



## REVISED SELF-NEGLECT POLICY AND BEST PRACTICE GUIDANCE

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## KEY MESSAGES RELATING TO PEOPLE WHO SELF-NEGLECT

The following key messages are drawn from research, practitioners' experience and lessons learned from Safeguarding Adults Reviews (SARs):

- **All agencies** have a role in supporting people who self-neglect, so please ensure you and your agency are fully committed to playing your part
- Try to find out **why the person is self-neglecting** – this may be connected with trauma, grief, mental health episodes or other experiences
- Try to really **get to know the person** and 'get alongside' them
- Don't just look at the current picture, but try to piece together the **person's life story** and find out what is important to them
- Be prepared for **long-term involvement** – self-neglect situations are rarely resolved quickly
- Look at the person's **family network** and any **community networks** and think about how these might help support the person (consider whether a Carer's assessment is needed)
- Communicate clearly and regularly with **all those involved with the person**
- Be clear about **your role and responsibilities** and those of **others**
- Undertake a **thorough risk assessment** and explain your concerns openly to the person who is self-neglecting
- Consider **mental capacity** in relation to the decisions which need to be made – is the person able to understand information / retain it / weigh it / communicate their decision?
- Also consider the person's **'executive functioning'** – they may appear to understand but can they / will they see the decision through in practice?
- Consider whether **advocacy** is needed
- Remember that **'self-funders'** are just as entitled to a care and support assessment as others whose care is funded by the Council
- Be prepared to **challenge** decisions if you don't agree with them, and escalate them if necessary
- Don't dismiss self-neglect as a **'lifestyle choice'** or take an initial rejection of support as final
- **Don't close a case** simply because the person refuses an assessment or won't accept a plan
- Self-neglect can be found in all areas of society, but **those who are homeless or living in temporary accommodation** may be at greater risk
- Always remember to **'Think Family'** and consider any risks to those living with or closely related to the person who is self-neglecting

## 'QUICK GUIDE' TO THE SELF-NEGLECT PROCEDURES (1)

Self-neglect concern identified

The agency / individual, providing ongoing support, which has identified self-neglect concerns convenes a **Multi-Agency Risk Management Meeting** to discuss the person's situation. All agencies expected to work together to review risks, and to agree on a support plan, strategies for engagement, monitoring arrangements and agency roles and responsibilities.

Note: please refer to points 2-4 below if the person appears to have a health or care and support need.  
**Refer immediately to Safeguarding if risks are considered high or very high**

Self-Neglect Plan drawn up (with the individual where possible) and Lead Agency / Lead Worker identified. Plan to include consideration of need for Care Act assessment and a strategy to include engagement with the person.

Mental Capacity to be assessed in relation to each risk identified, as appropriate. If person assessed as lacking mental capacity, Best Interests Decision to be made under MCA.

Regular Review Meetings held to review Plan.

Has Plan been successful in decreasing / moderating risks to acceptable level?

Yes

Self Neglect case closed when agencies are satisfied that sufficient progress has been made.

No

Safeguarding 'concern' (alert) raised:  
 Virgin Care Adult Safeguarding Team - 0300 247 0201  
 Out of Hours - 01454 615165

If risks considered high / very high, refer immediately to Safeguarding

Follow Self Neglect procedures. Lead agency identified.

Initial enquiry: Virgin Care/AWP

- Assess level of risk and significance to individual's circumstances and possible consequences.
- Complete risk indicator assessment tool (Appendix 1) and discuss with Council SA & QA Team.
- Decision by SA & QA Team within 4 working days

'No further action' or s.9 needs assessment or other limited actions

Section 42 Enquiry – Formal Safeguarding Procedures, using B&NES Multi-Agency Safeguarding Adults Policy and Procedures.

## **'QUICK GUIDE' TO THE SELF-NEGLECT PROCEDURES (2)**

1. It will normally be the responsibility of any agency/individual providing ongoing support, which first identifies an issue of Self-Neglect, to arrange an initial Multi-Agency Risk Management (MARM) meeting.
2. **However, where the person appears to have a need for care and support, a referral for a Care Act assessment should be made and this should be undertaken by Virgin Care or AWPT (as appropriate) within 28 days.** The agency/individual identifying self-neglect must consider whether a MARM meeting needs to be convened before the outcome of the assessment has been undertaken.
3. **Similarly, where the person appears to have specific health needs, a referral should be made to the appropriate Health professional(s) for relevant assessments to be undertaken.**
4. The agency/individual identifying the self-neglect concern should, wherever possible, make the person aware that they are referring them for the Health or social care assessment.
5. **An immediate Safeguarding Adults referral must be made if the risks are considered high or very high or where there appear to have been acts of neglect or abuse by a third party.** However, where this is not the case, these Self Neglect procedures should be followed.
6. A 'Lead Agency' should be agreed at an early stage – this should be the most appropriate agency involved with the person, e.g. Virgin Care, AWPT, a GP, the RUH, the police, a Housing agency or any other organisation involved with the person, either statutory or voluntary.
7. The self-neglecting person should always be informed of the meeting and invited to attend.
8. It will be the responsibility of all agencies to prioritise MARM meetings and discussions and to fully co-operate with the process, giving cases of Self-Neglect the same weight as those under the Multi Agency Safeguarding Adults Procedures. Any disputes regarding non-co-operation by a relevant agency which cannot be resolved should be escalated to the Council's Director of Safeguarding and Quality Assurance.
9. The MARM will consider any risk assessments which have been undertaken and decide what actions are required to engage and communicate with the person, by whom and by when. It will also agree a 'Lead Worker' to co-ordinate actions, and will set a date for a review meeting. A record of the meeting will be made and distributed as soon as possible after the meeting takes place (an agenda template is attached at Appendix 2).
10. While the Lead Worker will be responsible for co-ordinating and leading the work to engage the person, it remains the responsibility of all other agencies to work in partnership with the Lead Worker with the aim of improving the wellbeing of the person who is self-neglecting, and minimising risk to the person and others. The Lead Agency / Lead Worker role may change at any time if there are strong reasons to do so, but this decision should be clearly recorded and communicated to all those involved.

11. Following initial attempts to engage the person / minimise risks, including (where relevant) assessments of the person's mental capacity, a Review Meeting will be held to review progress, and further reviews will be arranged as required.
12. Creative approaches may well be needed to engage the person – and a Care Act (s.9) assessment of support needs and/or Carer's assessment may lead to services being provided.
13. A Safeguarding Adults referral can be made at any time if the risks have increased or cannot be adequately addressed.
14. The Self-Neglect Multi-Agency process will be only be closed when a clear reduction in risk can be demonstrated or when the case is escalated to the Safeguarding Adults procedures.
15. At the point of closure, a plan should be drawn up to establish ongoing arrangements for monitoring the situation (as appropriate) and this should include arrangements to ensure that the person themselves and / or people in the person's network know how to raise any further concerns in the future.

## 1. Purpose of this Policy and Guidance

- This document outlines the policy, procedures and guidance for dealing with concerns in relation to self-neglect for adults with care and support needs. It should be read alongside the [Joint Regional Safeguarding Adults Multi-Agency Policy](#) and [B&NES LSAB Multi-Agency Safeguarding Adults Procedures](#)  
[B&NES LSAB Multi-Agency Safeguarding Adults Procedures Flowchart - One Page](#)

B&NES LSAB expects all agencies, both statutory and voluntary, to engage fully with this Policy and Guidance in order to achieve the best outcome for the person.

Self-neglect is everyone's business!

There are various reasons why people self-neglect. Some people may make a conscious decision to live life in a way that may have a negative impact on their health, well-being or living conditions. Often people can be unwilling to acknowledge there may be a problem or to be open to receiving support to improve their circumstances.

They may have insight into their situation, or they may not; some people may have an underlying condition that impacts on their ability to care for themselves.

Part of the challenge when there are concerns about self-neglect is knowing when and how far to intervene, in particular if a person has the mental capacity to make the decision not to recognise there is a problem or to engage in improving the situation. This is because this usually involves making individual judgments about what is an acceptable way of living, balanced against the degree of risk to an adult and/or others.

Managing the balance between protecting adults from self-neglect against their right to self-determination is a serious challenge for both statutory and voluntary services. It calls for sensitive and carefully considered and recorded decision-making.

Dismissing self-neglect as a 'lifestyle choice' is not acceptable.

In addition, there is the question of whether the adult has the mental capacity to make an informed choice about how they are living and the amount of risk they are exposing themselves (and others) to. Assessing mental capacity and trying to understand what lies behind self-neglect is often complex. It is usually best achieved by working with other organisations and, where possible, extended family and community networks.

Sometimes people who self-neglect do not want help to change, which puts themselves and others at risk, for example through vermin infestations, poor hygiene, or fire risk from hoarding. However, improvements to health, wellbeing and home conditions can be achieved by spending time building relationships and gaining trust. This may include obtaining treatment for medical or mental health conditions or addictions, or it could be practical help with de-cluttering and deep-cleaning someone's home.

## 2. What is Self-Neglect?

There is no universally accepted definition of self-neglect but the Care Act Statutory Guidance (updated 2018) defines self-neglect as:

*'A wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'*

and states:

*'Where someone demonstrates lack of care for themselves and or their environment and refuses assistance or services. It can be long-standing or recent' (DH 2018: Annex J).*

The research literature suggests that self-neglect is generally made up of three elements:

- Lack of self-care (for example, neglect of personal hygiene, nutrition, hydration and/or health) and/or
- Lack of care of the domestic environment (for example, squalor or hoarding) and/or
- Refusal of services that would mitigate risk to safety and wellbeing.

The person concerned may recognise the term, but may not wish to use it to describe their own situation (Braye, Orr and Preston-Shoot, 2015).

### **Models of self-neglect**

Research provides a broad consensus on the main characteristics of self-neglect and the approach practitioners should take when working with people who are deemed to be self-neglecting. However, there is less consensus as to why people self-neglect.

Models of self-neglect encompass a complex interplay between physical, mental, psychological, social and environmental factors.

In some cases, a traumatic experience, such as bereavement, may have triggered the self-neglecting behaviour. Gaining a fuller understanding of a person's life history and experiences may well help to create a better insight into their behaviour and possible changes that can be affected.

### **Indicators of self-neglect**

Self-neglect is often defined across three main areas:

#### ***Lack of self-care, including:***

- neglect of personal hygiene
- dirty/inappropriate clothing
- poor hair care
- malnutrition
- poor hydration
- unmet medical health needs (e.g. refusing to take insulin for diabetes, refusing treatment for leg ulcers)
- eccentric behaviour leading to harm
- alcohol/substance misuse
- social isolation

***Lack of care of the environment, including:***

- unsanitary, untidy or dirty conditions which create a hazardous situation that could cause serious physical harm to the person or others
- poor maintenance of property / dwelling
- keeping lots of pets who are poorly cared for
- vermin
- lack of heating, running water or sanitation
- poor financial management leading to utilities being cut off etc

***Refusal of services that could alleviate these issues and mitigate against the risk of harm, including:***

- refusing prescribed medications
- declining community health care/support
- refusing help with personal hygiene from social/health care personnel
- refusing to allow other professionals interested in keeping the environment safe access to the property for appropriate maintenance (e.g. water, gas, electricity)

It is important to understand that poor environmental and personal hygiene may not necessarily be a result of self-neglect. It could arise as a result of cognitive impairment, poor eyesight, functional or financial constraints, or neglect by others. In addition, many people who self-neglect may lack the ability and/or confidence to come forward to ask for help, and may also lack others who can advocate or speak for them.

**Characteristics identified by people considered to self-neglect**

Research has identified the following common characteristics in people who are considered to be self-neglecting:

- Fear of losing control
- Pride in self sufficiency
- Sense of connectedness to the places and things in their surroundings
- Mistrust of professionals / people in authority

### **3. Hoarding**

Hoarding is one common aspect of self-neglect and typically involves the excessive collection and retention of any material to the point that this has a significant negative impact on the wellbeing of the person.

Hoarding is recognised as a mental disorder and is defined as involving a persistent difficulty discarding or parting with possessions because of a perceived need to save them. A person with hoarding disorder experiences distress at the thought of getting rid of the items. Hoarding involves the accumulation of items, regardless of actual value.

Hoarding often creates such cramped living conditions that homes may be filled to capacity, with only narrow pathways winding through stacks of clutter. Countertops, sinks, stoves, desks, stairways and virtually all other surfaces may be piled up with stuff. The clutter may spread to the garage, vehicles, garden and other storage facilities.

Hoarding ranges from mild to severe. In some cases, hoarding may not have much impact on a person's life, while in other cases it seriously affects their functioning on a daily basis.

People with hoarding disorder may not see it as a problem, making intervention challenging.

#### **Signs and Symptoms**

The first signs and symptoms of hoarding disorder often occur during the teenage to early adult years. Problems with hoarding gradually develop over time and, often, significant clutter has developed by the time it reaches the attention of others.

Signs and symptoms may include:

- Excessively acquiring items that are not needed or for which there is no space
- Persistent difficulty throwing out or parting with your things, regardless of actual value
- Feeling a need to save these items, and being upset by the thought of discarding them
- Building up of clutter to the point where rooms become unusable
- Having a tendency toward indecisiveness, perfectionism, avoidance, procrastination, and problems with planning and organising

Excessive acquiring and refusing to discard items results in:

- Disorganised piles or stacks of items, such as newspapers, clothes, paperwork, books or sentimental items
- Possessions that crowd and clutter walking spaces and living areas and make the space unusable for their intended purpose, such as not being able to cook in the kitchen or use the bathroom to bathe
- Buildup of food or rubbish to excessive, unsanitary levels
- Significant distress or problems functioning or keeping the person and others safe in their home
- Conflict with others who try to reduce or remove clutter from your home
- Difficulty organising items, sometimes losing important items in the clutter

## Reasons for Hoarding

People with hoarding disorder typically save items because:

- They believe these items are unique or will be needed at some point in the future
- The items have important emotional significance - serving as a reminder of happier times or representing beloved people or pets
- They feel safer when surrounded by the things they save
- They don't want to waste anything

However, hoarding disorder is different from collecting. People who have collections, such as stamps or model cars, deliberately search out specific items, categorize them and carefully display their collections. Although collections can be large, they aren't usually cluttered and they don't cause the distress and impairments that are part of hoarding disorder.

If, as a result of hoarding, the practitioner thinks there may be a risk of fire, they should seek advice from the local Fire Service. While a person's consent to involve the Fire Service should always be sought, it may be necessary to override their wishes if they are at risk of serious injury or death should a fire occur. Properties with large amounts of hoarded items also present a risk to neighbours and any fire fighters called to attend an incident. Experience has shown that people may be more willing to allow Fire Service workers into their property than other professionals.

## Hoarding animals

People who hoard animals may collect dozens or even hundreds of pets. Animals may be confined inside or outside. Because of the large numbers, these animals often aren't cared for properly. The health and safety of the person and the animals are at risk because of unsanitary conditions. The RSPCA and other animal charities may need to be involved.

## Clutter Image Rating Tool

In cases of hoarding, the practitioner should use the Clutter Image Rating Tool to assess the level that the hoarding has reached and determine the next course of action. The National Hoarding Assessment tool ([clutter image rating scale](#)) has been developed in partnership with Avon Fire and Rescue to be used by practitioners. Images are rated from 1 to 9 for level of seriousness. However, this Tool should be used as a guide only and should not replace professional decision making.

Agencies or individuals wishing to utilise the support of Avon Fire & Rescue Service should contact the Vulnerable Adults Referral Advocate on 0117 926 2061.

Specialised Hoarding Support Services such as <https://hoardingdisordersuk.org> can make a positive difference by providing practical, person-centred help and support people who are affected by hoarding and clutter issues and 'chronic disorganisation'.

## 4. The Legal Framework

A wide range of legislation is relevant to the issue of self-neglect. This section lists the key powers which are most significant but a more detailed section is provided at Appendix 5:

### The Care Act 2014

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

#### **Assessment**

The Local Authority must undertake a needs assessment, *even when the adult refuses*, where:

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

*(Care Act 2014 sections 9 and 11)*

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

#### **Safeguarding**

The Local Authority must make, or cause to be made, whatever enquiries it thinks necessary to enable it to decide what action should be taken in an adult's case, when the Local Authority has reasonable cause to suspect that an adult in its area:

- 1) has needs for care and support,
- 2) is experiencing, or is at risk of, self-neglect, and
- 3) as a result of those needs is unable to protect him or herself against self-neglect, or the risk of it. *(Care Act 2014 s.42)*

#### **Advocacy**

If the adult has 'substantial difficulty' in understanding and engaging with a Safeguarding Enquiry, the local authority must ensure that there is an appropriate person to help them and, if there isn't, arrange an independent advocate.

*(Care Act 2014 s.42)*

### Mental Capacity Act 2005

[The Mental Capacity Act \(2005\)](#) states that a person is assumed to have mental capacity unless there is a reason to believe otherwise. It also states that a person should not be deemed to lack mental capacity just because they make an 'eccentric or unwise' decision. In view of the nature of self-neglect, it is important that capacity assessments are carried out face to face where possible.

The five key principles outlined in the [The Mental Capacity Act Code of Practice](#) must be kept in mind when considering any particular case where there are concerns of self-neglect:

- 1) **Assumption of Capacity:** Every adult has the right to make his or her own decisions and must be assumed to have capacity to do so unless it is proved otherwise. This means that you cannot assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability.
- 2) **Support:** A person must be given all practicable help before anyone treats them as not being able to make their own decisions. This means you should make every effort to encourage and support people to make the decision for themselves. If lack of capacity is established, it is still important that you involve the person as far as possible in making decisions.
- 3) **Unwise Decisions:** People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people.
- 4) **Best Interests:** Anything done for or on behalf of a person who lacks mental capacity must be done in their best interests.
- 5) **Least Restrictive Option:** Someone making a decision or acting on behalf of a person who lacks capacity must consider whether it is possible to decide or act in a way that would interfere less with the person's rights and freedoms of action, or whether there is a need to decide or act at all. Any intervention should be weighed up in the particular circumstances of the case.

The MCA also requires that an Independent Mental Capacity Advocate (IMCA) should be involved where a person is deemed to lack mental capacity to make specific important decisions and where there is no one independent, such as a family member or friend, who is able to represent the person.

Where an individual who is self-neglecting is unable to agree to have their needs met because they are assessed as lacking mental capacity to make specific decisions in relation to this, then the principles of the Best Interests process must be followed in line with the Mental Capacity Act.

The MCA 2005 is particularly relevant to self-neglecting behaviour in a number of ways, not least because of the key principle that a person "is not to be treated as unable to make a decision merely because he makes an unwise decision."

Capacity is time and decision specific, so capacity assessments must be undertaken in relation to particular decisions.

Where a person is considered to lack capacity, all decisions must be made in their best interest and the decision-maker must follow a 'best interest checklist'.

Where it is difficult to assess whether the individual lacks mental capacity to make specific decisions regarding their serious self-neglect and/or there is a conflict of opinion between professionals, then an application can be made to the Court of Protection to request an independent assessment via a Court Appointed Visitor.

## **Deprivation of Liberty**

Where a best interests decision involves depriving someone who lacks mental capacity of their liberty, there are additional legal safeguards, the Deprivation of Liberty Safeguards (DoLS), that must be followed for people living in a care home or hospital setting.

For those living in the community who lack mental capacity and are deprived of their liberty, an application must be made to the Court of Protection.

For more guidance on the MCA 2005, follow this link to the SCIE website:  
<https://www.scie.org.uk/mca/introduction/mental-capacity-act-2005-at-a-glance>

*Please see section 5 below for more guidance on Mental Capacity assessments, and Appendix 5 for further details about the legislation.*

## **Mental Health Acts 1983 and 2007**

Section 2 of the Mental Health Act 1983 (MHA) allows for someone to be detained for a maximum of 28 days for assessment and section 3 allows for someone to be detained for a maximum of up to six months for treatment (renewable in certain circumstances).

An application for a person to be admitted to hospital can only be made by an Approved Mental Health Practitioner (AMHP) or the patient's 'nearest relative' and when two doctors have confirmed that a person is suffering from a mental disorder and needs to be detained in their own interest.

Other sections of the MHA provide powers in relation to Guardianship.

## **Human Rights Act 1998**

Public bodies have a positive obligation under the European Convention on Human Rights (ECHR, incorporated into the Human Rights Act 1998 in the UK) to protect the rights of the individual. In cases of self-neglect, articles 5 (the right to liberty and security) and 8 (the right to private and family life) of the ECHR are of particular importance.

These are not absolute rights: they can be overridden in certain circumstances. However, any infringement of these rights must be lawful and proportionate, which means that all interventions undertaken must take these rights into consideration. For example, any removal of a person from their home which does not follow a legal process (e.g. under the Mental Capacity or Mental Health Acts) is unlawful and would be challengeable in the Courts.

### **Other key legislation includes:**

**Public Health Act 1936 and 1961:** Powers to deal with 'filthy and verminous premises'.

**The Housing Act 2004:** 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.

**Building Act 1984:** Gives the Local Authority powers to undertake works in certain circumstances.

**Housing Act 1985 (as amended by the Housing Act 1996) and Housing Act 1988 and Housing Act 2004:** Provide grounds for eviction of a tenant in certain circumstances

**Acceptable Behaviour Contracts:** Voluntary, non-legally binding agreements between an individual and the housing department, police or registered social landlord which can provide an alternative or preliminary step towards injunctions or eviction proceedings.

**Animal Welfare Act 2006:** Makes it an offence to cause an animal to suffer where that suffering is unnecessary, and also places a duty on people to meet the welfare needs of animals that they are responsible for.

**Environmental Protection Act 1990:** Gives the local authority a power of entry to deal with a statutory nuisance.

**Prevention of Damage by Pests Act 1949:** Gives local authorities a duty to take action against occupiers of premises where there is evidence of rats or mice.

**Public Health (Control of Disease) Act 1984, amended by the Health and Social Care Act 2008:** Where there is significant risk to human health, the local authority can apply for an order imposing restriction or requirements to protect against infection or contamination.

**Anti-Social Behaviour, Crime and Policing Act 2014:** Introduced Injunctions to Prevent Nuisance and Annoyance (IPNA) and Community Protection Notices.

**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/she knowingly permits or allows production or supply of illegal drugs on their premises.

**Protection of Property (National Assistance Act 1948):** The Local Authority has a duty to provide a service for people who are known to adult social care services and who have no relatives or friends willing or able to look after their home and personal property during periods of admission to hospital or residential care.

**Powers of Entry:** Powers of entry are available to the police, to Approved Mental Health Professionals (AMHPs) and to the Local Authority in specific situations. See the table at Appendix F for more details.

**Court of Protection:** The Court of Protection can be asked to determine whether the person has the mental capacity to make a decision on a specific matter, and/or where they lack capacity, to decide what is in the individual's best interests.

**Inherent Jurisdiction of the High Court:** The inherent jurisdiction of the High Court can be used to protect people who have the mental capacity to make decisions, but cannot exercise that capacity freely.

## 5. Mental Capacity

A proper understanding of mental capacity is a crucial aspect of working with people who self-neglect. Assessment of mental capacity should consider whether there are any concerns about possible duress and whether the individual is being influenced or exploited by others who may not have their best interests at heart. Where the individual has mental capacity but is not able to exercise choice as a result of duress or exploitation, legal advice should be sought regarding an inherent jurisdiction application to the High Court.

Mental capacity assessments are both time and decision specific and should therefore be considered and / or repeated as risk increases and in relation to each individual risk.

**Research highlights the need to consider 'executive functioning' when supporting people who self-neglect.**

It is important to assess whether people who self-neglect can:

- Understand, retain, use and weigh relevant information, including information about the consequences of any decision (mental capacity) **and**
- Implement their actions (executive functioning).

Impairment of executive functioning can make it difficult for a person to make decisions in the moment when the decision needs to be executed; for example, they may recognise the need to eat and drink, but fail to act on that need. (Braye, Orr and Preston-Shoot, 2015)

'Articulate and demonstrate' models of assessment (tell me, then show me) can be effective in assessing both types of capacity.

The person should be supported to make an informed decision. This means that professionals may need to take time explaining the likely consequences of all courses of action.

Situations of self-neglect can lead to competing value positions – those of respect for autonomy and self-determination, as opposed to 'duty of care' and promotion of dignity. Evidence suggests that finding the right balance is a difficult judgement but this is best achieved through multi-agency working and co-operation, and through a relationship where 'concerned curiosity' type questions are asked.

Respect for autonomy must include a questioning of the extent to which apparent 'lifestyle choice' is really 'chosen' or whether it stems instead from a perceived lack of viable options, or demotivation from other life events and experiences, or difficulties with executive functioning. And, even where autonomy is being exercised, respectful challenge may well be appropriate, particularly where others too may be at risk. This can require persistence rather than time-limited involvement: respect for autonomy does not mean abandonment. Equally, prioritising protection does not mean a denial of the person's wishes and feelings, or attempts to remove all risk.

Strong emphasis needs to be placed by practitioners on the importance of inter-agency communication, collaboration and the sharing of risk.

### **Assessing mental capacity in relation to self-neglect**

When assessing capacity in relation to self-neglect, the key question to consider is whether the adult has the capacity to understand their situation and the consequences arising from it. The assessment should consider:

- Does the adult understand they have a problem with self-neglect?
- Is the adult able to weigh up the alternative options? e.g. being able to move around their accommodation unhindered, being able to sleep in their bed, cook in their kitchen?
- Can the adult retain the information given to them?
- Can the adult communicate their decision?

Practitioners should remember the empowering principles of the MCA. It is essential that any capacity assessment is clearly documented in case records.

When a person is assessed as lacking capacity, a Best Interests decision should be made on their behalf and the least restrictive option should always be preferred.

### **'Executive functioning'**

As described earlier, when assessing the mental capacity of a person who is self-neglecting, it is important to consider not only their decision-making ability but also their ability and willingness to carry out the decisions made - known as 'executive functioning'. This should - as far as possible - be tested out in a practical way, by observing whether the person is able to put their decision-making into practice.

The mental capacity decision should include both the ability to understand the consequences of a decision and the capacity to carry it out.

### **Other Powers available under the Mental Capacity Act 2005**

The Mental Capacity Act allows for a person to be deprived of their liberty under the Deprivation of Liberty Safeguards (DoLS) where this is deemed necessary. In addition, the Court of Protection has powers to authorise a person's removal from home, where they are objecting, or to take other proportionate actions, in certain limited situations.

In urgent situations, where it is believed that an adult lacks mental capacity (but it has not yet been possible to satisfactorily assess them), and the home situation requires urgent intervention, the Court of Protection can make an interim order to allow intervention to take place.

The Court will however expect to see evidence of professional action planning, decision making and recording.

## 6. Assessment of the Person's Situation

Self-neglect is a complex issue and it is important to understand the person's unique circumstances and their perception of their situation as part of any assessment and intervention.

It is crucial to consider how to engage the person at the beginning of the assessment. If an appointment letter is being sent, careful consideration should be given to what it says and whether this is the best way to engage the person. The usual standard appointment letter is unlikely to be the beginning of a lasting, trusting professional relationship if it is perceived as being impersonal and authoritative.

Home visits are important and practitioners should not rely on reports by other people. The practitioner will need to use their professional skills to be invited into the person's house and observe for themselves the conditions of the person and their home environment. Practitioners should discuss with the person any causes for concern about their health and wellbeing and obtain the person's views and understanding of their situation and the concerns of others. The assessment should include the person's understanding of the cumulative impact of a series of small decisions and actions as well as the overall impact.

It is important that, when undertaking the assessment, the practitioner does not accept the first, and potentially superficial, response rather than exploring more deeply into how a person understands and could act on their situation, and this may require more than one visit. Sensitive and comprehensive assessment is important in identifying capabilities and risks. It is important to look further and tease out the possible significance of personal values, past traumas and social networks.

In cases of hoarding, the practitioner can use the *Clutter Image Rating Tool* ([clutter image rating scale](#)) as a useful guide to assess the level that the hoarding has reached and determine the next course of action, *but this should not be a substitute for professional judgement*.

It is helpful to collect and share information with a variety of sources, including other agencies, to complete a picture of the extent and impact of the self-neglect and to work together to support the individual and assist them in reducing the impact on their wellbeing and on others.

The Multi-Agency Risk Management Meeting should be used to share information and agree an approach to minimising the impact of specific risks and improving the person's wellbeing (see section 9 below). Wherever possible, the person themselves should be included in the meeting, along with significant others and an independent advocate where appropriate.

It is important to undertake a risk assessment which takes into account an individual's preferences, histories, circumstances and lifestyle to achieve a proportionate and reasonable tolerance of acceptable risks. An example of a risk assessment can be found in the Crisis Intervention Plan template at Appendix 3.

A case should **not** be closed simply because the person refuses an assessment or refuses to accept a plan to minimise the risks associated with the specific behaviour(s) causing concern.

## 7. Interventions

The starting point for all interventions should be to encourage the person to do things for themselves. This approach should be revisited regularly throughout the period of the intervention. All efforts and the responses of the person to this approach should be recorded fully.

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

It is important to note that a gradual approach to gaining improvements in a person's health, wellbeing and home conditions is more likely to be successful than an attempt to achieve considerable change all of a sudden, which is how the adult may perceive it.

Often concerns around self-neglect are best approached by different services pulling together to find solutions. Co-ordinated actions by housing officers, mental health services, GPs and DNs, social work teams, the police and other public services and family members have led to improved outcomes for individuals.

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

As self-neglect is often linked to disability and poor physical functioning, a key area for intervention is often assistance with activities of daily living, from preparing and eating food to using toilet facilities. The range of interventions can include adult occupational therapy, domiciliary care, housing and environmental health services and welfare benefit advice.

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

The person, carer or advocate should be fully informed of the services offered and the reasons why the services were not implemented. There is a need to make clear that the person can make contact at any time in the future for services. However, where the risks are high, arrangements should also be made for ongoing monitoring and, where appropriate, making proactive contact to ensure that the person's needs, risks and rights are fully considered and to monitor any changes in circumstances.

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

Where the conditions of the home or dwelling are such that they appear to pose a serious risk to the adult's health from unsafe premises, or their living conditions are becoming a nuisance to neighbours/affecting their enjoyment of their property, advice from Environmental Health should be sought and joint working should take place.

There will be times when the impact of the self-neglect on the person's health and well-being or their home conditions or neighbours' environmental conditions are of such serious concern that practitioners may need to consider what legislative action can be taken to improve the situation when persuasion and efforts of engagement have failed. Such considerations should be taken as a result of a multi-disciplinary, multi-agency intervention plan with appropriate legal advice.

### **Undertaking assessments where the person refuses an assessment**

As a matter of practice, it will always be difficult to carry out an assessment fully where an adult with mental capacity is refusing to be involved. Practitioners should record fully all steps that have been taken to carry out a needs assessment, including what steps have been taken to involve the person and any carer, and assessing the person's desired outcomes for their day to day life. They should also record whether the provision of care and support would contribute to the achievement of these outcomes.

In the case of an adult's repeated refusal, it may not be possible to carry out a full needs assessment or provide any care and support. Case recording should evidence that all necessary steps have been taken to carry out the assessment and that these were necessary and proportionate. It should also evidence that appropriate information and advice has been provided to the adult, including how to access care and support in the future.

If the adult has refused an assessment or services and remains at high risk of serious harm, consideration should be given to carrying out a Safeguarding enquiry.

## **8. Advocacy**

At the start of an enquiry process, or at any later point, the ability of the adult to understand and engage in the enquiry must be assessed and recorded. If the adult is likely to have 'substantial difficulty' in understanding and engaging in the Care Act Safeguarding Enquiry and/or section 9 care and support needs assessment, it is essential that there is an appropriate person to help them and, if there isn't, the worker must arrange an independent advocate.

## **9. The Multi-Agency Risk Management Meeting (MARM)**

If the risks relating to a person's self-neglect appear low, the usual adult support services will be the most proportionate and least intrusive way of addressing the risk of self-neglect, although it is important to monitor the situation and identify any escalation of risks.

Where significant self-neglect concerns are apparent, it is essential that a **Multi-Agency Risk Management Meeting (MARM)** is held, involving all the relevant agencies, the person themselves (wherever possible) and other members of the person's network as appropriate.

The meeting should normally be convened by, and chaired by, the agency most closely involved with the person, which has identified the issue of self-neglect.

However, where the person appears to have a need for care and support, a referral for a Care Act assessment should also be made and this should be undertaken by Virgin Care or AWPT (as appropriate) within 28 days. The agency/individual identifying self-neglect must consider whether a MARM meeting needs to be convened before the outcome of the assessment has been undertaken and the reasons for the decision here recorded in full.

Similarly, where the person appears to have health needs, a referral should be made to the appropriate Health professional(s) for relevant assessments to be undertaken. The agency/individual identifying the self-neglect concern should, wherever possible, make the person aware that they are referring them for the Health or social care assessment.

The purpose of the meeting will be to consider the risks and the person's willingness to accept support and to agree a Self-Neglect Plan to address the issues raised. This plan should be clear about the roles and responsibilities of the various professionals involved and include timescales for actions to be completed. A date should be set for a Review Meeting.

In these circumstances it is essential that all relevant agencies are aware of and involved in the case, and that information is being shared appropriately and plans are being agreed. Any concerns about lack of involvement by a particular agency or individual should be recorded and escalated through senior managers. If there is a significant lack of co-operation which cannot be resolved, this should be escalated to the Council's Director of Safeguarding and Quality Assurance via the [Multi-Agency Protocol for resolving and escalating professional differences of opinion regarding safeguarding decisions](#), [LSAB & LSCB Escalation Protocol \(June 2018\)](#) and [Escalation Report Proforma](#)

### **Deciding what action is needed**

Where concerns of self-neglect are established, the practitioner should focus on building a relationship with the adult to persuade them to receive assistance to improve their health, wellbeing and living conditions. The aim should be:

- To empower the person who is neglecting him/herself as far as possible to understand the implications of their actions
- To help the person, both individually and collectively with others (e.g. family, friends, other professionals and agencies) without colluding with the person or seeking to avoid the issues presented
- To avert the potential need for statutory intervention wherever possible. This may be achieved by providing some form of low level monitoring

Whether or not the adult has capacity to give consent, action may need to be taken if others are or will be put at risk if nothing is done or where it is in the public interest to take action. Wishes need to be balanced alongside wider considerations such as level of risk or risk to others, including any children who could be affected.

In some cases, a Care Act assessment or Carer's assessment should be undertaken and, if the person is found to be eligible, appropriate services offered. In extreme circumstances, it may be necessary to intervene using statutory powers, for example where the conditions in the house warrant intervention by environmental health services or the involvement of the RSPCA. If any agency needs to take such steps, the reasons for doing so should be clearly documented.

It will often be necessary to be creative and imaginative in working with people who self-neglect, and to celebrate small steps forward.

The Lead Worker should ensure that, where the person has capacity to decline intervention after all reasonable efforts have been made to engage them, and the risk is considered acceptable by the professionals involved, the person knows how to easily get back in touch with the team, as do all significant others involved.

Just because the person has declined support before does not mean they will in the future, and support should continue to be offered as appropriate.

The Lead Worker should provide feedback to all parties involved with the person on the outcome of the process and what actions are to be taken, or not taken, with the reasons why.

## 10. Self-Neglect Procedures or Safeguarding?

The Care Act Statutory Guidance (2018) states: *“It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult’s ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.”*

Where an adult is engaging with and accepting assessment or services that will meet their care and support needs (including those relating to self-neglect), they are *not* demonstrating that they are ‘unable to protect themselves’ as set out in the criteria for a s.42 Safeguarding response.

**However, where there is reasonable cause to suspect that the adult is unable to protect him or herself from self-neglect or the risk of it as a result of their care and support needs, and the risk is high or very high, a Safeguarding concern should immediately be triggered.** This will also be the case where previous attempts to work in a multi-agency way (as set out above) have failed to produce a reduction in risk.

Any agency or individual that is concerned that the Self-Neglect Plan is not reducing risks to an acceptable level should raise a safeguarding concern.

- The s.42 enquiry process will determine what action is needed, using the standard [Joint Regional Safeguarding Adults Multi-Agency Policy](#) and [B&NES LSAB Multi-Agency Safeguarding Adults Procedures](#) [B&NES LSAB Multi-Agency Safeguarding Adults Procedures Flowchart - One Page](#)

## Safeguarding Enquiries

The aims of statutory Care Act (s.42) safeguarding enquiries in self-neglect cases are to:

- establish facts and provide a description of the self-neglect
- ascertain the adult's views and wishes
- assess the needs of the adult for protection and support and how those needs might be met
- protect and support the adult from self-neglect in accordance with the wishes of the adult, and in line with their mental capacity to make relevant decisions about their care and support needs
- promote the wellbeing and safety of the adult through a supportive and empowering process

Any safeguarding enquiries or assessments that are made will need to be appropriate and proportionate to the individual circumstances of the case. These must be formulated and agreed between the practitioner and the Safeguarding Adults / Quality Assurance Team Manager who chairs the case. *Making Safeguarding Personal* principles should always be applied.

Any enquiries or assessments made, and actions taken, must be lawful and proportionate to the level of risk involved.

Where an adult has died as a result of self-neglect, or has experienced significant harm, and there is concern about how agencies worked together, consideration should be given to whether a Safeguarding Adult Review (SAR) should be undertaken by the Safeguarding Adults Board, following the [Safeguarding Adults Review Policy](#)

## Safeguarding Plans

Where the risks to independence and wellbeing are severe (e.g. there is a risk to life or to others) and cannot be adequately managed or monitored through other processes, it will be necessary to create a Safeguarding Plan to monitor the risk in conjunction with other agencies. This should follow the same or a similar format to the Crisis Intervention Plan used under the Self-Neglect pathway and will usually involve a range of agencies to undertake specific actions and retain ongoing oversight and involvement.

Safeguarding plans should:

- be person-centred and outcome focused
- be proportionate to the risk involved & be the least restrictive alternative
- demonstrate multi-agency working and sharing of information
- have agreed timescales for review and monitoring of the Plan
- have an agreed Lead Worker with responsibility to monitor and review the Plan

All those involved should be clear about their roles and actions.

If the Safeguarding Plan is rejected by the person and the risks remain high, a Review Meeting may need to be brought forward to consider these issues and alternative options.

The Safeguarding case should not be closed just because the adult is refusing to accept the Self-Neglect or Safeguarding Plan.

## 11. Data Protection Issues

Good information sharing is essential in working with people who self-neglect.

The General Data Protection Regulations (GDPR), which apply from 25 May 2018, retain many of the concepts and principles found in the Data Protection Act (DPA). The Information Commissioner's Office (ICO) states that *'personal information should only be held for as long as it is necessary for the purpose for which it was originally obtained.'*

However, while the GDPR places greater emphasis on the need to justify the rationale for retaining personal information, organisations will remain compliant as long as they are able to demonstrate why it is necessary to keep this information for safeguarding purposes as long as the lawful basis for holding this information remains.

Under Article 23, sharing data is permissible *'if there is a risk to an individual, or society, of ... not sharing the information'*, but only *'where the restriction respects the essence of the individual's fundamental rights and freedoms and is a necessary and proportionate measure in a democratic society to safeguard the protection of the individual, or the rights and freedoms of others.'*

## 12. References and Further Reading

Braye, S., Orr, D. and Preston-Shoot, M. [Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care](#)

Braye S, Orr D and Preston-Shoot M (2011) SCIE report 46: Self-neglect and Adult Safeguarding: findings from research. London: SCIE

Braye S, Orr D and Preston-Shoot M (2015) Practice tool: Working with people who self-neglect. Dartington; Research in Practice for Adults

DH (2016) Care and support statutory guidance. Updated 9th May 2016. Available online:  
<https://www.gov.uk/guidance/care-and-support-statutory-guidance/annexes>

Naik AD, Lai JM, Kunik ME and Dyer CB (2008) Assessing capacity in suspected cases of self-neglect. *Geriatrics*, 63, 2, 24-31. Full text available online:  
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847362/>

SCIE Self-neglect resources and services:  
[https://www.scie.org.uk/atoz/?f\\_az\\_subject\\_thesaurus\\_terms\\_s=self-neglect&st=atoz](https://www.scie.org.uk/atoz/?f_az_subject_thesaurus_terms_s=self-neglect&st=atoz)

## 13. Acknowledgements

Thanks are due to the following organisations for sharing their Self-Neglect policies and procedures:

South Gloucestershire Safeguarding Adults Board

Oxfordshire County Council / RiPFA

## Appendix 1:

### Self-Neglect Risk Indicator Assessment Tool

Name:	DoB:	ID No:
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<b>Risk Indicator</b>	<b>Supporting evidence</b>
History of crisis incidents with life threatening consequences	
High risk to others	
High level of multi-agency referrals received	
Non-engagement with agencies	
Risk of domestic violence	
Fluctuating mental capacity, history of safeguarding concerns / exploitation	
Financial hardship, tenancy / home security risk	
Likely fire risk	
Public order issues; anti-social behaviour / hate crime / offences linked to petty crime	
Unpredictable / chronic health conditions. Serious concerns for health and well-being that require an immediate response	
Significant substance misuse	
The individual's network presents high risk factors.	
Environment presents high risks and hazards that could result in injury to self and / or others, a health risk or possible eviction	
History of a chaotic lifestyle	
The individual has little or no choice over vital aspects of their life, environment or financial affairs	
Others	

### Assessment of Need and Risk (Self-Neglect)

Name:	DoB:	ID No:
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Description of home situation	
Engagement with essential activities of daily living (e.g. ability to use the phone / pendant alarm, shopping, food preparation, housekeeping, laundry, mode of transport, responsibility for medication, ability to handle finances).	
Functional and cognitive abilities of the person	
Family and social support networks	
Medical history, to include engagement with professionals, treatments and interventions	
Mental health conditions or substance misuse issues	
Social history - to include any social care services offered / in place	
Environmental assessment, to include any information from family/professionals/others (this should include any environmental health monitoring in place)	
A description of the self-neglect and impact on the person's health and well-being	
A historical perspective of the situation	
The person's own perspective about their situation and needs	
The person's own mental capacity in relation to risks identified (please list) and how this has been assessed (please consider the person's 'executive functioning')	
The willingness of the person to accept support	
The views of family members, health and social care professionals and other people in the person's network	
Assessor's conclusion and recommendations	

## Appendix 2

### Self-Neglect

#### Multi-Agency Risk Management Meeting

#### Draft Agenda

##### **1. Welcome and introduction**

- Apologies
- Roles of agencies/professionals/individuals represented

##### **2. Details of the adult at risk of self-neglect**

- Confirm whether adult at risk is aware of safeguarding alert/procedures in place to manage concerns of self-neglect
- Views (if known) of the adult at risk, and the outcomes that they are seeking
- Agency involvement (in place/refused)

##### **3. Details of mental capacity**

- Decision(s) and associated risks and consequences against which mental capacity (including 'executive functioning') has been assessed
- How capacity assessment was carried out, when and by whom
- If mental capacity has been assumed, how has this assumption been reached?
- Any identified concerns
- Is a legal view required?

##### **4. Assessment of risk indicators**

- Agree severity of risks identified

##### **5. Practical support and strategies to minimise the risks**

##### **6. Agree actions to manage risks and identify triggers for review**

##### **7. Communicating with the person at risk**

- Agree who is best placed to talk to the adult at risk, empower them to make decisions and to take action

##### **8. Agree Lead Agency / Lead Worker to co-ordinate ongoing work**

##### **9. Agree Self-Neglect Action Plan / Crisis Intervention Plan**

##### **10. Review - agree timescales for review**



Person at risk of self neglect  
**Crisis Intervention Plan**

**Adult at Risk:**

**CIP completed by:**

**D.o.B:**

**Liquid Logic No:**

**Age:**

**NHS No:**

**Date of original referral:**

**Date CIP completed:**

**Dates of any multi-agency meetings:**

*Note: The Lead Agency is responsible for arranging an immediate Multi-Agency Risk Management meeting (MARM) to consider the risks and draw up a Crisis Intervention Plan in line with the B&NES LSAB Revised Self-Neglect Policy and Best Practice Guidance (revised June 2018).*

**1. Person's circumstances / background**

*Please describe the nature of the person's accommodation / daily living / support provided / nature of self-neglect etc*

**2. Person's views and capacity to consent to Crisis Intervention Plan**

*What are the person's views on his / her situation?  
(Does an IMCA or Care Act advocate need to be appointed?)*

### **3. Views of other significant people**

*This should include family members / other members of the social network / professionals.*

### **4. Further relevant information**

*Please include details of whether this case has been considered under Safeguarding procedures and reasons given by Chair for their decision etc.  
Also please consider family and social support networks / person's medical history (where relevant) / mental health issues etc.*

### **5. Risk(s) / Cause for Concern**

*Please include nature / level of risk. More than one type of risk may apply.*

### **6. Risk Reduction Strategies / Actions attempted or currently in place**

*What has already been tried? When? With what degree of success? What is the current Action Plan?*

**7. Unmanaged Risks and Seriousness of Risk**

*What risks remain and how serious are they?*

**8. Agreed Actions**

*Actions resulting from the Multi Agency Risk Management Meeting:*

	<b>Action</b>	<b>By Whom</b>	<b>By When</b>
1.			
2.			
3.			
4.			
5.			
6.			

**9. Contact details of all those involved**

<b>Name</b>	<b>Role</b>	<b>Contact Details</b>

## **10. Agreement to the Crisis Intervention Plan**

Signed and Dated (Lead Worker):

Service User:

Line Manager:

Family/Carer/Service Provider:

Others:

## **11. Review Date / Time / Venue**