refer to Appendix F.

7. The Challenge

Part of the challenge is knowing when and how far to intervene when there are concerns about self-neglect and a person makes a capacitated decision not to acknowledge there is a problem or to engage in improving the situation, as this usually involves making individual judgments about what is an acceptable way of living, balanced against the degree of risk to an adult and/or others.

Managing the balance between protecting adults from self-neglect (and fulfilling our own duty of care) against their right to self-determination is a serious challenge and ethical dilemma for public services. Balancing choice, control, independence and wellbeing calls for sensitive and carefully considered decision-making. Dismissing self-neglect as a "lifestyle" choice is not an acceptable solution in a caring society .It is important to recognise that assessments of self-neglect and hoarding are grounded in and influenced by personal, social and cultural values and staff working with the adult should always reflect on how their own values might affect their judgement.

Ethical dilemmas

Respect for autonomy & self-determination

- Professional codes of ethics
- Personalisation
- MCA principles
- ECHR articles 8 and 5
- Legal limitations to state power

Duty to protect and promote dignity

- The state's duty to protect from foreseeable harm
- Human dignity compromised: "surely someone could/should have done something"
- ECHR articles 2 and 3
- Risk to others

Empowerment ← **Making safeguarding personal** → **Protection**

8. Assessing Mental Capacity

Mental capacity describes a person's ability to make a specific decision at a specific time. An individual is deemed to lack "Capacity" if at the time a decision is required; he/she is unable to make that decision because of an impairment or disturbance in the functioning of the mind or brain. This may be temporary or permanent.

Consideration needs to be given at an early stage to determining if the individual has the capacity to understand and make informed decisions about their responses to agencies concerns about their apparent self-neglecting behaviour, and this should be revisited throughout the process.

The Mental Capacity Act outlines 5 key principles which must underpin all decisions taken in relation to the Act.

https://www.scie.org.uk/files/mca/directory/bild-poster.pdf?res=true

Assessing mental capacity and trying to understand what lies behind self-neglect is often complex. It is usually best achieved by working with other organisations and, if they exist, extended family and community networks.

Assessing capacity follows a formal 'functional test' as laid out in the Mental Capacity Act. If the person, with all available support, is unable to demonstrate capacity, then it will be necessary to make a best interest decision on behalf of that individual. In some instances, particularly where an individual displays addictive or compulsive behaviour, it may be necessary to explore whether they are in fact capable of following through their apparent capacitous decision. Many individuals are judged to have mental capacity around a specific issue because they are able to weigh and communicate an intention, but they are unable to demonstrate that intention in practice. It is important that practitioners can distinguish between someone having the ability to appear to have the capacity to understand the risks associated with their behaviour/ a particular course of action, and making an unwise decision; and the Executive Capacity/ ability to put their decisions into practice.

All assessments of capacity must be clearly documented. This includes assessments in relation to the decision whether or not to accept the support being offered, and decisions around any proposed enforcement actions.

9. Guidance from the Care Act 2014

The Care Act 2014 places specific duties on the Local Authority in relation to self-neglect:

9.1 Assessment

Under Sections 9 and 11 of the Care Act 2014, the Local Authority must undertake a needs assessment, even when the adult refuses, where:

- it appears that the adult may have needs for care and support,
- and is experiencing, or is at risk of, self-neglect.

This duty applies whether the adult is making a capacitated or incapacitated refusal of assessment.

9.2 Enquiry

Under Section 42 of the Care Act 2014, the Local Authority must make, or cause to be made, whatever enquiries it thinks necessary to enable it to decide what action should be taken in an adult's case, when:

The Local Authority has reasonable cause to suspect that an adult in its area:

- has needs for care and support,
- is experiencing, or is at risk of, self-neglect, and
- as a result of those needs is unable to protect himself or herself against self-neglect, or the risk of it.

A Safeguarding Enquiry may be an appropriate response to a situation of self neglect. However, the Care Act guidance suggests 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."

In cases where the adult is no longer able to protect themselves by controlling their own behaviour, action will be required which balances the individual's autonomy and dignity, with harm reduction.

9.3 Advocacy

If the adult has 'substantial difficulty' in understanding and engaging with a Care Act Section 42 Enquiry, the local authority must ensure that there is an appropriate person to help them, and if there is no-one appropriate available, arrange an independent advocate or Independent Mental Capacity Advocate (IMCA).

9.4 Strengths based approach

The starting point for all interventions should be to encourage the person to do things for themselves, as outlined in the 6 safeguarding principles and also the Care Act principles of preventing, reducing and delaying the need for statutory services. Where this fails in the first instance, this approach should be revisited regularly throughout the period of intervention.

The aim of developing a working relationship with the individual, should be around assisting them to use their existing strengths and available assets to manage their situation with the minimal amount of external support required, so as to foster independence. All efforts and response of the person to this approach should be recorded fully by each agency involved.

The approach	What this might mean in practice
Building rapport	Taking time to know the person; refusing to be shocked; avoiding kneejerk; finding interests, history, stories
Finding the right tone	Being honest while also being non-judgemental, separating the person from the behaviour
Finding the right person	Working with or though someone who is well placed to get engagement
Going at individual's pace	Moving slowly and not forcing things; continued involvement over time
Finding something that motivates the individual	Linking to interests or drivers for the self-neglect (eg waste/environment/recycling)
Agreeing a plan	Making clear what is going to happen; the next visit might be the initial plan
Starting with practicalities	Providing small practical help at the outset may help built trust
Bartering	Linking practical help to another element of agreement - bargaining
Focusing on what can be agreed	Finding something to be the basis of initial agreement, that can be built on later
Keeping company	Being available and spending time to built up trust
Being honest	Being honest about potential consequences

Factors to keep in mind during those early stages
What is the person's own view of the self-neglect
Is the self-neglect important to the person in some way? Does it play a role as a coping mechanism?
Does the person have mental capacity in relation to specific decisions about self-care and/or acceptance of care and support?
Is the self-neglect intentional or not?
Is the self-neglect a recent change or a long-standing pattern?
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 relationship be interconnected with the self-neglect?
What strengths does the person have-what is he or she managing well and hoe might this be built on? What motivation for change does the person have?

10. Key Considerations

10.1 Risk Assessment

Crucial to all decision making is a robust risk assessment, preferably multi-agency, that includes the views of the adult and their personal network. The risk assessment should consider:

- The facts of the situation, including the nature and extent of the concern
- An assessment of the individual's mental capacity to make decisions in relation to the apparently neglectful behaviour and their consent to intervention;
- Indications of mental health issues;
- The level of risk to the adult's physical health;
- The level of risk to their overall wellbeing;
- Effects on other people's health and wellbeing (including members of the public, family members or professionals, neighbours);
- Serious risk of fire;
- Serious environmental risk e.g. destruction or partial destruction of accommodation.
- Existing agency intervention and its effectiveness

For guidance as to the types and seriousness of risk, please see Appendix G.

A risk assessment must also consider whether anyone else is at risk as a result of the individual's self-neglect. This may include children or other adults with care and support needs. Whilst your actions may be limited in relation to the individual themselves, you may have a duty to take action to safeguard others. If you are concerned that a self-neglecting parent may be neglecting children in their care also, you should seek children's social work advice /make a referral using the following:

York: childrensfrontdoor@york.gov.uk

North Yorkshire: 01609 780780 or email: Children&families@northyorks.gov.uk

Children's Social Care may identify children who are/ may be suffering neglect when it is believed that parent/carer self-neglect/ hoarding is a key contributory factor, Children Social Care may therefore contact Adult Social Care to discuss adult assessment and scope for joint working.

When self-neglect and /or hoarding is resulting or contributing to levels of child neglect that reach threshold for a Children's Social Care strategy discussion, Adults Social Care should be invited to attend so that any joint actions can be discussed.

Often people who self-neglect do not want help to change, which puts themselves and others at risk, for example through vermin infestations, poor hygiene, or fire risk. There may be occasions therefore where it becomes necessary for legal powers of enforcement to be used. Appendix C provides a useful list of available powers.

In cases of animal collecting, the practitioner will need to consider the impact of this behaviour carefully. Where there is a serious impact on the adult's health and wellbeing, the animals' welfare, or the health and safety of others; the practitioner should collaborate with the RSPCA and public health officials. Although the reason for animal collecting may be attributable to many reasons, including compensation for a lack of human companionship and the company the animals may provide, considerations have to be given to the welfare of the animals and potential public health hazards.

10.2 A Multi-agency response

Given the complex and diverse nature of self-neglect, responses by a range of organisations are likely to be more effective than a single agency response. Co-ordinated actions by housing officers, mental health services, GPs and DNs, social work teams, the police and other public services and family members have led to improved outcomes for individuals.

Interventions may include action by landlords, by environmental health, Housing Standards and Adaptations (York) or by the RSPCA; there may be a need to draw on community resources and creative solutions which help to engage a prior interest; intervention may be therapeutic including treatment for mental ill health, bereavement and drug or alcohol use; or there may be a need for legal intervention such as possession or eviction notices.

Fire authorities can be key to intervention-most having prevention strategies which use the International OCD Foundations clutter image rating in relation to residents who hoard. This tool helps to provide a consistent and reliable assessment of risk, so including local Fire Services in the multi-agency response to hoarding situations is of particular use.

Self-neglect work has been agreed as a multi-agency priority and there is an expectation that:

- All partner agencies will engage when this is requested by the lead agency as appropriate or required; and
- Where an agency is the lead agency, they take responsibility for coordinating multi-agency partnership working.

10.3 Building relationships

Efforts should be made to build and maintain supportive relationships through which services, where deemed necessary, can in time, be negotiated. This involves a person-centred approach that listens to the person's views of their circumstances, builds on their strengths and seeks informed consent where possible before any intervention.

It is important to note that a gradual approach to gaining improvements in a person's health, wellbeing and home conditions is more likely to be successful than an attempt to achieve considerable change all of a sudden. It should also be considered and respected that an individual may choose to live a certain way, for example choosing to be homeless, and support should focus on reducing risk to that individual and others, rather than action which will infringe their right to a private life.

The individual may have experienced significant trauma in their life such as bereavement, homelessness, abuse or health issues. They may have had poor experiences of engagement with services in the past which may prevent them from wanting to engage. When people are supported over longer periods and do accept change (including treatment for medical or mental health conditions or addictions, or practical help with de-cluttering and deep cleaning their home), some research has shown that they rarely go back to their old lifestyle. Building a relationship over time also supports in the understanding as to why a person may be self-neglecting such as social isolation and loneliness and whether there are other agencies or organisations which may be able to support in tackling underlying issues.

The amount of time it may take to build up a trusting relationship with an individual in these circumstances should not be under-estimated and staff must be empowered by their managers to be able to take the time required. As outlined above (section 4.3), the involvement of an Independent advocate or an Independent Mental Capacity Advocate (IMCA) should be considered in appropriate circumstances. Where the individual refuses to participate or engage with agencies or provide access, information obtained from a range of other sources may 'hold the key' to achieving access or to determining areas / levels of risk.

10.4 Targeting activities of daily living

As self-neglect is often linked to disability and poor physical functioning, often a key area for intervention is assistance with activities of daily living, from preparing and eating food to using toilet facilities.

Research supports the value of interventions to support routine tasks; however cleaning interventions alone, where home conditions are of concern, do not emerge as effective in the longer term. They should therefore take place as part of an integrated, sustainable multi-agency plan.

The range of interventions can include adult occupational therapy, domiciliary care, housing and environmental health services, Housing Standards and Adaptations (York), welfare benefit advice and links into appropriate community groups or resources.

11 Raising concern about self-neglect

All concerns should be directed in the first instance, via the customer contact workers/ customer service centre, to a Safeguarding worker. The Safeguarding worker will triage the Concern and decide whether it meets the Care Act criteria for a Safeguarding Enquiry. If it does, then this process will take precedence, and will be the mechanism by which the self-neglect can hopefully be addressed.

11.1 The Multi-Agency Self-neglect meeting (MASM)

The Safeguarding worker may decide either following a Safeguarding Enquiry, or without one, that a Multi-agency self-neglect meeting (MASM) may be the more appropriate course of action. This may result from a Safeguarding Enquiry where, for example, the adult has capacity and is declining safeguarding involvement, but the risk to themselves or others remains high.

A Multi-agency self-neglect meeting (MASM) can be used when an individual's decision making is creating significant concern about their safety, and existing involvement by organisations has failed to resolve the issues. A MASM is appropriate when the individual has capacity to make the decision(s) causing the concern and the concerning behaviour/'self-neglect' is likely to result in significant harm or may result in their death. NB. A MASM can be considered for those adults who are in high risk relationships.

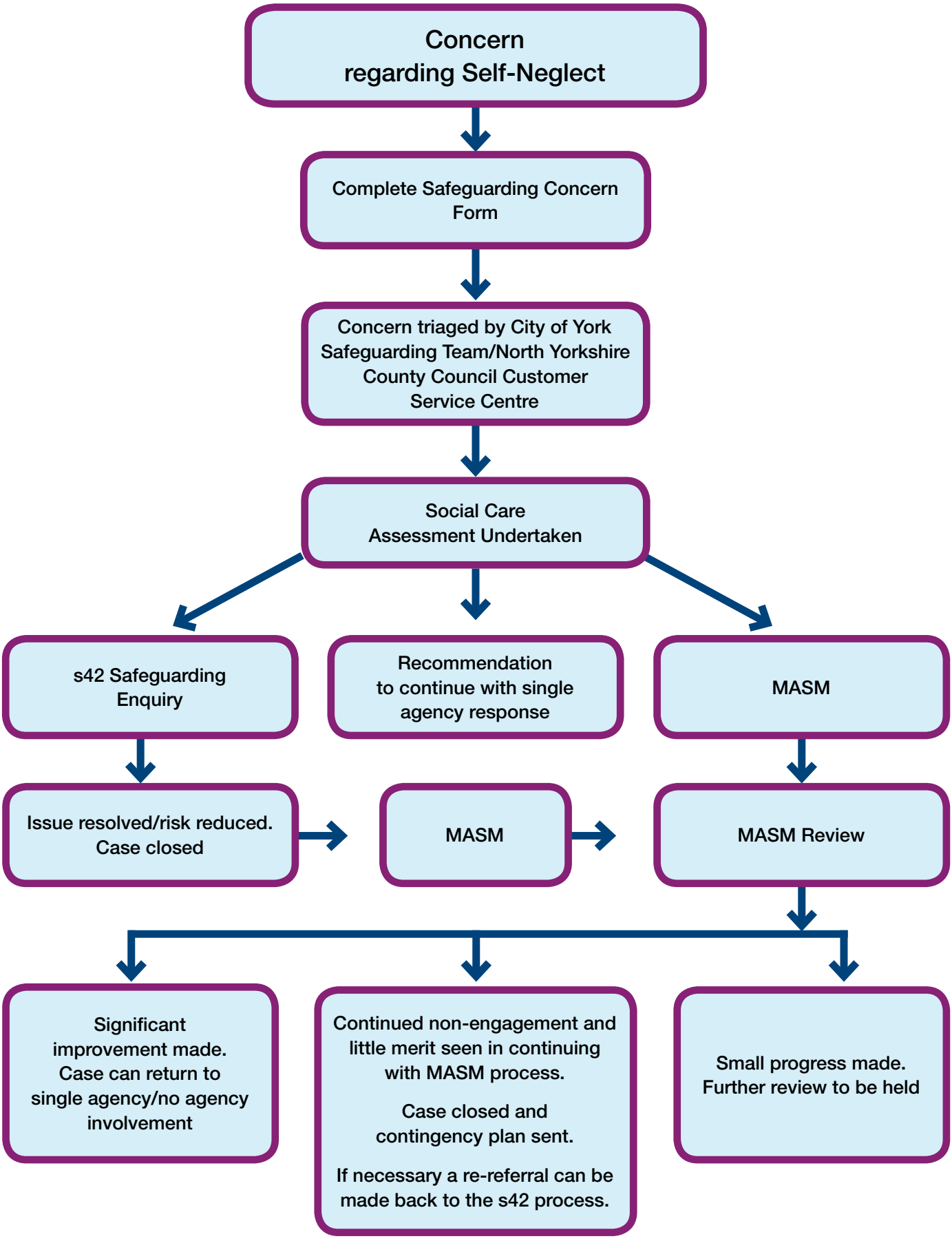
A MASM should be chaired by the agency with the most involvement/knowledge/likely intervention with the adult. All relevant agencies should be invited, and there is an expectation that a deputy or at minimum a written report is sent where the main contact is unavailable (for example, a chronology of involvement). This agency maintains lead responsibility for the MASM process until the point of exit. At this stage, the local authority safeguarding adults' service will need to assess whether the necessary steps have been taken to safeguard the individual. The local authority Safeguarding adults service take responsibility for opening and closing the MASM process on the system, once all attendees at the meeting have agreed that the process should cease (see 'Exiting the MASM process' next page).

Possible agencies and professionals to engage with the MASM include Environmental Health, Housing Standards and Adaptations (York); Housing Providers; Community Wardens; Care Agencies; Community Safety; North Yorkshire Fire and Rescue Service; GP; North Yorkshire Police; Community Health Services; District Nurses; Acute Hospital Trusts; Learning Disability Services; Age UK; Yorkshire Ambulance Service; Transport providers; Community Networks; Legal advice / services; Providers of utilities – gas, electricity, water, telephone, RSPCA. In addition, always consider the involvement of people who know the adult (Family, Carers, Neighbours, Power of Attorney holders) and most importantly, the adult themselves where possible.

The purpose of the meeting is to agree on the risks present to the individual and/ or others and to formulate a plan to endeavour to engage with the individual in order to reduce/mitigate the risks.

Every effort should be made by all of those involved with the individual to engage with them and promote their involvement in the process as far as possible. The individual should be informed and invited to any meetings about them. The MASM Proforma should be used for all meetings (See Appendix D)

The below flowchart illustrates the 'Journey of Support', or procedure which should be followed when a concern is raised regarding self-neglect resulting in significant harm to the person or others.


Concern
regarding Self-Neglect
Complete Safeguarding Concern Form
Concern triaged by City of York Safeguarding Team/North Yorkshire County Council Customer Service Centre
Social Care Assessment Undertaken
s42 Safeguarding Enquiry
Recommendation to continue with single agency response
MASM
Issue resolved/risk reduced. Case closed
MASM
MASM Review
Significant improvement made. Case can return to single agency/no agency involvement
Continued non-engagement and little merit seen in continuing with MASM process.
Case closed and contingency plan sent.
If necessary a re-referral can be made back to the s42 process.
Small progress made. Further review to be held

11.2 Exiting the MASM process

Exiting the MASM process should only occur in one of two situations;

i) The individual's situation has improved to such an extent that all of the agencies involved are in agreement that the potential risks are now so minimal that exiting is appropriate. This may however mean that some or all of the agencies continue to monitor the situation in line with their own policies.

ii) All actions have been carried out, but the risks remain and the individual is fully aware of the consequences associated with their choices and still does not wish to engage. If all agencies are in agreement that further MASM Meetings are unlikely to have an impact on the situation, the process can be ended via a formal MASM Review. In all cases removed from the MASM process, the individual must be provided with an appropriate contingency plan containing the contact points for services which could assist them in the future

If however, there are still ongoing potential risks to other people posed by the actions of either the individual or another source of harm, following implementation of the MASM process, all agencies have a responsibility to continue to work together to minimise or remove these risks.

Where agencies are unable to engage the person and obtain their acceptance to implement services to reduce or remove risks arising from self-neglect, the reasons for this should be fully recorded and maintained on the person's case record, with a full record of the efforts and actions taken.

The person, carer or advocate should be fully informed of the services offered and the reasons why the services were not implemented. There is a need to make clear that the person can contact the Council or any other services, at any time in the future.

However, where the risks are high, arrangements should be made for ongoing monitoring and, where appropriate, making proactive contact to ensure that the person's needs, risks and rights are fully considered and to monitor any changes in circumstances.

The local authority safeguarding team will close the process on the system once this has been agreed by the MASM, and the reasons for closure should be recorded in full.

11.3 Recording and documentation

There must be detailed recording throughout this process to ensure that all decisions are clear, transparent and explained to the individual concerned.

Documentation must be recorded and distributed to all parties who attend the MASM meetings. Responsibility for this lies with the agency providing the Chair. If there are any queries or questions raised from the documentation then these should be sent back to the Meeting Chair. Individual agencies will also need to keep their own records of their specific involvement.

11.4 Information sharing

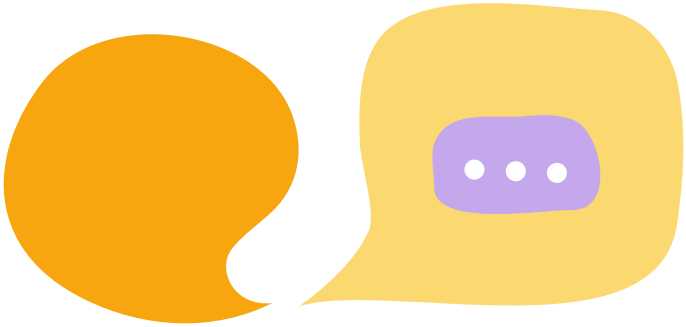
The Care Act 2014 states that information sharing should be consistent with the principles set out in the Caldicott Review published 2013 "Information to share or not to share: the information governance review" ensuring that:

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

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

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

- Necessary for the purpose for which it is being shared.
- Shared only with those who have a need for it.
- Be accurate and up to date.
- Be shared in a timely fashion.
- Be shared accurately.
- Be recorded proportionately demonstrating why a course of action was chosen – I did this because… I ruled this out because… I chose this because…
- Be shared securely.



Appendix A: Glossary of Terms

Adult at Risk

Safeguarding duties apply to an adult who:

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

(Care Act 2014)

Mental Capacity

Mental capacity describes a person's ability to make a specific decision at a specific time. An individual is deemed to lack "Capacity" if at the time a decision is required; he/she is unable to make that decision because of an impairment or disturbance in the functioning of the mind or brain. This may be temporary or permanent.

Significant Harm

This is a term that is used to define;

- Is not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional or behavioural development.
- The individual's life could be under serious threat
- There could be a serious, chronic and / or long lasting impact on the individual's health or physical / emotional / psychological well-being.

Significant risk:

Where there are indicators that change is likely to occur in levels of risk in the short to medium term, appropriate action should be taken or planned.

Indicators of significant risk could include:

- History of crisis incidents with life threatening consequence
- High risk to others
- High level of multi-agency referrals received
- Risk of domestic violence
- Fluctuating capacity, history of safeguarding concerns / exploitation
- Financial hardship, tenancy / home security risk
- Likely fire risks
- Public order issues; anti-social behaviour / hate crime / offences linked to petty crime
- Unpredictable/ chronic health conditions
- Significant substance misuse, self-harm
- Network presents high risk factors
- Environment presents high risks
- History of chaotic lifestyle; substance misuse issues
- The individual has little or no choice or control over vital aspects of their life, environment or financial affairs.

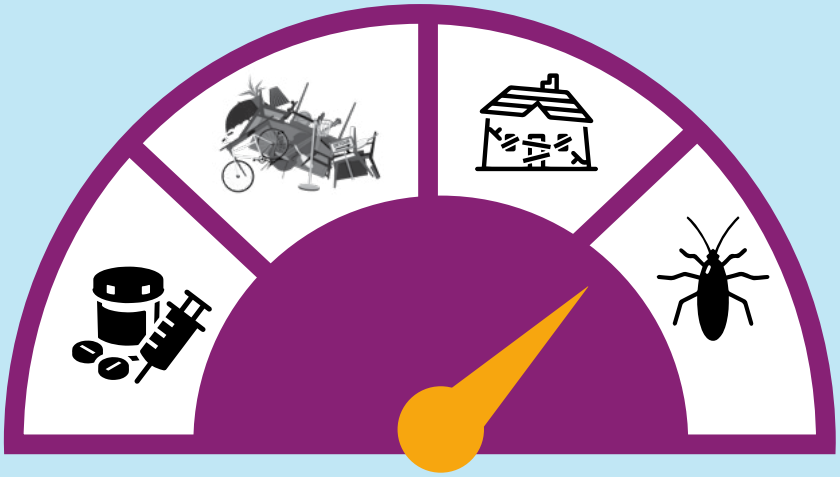
Multi Agency Self-Neglect Meeting (MASM)

A MASM is appropriate when the individual has capacity to make the decision(s) causing the concern and the concerning behaviour/'self-neglect' is likely to result in significant harm or may result in their death.

Appendix B: Indicators of self-neglect

- Living in very unclean, sometimes verminous circumstances, such as living with a toilet completely blocked with faeces
- Neglecting household maintenance, and therefore creating hazards within and surrounding the property
- Obsessive hoarding
- Poor diet and nutrition. For example, evidenced by little or no fresh food in the fridge, or what is there, being mouldy
- Declining or refusing prescribed medication and / or other healthcare support
- Refusing to allow access to health and / or social care staff in relation to personal hygiene and care
- Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity)
- Being unwilling to attend external appointments with professional staff
- Whether social care, health or other organisations (such as housing)
- Poor personal hygiene, poor healing / sores, long toe nails;
- Isolation
- Failure to take medication
- Substance misuse
- Increased debt.

The above is a list of examples and is not an exhaustive list of indicators of self-neglect. If there is a concern that an adult is experiencing self-neglect, staff should always seek guidance at an early stage.



Appendix C:
Drug and alcohol misuse

The term drug and alcohol misuse is defined as “drug and / or alcohol taking which causes harm to the individual, their significant others or the wider community”. It can sometimes be referred to as “substance misuse”. The term drug refers to “psychoactive drugs including illicit drugs, prescribed and non- prescribed pharmaceutical preparations.” The term misuse refers to the “illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence”.

The duty to promote wellbeing and making safeguarding personal is central to The Care Act 2014. One definition of self-neglect would be where a person is suffering a significant impact on their wellbeing as a result of substance misuse or the chaotic lifestyle and risk taking behaviour associated with this. This can include, but may not be exclusive to:

- Attachment to their substance of choice and prioritising this above all else, impacting on their relationships with others;
- Financial difficulties due to expenditure on drugs/ alcohol resulting in debts and inability to pay for food, gas, electric and other basic daily needs;
- Risk of homelessness if unable to adhere to tenancy agreements;
- Deterioration in physical and mental health;
- Risk of overdose or use of multiple substances;
- Risk of engaging in criminal activity to fund their lifestyle;
- Exploitation by others, including sexual or financial exploitation.

The Care and Support Statutory Guidance (2014) is clear that “Local authorities must consider (when considering an appearance of need) at this stage if the adult has a condition as a result of either physical, mental, sensory, learning or cognitive disabilities or illnesses, substance misuse or brain injury”. This means that individuals who substance misuse should be provided with the same offer of services and support as other client groups (dependent upon their level of need) – e.g. advice, signposting, care assessment, and in particular safeguarding adults procedures.

It may be particularly difficult to engage with individuals who substance misuse and who are self-neglecting. Professionals must work to forge relationships with individuals in order to gain their trust and confidence. Attempts at engagement may need to be repeated several times before an individual begins to engage. It may be important to determine any services involved with the person and how they engage with them to build on other potentially positive relationships.

Substance Misuse Support

North Yorkshire:

North Yorkshire Horizons – an adult specialist drug and alcohol service which offers a range of free, confidential and non-judgmental treatment and recovery support for individuals and their families whose lives are affected by drugs or alcohol.

Treatment and recovery options available include:

- One-to-one
- Structured group therapy work
- Support to family members, involving them as part of your recovery plan wherever possible and with consent
- Health and wellbeing checks, health screenings, blood testing and vaccinations
- Help to achieve a balanced approach to life through therapeutic intervention
- Support to reduce the harm of drugs and prevent overdose
- Substitute medication when suitable
- Detox and rehab services
- Peer mentor/volunteer support

Eligibility criteria

- Aged 18 years
- Resident within the North Yorkshire County Council area
- Misuse illicit and illicitly obtained prescription drugs, and new psychoactive substances
- Are harmful or dependent alcohol users

Referral can be made by individuals, family members and professionals via the **Single Point of Access** on **01723 330730** (9am to 5.30pm, Monday to Friday) or via email on info@nyhorizons.org.uk

City of York:

The York Drug and Alcohol Service is delivered in partnership with Changing Lives and Spectrum Community Health.

They offer a specialist advice service to individuals, young people, families and local communities affected by their own or someone else's substance misuse.

York Drug and Alcohol Service

3 Blossom Street, York, YO24 1AU

Telephone: 01904 464680

Email: york@changing-lives.org.uk

www.changing-lives.org.uk

Additional Support

- NHS Choices - drinking and alcohol includes information and support about alcohol abuse and addiction, and links to support services for those with alcohol problems and their families, including detoxification and rehabilitation.
- NHS - drug addiction is a guide to different types of drug treatment and what they involve.
- Alcohol Concern helps people through offering information, advice and guidance
- You can call the national helpline, **Drinkline on 0300 123 1110** (weekdays 9am to 8pm, weekends 11am to 4pm).
- Alcoholics Anonymous provide help with a drinking problem at help@alcoholics-anonymous.org.uk or phone the **national help line free on 0800 9177 650.**
- SMART Recovery helps people recover from addictive behaviour and lead meaningful and satisfying lives.

Appendix D:
Powers of Intervention

If the individual has been found to lack capacity in relation to decisions surrounding their self-neglecting behaviour then reference should be made to the Mental Capacity Act 2005 and the duty to act in the best interests of the person.

In situations where an adult has capacity it is essential that legal advice is sought in the first instance. It will be necessary to explore the reasons as to why the person is refusing to engage as it may be appropriate to make an application in the High Court to invoke its inherent jurisdiction. A vulnerable adult with capacity may be entitled to the protection of the inherent jurisdiction if incapacitated from making the relevant decision because of constraint, coercion or undue influence placed on them by another. Whether this is appropriate action to take will therefore depend upon the individual's circumstances and the risks that they are subjected to.

There is a high evidential threshold associated with such applications and so legal advice must be sought to discuss the individual facts of the case.

If there is reason to believe that the person may be suffering from a mental disorder and at immediate risk, there may also be a power to intervene under section 135 of the **Mental Health Act 1983**. This provision allows an Approved Mental Health Professional to make an application permitting a police officer to enter the premises of someone who is appears to have a mental disorder and is either being "ill-treated, neglected or kept otherwise than under proper control" or if living alone is unable to care for himself.

There must be evidence, however, of the appearance and immediate risk to the person, an existing diagnosis of a mental disorder is not enough in itself to intervene.

In all circumstances, legal advice should be sought before any intervention is made.

Public Health Act 1936

The Public Health Acts 1936 and 1961 contain the principal powers to deal with filthy and verminous premises.

Section 83 Cleansing of Filthy or Verminous Premises.

1. Where a local authority, upon consideration of a report from any of their officers, or other information in their possession, are satisfied that any premises –

a) Are in such a filthy or unwholesome condition as to be prejudicial to health, or b) Are verminous.

The local authority shall give notice to the owner or occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the condition of the premises.

The steps which are required to be taken must be specified in the notice and may include:

- Cleansing and disinfecting
- Destruction or removal of vermin
- Removal of wallpaper and wall coverings
- The interior surface of premises used for human habitation or as shops or offices to be papered, painted or distempered, and
- Interior of any other premises to be painted, distempered or whitewashed.

There is no appeal against a Section 83 notice and LA has the power to carry out works in default and recover costs. The LA also has the power to prosecute for non-compliance.

Section 84 Cleansing or Destruction of Filthy or Verminous Articles:

A local authority can apply on the certificate of the proper officer of the authority of health for the cleansing, purification or destruction of articles necessary in order to prevent injury, or danger of injury, to health.

Section 85 Cleansing of Verminous Persons and Their Clothing:

On the application of any person or a proper officer of the authority, a local authority can take necessary measures to free a person and his clothing from vermin including removal to a cleansing station, where applicable (not currently used in York). A court order can be applied for where the person refuses to comply.

The LA cannot charge for cleansing a verminous person and may provide a cleansing station under Section 86 of the Public Health Act 1936.

The Public Health Act 1936 S81 also gives Local Authority's power to make by laws to prevent the occurrence of nuisances from filth, snow, dust, ashes and rubbish.

The Public Health Act 1961

The Public Health Act 1961 amended the 1936 Act and introduced:

Section 34 Accumulations of Rubbish

This gives a local authority power to remove accumulations of rubbish on land in the open air.

Section 36 Power to Require Vacation of Premises During Fumigation:

Makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation free of charge must be provided and there is the right of appeal. This process is not currently used by City of York.

Section 37 Prohibition of Sale of Verminous Articles:

And provides for household articles to be disinfested or destroyed at the expense of the dealer (owner).

Housing Act 2004

Allows LA to carry out risk assessment of any residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. If the hazard is a category 1 there is a duty by the LA to take action. If the hazard is a category 2 then there is a power to take action. However an appeal is possible to the Residential Property Tribunal within 21 days. A local authority can prosecute for non-compliance.

Building Act 1984 Section 76 (defective premises):

This Act is available to deal with any premises which are in such a state as to be prejudicial to health or a nuisance. It provides an expedited procedure; the LA may undertake works after 9 days and recover expenses, unless the owner or occupier states intention to undertake the works within 7 days. There is no right of appeal and no penalty for non –compliance.

Environmental Protection Act 1990 Section 79 (statutory nuisance):

This refers to any premises in such a state as to be prejudicial to health or a nuisance. Action is by Section 80 abatement notice; the recipient has 21 days to appeal.

Prevention of Damage by Pests Act 1949:

Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice. They have a duty to secure that its district is free from rats and mice.

Public Health (Control of Disease) Act 1984 Section 46:

Imposes a duty on Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased.

The Act also 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.

Human Rights Act 1998

Public authorities must act in accordance with the Convention of Human Rights, which has been enacted directly in the UK by the Human Rights Act 1998 and therefore can be enforced in any proceedings in any court.

Article 5 – The Right to Liberty and Security.

Everyone has the right to liberty and security of persons.

Article 8 – Right to respect for Private and Family Life

Everyone has the right to respect for his private and family life, his home and his correspondence.

There shall be no interference by a public authority with the exercise of this right except such is permitted by the law, is for a lawful purpose e.g. is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or the protection of the rights and freedoms of others and is proportionate.

The First Protocol Article 1 – Protection of Property

Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one should be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

Anti-Social Behaviour Crime and Policing Act 2014

Anti-social behaviour is defined as persistent conduct which causes or is likely to cause alarm, distress or harassment or an act or situation which is, or has the potential to be, detrimental to the quality of life of a resident or visitor to the area.

Questions about whether an application for an Criminal Behaviour Order would be appropriate should be made to the designated police officer (it may be appropriate to involve the police in the multi-agency work), the registered social landlord or the local authority.

Misuse of Drugs Act 1971

Section 8 (this creates an offence if the occupier of premises permits certain acts to take place on the premises).

'A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises…'

s8 (a) Producing or attempting to produce a controlled drug…'

s8 (b) Supplying or attempting to supply a controlled drug to another …or offering to supply a controlled drug to another….'

s8 (c) Preparing opium for smoking's8 (d) Smoking cannabis, cannabis resin or prepared opium'

Appendix E: MASM Proforma

Name of person	
Address	
Date of Meeting	
In Attendance:	**Chair:**
Apologies:	

Purpose of Meeting: To co-ordinate a multi-agency meeting to share information, assess risk and produce a plan to minimise the potential risk to and/or from a vulnerable adult.

Please explain why client or patient did not attend the meeting:

Situation (Consider all relevant circumstances. Key worker to provide succinct case overview, why we are here, what brought us to this meeting, etc.?)

Does the person have capacity? (What are the specific mental capacity issues, who assessed them, are they recorded and what are the outcomes? What is their understanding of the potential cause, queries of this situation?)

Regaining of Mental Capacity – Where appropriate

What are the specific risks to this person and/or others? (Usually care, finances, possibly treatment, something else?) *Record individual risks and rate on a risk scale i.e. low, medium, high.(Refer to Thresholds document)

What are the person's wishes, past and present views, feelings beliefs and values?

What are the views of others? (Consider everyone's views and record these, can include: family, carers, relatives, others as per case needs ect.)

Is there an advocate? (What are their views?)

What actions and interventions have taken place to date?

Conclusion/Outcomes (Reflect on the discussions of each point in the pro-forma and attempt and encourage all to reach an agreed overview of the issues and outcomes.)

Recommendations/Outcomes (Be specific, names/ people/ lead agency for each issue/identifies tasks with time frames. Set a review date.)

1.

2.

3.

4.

5.

Chair persons (Name, title, signature and date)

Appendix F: City of York and North Yorkshire Hoarding Policies

A hoarding disorder is where someone acquires an excessive number of items and stores them in a chaotic manner, usually resulting in unmanageable amounts of clutter. The items can be of little or no monetary value.

Hoarding is considered a significant problem if:

- the amount of clutter interferes with everyday living – for example, the person is unable to use their kitchen or bathroom and cannot access rooms
- the clutter is causing significant distress or negatively affecting the quality of life of the person or their family – for example, they become upset if someone tries to clear the clutter and their relationship suffers

Hoarding disorders are challenging to treat because many people who hoard frequently do not see it as a problem, or have little awareness of how it's affecting their life or the lives of others.

Many do realise they have a problem but are reluctant to seek help because they feel extremely ashamed, humiliated or guilty about it.

It's really important to encourage a person who is hoarding to seek help, as their difficulties discarding objects can not only cause loneliness and mental health problems but also pose a health and safety risk. If not tackled, it's a problem that will probably never go away.

Why someone may hoard

The reasons why someone begins hoarding are not fully understood.

It can be a symptom of another condition. For example, someone with mobility problems may be physically unable to clear the huge amounts of clutter they have acquired, and people with learning disabilities or people developing dementia may be unable to categorise and dispose of items.

Mental health problems associated with hoarding include:

- severe depression
- psychotic disorders, such as schizophrenia
- obsessive compulsive disorder (OCD)

In some cases, hoarding is a condition in itself and often associated with self-neglect.

These people are more likely to:

- live alone
- be unmarried
- have had a deprived childhood, with either a lack of material objects or a poor relationship with other members of their family
- have a family history of hoarding
- have grown up in a cluttered home and never learned to prioritise and sort items

Many people who hoard have strongly held beliefs related to acquiring and discarding things, such as: “I may need this someday” or “If I buy this, it will make me happy”. Others may be struggling to cope with a stressful life event, such as the death of a loved one.

Attempts to discard things often bring up very strong emotions that can feel overwhelming, so the person hoarding often tends to put off or avoid making decisions about what can be thrown out.

Often, many of the things kept are of little or no monetary value and may be what most people would consider rubbish.

The person may keep the items for reasons that are not obvious to other people, such as for sentimental reasons, or feeling the objects appear beautiful or useful. Most people with a hoarding disorder have a very strong emotional attachment to the objects.

What’s the difference between hoarding and collecting?

Many people collect items such as books or stamps, and this is not 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.

For example, someone who collects newspaper reviews may cut out the reviews they want and organise them in a catalogue or scrapbook. Someone who hoards may keep large stacks of newspapers that clutter their entire house and mean it’s not actually possible to read any of the reviews they wanted to keep.

Signs of a hoarding disorder

Someone who has a hoarding disorder may typically:

- keep or collect items that may have little or no monetary value, such as junk mail and carrier bags, or items they intend to reuse or repair
- find it hard to categorise or organise items
- have difficulties making decisions
- struggle to manage everyday tasks, such as cooking, cleaning and paying bills
- become extremely attached to items, refusing to let anyone touch or borrow them
- have poor relationships with family or friends

Hoarding can start as early as the teenage years and gets more noticeable with age. For many, hoarding becomes more problematic in older age, but the problem is usually well established by this time.

It’s thought that around 1 or 2 people in every 100 have a problem with hoarding that seriously affects their life.

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:

- newspapers and magazines
- books
- clothes
- leaflets and letters, including junk mail
- bills and receipts
- containers, including plastic bags and cardboard boxes
- household supplies

Some people also 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're extremely reluctant to delete.

Why hoarding disorders are a problem

A hoarding disorder can be a problem for several reasons. It can take over the person's life, making it very difficult for them to get around their house. It can cause their work performance, personal hygiene and relationships to suffer.

The person hoarding is usually reluctant or unable to have visitors or even allow tradesmen in to carry out essential repairs, which can cause isolation and loneliness.

The clutter can pose a health risk to the person and anyone who lives in or visits their house. For example, it can:

- make cleaning very difficult, leading to unhygienic conditions and encouraging rodent or insect infestations
- be a fire risk and block exits in the event of a fire
- cause trips and falls
- fall over or collapse on people, if kept in large piles

The hoarding could also be a sign of an underlying condition, such as OCD, other types of anxiety, depression and dementia.

If you believe an individual you are working with is displaying hoarding behaviour, you should refer to the Hoarding Policy for your local area.

For those within City of York, the hoarding policy can be found on the City of York website.

For those within North Yorkshire you should contact your Borough and District Council and not North Yorkshire County Council.

Appendix G: Case Studies

Case Study one from Plymouth Safeguarding Adults Board

Ruth Mitchell was forty years old when she died at her home, where she lived alone, on 2nd September 2012. The Coroner found the cause of death as bronchopneumonia and pulmonary embolism. When found in her flat she was malnourished, underweight and had consumed significant quantities of alcohol. She had not taken her anti-psychotic medication.

Ruth had been known to mental health services for 16 years, and diagnosed with Schizophrenia and latterly depression. The last psychiatrist to see Ruth, described her symptoms of psychosis as “minimal and low grade” though she continued to live a solitary and isolated lifestyle. She attended a day therapy programme and was supported in the community by a social worker and Community Psychiatric Nurse (CPN).

After the separation from her partner and child in 1999 there was an escalation in Ruth’s use of alcohol and she was referred to alcohol services by her CPN at that time, Ruth did not pursue this referral.

In 2002, 2003, 2004 and 2006 Ruth was assessed under the Mental Health Act 1983. Unwell, she had cut up her carpets and curtains, and sawn up furniture, and had altercations with neighbours. She was not detained on any of these occasions.

Her parents were able to actively support her me but she distanced herself from them over time due to sensitive information being shared between them and her care team. Ruth moved properties following the altercation with her neighbour in 2004 and downsized, which prohibited contact with her children.

During 2006/2007 Ruth’s CPA care plan was a visit once a month to her home by her care coordinator, six monthly appointments with her psychiatrist and annual reviews with her GP.

In June 2007 a CPA took place and it was agreed that Ruth would be stepped down from the Enhanced Care Programme Approach to standard care. Ruth’s parents made a complaint to the mental health service stating that she was socially isolated and was becoming increasingly dependent upon alcohol with no apparent treatment strategy. Ruth was discharged from care-coordination and the GP was contacted to say that they should contact mental health services should they have any concerns, or if Ruth failed to pick up her prescriptions. The GP notes only stated that they should inform the mental health team if prescriptions were not collected.

Ruth continued to pick up her prescriptions between August 2007 and just before her death, and therefore no concerns were raised by the GP. At an outpatient appointment at the GP’s on 26 February 2008, Ruth’s goals were to be discharged and no longer take medication. Those present expressed concern about her social isolation and evidence of alcohol intake.

In March and April 2008 Gas Engineers commissioned by Plymouth City Council attempted to undertake an annual safety check but were unable to gain access. They therefore capped the gas supply to her flat and she had no heating or hot water from this point until her death in September 2012. Plymouth City Council were unaware that Ruth was vulnerable and took no supportive action to check how she may keep warm. There is no record that PCC informed the mental health service that the gas supply had been capped.

In May 2008 Ruth wrote to the DWP to say she had been discharged from mental health services and asked for a form to 'sort out her finances'. Her claim for Disability Living Allowance ceased at this time and she lived on income support of £60-65 per week.

Between 2008 and 2012 the Plymouth Community Homes repairs team visited Ruth to undertake repairs on five occasions. Ruth was seen by medical professionals, including her GP and Mental Health team on 17 occasions between 2008-2012. She was also visited by the police due to concerns raised by neighbours on four occasions. In addition, Ruth's parents made a number of complaints and raised concerns about her welfare throughout this period.

In January 2011, a health professional visited Ruth and noted 'Flat has become sparser than before; no flooring, won't let people in to test gas heater; not bathing, no cooker, drinking again, left door open, brought man back'. It was evidenced at this point that Ruth was self-neglecting, she was also drinking alcohol and engaging in risky business. Ruth's father contacted the health professional but did not get a response.

Ruth was found in her flat after Police forced entry following concerns from her neighbour. It was noted that she had been dead for some time.

In the case of Ruth, agencies worked very separately and shared no information. The two frameworks which may have prompted information sharing and working together, i.e. CPA or MASM were not used, so reducing the focus on responding to Ruth's self-neglecting behaviour.

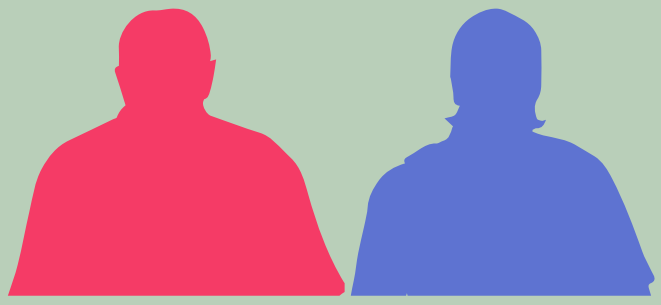
Recording practices were poor and case notes were not kept up to date. Risk assessments emphasised Ruth's clinical presentation, omitted any assessment of the impact of alcohol and were reliant on her self reports about her wellbeing. With one exception, assessments did not take account of third party concerns or observations of her environment.

Professional understanding of the provisions of the Mental Capacity Act 2005 during the scoped period was limited to assuming capacity based on Ruth's verbal account of her rationale for making decisions. The concept of executive capacity appeared unknown.

Ruth was not engaged in a relationship with any agency sufficiently to enable work to support her to make changes in her life.

Local case studies

Case Study Two



Two brothers with mild learning disabilities lived in their family home, where they had remained following the death of their parents some time previously. Large amounts of rubbish had accumulated both in the garden and inside the house, with cleanliness and self-neglect also an issue. They had been targeted by fraudsters, resulting in criminal investigation and conviction of those responsible, but the brothers had refused subsequent services from adult social care and their case had previously been closed.

The local authority received a concern that the brothers were at risk of self-neglect. It was not known if there was reasonable cause to suspect brothers were able to protect themselves from self-neglect or the risk of it, and so a s42 enquiry was not triggered. The needs assessment commenced, and as this progressed, it became clear that- with the right level of support to encourage the brothers to accept services- they were able and had mental capacity to take measures to protect themselves from the risk of self-neglect.

They developed a good relationship with their social worker, and as concerns about their health and wellbeing continued it was decided that the social worker would maintain contact, calling in every couple of weeks to see how they were, and offer any help needed, on their terms. After almost a year, through the gradual building of trust and understanding, the brothers asked to be considered for supported housing; with the social worker's help they improved the state of their house enough to sell it, and moved to a living environment in which practical support could be provided.

Local case studies

Case Study Three

Ms T lives alone. She has been diagnosed as having a severe compulsive disorder which manifests itself in hoarding. Ms T experiences high levels of anxiety which impacts on her ability to attend to personal care and eat. There are unopened bags of cooked food that Ms T says she has forgotten to eat. Ms T says she is aware of the risk to her health and environment and has noticed vermin droppings in the kitchen. She says she does not clean her home as it causes her anxiety to move things and throw things away.

Ms T gathers all her letters but doesn't open them. Ms T only goes out to familiar places where there are familiar faces.

The Local Authority received a concern about risk of harm through self-neglect. After checking with mental health services, it was found that Ms T had recently seen a psychiatrist. The psychiatrist was contacted and has a clear view that Ms T has full mental capacity to understand these risks, how her mental disorder affects these risks, and to make decisions about her care and support needs.

There is no reason to suspect that Ms T is unable to protect herself from self-neglect, but the Local Authority still has a duty to undertake a needs assessment. The needs assessment was undertaken and Ms T expressed a wish to try to continue to manage her needs herself, as she feels this is the best way for her to cope with her mental health in the longer term. The Local Authority provided information and advice on support services and how to access these. Outcomes were fed back to the psychiatrist who will continue to monitor Mr T's mental health.

Local case studies

Case Study Four

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

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

Appendix H:
Risk Assessment Matrix

Self-Neglect & Hoarding Assessment Tool Types & Seriousness			
Level of Risk	**Minimal Risk** Examples of concerns that do not require formal safeguarding procedures and can be dealt with by other systems e.g. Health / GP intervention, community engagement, counselling, developing a rapport.	**Moderate**	**High / Critical**
		The examples below are likely to indicate the need for a referral for formal procedures. If there is any immediate danger of a crime or abuse to an individual evident, call 999 straight away and make a safeguarding referral.	
Self-Neglect	Person is accepting support and services Health care is being addressed Person is not losing weight Person accessing services to improve wellbeing There are no carer issues Person has access to social and community activities Person is able to contribute to daily living activities Personal hygiene is good	Access to support services is limited Health care and attendance at appointments is sporadic Person's weight has decreased or increased significantly in a short space of time Persons wellbeing is partially affected Person has limited social interaction Carers are not present Person has limited access to social or community activities Persons ability to contribute toward daily living activities is affected Personal hygiene is becoming an issue Unexplained debt Homelessness/Rough sleeping	The person refuses to engage with necessary services Health care is poor and there is deterioration in health Weight is reducing Wellbeing is affected on a daily basis Person is isolated from family and friends Care is prevented or refused The person does not engage with social or community activities The person does not manage daily living activities Hygiene is poor and causing skin problems Aids and adaptations refused or not accessed

Self-Neglect & Hoarding Assessment Tool Types & Seriousness

Level of Risk	Minimal Risk Examples of concerns that do not require formal safeguarding procedures and can be dealt with by other systems e.g. Health / GP intervention, community engagement, counselling, developing a rapport.	Moderate	High / Critical
		The examples below are likely to indicate the need for a referral for formal procedures. If there is any immediate danger of a crime or abuse to an individual evident, call 999 straight away and make a safeguarding referral.	
Hoarding property	All entrances and exits, stairways, roof space and windows accessible. Smoke alarms fitted and functional or referrals made to fire brigade to visit and install. All services functional and maintained in good working order. Garden is accessible, tidy and maintained	Only major exit is blocked Only one of the services is not fully functional Concern that services are not well maintained Smoke alarms are not installed or not functioning Garden is not accessible due to clutter, or is not maintained Evidence of indoor items stored outside Evidence of light structural damage including damp Interior doors missing or blocked open Excess cold in the property	Limited access to the property due to extreme clutter Evidence may be seen of extreme clutter seen at windows Evidence may be seen of extreme clutter outside the property Garden not accessible and extensively overgrown Services not connected or not functioning properly Smoke alarms not fitted or not functioning Property lacks ventilation due to clutter Evidence of structural damage or outstanding repairs including damp Interior doors missing or blocked open Evidence of indoor items stored outside

Self-Neglect & Hoarding Assessment Tool Types & Seriousness

Level of Risk	Minimal Risk Examples of concerns that do not require formal safeguarding procedures and can be dealt with by other systems e.g. Health / GP intervention, community engagement, counselling, developing a rapport.	Moderate	High / Critical
		The examples below are likely to indicate the need for a referral for formal procedures. If there is any immediate danger of a crime or abuse to an individual evident, call 999 straight away and make a safeguarding referral.	
Hoarding – Household functions	No excessive clutter, all rooms can be safely used for their intended purpose. All rooms are rated 0-3 on the Clutter Rating Scale No additional unused household appliances appear in unusual locations around the property Property is maintained within terms of any lease or tenancy agreements where appropriate. Property is not at risk of action by Environmental Health/Housing Standards and Adaptations (York)	Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose. Clutter is causing congestion between the rooms and entrances. Room(s) score between 4-5 on the clutter scale. Inconsistent levels of housekeeping throughout the property Some household appliances are not functioning properly and there may be additional units in unusual places. Property is not maintained within terms of lease or tenancy agreement where applicable. Evidence of outdoor items being stored inside	Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose. Room(s) scores 7 - 9 on the clutter image scale and not used for intended purpose Beds inaccessible or unusable due to clutter or infestation Entrances, hallways and stairs blocked or difficult to pass Toilets, sinks not functioning or not in use Resident at risk due to living environment Household appliances are not functioning or inaccessible and no safe cooking environment Resident is using candles Evidence of outdoor clutter being stored indoors. No evidence of housekeeping being undertaken Broken household items not discarded e.g. broken glass or plates Concern for declining mental health Property is not maintained within terms of lease or tenancy agreement where applicable and is at risk of notice being served by Environmental Health/ Housing Standards and Adaptations (York)

Appendix I: Further Support

1.	**York City Council website**: www.york.gov.uk
2.	**York Safeguarding Adults Board:** www.safeguardingadultsyork.org.uk
3.	**York Safeguarding Children's Board:** www.saferchildrenyork.gov.uk
4.	N**orth Yorkshire County Council Website:** http://www/northyorks.gov.uk
5.	**North Yorkshire Safeguarding Adults Board:** www.safeguardingadults.co.uk
6.	**North Yorkshire Safeguarding Children's Board:** http://www.safeguardingchildren.co.uk/
7.	**Buttle UK -** http://www.buttleuk.org/ Buttle UK, formerly known as The Frank Buttle Trust, is the largest UK charity providing grant aid solely to individual children and young people in desperate need.
8.	**Cloud's End CIC** www.cloudsend.org.uk Resources to help hoarders and housing associations dealing with hoarding
9.	**Glasspool -** http://www.glasspool.org.uk/ The Glasspool Trust is one of the few national charities making grants to individuals which has no restrictions on the type of beneficiary. Their aim is to provide timely, life-enhancing support to people in need; short-term involvement for long-term impact.
10.	**Help for Hoarders** www.helpforhoarders.co.uk Information support and advice for hoarders and their families. Including and an online support forum;W
11.	**Hoarding UK** www.hoardinguk.org Information and support for hoarders and agencies, including local support groups;
12.	**OCD UK** www.ocduk.org/hoarding Information and support about Obsessive Compulsive Disorder, which includes hoarding;
13.	**SCIE:** Adult safeguarding - Self neglect https://www.scie.org.uk/adults/safeguarding/selfneglect/
14.	**The Association of Professional De-Clutterers and Organisers (UK)** www.apdo-uk.co.uk Provide support, networking and promotion for members of the Professional Organising & Decluttering industry, and information and services for their clients.
15.	**The Vicars Relief Fund -** https://smitf.flexigrant.com The VRF is a homelessness prevention fund. We offer a rapid response service by awarding small but essential grants to help alleviate housing difficulties for vulnerable people in their time of need. We aim to respond to all applications within five working days of them being submitted.
16.	**Turn 2 Us -** https://www.turn2us.org.uk/ Turn2us helps people in financial need gain access to welfare benefits, charitable grants and other financial help – online, by phone and face to face through our partner organisations.

Appendix J: Single page briefing on Self-Neglect

What is self-neglect?

An individual may be considered as self-neglecting and therefore maybe at risk of harm where they are:

- Either unable, or unwilling to provide adequate care for themselves
- Not engaging with a network of support
- Unable to or unwilling to obtain necessary care to meet their needs
- Unable to make reasonable, informed or mentally capacitated decisions due to mental disorder (including hoarding behaviours), illness or an acquired brain injury
- Unable to protect themselves adequately against potential exploitation or abuse
- Refusing essential support without which their health and safety needs cannot be met and the individual lacks the insight to recognise this

Examples of self-neglect

- Lack of self-care – examples: neglect of personal hygiene, nutrition, hydration, health, thereby endangering safety and wellbeing,
- Lack of care of one's environment – examples: squalor and hoarding,
- Refusal of services that would mitigate risk of harm.

When is self-neglect a safeguarding issue?

Self-neglect is a safeguarding issue when the person who self-neglects:

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

It may also be a safeguarding concern if the adult who is self-neglecting is a carer for an adult at risk. In these circumstances, always raise a safeguarding concern.

What to do if you are concerned someone is or may be self-neglecting

Always report the situation quickly.
This can be done by either:

- Through contacting the appropriate manager in your organisation
- Contacting your local safeguarding team, details can be found at page 2 of this document

Appendix K: Communicating with a person who hoards

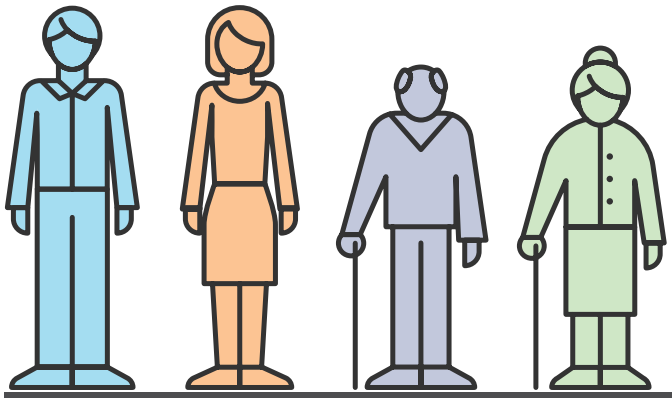
When talking to someone who hoards DO NOT:
Use judgemental language. Like anyone else, individuals with hoarding will not be receptive to negative comments about the state of their home or their character (e.g. “What a mess!” ‘’What kind of person lives like this?”) Imagine your own response if someone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

Appendix K: Communicating with a person who hoards

When talking to someone who hoards DO:
Imagine yourself in that persons shoes. How would you want others to talk to you to help you manage your anger, frustration, resentment, and embarrassment?
Match the person's language. Listen for the individual's manner of referring to his/her possessions (e.g. "my things", "my collections") and use the same language (i.e. "your things", "your collections").
Use encouraging language, In communicating with people who hoard about the consequences of hoarding, use language that reduces defensiveness and increases motivation to solve the problem (e.g. "I see that you have a pathway from your front door to your living room. That's great that you've kept things out of the way so that you don't slip or fall. I can see that you can walk through here pretty well by turning sideways. The thing is that somebody else that might need to come into your home, like a fire fighter or an emergency responder, would have a pretty difficult time getting through here. They have equipment they're usually carrying and fire fighters have protective clothes that are bulky. It's important to have a pathway that is wide enough so that they could get through to help you or anyone else who needed it. In fact, the safety law states that (insert wording about exits/ways out must be clear], so this is one important change that has to be made in your home".

City of York and North Yorkshire
Multi-Agency Practice Guidance:

Working with Adults who Self Neglect



Contact us

Safeguarding Adult Boards

w: www.safeguardingadults.co.uk

e: nysab@northyorks.gov.uk

t: 01609 780 780 (customer services - Emergency Duty Team out of hours)

North Yorkshire Safeguarding Adults Board, County Hall,
Northallerton, North Yorkshire, DL7 8DD

w: www.safeguardingadultsyork.org.uk

t: (01904) 555111 (office hours)

f: (01904) 554055

t: out of hours (01904) 534527

You can request this information in another language or format at
www.northyorks.gov.uk/accessibility

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