Suffolk Safeguarding Adults Board

SELF-NEGLECT AND HOARDING

Suffolk Multi-agency policy and practice guidance

This guidance is provided for key stakeholders in their role to engage in effective multi-agency working in order to maximise positive outcomes.

In addition, this document highlights the key legislative frameworks that exist to support adults who may be self-neglecting and/ or living in hoarded conditions whilst providing professionals with an understanding of options and principles of intervention.

Policy

Practice guidance

Referral pathway

Key information

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Authors:	Amanda Takavarasha (Adult Safeguarding Manager) and Paula Youell (Head of Adult Safeguarding)
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1. INTRODUCTION

1.1 This policy is endorsed and produced by the Suffolk Safeguarding Adult's Board (SAB) within the context of the duties set out in paragraph 14.2 of the Care Act (2014) Care and Support Statutory Guidance[1]. It should be referred to where an adult at risk is believed to be self-neglecting. The Suffolk SAB is a positive means of addressing issues of self-neglect and as a multi-agency safeguarding partnership, is the appropriate forum where strategic decisions can be made to deal with what are often complex and challenging situations for practitioners and managers as well as communities more broadly.

1.2 Under Section 42 of the Care Act 2014[2], Safeguarding duties apply to an adult who meets the following criteria:

- 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.

1.3 An adult who meets the above criteria is referred to as an 'adult at risk'[3]. Safeguarding duties also apply to family carers experiencing intentional or unintentional harm from the adult they are supporting or from professionals and organisations they are in contact with.

1.4 In places where this policy only refers to "self-neglect", this also includes hoarding.

2. A MULTI-AGENCY APPROACH

2.1 Research suggests that on average between 2% and 5% of the population experience varying degrees of self-neglect. It may be that some individuals will not meet the criteria for any one or a number of agencies' or organisations' eligibility thresholds and as such, previous experience of attempting to engage may have had limited or no success. These factors increase the risk of harm and should be identified as risk indicators that may prompt action under these self-neglect procedures.

2.2 The Suffolk SAB has identified that responding to Self-neglect is a multi-agency priority and there is an expectation that:

- In line with Section 6 and 7 Care Act 2014, all partner agencies will engage and cooperate when this is requested by the lead agency as appropriate or required; and
- Where an agency is the lead agency depending on the circumstances of each case, they take responsibility for coordinating multi-agency partnership working.
- All partner agencies will maintain a robust data information system in regard to self-neglect and hoarding, with the aim that this should inform service delivery, justify decisions taken, identify trends and gaps, identify the need for resources and a tool to benchmark trends/practice within the five geographical areas of the county.

[1] The Care and Support Statutory Guidance (Issued under the Care Act 2014) Department of Health 2014 updated August 2017
[2] Care Act 2014 Section 42 (1)
[3] Previously referred to as "Vulnerable Adult".

2.3 Failure to engage with individuals who are not looking after themselves (whether they have mental capacity or not) may have serious implications for, and a profoundly detrimental effect on, an individual's health and wellbeing. It can also impact on the individual's family and the local community.

2.4 Public authorities, as defined in the Human Rights Act 1998[4] and the Care Act 2014[5] in accordance with the Wellbeing Principle[6] and Safeguarding Principles[7], must act in accordance with the requirements of public law.

2.5 Authorities are expected to act within the powers granted to them. They must act fairly, proportionately, rationally and in line with the principles of the Care Act (2014), the Mental Capacity Act (2005) and consideration should be given to the application of the Mental Health Act (1983) where appropriate.

3. The Aim of the Policy and Practice Guidance

3.1 The purpose of this policy and practice guidance is to reduce risk and where possible prevent serious injury or death of individuals who appear to be self-neglecting by ensuring that:

- Individuals are empowered as far as possible, to understand the implications of their actions and/or behaviours
- There is a shared, multi-agency understanding and recognition of the issues including those involved in working with individuals who self-neglect
- There is effective multi-agency working and practice and concerns receive appropriate prioritisation
- That all agencies and organisations uphold their duties of care
- There is a proportionate response to the level of risk to self and others.

3.2 *This is achieved through*:

- Promoting a person-centred approach which supports the right of the individual to be treated with respect and dignity, and to be in control of, and as far as possible, to lead an independent life
- Aiding recognition of situations of self-neglect
- Increasing knowledge and awareness of the different powers and duties provided by legislation and their relevance to the particular situation and individuals' needs, this includes the extent and limitations of the 'duty of care' of professionals
- Promoting adherence to a standard of reasonable care whilst carrying out duties required within a professional role, in order to avoid foreseeable harm
- Promoting a proportionate approach to risk assessment and management
- Clarifying different agency and practitioner responsibilities and in so doing, promoting transparency, accountability, evidence of decision-making processes, actions taken and
- Promoting an appropriate level of intervention through a multi-agency approach.

[4] Human Rights Act Section 6 (3b)

[5] Care Act Section 1(4) and section 6(7)

[6] The "wellbeing principle" paragraphs 1.1 -1.6 chapter 1 Care and Support Statutory Guidance, Department of Health October 2014

[7] Empowerment, Prevention, Proportionality, Protection, Partnership, Accountability

4. DEFINITIONS

The following definitions are relevant to these Policy and Operational Guidance:

4.1 Self-Neglect

4.1.1 There is no accepted operational definition of self-neglect nationally or internationally due to the dynamic and complexity of self-neglect.

4.1.2 Gibbons et al (2006)[8] defined it as "the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and wellbeing of those who self-neglect and perhaps to their community".

4.1.3 The Care Act Guidance[9] states that self-neglect covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry[10]. 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. Locally, the Suffolk Multi-Agency self-neglect and hoarding risk assessment guidance tool will be used to determine the pathway of a concern.

4.2 Key indicators

There is a continuum of indicators which, when combined, may indicate the presence of self-neglect. There is no clear point at which lifestyle patterns become self-neglect, and the term can apply to a wide range of behaviour and different degrees of self-neglect. The following list is not exhaustive and should be considered in conjunction with the risk assessment guidance tool on page 25 and all information within this document:

- 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
- Portraying eccentric behaviour / lifestyles
- Obsessive hoarding
- Poor diet and nutrition. For example, evidenced by little or no food in the fridge, or what is there, being mouldy
- Declining or refusing prescribed medication and / or other community healthcare support
- Refusing to allow access to health and / or social care professionals 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), housing services
- Repeated episodes of anti-social behaviour – either as a victim or source of risk

[8] Gibbons, S., Lauder, W. and Ludwick, R. (2006), Self-Neglect: A Proposed New NANDA Diagnosis. International Journal of Nursing Terminologies and Classifications, 17: 10–18. doi: 10.1111/j.1744-618X.2006.00018.x

[9] The Care and Support Statutory Guidance (Issued under the Care Act 2014) Department of Health 2014 updated August 2017

[10] Local Authority's Duty to Make Enquiries under Section 42 (2) Care Act 2014

- Being unwilling to attend external appointments with professionals in social care, health or other organisations (such as housing)
- Total lack of personal hygiene resulting in poor healing / sores, long toe nails, unkempt hair, uncared for facial hair, body odour, unclean clothing;
- Isolation; either of an individual or of a household or family unit
- Failure to take medication.
- Repeated referrals to Environmental Health

4.3 Contributory Factors

Self-neglect involves the complex interplay of physical, mental, social, personal and environmental factors, all of which must be explored in order to understand the meaning of self-neglect in the context of each individual's life experience. This will assist professionals to intervene in the most applicable way while assisting individuals to recognise and address the root causes of their circumstances. This list is not exhaustive.

- *Physical health issues*
  - Impaired physical functioning
  - Pain
  - Nutritional deficiency
- *Mental health issues*
  - Depression
  - Frontal Lobe dysfunction
  - Impaired cognitive functioning
- *Substance misuse*
  - Alcohol
  - Other drugs
- *Psychosocial factors*
  - Diminished social networks; limited economic resources
  - Poor access to social or health services
  - Personality traits; traumatic histories/ life-changing events; perceived self-efficacy.

4.4 Hoarding

4.4.1 Hoarding disorder was previously considered a form of Obsessive Compulsive Disorder (OCD). Hoarding is now considered a standalone mental disorder and is included in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 2013 but does not appear in the ICD 10 (World Health Organisation, 2010). However, hoarding can also be a symptom of other mental disorders. Hoarding disorder is distinct from the act of collecting and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects which can be well in excess of the real value.

4.4.2 Please see page 27 for the Clutter rating images.

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

4.5 Diagnostic criteria

A diagnosis of Hoarding Disorder can only be made by a specialist medical practitioner. There are five diagnostic criteria[11] for identifying a case of hoarding disorder, namely:

1. Persistent difficulty discarding or parting with possessions, regardless of their monetary value.

2. This difficulty is due to a perceived need to save items and distress associated with discarding items.

3. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas.

4. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

5. The hoarding is not attributable to another medical condition or mental disorder.

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

- Clothes
- Newspapers, magazines or books
- Bills, receipts or letters and junk mail
- Food and empty food containers
- Animals
- Medical equipment
- Collectibles such as toys, video, DVD, or CDs
- Antiques
- Human excrement
- Electronic data such as emails, photographs and documents

4.6 Factors to consider during assessment and when tailoring intervention and support

- *Demotivation*
  - Self-image
  - Negative cognitions
- *Different standards*
  - Indifference to social appearance
- *Inability to self-care*
  - Physical and practical challenges
- *Influence of the past*
  - Childhood experiences

[11] Diagnostic and Statistical Manual of Mental Disorders (DSM–5)

- Loss
- Abuse
- Bereavement

- *Positive value of hoarding*
  - Emotional comfort
  - A sense of connection
  - Utility
- *Beyond control*:
  - Voices
  - Obsessions
  - Physical ill-health

See Appendix 3 for Do's and Don'ts when working with an individual who hoards.

4.7 Risk

4.7.1 Perceptions of what constitutes intolerable risk or what is or is not an acceptable standard within which to live will vary amongst different people, including the adult at risk. It is important to gather information from a variety of sources before making shared multiagency decisions about the level of risk where possible, with the adult at risk remaining central to the process. The following indicators of harm may be used to gauge the level of risk posed:

4.7.2 Significant harm:

- Impairment of, or an avoidable deterioration in, physical or mental health, and the impairment of physical, intellectual, emotional, social or behavioural development
- The individual's life could be or is under threat
- There could be a serious, chronic and/or long-lasting impact on the individual's health physical/emotional/psychological well-being.

4.7.3 Significant risk:

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
- Fluctuating capacity, history of safeguarding concerns / exploitation
- Financial hardship, tenancy / home security risk; risk of eviction
- Likely fire risks
- Evidence of Domestic Abuse
- Public order issues; anti-social behaviour / hate crime / offences linked to petty crime
- Unpredictable/ unmanaged or unstable 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.
- History of frequent hospital admission/ paramedic call out.

4.8 *Fire Risk*

Hoarding can pose a significant risk to both the people living in the hoarded property and those living in adjoining properties as well as emergency services personnel. Where an affected property is identified regardless of the rating on the hoarding scale, occupants need to be advised of the increased risk and identify a safe exit route in addition to the need for smoke and carbon monoxide detection (alarms). Appropriate professional fire safety advice must be sought and a multi-agency approach may be required to reduce risk. This will assist Suffolk Fire and Rescue Service to respond appropriately, which may include a fire safety check as part of the multi-agency approach. Once the risks have been addressed, records must be updated.

5. KEY AGENCIES AND THEIR ROLES

5.1 Acute and Community Hospitals and NHS Community Bed settings

Community based therapists and nursing staff are often the first people to observe hoarding and self-neglect related problems. These professionals can be key to identifying triggers and changes in behaviour which are then fed into the multi-disciplinary team. Therapists who work in acute wards may observe hoarding and other self-neglect related behaviours when undertaking access visits or home visits to help inform the discharge planning process. Therapists can assess and report on how an adult's self-neglect or environment impacts on their overall ability to be safe at home and help determine the level of risk posed to the client and others (family members, neighbours etc). Discharge planning should commence as soon as possible to support good communication and effective multi-agency working in order to reduce risks following discharge.

5.2 Adult and Community Services

In the majority of circumstances, the usual Care Act Assessment procedures will be the best route to provide an appropriate intervention. If assessed as having mental capacity to make informed decisions on the issues raised, then the person has the right to make their own choices. However, the social care practitioner must ensure that the person has fully understood the risk and likely consequences if they decline services. Involvement with the person should not stop at this point and efforts should be made to engage the person in the management of risks and to form a relationship with them to do this.

If the person is assessed as not having the mental capacity to make the relevant decisions then care should be provided in line with "best interest" principles (s.4 MCA). If any proposed care package might amount to a deprivation of liberty consideration must be given as to whether it would be necessary to obtain authorisation under the DoLS procedure or an order from the Court of Protection. Assessment of self-neglect should include assessment of any health issues such as impaired sight and mobility, pain issues, or long-term conditions that may be contributing towards the self-neglect.

5.3 Ambulance Services

Ambulance staff are called to people's properties in emergency situations and often access parts of the property that other professionals may not ordinarily see. They are able to assess an individual's living environment and physical health and often raise concerns with Adult and Community Services and General Practices. This is a brief observational assessment and may not give a holistic view.

5.4 Children and Young People's Services

Safeguarding Children refers to protecting children from maltreatment, preventing the impairment of their health or development and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care. Growing up in a hoarded property can put a child at risk by affecting their development and in some cases, leading to the neglect of a child, which is a safeguarding issue.

The needs of the child at risk must come first and any actions taken must reflect this. Therefore, where children live in a property where there is an issue with safeguarding and/ or hoarding, a referral should always be made to Children and Young People's Services.

5.5 Domiciliary care providers

Care agencies are commissioned by Adult and Community Services, the Clinical Commissioning Group or self-funded by individuals to provide support to people in their own homes. They have a role in both identifying people who self-neglect and hoard and in working with them.

5.6 Environmental Health Services

Environmental Health Services have a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premises is materially affecting neighbouring premises. Environmental Health is a frontline agency in raising alerts and early identification of cases of self-

neglect and hoarding. Where properties are verminous or pose a statutory nuisance, Environmental Health will take a leading role in case managing the necessary investigations and determining the most effective means of intervention. Where the individual is residing in conditions that only pose a threat to their own welfare, the powers available to Environmental Health may have limited or no effect. In cases involving persistent hoarders, the powers may only temporarily address and/or contain the problem. Therefore, utilising powers under public health legislation in isolation is often inappropriate due to the complexities of self-neglect and hoarding and it may not be the most effective use of resources, particularly where a coordinated approach could provide immediate protection of the individual and others or promote a long-term solution.

5.7 Housing departments

Under Part 1 of the Housing Act 2004, housing departments have powers to take enforcement action where there is any risk of harm to the health or safety of an actual or potential occupier of a dwelling or house of multiple occupation which arises from a deficiency in the dwelling or house of multiple occupation or in any building or land in the vicinity (whether the deficiency arises as a result of the construction of any building, an absence of maintenance or repair, or otherwise). The housing department can require access to residential premises in their district to assess if such a hazard exists. The duty to inspect the property is restricted to where there is an official complaint made either to the Justice of the Peace or local council. However, where there is evidence that there is imminent risk of serious harm to the health and safety of the occupier, the local authority has emergency power to serve a remedial action notice or emergency probation notice prohibiting the use of the property. There are also powers to serve a deferred action notice and take emergency remedial action. There is no requirement that the property is owned by the local authority, nor is the capacity of the inhabitant relevant to the exercise of these powers. However, use of these powers in isolation will have limited effect on those who have persistent behaviours. The Housing Act powers cannot be used to remove hoarded items or address any health and safety problems that are the result of the owner's actions.

5.8 Mental health services

Mental health services have a crucial role as for many individuals, hoarding or self-neglect are often the manifestations of an underlying mental health condition. Mental Health professionals may offer key insight into how best to intervene where the adult hoards or has a diagnosed mental health condition. Where relevant, powers conferred by the Mental Health Act 1983 (MHA) to Approved Mental Health Professionals (AMHP) enable the mental health service to take such steps as they consider necessary and proportionate to protect a person form the immediate risk of significant harm.

5.9 Police

The police have powers of entry and so may be pivotal in gaining access to conduct assessments if all else fails. Under section 17 (1) (a) of the Police and Criminal Evidence Act 1984, the police have the power to enter without a warrant if required to save life or limb; or prevent serious damage to property; or to recapture a person who is unlawfully at large whilst liable to be detained.

5.10 Primary health services

In some cases of chronic or persistent self-neglect, individuals who are reluctant to engage with Adult and Community Services or other agencies may engage with primary health care services such as their GP, district nursing service etc. GPs and district nurses often carry out home visits to people with care and support needs and may be the first people to notice a change in the person's home environment. Alternatively, failure to keep health appointments or to comply with medication may indicate self-neglect. As well as raising alerts and providing information, primary health services can be very effective in forming a relationship with the person and in addressing underlying concerns. Primary health services should monitor those individuals who are engaged with their service and show signs of significant self-neglect or hoarding. Monitoring might include a regular check in with, and offer of intervention to, someone who is reluctant to engage. If deterioration is such that risks to

the person or to others are assessed as high by the health professional then a multi-agency response will be required.

5.11 Private decluttering companies

There are a number of private companies and not for profit social enterprises who offer specialist deep cleaning, decluttering and garden clearance services. Their staff are specially trained to understand the complexities of hoarding and how to respond appropriately in sensitive circumstances.

5.12 Private landlords/housing associations/registered social landlords

Private landlords/housing associations and registered social landlords have an obligation to ensure that their properties are in a good state of repair and are fit for human habitation. Where the tenant is responsible for the disrepair the landlord has a right of action, including ultimately seeking possession of the premises. The role of the landlord/housing association and powers afforded to them means that they have a key role in alerting the statutory authorities to particular cases and that consideration should always be given to their inclusion within multi-agency discussions.

5.13 RSPCA

Animal hoarders own a high number of animals for which they may be unable to provide adequate standards of nutrition, sanitation, shelter and veterinary care. Hoarders often care about their animals deeply but may not see or understand that the living conditions could result in animal neglect. This neglect can involve cramped, poor living conditions and in extreme cases, result in starvation, illness or death. Animal hoarders are often in denial about their inability to provide appropriate care for their animals and typically believe that no-one else can care for their animals like they do. Sensitivity is vital as animal hoarders often hold the belief that if they seek help, or allow external intervention, their animals will be euthanised or taken away from them. Professionals can contact the RSPCA who can offer advice and assistance to improve animal welfare, including giving people time to make improvements to their standards of care. Where assistance is declined, or in extreme cases of neglect, the RSPCA can consider prosecution under laws such as the Animal Welfare Act 2006.

5.14 Suffolk Information Partnership (SIP)

SIP are a network of voluntary sector, local authority and health organisations who strategically influence local organisations' thinking about the importance of effective, quality information.
SIP facilitate the delivery of joined up ways of working with the voluntary and statutory sectors to provide a range of clear, quality information for people which enables them to make informed choices and which improves the experience and outcomes for those needing to access services. SIP can provide information on trusted tradesmen or FIRE home safety assessment etc.

5.15 Suffolk Fire and Rescue Service

Suffolk Fire and Rescue Service is best placed to work with individuals to assess and address fire risk and to develop strategies to minimise significant harm caused by potential fire risks in the home. Suffolk Fire and Rescue Service will also raise alerts when called to or visiting addresses where significant risk is identified or where homes have damage because of a fire and the individual continues to live at that address. Suffolk Fire and Rescue Service will raise alerts, carry out Safer Home Visits and offer advice to individuals assuring them of the necessity and principles of fire prevention in the home. Suffolk Fire and Rescue Service have on occasion managed to enter a home for a referral where home access is refused to other services due to the trusted nature of their work.

5.16 Utility companies/building and maintenance workers

Utility companies/ building and maintenance workers have an important role in the identification of hoarding and self-neglect as they visit people's homes to read meters, carry out inspections or carry out building/maintenance work. Engagement of utility companies and other companies/workers who enter peoples' homes is therefore important so that reports of hoarding and self-neglect can be received and appropriate action taken.

6. MAKING SAFEGUARDING PERSONAL

6.1.1 Making Safeguarding Personal is about seeing people as experts in their own lives and working alongside them in a way that is consistent with their rights and capacity and that prevents harm occurring wherever possible. Safeguarding should be person-led and outcome focused, engaging the adult at risk in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. Most importantly it is about listening and providing the options that support individuals to help themselves.

6.1.2 Whilst every effort must be made to work with adults experiencing abuse within the present legal framework, there will be some occasions on which adults at risk will choose to remain in dangerous situations. It may be that even after careful scrutiny of the legal framework, professionals will conclude that they have no power to gain access to a particular adult at risk. Professionals may find that they have no power to remove the adult from a situation of risk or intervene positively because the adult refuses all help or wants to terminate contact with the professionals. In these extremely difficult circumstances, professionals will be expected to continue to exercise as much vigilance as possible and make a referral to the High Risk Self-Neglect and Hoarding Panel (See pathway on page 17 and information on the High-Risk Panel on page 23).

6.2 Mental Capacity and self-neglect

6.2.1 When concerns about self-neglect are raised, there is a need to be clear about the person's mental capacity[12] in respect to the key decisions in relation to the proposed intervention.

6.2.2 If there are any doubts about the person's mental capacity, especially regarding their ability to 'choose' their living conditions or refuse support, then where possible a mental capacity assessment should be undertaken. In extreme cases of self-neglect and/or hoarding behaviour, the very nature of the environment should lead professionals to question whether the client has capacity to consent to the proposed action or intervention and trigger an assessment of that person's mental capacity.

6.2.3 The professional responsible for undertaking the capacity assessment will be the professional 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 multidisciplinary team, they are responsible for making the final decision about a person's capacity.

6.2.4 There may be circumstances in which it is useful to involve therapists in capacity assessments. For example, Occupational Therapists where the decision is around managing tasks within the home environment or Speech and Language Therapists where the person has communication difficulties.

6.2.5 Strong emphasis needs to be placed by practitioners on the importance of inter-agency communication, collaboration and the sharing of risk. The autonomy of an adult with capacity should be respected including their right to make what others might consider to be an "unwise decision". However, this does not mean that no further action regarding the self-neglect is required. Efforts

[12] Mental Capacity Act 2005

should be directed to building and maintaining supportive relationships through which services can in time be negotiated.

6.2.6 Capacity assessments may not take full account of the complex nature of capacity. Self-neglect and adult safeguarding: findings from research, SCIE report 46 highlights the difference between capacity to make a decision (decisional capacity) and capacity to actually carry out the decision (executive capacity). However, this distinction does not currently exist in policy or guidance.

6.2.7 NB: It is good practice to consider or assess whether the person has the capacity to act on a decision that they have made (executive capacity). See Appendix 4 for guidance on assessing executive capacity in relation to self-care. An individual who self neglects may have decisional capacity but may lack the ability to execute their decision, hence the requirement to assess both decisional and executive capacity.

6.2.8 Any capacity assessment carried out in relation to self-neglect and or hoarding behaviour must be time and decision specific, and relate to a specific intervention or action. If the person is assessed as not having capacity to make decisions in relation to their self-neglect, then any decisions should be made following the best interests process, which includes taking into account the person's views and taking the least restrictive action. Due to the complexity of such cases, there must be a Best Interests Meeting, chaired by a manager or other senior or experienced professional from the appropriate organisation and appropriately recorded in formal minutes. Additionally, consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed. Fluctuating capacity should be considered and evidenced.

6.2.9 In particularly challenging and complex cases, it may be necessary for the organisation to seek legal advice in order to refer to the Court of Protection (COP) to make the best interests decision.

Further information can be found on the Suffolk County Council website under Mental Capacity and Deprivation of Liberty Safeguards.

6.3 Advocacy and Support

6.3.1 It is essential to ensure all efforts are made to include the person suspected of self-neglecting and ensure that they are consulted with and included in discussions. Concerns should be raised directly with the adult at the earliest opportunity. If there is concern that the person has substantial difficulty participating in any aspect of the process, the involvement of an independent advocate or appropriate friend or family member **must** be considered for the individual.[13] The involvement of a family member does not negate a referral to an Independent Mental Capacity Advocate (IMCA) were relevant.

6.3.2 A person who is employed to provide or arrange care or treatment for the adult at risk cannot act as their advocate. 'Substantial difficulty' would be characterized by the individual's inability to understand, retain, or weigh up information relevant to the enquiry or to communicate their wishes, views, and feelings (whether by talking, using sign language or any other means).

[13] Section 67 & 68 Care Act 2014

6.3.3 The ‘support’ element refers to the advocate’s role of assisting the adult to understand the process of external support and intervention while the ‘representation’ is about ensuring that the individual’s voice is heard and that all intervention reflects their views as far as appropriate.

6.3.4 Intervention and support can commence prior to the appointment of an advocate if necessary but where required, an advocate must then be appointed as soon as possible.

6.4 Consent and Choice

6.4.1 Where an adult has mental capacity in relation to the relevant decisions, any proposed intervention or action must be with the person’s consent, except in the public interest where other people are affected or circumstances where a local authority or agency exercises their statutory duties or powers. See Appendix 5: Legislation.

6.4.2 If 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 levels of risk.

6.4.3 Where a self-neglecting individual chooses not to accept positive change to their circumstances, professionals working with them have a responsibility to explore that choice through respectful challenge and tactfully expressing concerned curiosity (See Do’s and Don’ts on page 33). Professionals need to explore the extent to which “choice” is in fact chosen, taking into account potential contributory factors to the individual’s situation which may shed light on their resistance. For example, considering the potential of undue influence by a third party being the reason an individual declines intervention or whether a deep-seated fear of care home placement or losing one’s pets stops someone from accepting intervention.

6.4.4 In the most high-risk, intractable cases where an adult has been identified as potentially self-neglecting, is refusing support, and in doing so is placing themselves or others at risk of significant harm, a referral should be made as outlined in the self-neglect pathway on page 17.

6.4.5 An adult at risk with no disturbance or impairment in the functioning of the mind may be entitled to the protection of the Inherent Jurisdiction[14] of the High Court if he/she is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors such as mental disorder or mental illness. They may also be reasonably believed to be, for some reason, deprived of the capacity to make the relevant decision, or disabled from making or expressing a free choice or genuine consent. Irrespective of this provision, adults with the mental capacity to make their own, sometimes unwise decisions, remain responsible for their own actions and any associated risk (however, as previously stated, this does not preclude them from professionals’ continued efforts to engage).

6.5 Duty of Care

6.5.1 Safeguarding adults at risk of harm often creates a tension for professionals between promoting an adult’s autonomy and their duty to try to protect them from harm. All professionals working with

[14] Inherent jurisdiction is a doctrine of the English common law that a superior court has the jurisdiction to hear any matter that comes before it, unless a statute or rule limits that authority or grants exclusive jurisdiction to some other court or tribunal

adults at risk should be aware of their duty of care in cases of self-neglect or hoarding, even when the individual has been assessed to have mental capacity in relation to the relevant decisions. Respect for autonomy and self-determination must always be balanced against the duty of care and promotion of dignity and wellbeing. The duty of care can be summarised as the obligation to exercise a level of care towards an individual, as is reasonable in all circumstances, by taking into account the potential harm that may reasonably be caused to that individual or his property. It means supporting an individual to achieve their chosen outcomes while maximising safety as far as practicable.

6.5.2 The Suffolk SAB has a duty to ensure that partner agencies protect Suffolk residents from foreseeable harm with consideration being given to others who may also be at risk, at which point an individual's autonomy may potentially be overridden in the public interest. The overall aim is not to be bureaucratic or paternalistic but to empower individuals to take control of shaping their own lives wherever possible and lead the pace of intervention.

6.5.3 Respect for autonomy does not mean abandonment. Working with self-neglecting adults often requires persistence over a long period rather than time-limited involvement.

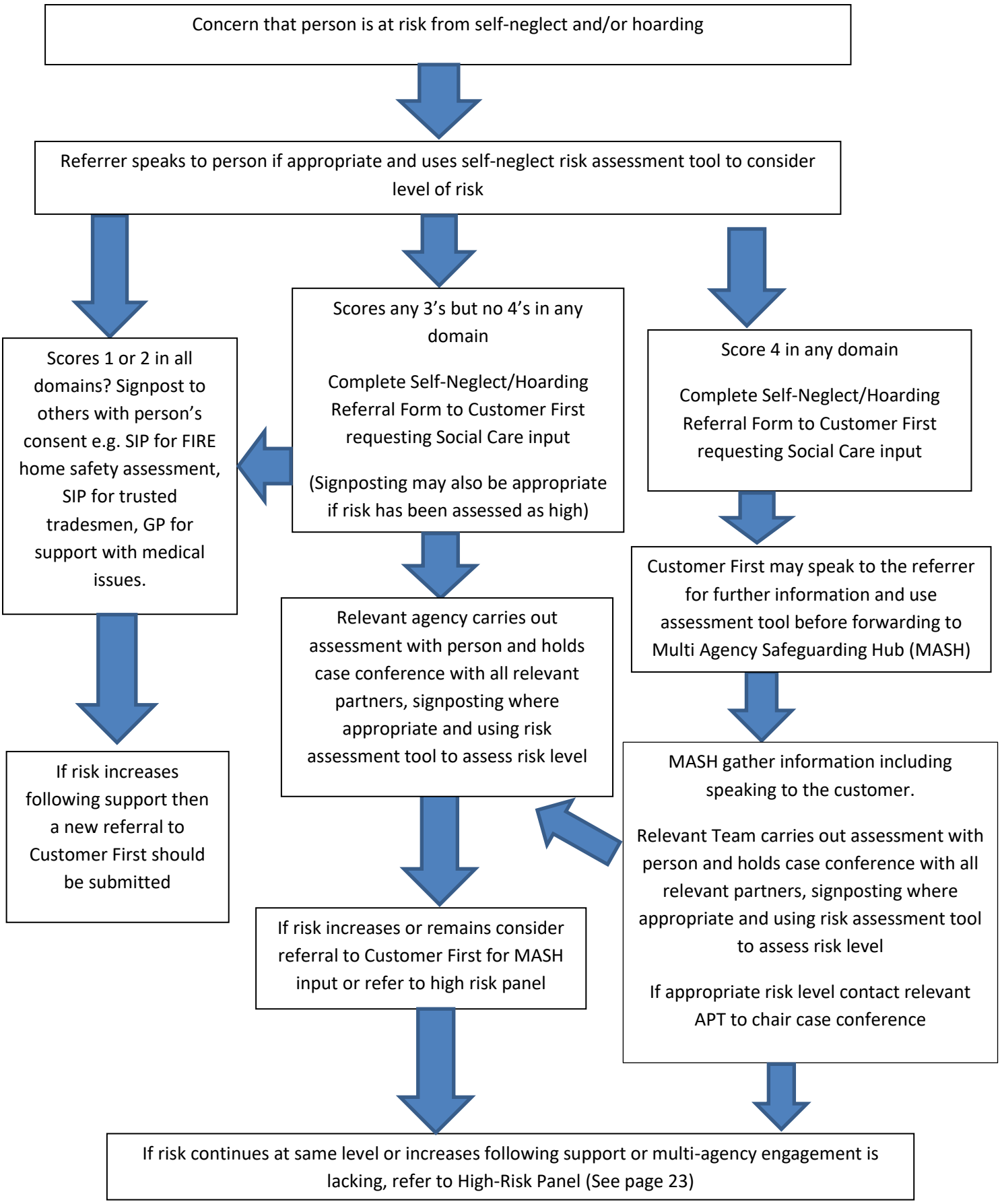
6.5.4 NB This policy requires that all cases of self-neglect and hoarding assessed as high-risk will not be closed prior to multiagency agreement and a clear record of all protective measures and shared decision making should be kept.

7. SAFEGUARDING CHILDREN

7.1 Safeguarding Children is about protection from maltreatment, preventing impairment of their health or development and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care. Growing up in a hoarded property can put a child at risk by affecting their development and in some cases, leading to the neglect of a child.

7.2 When addressing concerns of self-neglect and hoarding, professionals should determine whether there are children in the household who may need support or who are at risk. Where there are any child protection or child in need concerns, these must be referred to Children and Young People's Services as a matter of urgency by contacting Customer First on 03456066167. For further discussion, please contact the MASH Consultation Line on 03456061499.

SELF-NEGLECT AND HOARDING PATHWAY FOR PROFESSIONALS



8. PROCEDURES

Any organisation or individual that is concerned about an 'adult at risk' believed to be self-neglecting should follow the Self-Neglect and Hoarding Pathway (Page 17).

8.1 Assessment

8.1.1 An assessment should be carried out by the most appropriate agency depending on the nature of the concerns. In most instances, this would the referring agency. For example, where an individual is severely neglecting their health, the most appropriate lead agency may be the representative of the NHS such as District Nursing or Practice Surgery. Alternatively, Housing services or Environmental Health may be the most appropriate agencies to address hoarding and infestation while Social Care Services would intervene where individuals grossly neglect their personal care and other daily living activities. Assessments can also be carried out jointly on an interagency basis. This must be informed by the views of individuals themselves, wherever possible and practicable as well as by the views of carers and / or relatives where appropriate.

8.1.2 Specialist input may be required to clarify certain aspects of the adult's functioning and risk. This includes considering the request for a Mental Health Act assessment where this appears to be appropriate. Another example would be a referral for psychological input. Where there are concerns about mental capacity, a mental capacity assessment must be considered at an early stage in relation to their ability to make informed decisions regarding the risks identified.

8.1.3 Building a positive relationship with individuals who self-neglect is critical to achieving change for them, and ensuring their safety and protection. It is also key to maintaining the kind of contact that can enable interventions to be accepted with time.

8.1.4 It may be necessary to work creatively and across job roles in some instances to maximise engagement. For example, if the adult has developed a trusting relationship with one professional but declines the intervention of other agencies, that one professional may be guided by colleagues to ask other questions or assess other risk aspects that are pertinent to their respective roles pending further attempts at engagement.

8.1.5 Consider all members of the household when assessing needs and risks as in some cases, more than one family member may need an assessment in their own right.

8.1.6 Addressing self-neglect requires time and patience; improvements often take time to come to fruition, sometimes weeks, months or even longer. Short-term preventative interventions are unlikely to succeed so professionals will need to allow flexibility in such cases.

8.1.7 See Appendix 3 for examples of questions to ask during an assessment.

8.2 Consider appropriate procedure to respond to the risk

8.2.1 There may be occasions when it is appropriate to follow another procedure to coordinate all or some aspects of the issues identified.

8.2.2 Where the adult at risk's ability to make the relevant informed decisions is in question, the principles of the Mental Capacity Act must be followed.

8.2.3 If the apparent self-neglect may have developed as a result of abuse or neglect by others, the Suffolk Safeguarding Adults Policy and Operational Guidance and other SAB policies, protocols and guidance should be used. If there are any child protection or child in need concerns these must be referred to Children and Young People's services as a matter of urgency.

8.2.4 If other processes are considered more appropriate to use to support the individual, the self-neglect procedures may be ended at this point and all issues handed over to the practitioner/service taking responsibility for addressing the self-neglect as well as the other concerns. There must be clear documentation to evidence the handover of responsibilities if this is the case.

8.2.5 Depending on the level and nature of the risks identified, consideration may be given to the work of other agencies and practitioners being carried out in parallel with the self-neglect procedures.

8.3 The scope of this policy does <u>not</u> include:

- Issues of risk associated with **deliberate self-harm;** the intentional infliction of physical damage or injury by an individual to their own body. Anyone who self-harms should be advised to see their GP or other relevant health professional.

8.4 Referral process

8.4.1 The referral form (Appendix 2) should only be used when there is a concern that an individual is at significant risk of harm due to self-neglect or hoarding and a multi-agency case conference is required (and/or to be considered at the high risk self-neglect panel). See page 9 for definitions of significant harm and significant risk.

8.4.2 Please use the Multi-Agency self-neglect and hoarding risk assessment guidance tool (Appendix 1) to consider if this referral is necessary, individuals who score 4 in any domain on the tool are considered at risk of significant harm. If an individual does not score 4 but the referrer is still concerned that the individual is at risk of significant harm please contact the MASH Consultation Line for further discussion prior to making a referral – 0345 6061499.

8.5 Multi-Agency Case Conference

8.5.1 A Multi-Agency Case Conference will be considered where:

- The current level of professional intervention has not reduced the level of risk and significant risk remains
- It has not been possible to coordinate a multi-agency approach through work undertaken up to this point
- The level of risk requires a more formal information sharing process to agree and record a multi-agency action plan.

8.5.2 **The principles for arranging a multi-agency case conference are to consider:**

- The individual's view and wishes as far as known;
- Information, actions and current risks;
- The on-going lead professional / agency who will coordinate this work and
- Coordinate information-sharing in line with the principles of information sharing contained in the Suffolk Safeguarding Adults policy and operational guidance
- Evaluate relevant information to inform the most effective action plan.

NB: The Multi-Agency Case Conference is different from the Self-Neglect and Hoarding High-Risk Panel. For information on the High-Risk Panel, please see page 23 or visit the Suffolk SAB Website http://www.suffolkas.org/ for full Terms of Reference.

8.5.3 Suggested membership (this list is not exhaustive)

Adult at risk and their representative/s

Suffolk Fire and Rescue Service

East of England Ambulance Service

Primary, Acute and Community Health Care Services

Norfolk and Suffolk Foundation Trust

Adult and Community Services and Children and Young People's Services

Learning Disability Services

Environmental Health

Police

Housing Provider

Community Wardens and Community Safety

Care Agencies

Age UK Suffolk

Community/Voluntary Sector

Community Networks

Legal

8.5.4 Guidance for multi-agency case conference:

- The lead professional/ agency is responsible for convening the meeting and making arrangements such as venue, chairing and minute taking;
- The referring agency will make arrangements to involve the individual concerned.

- Every effort must be made to engage with the individual and to enable them to communicate their views to the meeting;
- If the individual does not wish to attend the meeting, representatives will need to consider how their views and wishes are to be presented at the meeting e.g. by the appointment of a formal or invitation extended to an informal advocate;
- Participants from all agencies identified should attend the meeting with an understanding of their responsibilities to share relevant information in order to reach an agreement on the way forward;
- It is important to ensure that any actions agreed comply with legislation and statutory duties. Legal representation at the meeting may need to be considered to facilitate discussions around relevant legal options. This may include application to the Court of Protection where there are concerns about mental capacity or to the High Court (Inherent Jurisdiction) where the individual is believed to be mentally capacitated.
- An action plan should be developed and agreed by members of the meeting. Where there are disagreements about any aspects of the plan, these should be resolved by consultation with a senior manager from the lead agency;
- The chair of the multi-agency meeting will ensure clarity is brought to timescales for implementing contingency plans, so that where there is legal and professional remedy to do so, risk is responded to and harm is reduced/prevented.

NB: The chair is not responsible for ensuring that identified action points are correctly followed up. It is the responsibility of the lead practitioner/ each agency representative to ensure identified actions are implemented and followed up.

8.5.5 Outcomes of the meeting will include the following:

- An action plan – including contingency plans and escalation process;
- Agreement of monitoring and review arrangements and who will do this;
- An agreement of a communication plan with the individual / other key people involved
- An agreement regarding which agency/ies will take the lead in the case and
- Agreement of any trigger points that will determine the need for an urgent multi-agency review meeting or referral to the High-Risk Panel.

8.5.6 Appropriate written communication should be forwarded to the individual concerned, irrespective of the level of their involvement to date. This communication will include setting out what support is being offered and / or is available and providing an explanation for this. Should this support be declined, it is important that the individual is aware that, should they change their mind about the need for support, then contacting the relevant agency at any time in the future will trigger a re-assessment. Careful consideration will be given as to how this written record will be given, and where possible explained, to the individual.

8.5.7 Multi-agency review meeting (Further Case Conference)

The Case Conference may decide to set a further meeting to bring professionals back for the purpose of revisiting the original assessments, particularly in relation to the individual's current functioning, risk assessments and known or potential rates of improvement or deterioration in:

- The individual,
- Their environment, or
- In the capabilities of their support system.
- Decision specific mental capacity assessments will have been reviewed and are shared at the meeting. Discussion will need to focus upon contingency planning based upon the identified risk(s).

8.5.8 It may be decided to continue providing opportunities for the individual to accept support and monitor the situation. Clear timescales must be set for providing opportunities and for monitoring and who will be involved in this.

8.5.9 Where possible, indicators that risks may be increasing will be identified and that will trigger agreed responses from agencies, organisations or people involved in a proactive and timely way.

8.5.10 A further meeting date will be set at each multi-agency review until there is agreement the situation has become stable and the risk of harm has reduced to an agreed acceptable level.

8.5.11 Where agencies are unable to implement support or reduce risk significantly, the reasons for this will be fully recorded and maintained on the individual's file, with a full record of the efforts and actions taken. In these circumstances, Legal advice must be sought.

8.6 High Risk Panel

8.6.1 The Self-Neglect and Hoarding High Risk Panel supports agencies in their work to lower and manage risk for both residents and their immediate neighbours, where partners feel they have exhausted internal mechanisms for managing the risk or where more formal consultation with colleagues from other agencies would enhance their response.

8.6.2 The panel is collaboratively owned by participating agencies operating in Suffolk. It will be administered on behalf of the participating agencies by Suffolk County Council, Adult and Community Services, and chaired by a nominated senior officer.

8.6.3 The panel will consider case presentations for situations which have already been considered within partner agencies' risk assessment processes and/or the Self-Neglect Multi-Agency Case Conference and significant risk remains.

8.6.4 Reasons for referring to the High-Risk Panel may include:

a) The conference chair is concerned of a lack of progress
b) Lack of progress identified at the case conference
c) Public safety remains a concern
d) Lack of partnership engagement
e) Disagreement on deployment of resources

Please see the separate Self-Neglect and Hoarding High Risk Panel Terms of Reference for full details. This can be found on the Suffolk SAB Website.

8.7 Record keeping, information sharing and confidentiality

8.7.1 The identified lead agency coordinates information gathering and determines the most appropriate actions to address the concerns. The key principles of information sharing and confidentiality are laid out in the Care Act Guidance section (14.150) which outlines the importance of obtaining informed consent, 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.

8.7.2 Where an adult has refused to consent to information being disclosed (section.14.158) or consent cannot be established for these purposes, then practitioners must consider whether there is an overriding public interest that would justify information sharing (e.g. because there is a risk that others are at risk of serious harm).

8.7.3 In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies. The Home Office and the Office of the Information Commissioner have issued general guidance on the preparation and use of information.
Information sharing within these procedures should be in line with the principle of information sharing contained in the Care Act Guidance[15] which will ensure information gathered at this stage is to inform:

- Decision making regarding whether further multi-agency information sharing is required;
- The completion of an initial Risk Assessment and ensuring any urgent actions are carried out. E.g. Contacting emergency services, Suffolk Fire and Rescue Service, completing safety checks and where necessary seeking urgent medical intervention.
- Where there are concerns about the individual's ability to make informed decisions due to a mental disorder or ill health, consideration must be given to carrying out a Mental Capacity Assessment in relation to any decisions they may need to be made regarding their safety or the safety of others.

8.7.4 Information gathering will aim to build an understanding of:

i. any previous successful engagement with the individual
ii. approaches that appeared to disengage the individual
iii. an insight into the individual's wishes and feelings including previous wishes or life experiences that may inform a Best Interests decision
iv. the views of anyone who has or has had contact with the individual including relatives and neighbours

8.7.5 When working with individuals who may be reluctant to communicate, the risk of miscommunication between agencies is greater than usual. It is important to ensure that all relevant information is available to those who undertake any assessments.

8.7.6 Use information available as in (i) above of any previous successful engagement with the individual to facilitate direct communication with the individual if possible. This should be appropriate to the person's needs such as making use of interpreters for those who speak English as a second

[15] The Care and Support Statutory Guidance (Issued under the Care Act 2014) Department of Health 2014 updated August 2017

language or British Sign Language signers when required. This should ensure that the assessment will inform any actions to be taken and include the wishes and feelings of the individual (iii). The following key principles must be applied:

- ✓ Balancing individuals' rights and agencies' duties and responsibilities.
- ✓ All individuals have the right to take risks and to live their lives as they choose.
- ✓ These rights including the right to privacy will be respected and weighed when considering duties and responsibilities towards them.

8.7.7 They will not be overridden other than where it is clear that the consequence would be seriously detrimental to their, or another person's health and wellbeing and where it is lawful to do so with the least restrictive option.

8.7.8 The case record will include a complete and up to date summary record of the efforts and actions taken by all other agencies involved. Individual agencies will also need to keep their own records of their specific involvement.

8.7.9 Accurate records that demonstrate adherence to this document and locally agreed case recording Policy and Operational Guidance must be maintained.

Appendix 1:

Suffolk Multi-Agency self-neglect and hoarding risk assessment guidance tool

This document is for guidance purposes and to be used to prompt discussion with the customer and aide multi-agency professional planning and decision making. The document can be used at referral stage and also as an ongoing risk assessment tool.

The following scale is not exhaustive but allows the professionals to consider the observed living conditions of the customer. The Signs of Safety assessment and planning document which follows can be used to support further consideration of required next steps.

The score is for assessment purposes only and may be re-visited at any time to measure progress and prompt discussion with the customer and other professionals.

WHEN USING THE RISK SCORE BELOW CONSIDER WHETHER THE PERSON HAS THE MENTAL CAPACITY TO UNDERSTAND THE RISK ASSOSICIATED WITH THEIR LIVING CONDITION. ALSO CONSIDER WHETHER THE PERSON HAS CAPACITY TO EXECUTE CHANGES TO REDUCE THE RISK.

For further information including more in-depth assessment tools refer to Suffolk County Council hoarding and self-neglect policy

Physical well-being and self-care			
Eating and drinking 1	2	3	4
Aware of nutritional needs and provides excellent/good quality food and drink	Quality of food and/or drink inconsistent through lack of knowledge or effort	Quality of food and/or drink is consistently poor through lack of effort; consistent support required to improve any quality Poor food safety. May be experiencing health related issues	Quality and frequency of food and/or drink consistently not a priority despite support leading to health issues of concern such as dehydration, malnutrition, infection, diarrhoea, vomiting and/or significant weight loss
Washing/bathing 1	2	3	4
Clean, bathed and groomed regularly with clean, weather appropriate clothing	Irregular bathing and occasional weather inappropriate clothing	Occasionally bathed but seldom groomed. Clothing often dirty and/or unsuitable to weather conditions Concerns that this maybe having an impact on health of low level concern which is responsive to treatment in the community.	Seldom/never bathed or clean, concern regarding odour. Dirty and/or poor condition of clothing (Maybe wholly unsuitable to weather conditions) Poor health of significant concern such as skin infections, sores, abscesses. Likely to unmanageable within community setting.

Medical needs 1	2	3	4
Medical advice sought proactively for all health matters	Seeks advice from professionals on matters of genuine and immediate concern. Occasionally fails to keep appointments	Only seeks advice when illness becomes moderately severe. Fails to keep some medical appointments and takes only partial medical advice	Only seeks help when illness becomes critical (emergencies), this can also be ignored. Clear disregard for own welfare and/or fails to consistently take medication leading to physical ill health and frequent hospital admissions. Significant mental ill health may also be of concern

Living conditions			
Home Amenities 1	2	3	4
Home is well maintained and useable. Essential and additional amenities- heating, power, water, useable shower/bath, cooker and fridge	All essential amenities - heating, power, water, useable shower/bath, cooker and fridge Some repairs needed and amenable to repair or able to self -repair	Lack of some essential amenities or lack of access to essential amenities due to hoarding In disrepair - unable and /or unamenable repair	Little or no essential amenities or hoarding prevents safe use of any amenities within the home Dangerous Disrepair – significant risk to well-being of person and/or others
Home and garden cleanliness 1	2	3	4
Takes pride in appearance of home and garden which is clean and tidy (ref clutter score pic 1)	Cleanliness is not of concern However, level of untidiness may be having some impact on well-being but manageable (ref clutter score pic 2-3)	Unclean and/or cluttered home and/or garden Dirty (bad odour) Some infestations Animal/human waste Food waste These are having a moderate impact on person's health and well-being and with support could be managed (ref clutter score pic 4-6)	Hoarding within unclean environment of home and garden Dirty (bad odour) Some infestations Animal/human waste Food waste These are significantly impacting on person's health and well-being – consider whether there is any impact on animals or children in the property also (ref clutter score 7-9)

Home safety 1	2	3	4
Essential safety features, secure doors and windows Safe gas and electrical appliances, smoke alarms, CO2 alarms Home escape plan pertinent to needs of the person Additional appliances/assistive technology pertinent to needs of the person	All doors and windows in use and accessible Possible fire risk - Lacking/insufficient essential safety features, DIY that is not safe, overloaded electrical sockets Lacking an escape plan	Limited access to windows and doors Increased fire risk - No essential safety features. Some possible hazards of escape/fire due to disrepair and/or clutter Evidence of smoking Flammable items stored in the home, consider stocked piled continence aids, paraffin based medications, irresponsible use of oxygen No escape plan Person is unable to sleep in a bed and must sleep in an alternative place due to clutter or hygiene. Rough sleeping while declining all offers of support to reduce significant risk. Risk of entry by intruders – Problems keeping a dwelling secure against unauthorised entry due to disrepair, and the maintenance of defensible space.	Access/exit via one route only or unable to exit unaided due to mobility No essential safety features Significant fire risk - Definite hazard of escape/fire from disrepair or clutter-exposed electric wires and sockets, unsafe electronic items Evidence of cigarette burns to clothes or bedding Evidence of small fires or burns Unsafe storage or use of flammable liquids or gases Excessive damp or mould overgrowth Excess cold in winter with no functioning heating system or hot water. Person is unable to sleep in a bed and is forced to sleep in uncomfortable and/or insanitary conditions
Own views of safety in home and environment 1	2	3	4
Fully aware of personal safety issues - trips, slips and falls	Variable awareness and perception of personal safety issues, accepting of advice	Oblivious to personal safety issues and/or reluctant to accept advice due to lack of motivation or understanding	Unconcerned about personal safety issues Lacks motivation or understanding to address concerns

Clutter Image Rating Scale

Please select the photo that most accurately reflects the amount of clutter in the room. The Suffolk County Council Self Neglect and Hoarding policy contains clutter images for each room in the home; however, the following images may be used for guidance and early assessment purposes.
More information and free downloads including bedroom and living room clutter images can be found at: http://www.helpforhoarders.co.uk/


1


2


3


4


5


6


7


8


9

Signs of Safety and Wellbeing Assessment and Planning

The Signs of Safety and Wellbeing Principles places the front-line practitioner as the arbiter of whether intervention works.
Relationships with the customer and other professionals are fundamental to ensuring the elements within the Signs of Safety and Wellbeing approach are meaningful and the customers views are placed at the centre of any decisions and/or actions taken.

Using the three domains below will assist risk based discussions in alignment with the desired outcomes of the customer whilst recognising professional concerns.

1. What are we worried about?	2. What's working well?	3. What needs to happen/safety goals?
Indicators of risk of harm: **Action/Behaviour:** • **Severity** – How bad is the harm? • **Incidence** – How long has the concern existed? • **Impact** – what is the immediate impact of the concern? **Danger Statement/s:** • Who is worried and why? **Complicating Factor/s:** • What have you seen and heard Or • do you know that makes Addressing the worries for the future more difficult to sort out?	**Strengths:** **Action/Behaviour:** • Who is doing what that reduces the worries and how do we know? • What were the first, best and last times these actions/behaviours happened? • Impact – what difference has this made? **Existing Safety:** • What strengths have been demonstrated as protection • Over time relative to the future danger and equate to safety	**Agency Safety Goal/s:** **Action/Behaviour:** • Who must see who doing what and for how long to be satisfied that the person will be safe? **Customer Safety Goals:** • What does the customer want generally and regarding safety? **Next Steps:** ACTION: Who must do what and when as a next step towards reaching the goal/

Appendix 2: SUFFOLK HIGH RISK SELF-NEGLECT/ HOARDING REFERRAL FORM

This referral form should only be used when there is a concern that an individual is at significant risk of harm due to self-neglect or hoarding and a multi-agency case conference is required.

Please use the Multi-Agency self-neglect and hoarding risk assessment guidance tool to consider if this referral is necessary, individuals who score 4 in any domain on the tool are considered at risk of significant harm and will be referred to the Multi-Agency Safeguarding Hub (MASH). Any queries or for a discussion prior to making a referral please contact the MASH Consultation Line – 0345 6061499.

Details of person being referred

Name:

Address:

Date of Birth:

Contact telephone and/or email:

What is the property type (detached, semi etc) and tenure (owner-occupier, private tenant, housing provide tenant etc)?

Has the person consented to the referral? **Yes/No**

If No, is the referral being made in their best interests? **Yes/No**

Has a mental capacity assessment been completed? **Yes/No**

If yes please attach

What are the person's views and wishes?

ENTER PERSON'S VIEWS AND WISHES

Information about the referrer

Name:

Address:

Email:

Telephone:

Profession:

Organisation:

Reasons for referral:

ENTER REASON FOR REFERRAL

Using the risk assessment tool please provide scores for each area that you know of:

Eating and drinking	**1**	**2**	**3**	**4**	**Don't know**
Washing/Bathing	**1**	**2**	**3**	**4**	**Don't know**
Medical needs	**1**	**2**	**3**	**4**	**Don't know**
Home Amenities	**1**	**2**	**3**	**4**	**Don't know**
Home and Garden Cleanliness	**1**	**2**	**3**	**4**	**Don't know**
Home safety	**1**	**2**	**3**	**4**	**Don't know**
Own Views	**1**	**2**	**3**	**4**	**Don't know**

Describe what action has already been taken and by who?

(INCLUDE HISTORIC AND CURRENT PROFESSIONAL/AGENCIES INVOLVED E.G. POLICE, FIRE, GP, MENTAL HEALTH, HOUSING)

Is there a public health risk or risk to anyone else in the property (children, dependents, adults at risk, animals)?

ENTER PUBLIC HEALTH RISK INFORMATION

Please attach any additional documents of significance e.g. needs assessment.

Are there any dates when you would be unable to attend a case conference or high-risk panel?

(There is a requirement for the referrer to attend any case conference or high-risk panel following this referral. Please include the name and contact details of a representative from your organisation if you will be unable to attend)

ENTER INFORMATION REGARDING AVAILABILITY OR DETAILS AND CONTACT INFORMATION OF WHO WILL BE ATTENDING

Appendix 3: ASSESSMENT GUIDANCE

Example Questions for Assessing Self-Neglect and Hoarding

The following is a list of questions that could be asked where you are concerned about someone's safety in their own home and where there may be a risk of self-neglect or hoarding. Each question may lead to further questions such as finding out when the event occurred and what the outcome was.

1. How do you get in and out of your property, do you feel safe living here?

2. Have you ever had an accident, slipped, tripped up or fallen, how did it happen?

3. How have you made your home safer to prevent this (above) from happening again?

4. How do you move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)

5. How do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested?

6. How do you manage to keep yourself warm? Especially in winter?

7. Do you have an open bar fire or a convection heater?

8. When did you last go out in your garden? Do you feel safe to go out there?

9. Are you worried about other people getting in to your garden to try and break-in? Has this ever happened?

10. Are you worried about mice, rats or foxes, or other pests? Do you leave food out for them?

11. Have you ever seen mice or rats in your home? Have they eaten any of your food? Or got upstairs and be nesting anywhere?

12. Can you prepare food, cook and wash up in your kitchen?

13. Do you use your fridge? Can I have look in it? How do you keep things cold in the hot weather?

14. How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Have a wash, bath? Shower?

15. Can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)

16. Where do you sleep? Are you able to change your bed linen regularly? When did you last change them?

17. What do you do with your dirty washing?

18. How do you keep yourself warm enough at night? Have you got extra coverings to put on your bed if you are cold?

19. Are there any broken windows in your home? Any repairs that need to be done?

20. Have you experienced weight loss recently? How long ago?

21. When did you last see your GP?

22. Do you drink at home?

The following are questions regarding the imminent risk of fire. If the answer to any of these questions is yes, then this must be reported as a matter of urgency to the fire service and raised urgently through your line management system.

Significant danger

23. Has a fire ever started by accident?

24. Do you ever use candles or an open flame to heat and light here or cook on a camping gas or a barbeque inside your home?

25. Do you use your gas cooker to heat your home?

26. Do you smoke at home e.g. in bed?

27. Are there continence products or skin emollients stockpiled in your property? (Only a risk in conjunction with any of the previous three questions).

DO's and DON'Ts when talking to someone who hoards

DO:

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 have 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 are 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. Health and Safety regulations require for exits to be clear so this is one important change that has to be made in your home".

Highlight strengths. All people have strengths, positive aspects of themselves, their behaviour, or even their homes. A visitor's ability to notice these strengths helps forge a good relationship and paves the way for resolving the hoarding problem (e.g. "I see that you can easily access your bathroom sink and shower," "What a beautiful painting!", "I can see how much you care about your cat.")

Focus the intervention initially on safety and organisation of possessions and later work on discarding. Discussion of the fate of the person's possessions will be necessary at some point, but it is preferable for this discussion to follow work on safety and organisation.

DO NOT:

Use judgmental 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 are thinking. Individuals with compulsive hoarding are likely to notice non-verbal messages that convey judgement, 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. This does not preclude you from working with someone over a prolonged period of time to build rapport and enable them to take the lead in taking small steps towards achieving a safer environment. It is helpful to respectfully challenge views and decisions and express concerned curiosity about unwise decisions without arguing or active persuasion.

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 4: Example screening questions to assess decisional and executive function of capacity for self-care and self-protection

	Decisional capacity		Executive capacity (verification of task performance)
Domains of self-care and self-protection	**Appreciation of problems**	**Consequential problem solving**	
Personal needs and hygiene: Bathing, dressing, toileting, and mobility 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 or visual examination of hair, skin, and nails with consent. 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?	What if your heating [or hot water, washing machine, etc] stopped working; how would you fix the problem?	Third party reports of the home environment or a home safety assessment performed by an occupational therapist, fire service, domiciliary care agency, community health professional or other service.
	It is important to make basic repairs to one's home; do any parts of your home need repairs?		
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 taxi or other service] to take you to the store, how would you do that?	Ask individual to show you how they would use a phone to call a friend or other service to ask for a ride. [Individual should demonstrate all steps for making a call and getting information.]

	Decisional capacity		Executive capacity (verification of task performance)
Domains of self-care and self-protection	**Appreciation of problems**	**Consequential problem solving**	
Medical self-care: Medication adherence, wound care, and appropriate self-monitoring	Check awareness that 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 [or not]. How would this affect your everyday life?	Ask to see all medication bottles from home, even empty ones. Health professionals and domiciliary carers can review medication fill and refill dates and pill counts, or request a home medication assessment.
Financial affairs and estate: Managing cheque book, paying monthly bills, and entering binding contracts	What difficulties do you have paying your monthly bills on time?	How could asking [cite individual] to help you with paying your bills be better than managing your monthly income and paying bills by yourself? What would happen if things continued as they are?	Third party reports of bank statements, uncollected debts, or bills. Can formally assess performance with routine financial tasks, such as 1- or 3-item transactions, including calculating change or conducting a payment simulation.
	Who can assist you with paying your monthly bills or managing your finances?		
		Are there any reasons why asking [cite individual] to manage your income might not help or might make things worse for you?	

Geriatrics. 2008 Feb; 63(2): 24–31

Appendix 5: LEGISLATION

Care Act 2014

The Care Act 2014 sets out a statutory framework for adult safeguarding which stipulates local authorities' responsibilities, and those with whom they work, to protect adults at risk of abuse or neglect. It includes self-neglect as a category of abuse and neglect.

Section 1: Duty to promote wellbeing which includes personal dignity, physical and mental health and emotional wellbeing, protection from abuse and neglect, control by the individual over their day-to-day life (including over care and support provided and the way they are provided), social and economic wellbeing, domestic, family and personal domains, suitability of the individual's living accommodation.

Section 6 and 7: Duties to cooperate

Section 42: Duty to make enquiries in response to allegations of abuse or neglect.

There are new responsibilities for the Director of Public Health in relation to infection which may involve neglect. The Act does not contain powers to enter a person's property.

Public Health Act 1936

Contains the principal powers to deal with filthy and verminous premises.

Section 83 - Cleansing of Filthy or Verminous Premises:

i. where a local authority (LA), 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

ii. the local authority (LA) 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
- interior of any other premises to be painted, distempered or whitewashed

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

Section 84 Cleansing or Destruction of Filthy or Verminous Articles: -

Applies to 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: -

The person themselves can apply to be cleansed of vermin or, upon a report from an

officer, the person can be removed to a cleansing station. A court order can be applied for where the person refuses to comply.

The Local Authority 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 Section 81 also gives Local Authority's power to make bylaws 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 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 must be provided and there is the right of appeal.

Section 37 Prohibition of Sale of Verminous Articles: -

Provides for household articles to be disinfested or destroyed at the expense of

the dealer (owner).

Housing Act 2004

Relates to possible health and safety effects on occupier. Hoarding can lead to fire hazards from accumulated materials. Due to hoarding, there may be a lack of repair/maintenance of property leading to other health effects on occupier such as lack of heating (excess cold) or washing/sanitary facilities. Usually used in private rented dwellings. Allows Local Authorities to carry out a risk assessment of residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. Housing hazards such as Domestic Hygiene, Pests and Vermin, Excess Cold, Fire. Service of Improvement or Hazard Awareness Notice usually on owner of premises requiring building defects being rectified to reduce the hazards. Council can charge for costs incurred serving notices.

If the hazard is a category 1 there is a duty by the Local Authority 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.

Building Act 1984

Section 76 is available to deal with any premises which are in such a state as to be prejudicial to health. It provides an expedited procedure i.e. the Local Authority may undertake works after 9 days 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.

There is further legislation that relates specifically to people – both the living and the deceased.

Environment Protection Act 1990

Section 79(a) refers to any premises in such a state as to be prejudicial to health or a nuisance. Action is by a Section 80 abatement notice and 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 ensure that its District is free from rats and mice.

Public Health (Control of Disease) Act 1984

Section 46 imposes a duty on the 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.

Mental Health Act

Admission for assessment (section 2)

Duration of detention: 28 days maximum.

Application for admission: by an Approved Mental Health Practitioner (AMHP) or the patient's nearest relative. The applicant must have seen the patient within the previous 14 days.

Procedure: two doctors must confirm that:

(a) the patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and

(b) he or she ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others.

Discharge: by any of the following:

Responsible clinician

Hospital manager

The nearest relative, who must give 72 hours" notice. The responsible clinician can prevent him or her discharging a patient by making a report to the hospital managers

MHT. The patient can apply to a tribunal within the first 14 days of detention.

Admission for treatment (section 3)

Duration of detention: up to six months, renewable for a future six months, then for one year at a time.

Application for admission: by nearest relative, or AMHP in cases where the nearest relative does not object, or is displaced by County court, or it is not „reasonably practicable" to consult him or her.

Procedure: two doctors must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that makes it appropriate for him or her to receive medical treatment in hospital; and

(b) appropriate medical treatment is available for him or her; and

(c) it is necessary for his or her own health or safety, or for the protection of others that he or she receives such treatment and it cannot be provided unless he or she is detained under this section.

Renewal: under section 20, the responsible clinician can renew a section 3 detention if the original criteria still apply and appropriate medical treatment is available for the patient's condition. The responsible clinician must consult another person of a different profession who has been professionally concerned with the patient's treatment.

Discharge: by any of the following:

Responsible clinician

Hospital managers

The nearest relative, who must give 72 hours" notice. If the responsible clinician prevents the nearest relative discharging the patient, by making a report to the hospital managers, the nearest relative can apply to an MHT within 28 days.

MHT. A patient can apply to a tribunal once during the first six months of his or her detention, once during the second six months and then once during each period of one year. If the patient does not apply in the first six months of detention, his or her case will be referred, automatically, to the MHT. After that, the case is automatically referred when a period of three years has passed since a tribunal last considered it (one year, if the patient is under 18).

Admission for assessment in cases of emergency (section 4)

Duration of detention: 72 hours maximum.

Application for admission: by an AMHP or the nearest relative. The applicant must have seen the patient within the previous 24 hours.

Procedure: one doctor must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that warrants reception into guardianship; and

(b) it is necessary in the interests of the patient's welfare or for the protection of others.

Note: the patient must be over 16. The guardian must a local social services authority, or person approved by the social services authority, for the area in which he or she (the guardian) lives. A guardian has the following powers

- to require a patient to live at a place specified by the guardian
- to require a patient to attend places specified by the guardian for occupation, training or medical treatment (although the guardian cannot force the patient to undergo treatment)

- to ensure that a doctor, social worker or other person specified by the guardian can see the patient at home.

Discharge: by any of the following

Responsible clinician

Local social services authority

Nearest relative

MHT. The patient can apply to a tribunal once during the first six months of guardianship, once during the second six months and then once during each period of one year.

Warrant to search for and remove patients (section 135)

Duration of detention: 72 hours maximum.

Procedure: if there is reasonable cause to suspect that a person is suffering from mental disorder and

(a) is being ill-treated or neglected or not kept under proper control; or

(b) is unable to care for him or herself and lives alone a magistrate can issue a warrant authorising a police officer (with a doctor and AMHP) to enter any premises where the person is believed to be and remove him or her to a place of s

Mentally disordered persons found in public places (section 136)

Duration of detention: 72 hours maximum

Procedure: if it appears to a police officer that a person in a public place is „suffering from mental disorder" and is „in immediate need of care or control", he or she can take that person to a „place of safety", which is usually a hospital, but can be a police station.

Section 136 lasts for a maximum of 72 hours, so that the person can be examined by a doctor and interviewed by an AMHP and „any necessary arrangements" made for his or her treatment or care.

Anti-Social Behaviour Orders

Anti-social behaviour is defined as where there is 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 Anti-Social Behaviour Order would be

appropriate should be made to the Police Inspector responsible for Hate Crime and Anti-Social Behaviour or the Anti-Social Behaviour Officer.

Consider inviting the relevant Neighbourhood Policing Team to participate in multi-agency work for individual cases.

Misuse of Drugs Act 1971

Section 8

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

Animal Welfare Act 2006 Offences (Improvement notice)

The Act makes it not only against the law to be cruel to an animal, but that a person must ensure that the welfare needs of the animals are met. Education for the owner is a preferred initial step, Improvement notice issued and monitored, If not complied with, this can lead to a fine or imprisonment. See also: http://www.defra.gov.uk/wildlife-pets/

Mental Capacity Act 2005

“A person is not to be treated as unable to make a decision merely because he makes an unwise decision”

There are five underpinning principles of the Mental Capacity Act.

You must:

1) Assume the person has capacity unless proved otherwise

2) Do not treat people as incapable of making a decision unless you have tried

all practicable steps to try to help them.

3) Allow people to make what may seem to you an unwise decision (if they have capacity)

4) Always do things, or take decisions for people without capacity in their best interest

5) Ensure that when doing something to someone, or making a decision on their behalf you choose the least restrictive

The two-stage test of capacity

You must use the following test to assess if the person has capacity:-

is there an impairment of, or disturbance in the functioning of the person’s mind or brain? If so,

is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at a given time (capacity is decision specific)

The person is able to make a decision and therefore has capacity if they:

a. understand the information relevant to the decision,

b. retain the information,

c. use or weigh that information as part of the process of making the decision, or

d. communicate his/her decision either by talking, signing, or any other means

It is very important to consider "executive capacity" – that is the ability of the individual to implement the action.

Best Interest Checklist

Where a person lacks capacity, all decisions must be made in their best interest. The checklist below gives some common factors that you must always take into account where a decision is being made, or an act is being done for the person who lacks capacity.

- involve the person who lacks capacity
- be aware of the persons past and present wishes and feelings
- consult with others who are involved in the care of the person
- do not make assumptions based solely on the person's age, appearance, condition or behaviour
- is the person likely to regain capacity to make the decision in the future?

You must formally record your decision by recording your Mental Capacity Assessment and storing this within the individual's electronic or paper file in accordance with your organisation's recording systems.

Police and Criminal Evidence Act 1984

The police have powers of entry and so may be pivotal in gaining access to conduct assessments if all else fails. Under section 17 (1) (a) of the Police and Criminal Evidence Act 1984, the police have the power to enter without a warrant if required to save life or limb; or prevent serious damage to property; or to recapture a person who is unlawfully at large whilst liable to be detained.

Prohibition or Restriction of use (Regulatory Reform (Fire Safety)Order 2005)

If a premises involves such risk to persons so serious that the use of the premises ought to be Prohibited or Restricted notice can be served on the responsible person (owner/occupier). The fire service can serve a prohibition or restriction notice to an occupier which will take immediate effect. In some circumstances, this can apply to domestic premises including single private dwellings where the appropriate criteria of risk to relevant persons apply.

Appendix 6: LINKS AND FURTHER READING

Suffolk County Council Customer First can be contacted on 03456 066 167.

https://www.suffolk.gov.uk/adult-social-care-and-health/

Suffolk Fire and Rescue Service

https://www.suffolk.gov.uk/suffolk-fire-and-rescue-service/fire-safety-in-the-home/

Contact the Duty Officer on 01473 260 588 to report a safety problem. In an emergency call 999.

Suffolk Safeguarding Adults Board

http://www.suffolkas.org/ MASH Consultation Line: 0345 606 1499

Suffolk Safeguarding Children's Board

http://suffolkscb.org.uk/ MASH Consultation Line: 0345 606 1499

RSPCA https://www.rspca.org.uk/home

Care and Support Statutory Guidance:

https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

Deborah Barnett's Self Neglect Toolkit:

https://www.dorsetforyou.gov.uk/media/218427/Self-neglect-toolkit/pdf/Self_Neglect_Toolkit.pdf

DSM 5 – Hoarding Disorder: https://www.psychiatry.org/patients-families/hoarding-disorder/what-is-hoarding-disorder

Mental Capacity Act 2005 Code of Practice:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

SCIE (2011) Self-neglect and adult safeguarding: findings from research (Report 46) available from https://www.scie.org.uk/publications/reports/report46.asp