SELF-NEGLECT
(INCLUDING CHRONIC HOARDING)
PROTOCOL

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1. Partners to the Protocol

1.1 The overarching purpose of the City & Hackney Safeguarding Adults Board (CHSAB) is to assure itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and prevent abuse and neglect where possible.

The London Borough of Hackney Council
The Metropolitan Police (City of London and Hackney)
The City of London Corporation
The London Fire Brigade
The London Probation Service
Hackney Council for Voluntary Services
Homerton University Hospital NHS Foundation Trust
East London NHS Foundation Trust
City and Hackney Clinical Commissioning Group
Care Quality Commission
Barts Health NHS Trust
Hackney Healthwatch
City of London Healthwatch
London Ambulance Service

2. Introduction Partners to the Protocol

"***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."***
(Department of Health, 2014)

2.1 Self-neglect often involves an interplay between mental, physical, social and environmental factors. 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. Social and environmental factors and physical health issues such as visual impairment and restricted mobility often contribute towards self - neglect and hoarding. Key triggers include: disability, poverty, lack of physical space in the home, and inequalities in terms of access to health and social care services.

2.2 Sometimes professional concerns do not match the individual's own perception of their situation. Adults that self-neglect usually have longstanding, recurring, complex needs and/or present with particular behaviours that mean they are difficult to work with.

2.3 Some people are difficult to engage with because of presenting behaviours associated with diagnosed or undiagnosed mental health problems, substance misuse/dependency issues, cognitive impairments or other anti-social behaviours. Working with adults who self-neglect can be very time consuming and stressful for staff as there are no straightforward and proven approaches available to follow. In most instances of self-neglect the person is assessed as having the mental

capacity to make relevant decisions in relation to their self-neglect. However, their behaviour may include not wishing to engage with services to make any changes to their situation. Risks as a result of this lack of engagement include: social isolation, verbal abuse, homelessness and a risk to health and wellbeing.

2.4 Research (*Self-neglect and adult safeguarding: findings from research, SCIE report 46, 2011)* suggests that a multi-agency, multi professional and multidisciplinary approach to self-neglect is the most effective one.

2.5 The Care Act 2014 has formally recognised self-neglect as a category of abuse and neglect and has brought self-neglect within the statutorily constituted functions of the City and Hackney Safeguarding Adults Board (CHSAB). This protocol is issued by the CHSAB and applies to all agencies represented on the CHSAB. It is outcome focused and outlines who is best placed to engage with the vulnerable person who self-neglects and how a coordinated multi-agency/multi-disciplinary/multi-professional approach should assist in achieving the best possible result. It offers clear guidance to operational staff and managers on how the needs or presenting problems of difficult to engage vulnerable adults who self-neglect should be addressed.

3. Aims of the Protocol

3.1 The aims of this Protocol are:

- to improve the management of adults who self-neglect
- to engage with, and support, those in the local community such as friends, relatives and neighbours who are often best placed to work with the person who is self-neglecting
- to facilitate appropriate outcome focused, solution-based intervention and support
- to facilitate people to remain in their own homes and reduce the risk of homelessness as a result of self –neglect issues such as hoarding and rent arrears
- to improve the co-ordination of services between agencies in taking responsibility for the management and support of adults who self –neglect
- to establish best practice guidance
- to improve knowledge of the relevant legislation.

3.2 Self-neglect often involves an interplay between mental, physical, social and environmental factors. 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. Social and environmental factors and physical health issues such as visual impairment and restricted mobility often contribute towards self - neglect and hoarding. Key triggers include: disability, poverty, lack of physical space in the home, and inequalities in terms of access to health and social care services.

4. Key Principles of the Protocol

4.1 This protocol is based on the following principles:

1. The most effective approach to self-neglect is to use consensual and relationship-based approaches. These may be more effective if carried out by, or in partnership with, non-statutory parties including family members, friends, housing officers, charities and voluntary sector organisations

2. The rights of individuals under the Human Rights Act (1998) should be supported and consensual, least restrictive interventions should be made unless there is evidence that a clear risk of significant harm exists to the person or others, which may require a non-consensual intervention

3. Given the subjective nature of clutter, disarray and the value of possessions and life-styles, it is necessary to use an objective rating scale to assist communication and understanding of the level and impact of hoarding

4. Risk of harm should always be considered in terms of harm to the individual and of harm to other people, for instance, neighbours

5. Because of the heterogeneous nature of hoarding and self-neglect, it is necessary to co-ordinate interventions across multiple organisations when concerns of risk of harm arise and to do this, a lead organisation has to be identified

6. Particularly high risk is present where:
    a. multiple organisations are involved, but their actions are not coordinated and there is no clear oversight and direction

    b. a person who hoards or self-harms is of concern to numerous different organisations but does not meet their threshold criteria.

5. Sharing Information

5.1 Due to the complex and diverse nature of self-neglect responses by arrange of organisations are likely to be more effective than a single agency response. Sharing information between organisations will usually require the person's consent and each organisation must consider when it is appropriate to share information without the person's consent, for example, if there is a public or vital interest.

6. Presenting problems of self-neglect

6.1 The presenting problems related to self-neglect can be wide ranging. For example:

- a person 'hoards' excessively and this impacts on the living environment causing health and safety concerns for them and for their neighbours
- signs of serious self-neglect are regularly reported by the public or other agencies but no change in the person's circumstances occur
- person's actions/inactions indicate a high risk of fire
- a person's personal or domestic hygiene exacerbates a medical condition and could lead to a serious health problem
- the accommodation becomes filthy (including problems associated with cats/dogs and their excrement) and verminous causing a health risk or possible eviction
- the person has no heating or water and refuses to move to alternative accommodation
- the person has no heating or water and refuses to move to alternative accommodation the person appears unkempt and/or exhibits extreme weight loss
- there are structural problems with the property and the person cannot afford repairs or refuses to consider alternative accommodation
- financial debt issues which may lead to rent arrears and the possibility of eviction
- there are health and safety issues around gas or electricity and the person refuses or cannot afford to get the appliances repaired
- anti-social behaviour intimidates neighbours and causes social isolation
- the conditions in the property cause a potential risk to people providing support or services e.g. paid carers.

6.2 This list is not exhaustive and there may be other areas of concern or a mixture of the above that highlight a difficulty for the vulnerable person and those trying to assist them.

6.3 It is important to recognise that assessments of self-neglect are grounded in, and influenced by, personal, social and cultural values and workers should always reflect on how their own values might affect their own judgements.

7. Hoarding

7.1 For the purposes of this protocol, hoarding is considered as an element of self –neglect. Hoarding refers to the acquisition of items with an associated inability to discard things that appear to others to have little or no monetary value to the point where it interferes with use of their living space or

activities of daily living. Hoarding can include new items that are purchased and hoarded. It can also include food items, items of no monetary value, refuse and animals.

7.2 It is important to distinguish between overcrowding and hoarding. The impact of overcrowding in a small living space may appear to workers as a hoarding issue when it is in fact a lack of living space for necessary possessions which is the presenting issue.

7.3 Hoarding Disorder has now been identified as a distinct diagnosis in the DSM 5 (American Psychiatric Association, 2013) but does not appear in the ICD 10 (World Health Organisation, 2010). Individuals may benefit from mental health intervention and should be encouraged to accept referral by their GP to psychological therapies or other relevant secondary mental health professionals for support.

7.4 **Signs of hoarding**: Conditions of extreme clutter, especially where bathroom facilities, food storage, oven, heating sources, and entry and exits are blocked, inability to throw things away that may seem to be, or actually are, rubbish, empty food containers, or papers stacked up in the living space.

8. Reasons for self–neglecting behaviour

8.1 There are a range of explanations for self-neglect (*Self-neglect and adult safeguarding: findings from research, SCIE report 46, 2011)* and a reluctance to accept intervention, including:

- psychiatric aetiology
- underlying personality disorder, depression, dementia, obsessive-compulsive disorder, trauma response, severe mental distress
- diminishing social networks and/or economic resources
- attempts to maintain continuity and control
- physical and nutritional deterioration
- personal philosophy such as pride in self-sufficiency
- a sense of connectedness to place and possessions
- in some cases, shame and efforts to hide state of residence from others.

8.2 Unpaid carers may self-neglect as a result of their caring responsibilities and workers should be aware of the impact that caring for a vulnerable person might have on the carer and ensure that a carer's assessment is carried out and appropriate support offered.

9. Working with those who self-neglect

9.1 Challenges to practitioners working with self –neglect issues include:

- divergent agency thresholds for triggering concern and involvement
- competing value perspectives e.g. duty of care versus choice and control
- understanding complex family relationships
- dealing with the emotional effect of self-neglect on those experiencing it
- care management workflow arrangements
- care management models that do not recognise the amount of time required to build relationships and engage in what are often long, slow negotiations
- the need for legal literacy (knowledge of all relevant legislation, including the Mental Capacity Act 2005 and the Mental Health Act 1983)
- the need for creative interventions which are flexible, negotiated and proportionate.

10. Mental Capacity and self-neglect

10.1 If concerns are raised by anyone about self-neglect, the statutory agency must be clear about the person's mental capacity in respect to the key decisions that may require intervention.

10.2 If there are any doubts about the person's capacity especially with regard to their ability to 'choose' their living conditions or refuse support, then where possible a mental capacity assessment should be undertaken. There may be circumstances in which it is useful to involve therapists in capacity assessments, for example, where the decision is around managing the home environment or where the person has communication difficulties and speech and language therapists could be helpful.

10.3 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. Good practice should involve considering whether the person has the capacity to act on a decision that they have made (executive capacity).

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

10.5 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. Additionally, consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed. IMCAs may be instructed in Safeguarding regardless of the level of involvement of family or friends.

11. Good practice

11.1 Good practice when working with self-neglect *(Self-neglect policy and practice: key research messages, SCIE, 2015)* is:

- taking the time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement. The theme that emerged most consistently in the research carried out by Braye, Orr and Preston Shoot in 2014 was the importance of establishing a relationship to secure engagement and achieving interventions that could make a difference

- trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history, rather than just the particular need that might fit into an organisation's specific role

- engaging with the individual's family/friends/support network (with the person's consent). Their knowledge and understanding of the person may assist with understanding the reasons for self-neglect and they may be best placed to provide support

- working at the individual's pace and being able to spot moments of motivation that could facilitate change, even if the steps towards it are small

- offering choices and having respect for the individual's judgements on the most appropriate form of help even when coercive measures are being taken. The degree to which the person is treated with respect can go a long way in creating a beneficial outcome

- ensuring an understanding of the nature of the individual's mental capacity in respect of self-care decisions

- being honest, open and transparent about risks and options

- having in-depth understanding of legal mandates providing options for intervention

- making use of creative and flexible interventions, including family members and community resources where appropriate

- engaging in effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals. If there are children living in the home of someone who self-neglects then children's services should be informed and from part of the multi-agency response.

11.2 In order for good practice to occur there is a need for:

- flexibility (to fit individual circumstances)

- negotiation (of what the individual might tolerate)

- proportionality (to act only to contain risk, rather than to remove it altogether, in a way that preserves respect for autonomy).

11.3 The worker should:

- show humanity

- be reliable

- show empathy

- demonstrate patience

- be honest

- work at the individual's own pace.

12. Autonomy versus a duty of care

12.1 There is often a difficult balance to be struck between respecting an individual's autonomy and having a duty of care.

12.2 Balancing choice, control, independence and wellbeing calls for sensitive and carefully thought through decision-making. It is important to understand each individual's situation and to try and find a way of working effectively with them. Both the Care Act and Making Safeguarding Personal emphasise the importance of involving the person in decision making and focusing on the outcomes that the person wants to achieve.

12.3 If there is a doubt about an individual's capacity to make a decision then a mental capacity assessment must be carried out. As referred to in section 10, the fact that an individual may be assessed as having capacity to make decisions around their lifestyle does not mean that professionals should withdraw from the situation. Individuals have the right to make what others

may consider to be an "unwise" decision. However, where there are concerns about the impact of these decisions on the person's health and well-being or the health and well-being of others then professionals should continue to try and work with the person and people close to them (with their consent) to negotiate creative solutions. This requires appropriate and sensitive engagement by those involved with the person. Consideration should be given as to whether the person meets the requirement for a Care Act Advocate

12.4 In certain circumstances coercive action may be imposed by organisations such as the housing department even when the person has the capacity to make a decision, for example, eviction from the property. In a life or limb situation the police would have powers to intervene.

12.5 If there is an assessed risk of significant harm to others, or to the person themselves if they lack the capacity to make the relevant decisions, then the professional's duty of care may require them to override the individual's right to exercise choice and control. Any restrictions imposed must be necessary to prevent harm, and proportionate to the risk of that harm. Any restrictions imposed for the protection of others must have the proper authorisation, e.g. the decision of a police officer or a court order. The individual and their supporter/advocate should be kept informed of any decisions made and actions to be taken and solutions acceptable to the person sought wherever possible.

13. Key agencies and their roles

Environmental health service (EHS)

13.1 The EHS has 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. EHS 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 EHS will take a leading role in case managing the necessary investigations and determining the most effective means of intervention.

13.2 Where the individual is residing in conditions that only pose a threat to their own welfare, the powers available to EHS 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 may not be the most effective use of resources, particularly where a coordinated approach could provide immediate protection of the individual and others and also promote a long term solution.

Housing department

13.3 Under Part 1 of the Housing Act 2004, the housing department has 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.

13.4 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.

13.5 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.

Private landlords/housing associations/registered social landlords

13.6 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.

13.7 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.

Adult social care

13.8 Adult social care will initially co-ordinate the multi-agency approach. In the majority of cases the usual community care 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 assessor must ensure that the person has fully understood the risk and likely consequences if they refuse 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.

13.9 If the person is assessed as not having 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.

13.10 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.

Mental health services

13.11 Mental health services will be the lead agency where the individual is eligible or believed to be eligible for mental health services. Mental health services will also have a crucial role within many investigations under this protocol as for many individuals hoarding or self-neglect are the manifestations of an underlying mental health condition.

13.12 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.

Police

13.13 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.

Primary health services

13.14 In some cases of chronic or persistent self-neglect individuals who are reluctant to engage with adult social care may engage with primary health care services such as their GP, district nursing service etc. GPs and district nurses carry out home visits to vulnerable older people 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.

13.15 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.

13.16 Primary health services should monitor those individuals who are engaged with their service and show signs of 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.

Acute and community health services

13.17 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. Community based therapists and nursing staff are often the first people to observe hoarding and self-neglect related problems. These professionals are key to identifying triggers and changes in behaviour which are then fed into the multi-disciplinary team.

13.18 Therapists can assess and report on how a client'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).

London fire brigade (LFB)

13.19 LFB is best placed to work with individuals to assess and address any unacceptable fire risk and to develop strategies to minimise significant harm caused by potential fire risks. LFB will also raise alerts when called to addresses repeatedly or where homes have significant damage because of a fire and the individual continues to live at that address.

13.20 LFB will raise alerts, carry out fire risk assessments and offer advice to individuals assuring them of the necessity of fire protection and prevention. LFB may gain entry where home access is refused to other services.

Utility companies/building and maintenance workers

13.21 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 hording and self-neglect can be received and appropriate action taken.

Domiciliary care providers

13.22 Care agencies are commissioned by the London Boroughs of Hackney and City of London to provide support to people in their own homes and are also commissioned directly by people who fund their own care. They have a role in both identifying people who self-neglect and hoard and in working with them.

14. Self–neglect and risk

Low level risk

14.1 It is vital that low level risk is addressed in order to ensure that the self-neglect does not escalate and result in high level risk.

14.2 At a low level of risk the most effective approaches to self-neglect are based on a long-term approach. This involves developing a relationship with the person who hoards or self-neglects, sensitively raising the problems their behaviour causes for them or for others and working with them to find solutions and providing assistance to put these into action. It may include working with someone close to the person who is able to assist the person to achieve change due to a long standing relationship with them.

14.3 Low-key monitoring of wellbeing may be the only form of assistance that is acceptable to the person. This may involve community-based voluntary organisations providing specific services such as visiting, floating support, befriending or support in managing finances, and will often involve members of the individual's social network. Support may also be provided to address mobility issues etc.

14.4 Interventions may include de-cluttering or cleaning, although any changes are likely to be temporary unless carried out in conjunction with other interventions such as relationship building with a worker from an appropriate agency e.g. floating support, or specialist psychological intervention.

14.5 Such approaches respect the legal right of people with mental capacity to have their autonomy respected, while still taking steps to assist with their safety and wellbeing.

14.6 Actions to help with daily living may help to build up relationships of trust. These actions might involve the provision of key items of furniture, or white goods such as fridges and microwaves. Ensuring that the person has medical attention to deal with specific health conditions is another way to build trust while acting to address concerns about wellbeing.

14.7 It is important to put a plan into place so that change can be maintained. This might take the form of a care package to ensure that help is provided on a regular basis, or involvement in meaningful activity that could replace but serve the same purpose as the person's previous lifestyle. For example, people who hoard could be linked into workshops or groups that make use of the hobbies or collecting passions that had led them to hoard in the first place.

14.8 Recognition should be given to the attachment that people often have to their possessions or surroundings, and the need to replace what is being given up with forward-looking interventions focusing on lifestyle, companionship and activities.

14.9 During any intervention, it is essential that those involved remain alert to risk factors, especially fire. A referral should always be made for a fire safety check. If the person persistently self - neglects/hoards and, whilst currently the living conditions may not be posing a significant risk they would do if left unaddressed, then environmental health services (or the landlord if appropriate) should be involved.

14.10 Some situations deteriorate rapidly and may require urgent escalation. If the person's self-neglect does not pose a statutory nuisance and the risk of harm is low, then the key agencies that need to be involved with the individual should be notified of the concerns and requested to monitor or signpost to relevant support.

14.11 It is important that approaches are coordinated to avoid situations where activity takes place without any specific aim, or actually conflicts with the interventions of other organisations and so it is important that a lead agency is identified to ensure coordination. The lead agency will not necessarily be responsible for implementing action or interventions but will monitor the actions and interventions of the agencies involved. The lead agency in Hackney is Hackney adult social care and in the City is the City of London adult social care.

Significant risk

14.12 Where significant risks of harm have been identified at the point of referral or when low level risk has increased following failed interventions from a single agency, a multi-agency response is required. Options should be explored at a multi-agency meeting and a plan of action agreed specifying what will be done, by whom and by when. If positive outcomes are not reached following this input, then a referral should be made to the high risk panel.

14.13 If there are any risks related to fire risk (such as incidents where there have been "near misses") and you do not feel that the risks have been sufficiently mitigated even with LFB involvement then you should consider referring to the high risk panel.

High level risk

14.14 If there is a high risk of serious harm then a referral should be made to the high risk panel. This panel will meet on a monthly basis but can be convened on an extraordinary basis if an immediate response is required due to the urgency of the situation. Options should be explored and a plan of action agreed specifying what will be done, by whom and by when.

14.15 Statutory interventions may include, but are not limited to, using Public Health legislation, sectioning or removing the person to a place of safety under the Mental Health Act or obtaining Court of Protection approval to remove someone from their home under the Mental Capacity Act.

15. Process for practitioners

Identification and referral pathway

15.1 Practitioners should use the following pathway:

1. Cases of hoarding and/or self-neglect may be referred to any of the agencies represented on the CHSAB by members of the public or by another agency.

2. The first step by the agency receiving the referral is to obtain as much information as possible and ascertain which, if any, agencies are already involved with the person.

3. A referral should then be made to either Hackney or City of London adult social care as the initial lead agencies in relation to cases of self-neglect or other risk behaviour by vulnerable adults.

Hackney adult social care only:

- the information and assessment team will establish whether the person is known to adult social care or mental health services

- if the person is known then the information and assessment team will establish who is best placed to take on the work and send the referral to them

- if the person is not known to adult social care or mental health services then the information and assessment team will carry out a screening assessment and take any appropriate actions. This may include referring on to a specialist service such as the mental health service.

Assessment

15.2 Sensitive and comprehensive assessment is of critical importance and should include an accurate assessment of the individual's mental and physical health status, family dynamics and family coping patterns and cultural beliefs.

15.3 The professional carrying out the assessment should:

1. ensure that the assessment is multi-agency/ multi-disciplinary and includes:
   - a detailed social and medical history

   - whether the presenting issue is self-neglect or is the result of underlying illness/disease

   - a historical perspective of the person and the situation

   - the person's perception of the situation, willingness to accept support, observation and self-reporting

- liaison with family members and people in the individual's network such as friends and neighbours

2. carry out a risk assessment to determine the level of seriousness of each identified risk. This should include observation of the individual and the home, activities of daily living, functional and cognitive abilities, nutrition, social supports and the environment

3. share information with other relevant professionals who may have a contribution to make in managing or monitoring the risks

4. use the "assessment tool guidelines" (see appendix 7) and the clutter image scale guidelines (see appendix 6) to explore the extent and the impact of the presenting problem

5. carry out a Mental Capacity Act assessment, if justified under the Mental Capacity Act. This will inform the actions taken

6. make a decision in liaison with the Safeguarding Adults Manager (SAM) as to whether a safeguarding enquiry is required. Under the Care Act a safeguarding enquiry is required if the person concerned is unable to protect themselves due to a support need. For example, if the person's mental health status or lack of capacity to make a relevant decision is causing or impacting on the self-neglect or other risk behaviours. If all efforts to work with a person in minimising risk are failing and the level of risk is assessed as significant then a safeguarding enquiry may be appropriate.

15.4 Operationally, there is a need for flexibility and proportionality in the allocation of self-neglect cases to adult social care or specialist teams. Also, in deciding whether or not to follow the safeguarding process. Decisions will depend on the complexity of the case and the nature of the self-neglect or other risk taking behaviour being presented.

Actions to make the person safer

Level 1 Signposting/referral/low level monitoring

15.5 Where the risk assessment identifies low level risk (for hoarding, images 1-3 on the clutter scale), a judgement will have to be made on whether or not any intervention is necessary. At this stage the best intervention is likely to be consensual, utilising friends, neighbours, family, health care assistants, district nurses, estate officers or the voluntary sector to engage and support the individual.

15.6 Signposting may include advising the individual to contact relevant organisations that may assist with repair and maintenance, or removal and cleaning or a professional making contact with these organisations themselves. A referral for a fire safety check should always be made if not already carried out. If the individual agrees, low level monitoring by the most appropriate person/agency may be initiated depending on the individual situation. All decisions made and actions taken must be recorded.

Level 2 Refer for a multi-agency meeting

15.7 If the self-neglect is assessed as being significant (for hoarding, images 4-6 on the clutter scale) then a multi-agency meeting should be called to consider and co-ordinate any multiagency involvement. The involved worker should first discuss the case with their line manager who will advise whether a multi-agency meeting should be convened.

15.8 The best intervention is still likely to be a consensual, collaborative one, utilising the person's support network. A fire safety check must always be considered and if there is a risk of fire or carbon monoxide poisoning, then an urgent multi-agency meeting must be arranged. Environmental health and housing input may be necessary.

15.9 The person at risk should be informed by the worker that a meeting will be taking place and why and this communication should be followed up in writing. The person at risk should be invited to the meeting, supported to attend if necessary, and it should be held at a time and venue suitable for them.

A manager should chair the multi-agency meeting

15.10 The meeting will aim to arrive at the "best possible decision" possible as it is acknowledged that in many circumstances there are no easy solutions. It is important that the meeting is accurately recorded so that the thinking and processes used in reaching the decisions made/action points are clear.

15.11 Where a key person is identified to take the lead in engaging with the person at risk it is important that appropriate support is provided from relevant professionals when needed.

15.12 Before the multi-agency meeting concludes risks must be identified and a risk management plan must be outlined and any ongoing needs for the individual or their family and carers should be clearly identified and communicated to the relevant agencies. If the agency was not part of the intervention the chair of the meeting should take responsibility for conveying the ongoing needs to the relevant agency.

15.13 It may be necessary to build a relationship with the person that self neglects before they can be encouraged to accept any practical help. Consideration should be given as to whom would be best placed to build that relationship.

Level 3 High risk panel

15.14 If there is high risk as identified by the risk assessment or "assessment tool guidelines" e.g. images 7 – 9 on the cluster image rating then it will be necessary to refer to the multi-agency high risk panel to ensure the safety of the individual or others who may be affected.

15.15 If previous multi-agency work on cases assessed at level 2 has not resulted in sufficient risk mitigation or you have concerns that the situation will rapidly escalate, then a referral should be made to the multi-agency high risk panel.

15.16 If you or your manager are not sure whether the risk is sufficiently high for a referral to the high risk panel then you should go ahead and refer. The panel chair will provide feedback if the referral is not accepted by the panel.

15.17 **Timescale**: The panel will meet monthly but can be convened on an extraordinary basis in an urgent situation.

15.18 Potential triggers of referral to the high risk panel are:

1. repeated problems of self – neglect. When an agency's usual way of engaging with a vulnerable person has not worked and
   a) no other options appear available, or
   b) enforcement is being considered using statutory powers

2. serious concerns for health and wellbeing (of the person or others) that require an immediate response, for example, domestic abuse of a vulnerable person

3. fire risk, including "near miss" scenarios.

15.19 The high risk panel will consider and agree:

- whether or not urgent action needs to be taken and by whom (each agency representative can inform the panel of what their agency is able to do)
- whether or not a consensual approach is possible
- the legal remedies that are available
- timescales for action
- monitoring arrangements.

15.20 The core members of the high risk panel are:

- housing
- adult social care
- mental health services
- CCG
- CVS
- police
- other as appropriate e.g. One Hackney, fire brigade, ambulance service, trading standards.

15.21 A consensual, collaborative approach is still the most effective response and anyone who is able to get through the front door should be considered to be a key link. If there is high level risk then the meeting should consider whether or not coercive intervention is necessary, and if so, how it can be applied lawfully and quickly. The meeting should consider risk to others as well as to risk to the person themselves and consider whether there is the need for action to save life and limb. It is essential that a mental capacity assessment has taken place to determine how any intervention should be applied.

15.22 Where an individual is already in receipt of adult social care, known to the service or appears eligible for adult social care support the relevant social work team manager will ensure an allocated social worker is assigned to complete necessary assessments, including of the individual's mental capacity, community care or health needs. The allocated worker will act as lead in co-ordinating any plan for intervention.

Financial considerations

15.23 The financial implications of any agreed actions should not be a factor at the high risk panel in order to focus on the best outcome for the person at risk. Debates and disputes around funding should be resolved outside of the meeting.

16. Appendices

Appendix 1

Questions to ask about self-neglect and hoarding

Hoarding and self-neglect guidance for practitioners

1.1 The following is a list of questions to ask where you are concerned about someone's safety in their own home and where there may be a risk of self- neglect or hoarding.

1.2 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?

1.3 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 brigade 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?

Appendix 2

High Risk Panel: Terms of Reference

Purpose of the panel

- To provide a person-centred, timely and effective multi-agency response to situations where either the person referred has already been assessed at a high level of risk, there is a level of risk that is likely to rapidly escalate to a high level or where risk mitigation actions have previously been unsuccessful and the risk is ongoing. This includes "near miss" fire risk.

- To ensure that all relevant agencies work together to provide a co-ordinated and accountable response to the person's presenting issues/risks.

- To focus on the outcomes that the person wants to achieve to the greatest extent possible given the individual circumstances and risks.

- To feed up to the City and Hackney Safeguarding Adults Board (CHSAB) on presenting high risk issues and the number of referrals to the panel.

Objectives

1. To share information to increase the safety, health and well-being of adults with care and support needs who have been assessed at high levels of risk.

2. To explore all options to minimise risk and ensure that all interventions possible are taken to maintain the safety of those who are assessed as being at a high level of risk due to issues of self –neglect or other risk taking behaviours.

3. To identify agencies that need to be involved to mitigate identified risks.

4. To ensure that any work undertaken with the person is in the least restrictive way possible to achieve their safety.

5. To ensure that the person has been made aware of all relevant information/options.

6. To ensure that any decisions made/proposed actions involve the person (and with their consent anyone close to them) to the greatest extent possible and that their view has been taken into account in the decision making process.

7. To be aware of a person's right to make an unwise decision if they have been assessed as having mental capacity to make this decision unless there is a clear risk of significant harm to that person or others.

8. To ensure that the person is aware of the implications of any decisions/proposed actions.

9. To ensure that appropriate measures (including coercive measures) are taken if there is a clear risk of significant harm to that person or others. These should always be the least restrictive measures possible in the circumstances.

10. To provide clear professional advice to the relevant agencies involved.

11. To review actions taken by the member agencies on specific cases at the next panel meeting.

12. To monitor the implementation of local policies in relation to specific cases.

13. To identify policy issues arising from casework and raise these through the appropriate channels.

14. To contribute to the development of best practice.

15. To provide feedback to the City and Hackney Safeguarding Board (CHSAB) via the Task and Finish Group on presenting high risk issues and number of referrals to the multi-agency high risk panel etc.

Core membership

- Hackney adult social care
- Hackney Homes/private sector housing
- East London foundation trust
- Hackney CCG
- Hackney GP
- Hackney CVS
- Hackney metropolitan police

Other agency representatives may be required on a case by case basis e.g. HUH, LFB, LAS, drug and alcohol services, trading standards etc

Responsibilities of the core member agencies

1. The named member to attend all high risk panel meetings.

2. If the named member is unable to attend, an appropriate person in the agency must replace them.

3. To ensure that all referrals from their agency have been signed off by a manager and meet the threshold for the high risk panel.

4. To check their agencies records on all cases discussed at the high risk panel prior to the meeting.

5. To contribute to high risk panel discussions.

6. To make decisions on behalf of their agency and agree actions to be taken by their agency.

7. To follow up on actions agreed for their agency and provide feedback on the progress of these actions to the high risk panel co-ordinator.

8. To promote good practice within their agencies through updating colleagues about the multi-agency high risk panel, addressing any issues about the quality of their agency's multi-agency high risk panel referrals and supporting colleagues through the panel process.

Responsibilities of the high risk panel co-ordinator

1. To collate the referrals to the high risk panel.

2. To record the referrals onto a high risk panel spreadsheet.

3. To invite non-core agencies to the high risk panel if requested to do so by the chair.

4. To set up high risk panel meetings, including room bookings, sending out invites and papers. The papers should include the minutes of the last meeting, the agenda for the meeting and the completed referral forms.

5. To distribute an attendance sheet at each meeting.

6. To take minutes of the meeting and send these out to all high risk panel members.

7. To check and record that agencies have completed their agreed actions.

8. To record any actions fed back by the high risk panel members onto the multi-agency high risk panel spreadsheet.

9. To provide any data required for reporting purposes.

Responsibilities of the high risk panel chair

1. To read the referrals one week prior to the meeting and inform the co-ordinator if an agency which isn't a core member of the panel needs to attend e.g. the LFB.

2. To double check the referrals to ensure that that are appropriate for the multi-agency high risk panel.

3. To emphasise confidentiality/information sharing agreement at the beginning of each meeting.

4. To manage the order of cases presented at the meeting.

5. To agree any actions to be taken.

Frequency of meetings

The high risk panel will sit monthly.

Chair of the multi-agency high risk panel
The chair of the high risk panel is the ASC service manager for long term services.

Referral process

1. The person referred (and if applicable, their advocate/informal carer/ someone close to them) should be informed that their case is being referred to the high risk panel.

2. Referrals are via the high risk panel referral form.

3. Referrals must be submitted by the manager of the allocated worker.

4. Referrals should be sent to: trisha.brooks@hackney.gov.uk

5. Referrals should be sent one week before the high risk panel meeting. Referrals will be considered at shorter notice in exceptional circumstances.

During the high risk panel meeting

1. All attendees will sign an attendance sheet and provide details of their contact number and email address.

2. The Chair will set out the confidentiality/information sharing agreement and the purpose of the high risk panel.

3. Any outstanding follow-up actions from the previous high risk panel will be highlighted and new deadlines / actions agreed.

4. The Chair will go through the running order, enabling visiting agencies with no involvement on other cases to present cases before any cases being presented by core members.

5. Cases will be presented by the lead agency working with the person at risk. The allocated worker may be invited to present the case.

6. Cases will be presented verbally and in a clear way, focused on relevant facts, areas where there are gaps in knowledge and setting out the risk of harm. The adult at risk's experience/perspective will be represented.

7. All core member agencies will share information held by them on the person at risk

8. On all cases the Chair will invite professional opinion and actions from agencies and formulate a plan to reduce the risk. The Chair will agree specific and timed actions on each case including who will update the person at risk.

9. The high risk panel co-ordinator will take minutes during the meeting and will clarify any actions agreed with the Chair before the next case is heard.

Confidentiality
The high risk panel is not a public forum and attendance is limited to those agencies who are able to provide a contribution with regard to listed cases. All cases discussed at the high risk panel are strictly confidential and the information discussed should not be passed on to any individual or agency without the agreement of the Chair, with the following exception:

under the Criminal Procedure and Investigations Act 1986 (CPIA), if/when an individual is charged with an offence the police are required to disclose the existence of all material created as part of the investigation. As a result the existence of the community MARAC referral will be disclosed to the defence. However this will be listed as 'sensitive information' and will only be fully disclosed if a judge deems it absolutely necessary in the interests of justice. Even on the rare occasion when this may happen the defence will be issued with the following instructions:

'This material is disclosed to you in accordance with the provisions of the CPIA 1986, and you must not use or disclose it, or any information recorded in it, for any purpose other than in connection with these criminal proceedings. If you do so without the permission of the court, you may commit an offence.'

It is the duty of referring agencies and core members to store and communicate information pertaining to the multi-agency high risk panel safely.

High risk Panel: Information Sharing Agreement

1. Introduction

The high risk panel looks at the highest level risk cases in order to provide a co-ordinated multi agency approach to manage and mitigate risk.

Sharing information within and between agencies is vital for promoting the welfare of adults at risk and for providing effective and efficient services that are coordinated around the needs of the person. All information sharing needs to be managed in ways which respect a person's right to privacy and confidentiality and must be carried out in compliance with the Data Protection Act 1998 and the Human Rights Act 1998. The Mental Capacity Act 2005 is also relevant as all those coming into contact with adults with care and support needs should be able to assess whether someone has the mental capacity to make a decision concerning risk, safety or sharing information.

This information sharing agreement focuses on the sharing of sensitive or personal information between the local authority and its partners. This may include information about individuals who are at risk, service providers or those who may pose a risk to others. It aims to enable partners to share information appropriately and lawfully in order to improve the speed and quality of responses.

2. Key Principles

The Caldicott Principles (revised September 2013) state that all health and social care professionals have a personal and professional duty to access health or care records using the principles outlined below:

Principle 1 - Justify the purpose(s) for using confidential information.
Principle 2 - Only use it when absolutely necessary.
Principle 3 - Use the minimum that is required.
Principle 4 - Access should be on a strict need-to-know basis.
Principle 5 - Everyone must understand his or her responsibilities.
Principle 6 - Understand and comply with the law.
Principle 7 - The duty to share information can be as important as the duty to protect patient confidentiality.

Sharing information on a case by case basis will be carried out by the high risk panel in compliance with the standards set out in the Government's guidance 'Information Sharing for Professionals and Managers' which has been adopted in full by Hackney Council.

The guidance sets out seven key questions to be considered prior to sharing:

1. Is there a clear and legitimate purpose for you or your agency to share the information?
2. Does the information enable a living person to be identified?
3. Is the information confidential?
4. If the information is confidential, do you have consent to share?
5. If consent is refused, or there are good reasons not to seek consent to share confidential information, is there a sufficient public interest to share the information?
6. If the decision is to share, are you sharing information appropriately and securely?
7. Have you properly recorded your information sharing decision?

3. Consent

The Council recognises that it is important for individuals to understand what they are consenting to. In order to ensure that individuals can give informed consent, requests for personal information to be shared will be based upon a clear consent statement, which indicates the purpose(s) to which the information will be put.

There are two types of consent, explicit and implied.

For the consent to be explicit the data subject must signify their agreement and there must be some active communication between the parties.

Where consent is assumed from non-response to a communication or from a citizen's failure to return or respond to a leaflet, this is known as implied consent.

The level of consent required will be dependent upon the nature of the information to be shared. Explicit consent must be obtained if sensitive personal information is to be shared.

Obtaining consent coercively, for example, with implied threats of loss of access to services, is unlawful.

Individuals should not be given a false expectation that their refusal to provide consent will lead to information not being shared. Where there is a legal requirement to share information, individuals should be informed that this is the case.

Where an adult lacks the mental capacity to make that decision, a best interest decision to share information could be made – this must be properly explored and recorded in line with the Mental Capacity Act.

4. When should information be shared?

There are a number of circumstances in which information that is confidential can be disclosed. The most common is with the explicit consent of the individual, and this should be sought in the majority of cases where sharing information is planned.

Confidential information can be disclosed without consent if it is in the public interest to do so and if the public interest in disclosure is greater than that in withholding the information.

Key factors in deciding where the public interest lies, include the number of people to whom it will be disclosed, what purpose it will be put to and the actual benefit to the individual, the consequences of not sharing and the nature and extent of the information.

For information which is not covered by a duty of confidence, any sharing without consent will need to be fair in order to comply with the first data protection principle, consistent with the requirements of Article 8 of the Human Rights Act and comply with the common law principle that public authorities should only share information where there is a pressing requirement to do so.

Information should not be exchanged when it is to the detriment of the individual concerned unless there is an overriding legal mandate for so doing. For instance where harm to the individual is

suspected.

Where it is necessary for information to be shared, this will be done on a "need-to-know" basis only i.e. the minimum information consistent with the purpose for sharing will be given.

In the majority of cases the data subject should be informed that their information has been shared. Further guidance on when this may not be the case can be found in the Government's guidance 'Information Sharing for Professionals and Managers' as stated above.

5. Information required for the purpose of the prevention and detection of crime or fraud

The Data Protection Act allows disclosure of information where it is necessary for crime prevention and detection and the apprehension or prosecution of offenders. This can potentially be used by any organisation that investigates crime, e.g. fraud or theft, although is most commonly used by the Police.

The exemption does not give the police the power to demand the information. The Council has the discretion to decide whether to release it without breaching the requirements of the principles where the processing (i.e. disclosure) is necessary for the prevention and detection of crime, or the apprehension and prosecution of offenders.

Consideration will be given to whether all the information requested is necessary for the purpose stated. For example, access to an entire case file should not be provided when a summary of the case will be sufficient for the requestors needs.

6. Sharing information within the high risk panel

The information disclosed at the high risk panel shall be for the sole purpose of enabling the high risk panel representatives to discuss options to discharge their duty to safeguard the safety, health and well-being of adults at risk, witnesses, suspects and those repeatedly coming to notice. This is predominantly focused on adults but there may be occasions when children are also at risk and their safety would also need to be taken into consideration.

Minutes of each meeting will be taken to denote actions required. These will be forwarded electronically to and be retained by each member within his or her agency database. All documents forwarded will be marked as confidential.

Appendix 3

High Risk Panel Referral Form

DETAILS OF PERSON AT RISK							
NAME				MOSAIC/User ID			
Address							
AGE		DOB		GENDER			
USER GROUP Tick any appropriate user group	Learning Disability				Mental Health		
	Older People				Physical & Sensory		
	Substance Misuse				Other vulnerable people		
ETHNIC ORIGIN	White British		White Irish		Other White		
	White Traveller of Irish Heritage		White Gypsy/Roma				
	Black Caribbean		Black African		Other Black		
	Indian		Pakistani		Bangladeshi		
	Chinese		Other Asian		Mixed White and Black Caribbean		
	Mixed White and Black African		Mixed White and Asian		Mixed White and Chinese		
	Other						

DATE & TIME OF REFERRAL				
TENURE	Home Owner		Lease	
	Council Tenant		Private rented	
	Housing Association Tenant		Temporary Accommodation	
	Other			
SOURCE OF INITIAL REFERRAL	Neighbour		GP	
	Estate Officer		Floating Support Worker	
	Social Worker/ Community Nurse		Police	
	Fire Service		Other	

DETAILS OF THE PERSON COMPLETING THIS FORM			
NAME	JOB TITLE / PROFESSION	CONTACT DETAILS	DATE

DETAILS OF THE MANAGER AUTHORISING THIS REFERRAL			
NAME	JOB TITLE / PROFESSION	CONTACT DETAILS	DATE

Up to date background information on the person at risk and reasons for referral to the panel
Briefly outline the assessed risks to the person or others (include severity and likelihood of harm) and their views of the identified risks Please state whether there are any fire risks
Results of formal mental capacity assessment (including "executive capacity" i.e. the ability of the person to implement the decision)
Has the safeguarding adult's process been started and what stage is it at? If not started, why not?
What are the protective factors in the person's life? e.g. home care, placement, support from neighbours
Briefly outline the interventions that have already been tried and what the outcomes were

Has a multi-agency meeting already taken place? (if no, outline why this referral needs to go to the high risk panel)
Does the person engage with services? (If yes, explain why a referral to the high risk panel is required)
What outcomes are you seeking from this referral?
Has your manager approved this referral to the high risk panel (if not, then do not proceed with referral)
YES/NO

Appendix 4

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. 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:

a) 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
    i. are in such a filthy or unwholesome condition as to be prejudicial to health, or
    ii. are verminous

b) 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
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. 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) it is of 'urgent necessity' for the patient to be admitted and detained under section 2 and

b) waiting for a second doctor to confirm the need for an admission under section 2 would cause 'undesirable delay'

Note: the patient must be admitted within 24 hours of the medical examination or application, whichever is the earlier, or the application under section 4 is null and void.

Guardianship (sections 7-10)

Duration of guardianship order: up to six months, renewable for a further six months, then for one year at a time.

Application for reception into guardianship: by an AMHP or nearest relative.

Procedure: two doctors 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

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 e.g. by completing the Mental Capacity Act Checklist template and store this within the service user's electronic or paper file.

Appendix 5

LONDON FIRE BRIGADE

Referral Information Required
Referral Method
Full Name
Address Including Postcode
Telephone Contact Number
Whether Partner Agency should be present
Any mental health issues/disabilities
Any language or communication issues

North East Area Support Team
Tel: 0208 555 1200 Ext 35716
Email: NEAreaCFSTeam@london-fire.gov.uk

Routine/Office Hours Referrals
Resource Management Centre
Tel: 0208 555 1200 Ext 88111

Out of Hours/Emergency Referrals
Resource Management Centre
Tel: 0208 555 1200 Ext 88111
Please Provide Partnership Code
Hackney P1-XX

For the London Borough of Hackney only:
All referrals from Hackney Social Care will carry the source code **Hackney P1 – 01**

Clutter Image Rating: Kitchen


1


2


3


4


5

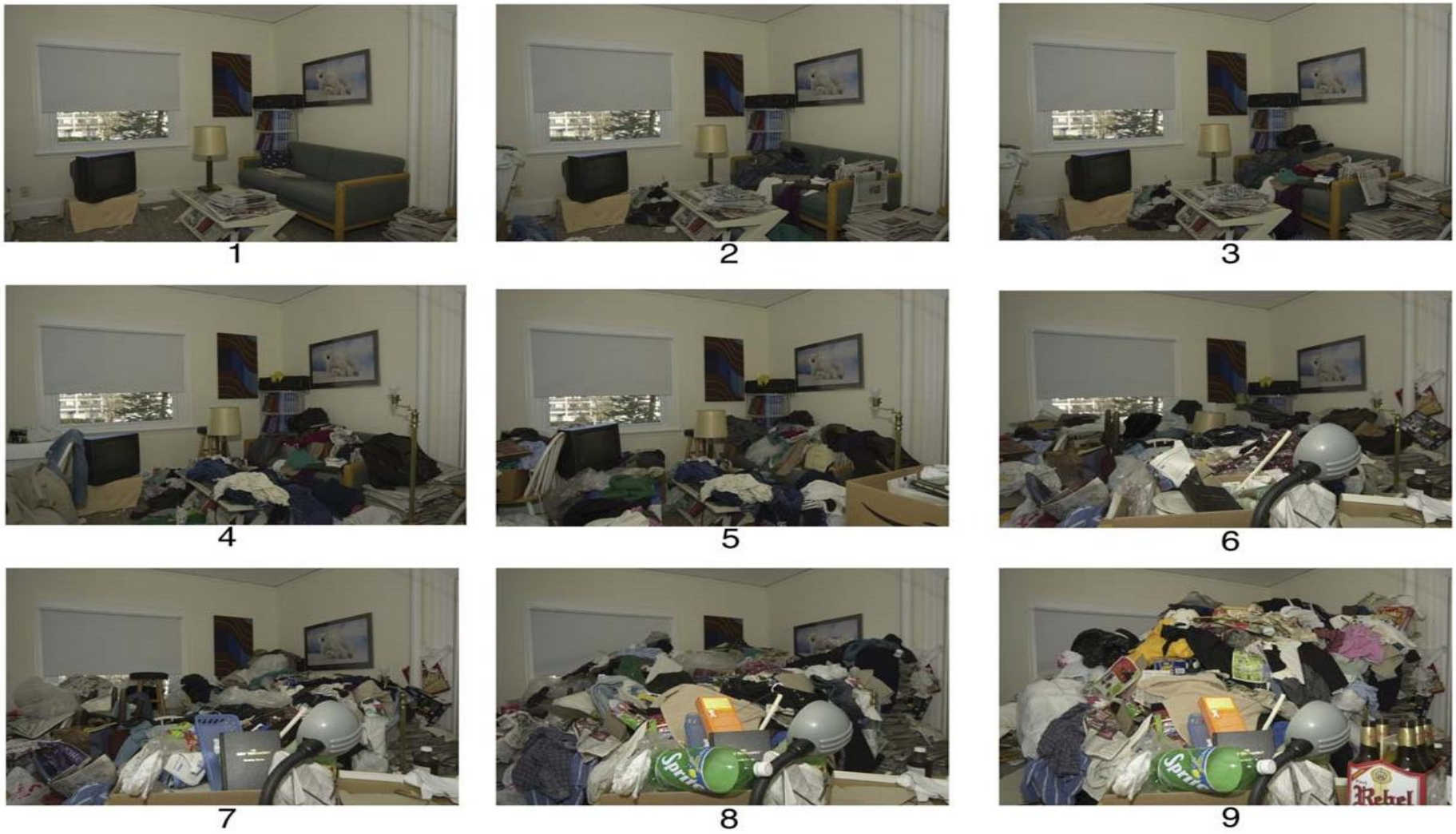

6


7


8


9

Clutter Image Rating: Living Room



Clutter Image Rating: Bedroom

1

2

3

4

5

6

7

8

9

Clutter Image Rating

Using the 3 series of pictures (CIR: Living Room, CIR: Kitchen, and CIR: Bedroom), please select the picture that best represents the amount of clutter for each of the rooms of your home. Put the number on the line below.

Please pick the picture that is closest to being accurate, even if it is not exactly right. If your home does not have one of the rooms listed, just put NA for "not applicable" on that line.

Room	**Number of closest corresponding picture (1-9)**
Living Room	_____
Kitchen	_____
Bedroom #1	_____
Bedroom #2	_____

Also, please rate other rooms in your house that are affected by clutter on the lines below. Use the CIR: Living Room pictures to make these ratings.

Dining room	_____	
Hallway	_____	
Garage	_____	
Basement	_____	
Attic	_____	
Car	_____	
Other Please specify:	_____	Please specify: _____

Appendix 7

Assessment Tool Guidelines

1. Property structure, services & garden area	• Assess the access to all entrances and exits for the property. (Note impact on any communal entrances & exits). Include access to roof space. • Does the property have a smoke alarm? • Visual Assessment (non-professional) of the condition of the Services (NPVAS) within the property e.g. plumbing, electrics, gas, air conditioning, heating, this will help inform your next course of action. • Are the services connected? • Assess the garden. size, access and condition.
2. Household Functions	• Assess the current functionality of the rooms and the safety for their proposed use e.g. can the kitchen be safely used for cooking or does the level of clutter within the room prevent it. • Select the appropriate rating on the clutter scale. • Please estimate the % of floor space covered by clutter • Please estimate the height of the clutter in each room
3. Health and Safety	• Assess the level of sanitation in the property. • Are the floors clean? • Are the work surfaces clean? • Are you aware of any odours in the property? • Is there rotting food? • Does the resident use candles? • Did you witness a higher than expected number of flies? • Are household members struggling with personal care? • Is there random or chaotic writing on the walls on the property? • Are there unreasonable amounts of medication collected? Prescribed or over the counter?

	• Is the resident aware of any fire risk associated to the clutter in the property?
4. Safeguard of Children & Family members	• Do any rooms rate 7 or above on the clutter rating scale? • Does the household contain young people or children?
5. Animals and Pests	• Are the any pets at the property? • Are the pets well cared for, are you concerned about their health? • Is there evidence of any infestation? e.g bed bugs. rats, mice, etc. • Are animals being hoarded at the property? • Are outside areas seen by the resident as a wildlife area? • Does the resident leave food out in the garden to feed foxes etc.
6. Personal Protective Equipment (PPE)	• Following your assessment do you recommend the use of Persona Protective Equipment (PPE) at future visits? Please detail • Following your assessment do you recommend the resident is visited in pairs? Please detail

Level 1 ***Clutter image rating 1 - 3***	Household environment is considered standard. No specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made subject to age and circumstances.
1. Property structure, services & garden area	1. All entrances and exits, stairways, roof space and windows accessible. 2. Smoke alarms fitted and functional or referrals made to fire brigade to visit and install. 3. All services functional and maintained in good working order. 4. Garden is accessible, tidy and maintained
2. Household Functions	1. No excessive clutter, all rooms can be safely used for there intended purpose. 2. All rooms are rated 0-3 on the Clutter Rating Scale 3. No additional unused household appliances appear in unusual locations around the property 4. Property is maintained within terms of any lease or tenancy agreements where appropriate. 5. Property is not at risk of action by Environmental Health.
3. Health and Safety	1. Property is clean with no odours, (pet or other) 2. No rotting food 3. No concerning use of candles 4. No concern over flies 5. Residents managing personal care 6. No writing on the walls 7. Quantities of medication are within appropriate limits, in date and stored appropriately.
4.Safeguard of Children & Family members	1. No Concerns for household members
5. Animals and Pests	1. Any pets at the property are well cared for 2. No pests or infestations at the property
6. Personal Protective Equipment (PPE)	1. No PEP required 2. No visit in pairs required.

Actions	Level 1
Referring Agency	• Discuss concerns with resident • Raise a request to the Fire Brigade for a home safety fire check • Refer for support assessment if appropriate. • Refer to GP if appropriate
Environmental Health	• No Action
Social Landlords	• Provide details on debt advice if appropriate to circumstances • Refer to GP if appropriate • Refer for support assessment if appropriate. • Provide details of support streams open to the resident via charities and self help groups. • Provide details on debt advice if appropriate to circumstances • Ensure residents are maintaining all tenancy conditions

Level 2 ***Clutter Image Rating 4 – 6***	**Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.**
1. Property structure, services & garden area	1. Only major exit is blocked 2. Only one of the services is not fully functional 3. Concern that services are not well maintained 4. Smoke alarms are not installed or not functioning 5. Garden is not accessible due to clutter, or is not maintained 6. Evidence of indoor items stored outside 7. Evidence of light structural damage including damp 8. Interior doors missing or blocked open
2. Household Functions	1. Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose. 2. Clutter is causing congestion between the rooms and entrances. 3. Room(s) score between 4-5 on the clutter scale. 4. Inconsistent levels of housekeeping throughout the property 5. Some household appliances are not functioning properly and there may be additional units in unusual places. 6. Property is not maintained within terms of lease or tenancy agreement where applicable. 7. Evidence of outdoor items being stored inside
3. Health and Safety	1. Kitchen and bathroom are not kept clean 2. Offensive odour in the property 3. Resident is not maintaining safe cooking environment 4. Some concern with the quantity of medication, or its storage or expiry dates. 5. No rotting food 6. No concerning use of candles 7. Resident trying to manage personal care but struggling 8. No writing on the walls

4.Safeguard of Children & Family members	1. Hoarding on clutter scale 4 -7 doesn't automatically constitute a Safeguarding Alert. 2. Please note all additional concerns for householders 3. Properties with children or vulnerable residents with additional support needs may trigger a Safeguarding Alert under a different risk.
5. Animals and Pests	1. Pets at the property are not well cared for 2. Resident is not unable to control the animals 3. Animal's living area is not maintained and smells 4. Animals appear to be under nourished or over fed 5. Sound of mice heard at the property. 6. Spider webs in house 1. Light insect infestation (bed bugs, lice, fleas, cockroaches, ants, etc)
6. Personal Protective Equipment (PPE)	1. Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent. 2. VIP required
Level 2	**Actions**
Referring Agency	• Refer to landlord if resident is a tenant • Refer to Environmental Health is resident is a freeholder • Raise an alert to the Fire Brigade and request a HSFV • Provide details of garden services • Refer for support assessment • Referral to GP • Referral to debt advice if appropriate • Refer to Animal welfare if there are animals at the property. • Ensure information sharing with all agencies involved to ensure a

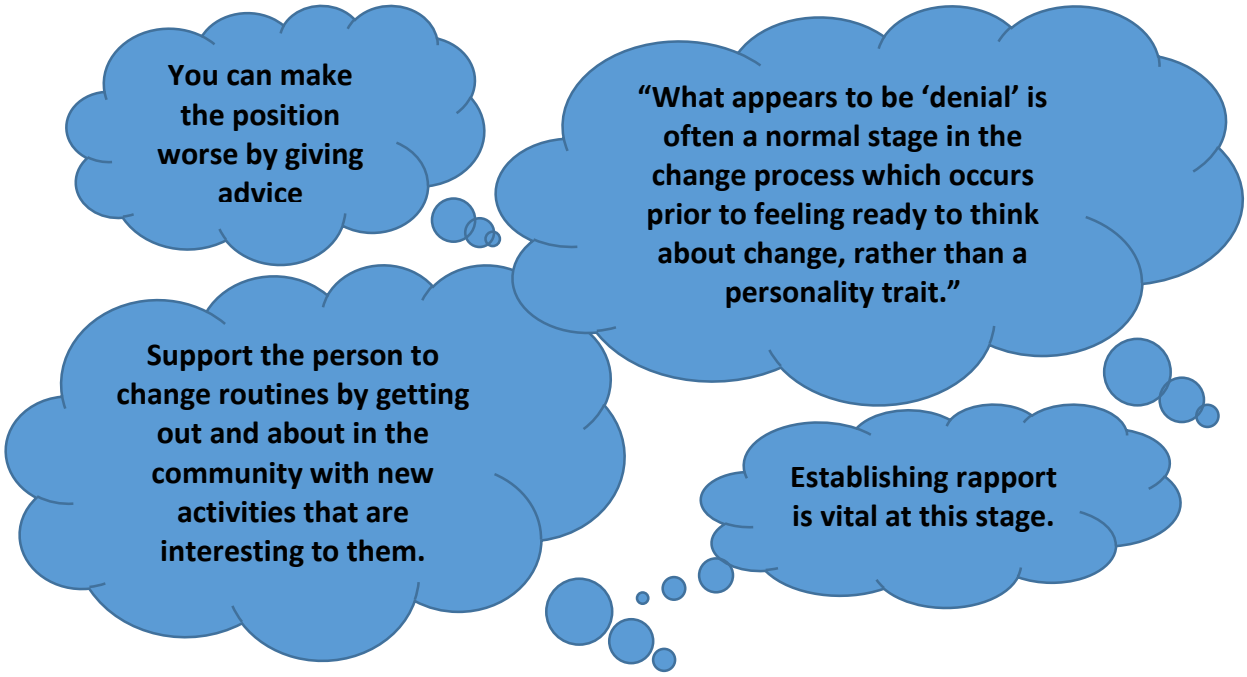
Level 3 ***Clutter image rating 7 - 9***	Household environment will require intervention with a collaborative multi agency approach with the involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents. Residents are often unaware of the implication of their hoarding actions and oblivious to the risk it poses.
1. Property structure, services & garden area	1. Limited access to the property due to extreme clutter 2. Evidence may be seen of extreme clutter seen at windows 3. Evidence may be seen of extreme clutter outside the property 4. Garden not accessible and extensively overgrown 5. Services not connected or not functioning properly 6. Smoke alarms not fitted or not functioning 7. Property lacks ventilation due to clutter 8. Evidence of structural damage or outstanding repairs including damp 9. Interior doors missing or blocked open 10. Evidence of indoor items stored outside
2. Household Functions	1. Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose. 2. Room(s) scores 7 - 9 on the clutter image scale 3. Rooms not used for intended purposes or very limited 4. Beds inaccessible or unusable due to clutter or infestation 5. Entrances, hallways and stairs blocked or difficult to pass 6. Toilets, sinks not functioning or not in use 7. Resident at risk due to living environment 8. Household appliances are not functioning or inaccessible 9. Resident has no safe cooking environment 10. Resident is using candles 11. Evidence of outdoor clutter being stored indoors.

	12. No evidence of housekeeping being undertaken 13. Broken household items not discarded e.g. broken glass or plates 14. Concern for declining mental health 15. Property is not maintained within terms of lease or tenancy agreement where applicable 16. Property is at risk of notice being served by Environmental Health
3. Health and Safety	1. Human urine and or excrement may be present 2. Excessive odour in the property, may also be evident from the outside 3. Rotting food may be present 4. Evidence may be seen of unclean, unused and or buried plates & dishes. 5. Broken household items not discarded e.g. broken glass or plates 6. Inappropriate quantities or storage of medication. 7. Pungent odour can be smelt inside the property and possibly from outside. 8. Concern with the integrity of the electrics 9. Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics. 10. Concern for declining mental health
4. Safeguard of Children & Family members	1. Hoarding on clutter scale 7-9 constitutes a Safeguarding Alert. 2. Please note all additional concerns for householders
5. Animals and Pests	1. Animals at the property at risk due the level of clutter in the property 2. Resident may not able to control the animals at the property

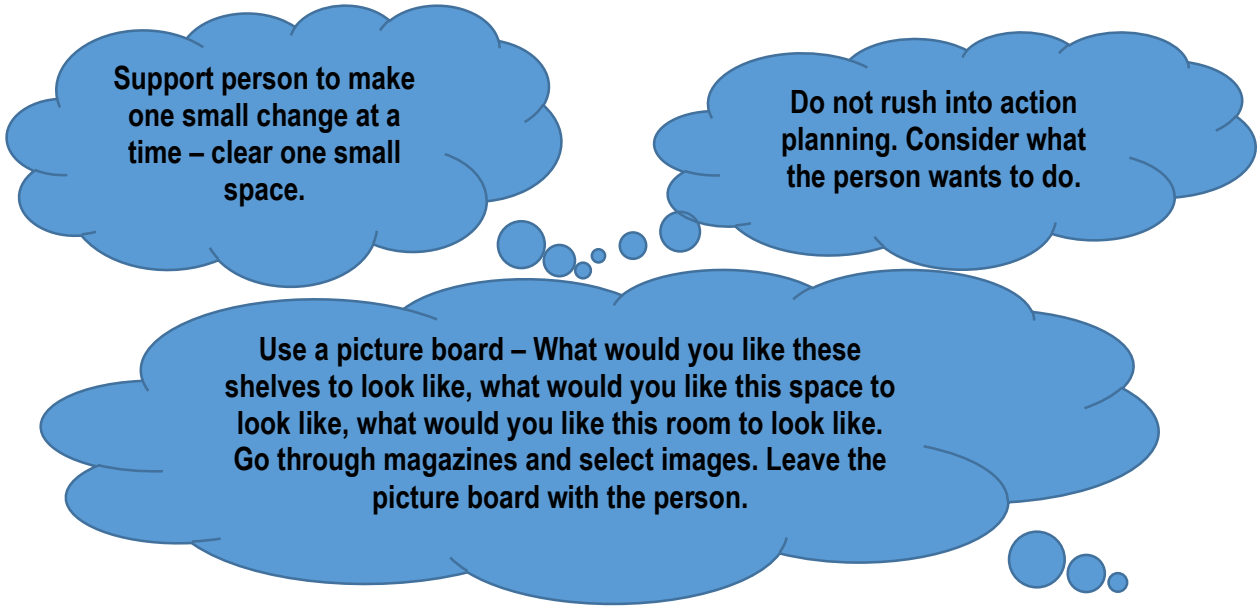
Appendix 8

Supporting Change

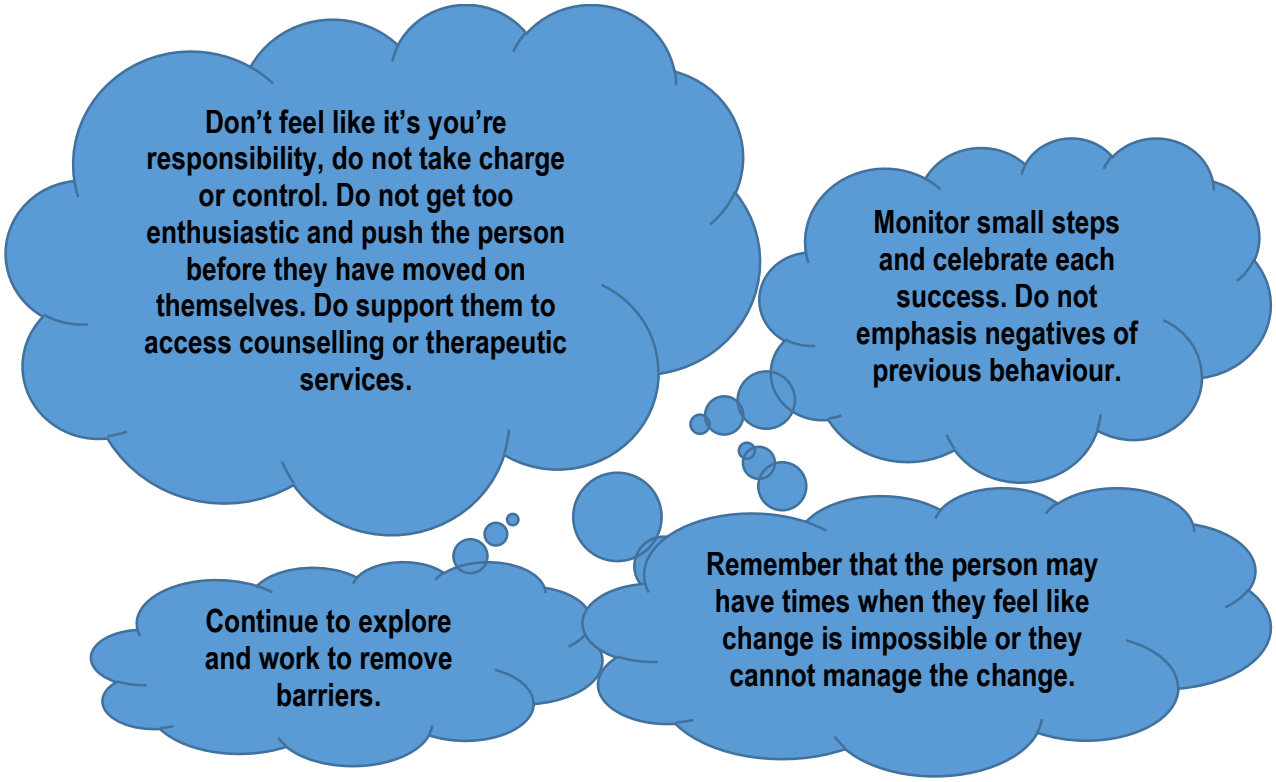
When a person is not considering change



Starting to consider change



Keeping up the change



Maintenance Skills

Most Useful:

- Be aware when support may still be required and when to let go
- Build regular support for the new behaviours
- Positive feedback on progress
- Affirm and praise
- Build new skills/behaviours
- Plan for coping and lapse
- Reinforcement of longer term goals

Least Useful:

- Let go too early
- Over emphasise exploring previous behaviour
- Hold them in dependency
- A person is likely to have periods of relapse. If this happens start the process again building on the strengths gained – no blame

(Fuller and Taylor 2005)

Appendix 9

When talking to someone who hoards

DO:

Imagine yourself in that persons shoes. How would you want others to talk to you to help you manage your anger, frustration, resentment, and embarrassment?

Match the person's language. Listen for the individual's manner of referring to his/her possessions (e.g. "my things", "my collections") and use the same language (i.e. "your things", "your collections").

Use encouraging language. In communicating with people who hoard about the consequences of hoarding, use language that reduces defensiveness and increases motivation to solve the problem (e.g. "I see that you have a pathway from your front door to your living room. That's great that you've kept things out of the way so that you don't slip or fall. I can see that you can walk through here pretty well by turning sideways. The thing is that somebody else that might need to come into your home, like a fire fighter or an emergency responder, would have a pretty difficult time getting through here. They have equipment they're usually carrying and fire fighters have protective clothes that are bulky. It's important to have a pathway that is wide enough so that they could get through to help you or anyone else who needed it. In fact, the safety law states that [insert wording about exits/ways out must be clear], so this is one important change that has to be made in your home".

When talking to someone who hoards

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're thinking. Individuals with compulsive hoarding are likely to notice non-verbal messages that convey judgment, like frowns or grimaces.

Make suggestions about the person's belongings. Even well-intentioned suggestions about discarding items are usually not well received by those with hoarding.

Try to persuade or argue with the person. Efforts to persuade individuals to make a change in their home or behaviour often have the opposite effect – the person actually talks themselves into keeping the items.

Touch the person's belongings without explicit permission. Those who hoard often have strong feelings and beliefs about their possessions and often find it upsetting when another person touches their things. Anyone visiting the home of someone with hoarding should only touch the person's belongings if they have the person's explicit permission

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.