BIRMINGHAM SAFEGUARDING ADULTS BOARD

"Safeguarding is everybody's business"

# Self-neglect and Hoarding Birmingham Multi-agency Guidance and Procedure

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# Guidance

# Introduction

This Guidance and Process was produced and endorsed by the Birmingham Safeguarding Adults Board (BSAB) within the context of the duties set out in paragraph 14.2 of the Care Act (2014) Care and Support Statutory Guidance[1]. It should routinely be referred to where an adult at risk is believed to be self-neglecting.

The guidance is intended to provide a framework for working with an adult at risk in Birmingham who self-neglects. The purpose is to identify self-neglect, reduce the associated risks; and wherever possible, prevent serious injury or death of adults at risk who appear to be self-neglecting.

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

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

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

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

The Care Act[3] states that self-neglect covers a wide range of behaviour; neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a Section 42 enquiry[4]. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding duties will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support.

Locally the Birmingham Multi-Agency Self-neglect and Hoarding Risk Assessment Guidance Tool and referral will be used to determine the pathway of a concern.

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

[2] Care Act 2014 Section 42 (1)

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

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

## Aim of the Multi Agency Guidance and Process

This policy and procedural guidance works towards reducing the risk; and wherever possible prevent the serious injury or death of an adult at risk who may appear to self-neglect by:

- providing a framework for ensuring adults at risk are empowered as far as possible, to understand the implications of their actions and/or behaviours
- promoting a shared, multi-agency understanding and recognition of the issues, including those involved in working with adults at risk who self-neglect
- providing a mechanism for ensuring there is effective multi-agency working and practice; and concerns receive appropriate prioritisation
- ensuring that all agencies and organisations uphold their duties of care
- ensuring a proportionate response to the level of risk to self and others.

This is achieved through:

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

**This guidance does not include issues of risk associated with deliberate self-harm by an adult at risk. If self-harm appears to have occurred due to an act of neglect or inaction by another individual or service, consideration should be given to raising a safeguarding adults concern with Adult Social Care**.

## The approach to self-neglect in Birmingham

The BSAB believes the challenges self-neglect presents are best addressed through following three key principles:

### Key Principle 1. Robust partnership working from the earliest practical stage.

- Early coordinated interventions from a range of partners, working together with the adult to assess needs and find solutions should be tried first, where this is possible.
- The partner agency that first identifies a concern about self-neglect should take the initial responsibility to bring together appropriate partners to discuss these concerns and identify the lead agency from that point.
- In some cases, a point may be reached where reporting concerns about self-neglect for an Adult Safeguarding Enquiry led by Birmingham City Council may be necessary.
- Where self-neglect is a concern, a risk assessment should be routinely completed before an agency closes a case due to the adult not co-operating, engaging or keeping appointments.
- Where there is multi-agency concern about an adult's self-neglect, no agency should close down its involvement without there first being a multi-agency discussion.
- If a dispute arises between practitioners of agencies about a professional judgement that cannot be resolved at their level, this should be escalated appropriately within each agency to seek a resolution.

## Key Principle 2. Interventions should draw upon knowledge of the kinds of approaches that tend to work best.

- Research has shown that some things tend to work better than others.
- The latest information on a range of approaches and interventions can be found in West Midlands regional guidance at

https://www.safeguardingwarwickshire.co.uk/safeguarding-adults/i-work-with-adults/west-midlands-regional-safeguarding-information-hub

## Key Principle 3. Agencies should place the adult at the centre of plans to support them

- An adult affected by self-neglect has a right to choice and control over their life to the greatest extent possible, and the principles of person-centred care and support should apply in any intervention with them. (Remember: "No decisions about me without me" (see section on MSP page 18).
- All workers have a duty of care to consider whether an adult at risk has the mental capacity to understand the risks caused by the decisions they make; and the impact these have upon their safety and wellbeing, or the safety and wellbeing of others.
- When an adult lacks the mental capacity to make a decision, the principles of the Mental Capacity Act must be applied (see page 19).
- The consent of the adult to share information with others should always be sought. If not obtained and there is a belief that the adult may be at risk of neglect, then a decision must be made to share information and with whom must be made (see page 20).
- However, whilst it is preferable to work with the consent of the adult, a balance must be struck between negotiated and imposed interventions.

Sometimes an agency's legal duties will require it to impose an approach upon an adult in order to protect others (see page 20 - Consent and Choice).

- The Six Principles of safeguarding adults (Empowerment, Prevention, Protection, Proportionality, Partnership and Accountability) must be applied with adults who self-neglect, as with safeguarding concerns.

## Self-neglect: what you need to know - The Basics

Self-neglect can take many different forms and may be the result of complex physical, mental, psychological and environmental factors; it can affect both adults with and without the mental capacity to understand the consequences of the way they live their life.

The adult may not see their self-neglect as a problem in the same way others do; they may disagree that anything needs to change and so reject offers of help. On the other hand, the adult may feel they have little or no control over the circumstances they live in and feel deep shame for the way they or their home presents. Worrying about how professionals will react may cause the adult to avoid contact. Self-neglect can have a serious negative effect on the wellbeing and safety of other people as well as the adult. Self-neglect can also occur as a result of other adults preventing access to, not co-operating with, or not engaging with services. In Birmingham such a case contributed to the circumstances that led to the death of an adult with care and support needs. It can be hard to understand why someone self-neglects or lives in a way so different from what others do.

Workers often face ethical dilemmas between respecting the wishes and choices of the adult, and their duty of care towards the person and others around them. Because each adult's situation is different, what might have helped support one person with their self-neglect may not be effective with another and no guidance can tell you what the right thing to do will be in every case.

Early coordinated interventions from a range of partners working together with the adult, to assess needs and find solutions, can help prevent problems from developing to the point where intrusive statutory actions may be necessary.

Visit the link for a case study highlighting the challenges and complexities around working with people who self-neglect:
https://www.bsab.org/downloads/download/9/serious-case-reviews

Read the learning for the Safeguarding Adults Review for Stephen:
Stephen - Safeguarding Adults Reviews | Birmingham Safeguarding Adults Board (bsab.org)

Read the guidance when people who self-neglect are not engaging with services which was developed following a Serious Case Review:
https://www.bsab.org/downloads/download/19/guidance-where-the-individual-or-family-are-not-engaging-with-services

## What is self-neglect?

There is no universal definition of self-neglect. Self-neglect is a general term used to describe how an adult who has care and support needs may put their health, safety and/or well-being at risk.

Self-neglect can be challenging and complex for practitioners to address because of finding the right balance between respecting a persons' autonomy and fulfilling a duty to protect the adults' health and wellbeing.

Gibbons et al (2006)[5] defined self-neglect as "the inability (intentionally or non-intentionally) to maintain a socially and culturally acceptable standard of self-care with the potential for serious consequences to the health and wellbeing of those who self-neglect and perhaps to their community"

The Care Act 2014 Statutory Guidance[6] defines self-neglect as:
*"a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding".*

Social Care Institute for Excellence (SCIE)[7] describes self-neglect as:

- Lack of self-care to an extent that it threatens personal health and safety
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid harm as a result of self-neglect
- Failure to seek help or access services to meet health and social care needs
- Inability or unwillingness to manage one's personal affairs

Self-neglect can occur as a result of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment (e.g. learning disability or brain injury), religious or cultural beliefs or through personal choice. It can be triggered by trauma and significant life events. It can also be a personal or lifestyle choice. It is an issue that can affect people from all backgrounds.

## Self – neglect key characteristics

There are a number of indicators which, when combined, may indicate the presence of self-neglect. There is no clear point at which lifestyle patterns become self-neglect, and the term can apply to a wide range of behaviour and different degrees of self-neglect.
The following list is not exhaustive and should be considered in conjunction with the risk assessment and referral tool (Appendix 3) and all information within this document:

- Living in very unclean, sometimes verminous circumstances, such as living with a toilet completely blocked with faeces

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

[6] Care and support statutory guidance - GOV.UK (www.gov.uk)

[7] Social Care Institute for Excellence (SCIE) Self neglect pages

- Neglecting household maintenance, and therefore creating hazards within and surrounding the property
- Portraying alternative lifestyles which some may perceive or judge to be eccentric behaviour
- Obsessive hoarding
- Poor diet and nutrition. For example, evidenced by little or no food in the fridge, or what is there, being mouldy
- Declining or refusing prescribed medication and/or other community healthcare support
- Refusing to allow access to health and/or social care professionals in relation to personal hygiene and care
- Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity), housing services
- Repeated episodes of anti-social behaviour – either as a victim or source of risk
- Being unwilling to attend external appointments with professionals in social care, health or other organisations (such as housing)
- Very poor or lack of personal hygiene or personal hygiene resulting in poor healing or sores, long toenails, unkempt hair, uncared for facial hair, body odour, unclean clothing, unkempt appearance
- Social withdrawal or Isolation from family, friends, community support network; either of an individual or of a household or family unit
- Failure to take medication
- Repeated referrals to Environmental Health

It is important for practitioners to understand poor environmental and personal hygiene may not necessarily always be a result of self-neglect. It could arise from a cognitive impairment, poor eyesight, functional and financial constraints. In addition, many people, particularly older people who self-neglect, may lack the ability and/or confidence to come forward to ask for help; and may also lack the support of others who can advocate or speak for them. They may then refuse help or support when offered or receive services that do not actually adequately meet their needs.

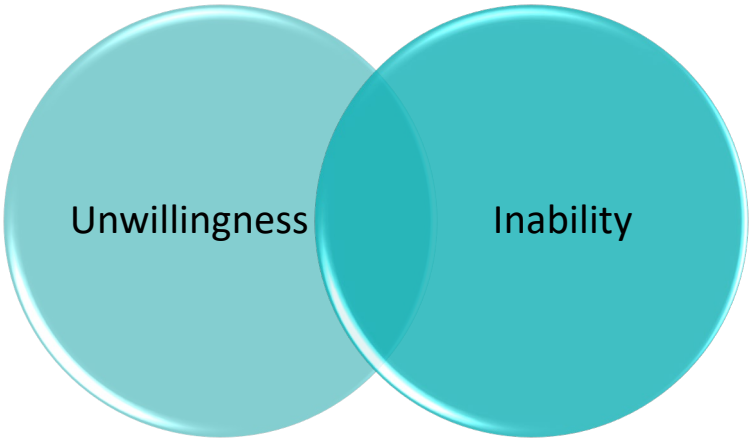
## Models of self-neglect

There is a consensus research on the main characteristics of self-neglect and the approach practitioners should take when working with people who are deemed to be self-neglecting. There is less consensus as to why people self-neglect.
Self-neglect is usually a symptom of other problems including:

- Deteriorating physical health
- Onset of depression or other mental health need
- Response to trauma
- Change in social networks or income
- Personal identity and philosophy

Self-neglect and hoarding has to be understood in the context of the individuals life experience.

Research in Practice for Adults (RiPFA) use the following diagram to show how self-neglect arises from an unwillingness or inability to care for oneself, or both.
It is interlinked where inability arises from the care and support needs of the individual.




The diagram above shows two blue circles, with unwillingness in the first circle and inability in the other one. The two circles overlap in the middle.

Braye et al (2014) identified six overarching themes in their research with people who self-neglect:

- Demotivation stemming from other factors;
- Other priorities;
- Different standards;
- Maintaining self-care;
- Uncertainty about reasons, and;
- Inability to self-care.

Health difficulties, homelessness, loss and social isolation were repeatedly cited as reasons why self-care had come to seem comparatively unimportant. This in turn could impact on self-image, further demotivating them and entrenching negative cognitions:
"I would sit here and not even have a wash. I got it in my head that I'm unimportant, so it doesn't matter what I look like or what I smell like."
Self-neglect had led some interviewees to fail to take steps to care for their health; the resulting deterioration or new diagnosis came as a shock that further worsened their tendencies to self-neglect."

Executive dysfunction – the inability to perform activities of daily living, even though the need for them may be understood, is seen as significant, and when this is accompanied by an inability to recognise unsafe living conditions, self-neglect may be the result.

The perceptions of people who neglect themselves have been less extensively researched. However, where they have, emerging themes are pride in self-sufficiency, connectedness to place and possessions and behaviour that attempts to

preserve continuity of identity and control. Traumatic histories and life-changing events are also often present in individuals' own accounts of their situation.

Differentiation between inability and unwillingness to care for oneself, and capacity to understand the consequences of one's actions, are crucial determinants of response.

Identification and intervention in potential situations of self-neglect is not dependent on any diagnoses of a physical or mental health condition, however hoarding is now recognised as a mental disorder by the Royal College of Psychiatrists.

## Hoarding

Sometimes, but not always, there are strong links between self-neglect and hoarding. Hoarding disorder was previously considered a form of Obsessive-Compulsive Disorder (OCD) but is now considered a standalone mental disorder. However, it can also be a symptom of other mental disorders. Hoarding disorder is distinct from the act of collecting and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice.

Hoarding is the excessive collection and retention of any material to the point that living space is sufficiently cluttered to preclude activities for what they are designed. Hoarding disorder is a persistent difficulty in discarding or parting with possessions because of a perceived need to save them.

A person with a hoarding disorder experiences distress at the thought of getting rid of the items. Excessive accumulation of items, regardless of actual value, occurs. The acquisition of, and failure to discard possessions which appears to be useless or of limited value (Frost & Gross,1993).

Compulsive hoarding is often considered a form of Obsessive-Compulsive Disorder (OCD) because between 18% and 42% of people with OCD experience some compulsion to hoard. However, compulsive hoarding can also affect people who do not have OCD.

Hoarding is now considered a standalone mental health disorder and is included in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) 2013. Hoarding can also be a symptom of other medical disorders.

Hoarding Disorder is distinct from the act of collecting and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice. The main difference between a hoarder and a collector is that people who hoard have strong emotional attachments to their objects which are well in excess of their real value. Hoarding does not favour a particular gender, age, ethnicity, socio-economic status, educational/occupational history or tenure type.

Further information about Hoarding can be found at: Hoarding disorder - NHS (www.nhs.uk) Also see **Appendix 1** for a photographic living environment assessment.

# Risk associated with Self-neglect

Perceptions vary about what constitutes intolerable risk or acceptable standards of risk. These vary among different people, including the adult at risk. It is important to gather information from a variety of sources before making shared multi-agency decisions about the level of risk where possible, with the adult at risk remaining central to the process. The following indicators of harm may be used to gauge the level of risk posed:

## Significant Harm

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

## Fire Risk

Hoarding can pose a significant risk to both the people living in the hoarded property and those living in adjoining properties as well as emergency services personnel. Where an affected property is identified, regardless of the rating on the Clutter Image Rating scale, occupants need to be advised of the increased risk and identify a safe exit route in addition to the need for smoke and carbon monoxide detection alarms.

Appropriate professional fire safety advice must be sought, and a multi-agency approach may be required to reduce risk. This will assist West Midlands Fire Service to respond appropriately, which may include a fire safety check as part of the multi-agency approach. Once the risks have been addressed, records must be updated.

Certain health treatments or provisions increase fire risk due to flammability, including oxygen, emollients, incontinence pads and airflow mattresses. The risk is highest for individuals who smoke.

# Key Agencies and their Roles

## Hospitals and Early Intervention Community Teams

Community based therapists and nursing staff are often the first people to observe hoarding and self-neglect related problems. These professionals can be key to identifying triggers and changes which are then fed into the multi-disciplinary team. Therapists who work in acute wards may identify self-neglect related behaviours when undertaking access visits or home visits to help inform the discharge planning process. Therapists can assess and report on how an adults' self-neglect or environment impacts on their overall ability to be safe at home and help determine the level of risk posed to the individual and others (family members, neighbours etc).

Discharge planning should commence as soon as possible to support good communication and effective multi-agency working to reduce risks following discharge.

If a patient is refusing medical treatment for their own sound reasons, the health care practitioner must make every effort to ensure that the person fully understands the risks of the refusal and continue supportive efforts to engage the person if appropriate.

## Adult Social Care Services

In the majority of circumstances, the Care Act 2014 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, the person has the right to make their own choices. However, the social care practitioner must ensure the person has fully understood the risk and likely consequences if they decline services.

Involvement with the person should not stop at this point and efforts should be made to engage the person in the management of risks and to form a relationship with them to do this.

If the person is assessed as not having the mental capacity to make the relevant decisions, care should be provided in line with “best interest” principles (s.4 MCA). If the Social Care Practitioner considers a proposed care package may lead to a Deprivation of Liberty (DoLS); consideration must also be given to whether it would be necessary to obtain authorisation under the Community DoLS procedure.
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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.

## Ambulance Services

Ambulance staff are called to people’s properties in emergency situations and often access parts of the property that other professionals may not ordinarily see. They are able to assess an individual’s living environment and physical health and often raise concerns with Adult Social Care Services and general practices. By its very nature, this is a brief observational assessment and may not give a holistic view.

## Domiciliary Care and Enablement

These services may be directly provided. Care agencies are commissioned by Adult Social Care Services, or self-funded by individuals to provide support to people in their own homes. Those providing the services have a role in both identifying people who self-neglect and hoard and in working with them.

## Environmental Health Services

Environmental Health Services have a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premises is materially affecting neighbouring premises.

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

## Housing

Under Part 1 of the Housing Act 2004, housing departments have powers to take enforcement action where there is any risk of harm to the health or safety of an actual or potential occupier of a dwelling or house of multiple occupation which arises from a deficiency in the dwelling or house of multiple occupation or in any building or land in the vicinity (whether the deficiency arises as a result of the construction of any building, an absence of maintenance or repair, or otherwise). The housing department can require access to residential premises in their district to assess if such a hazard exists. The duty to inspect the property is restricted to where there is an official complaint made either to the Justice of the Peace or local council. However, where there is evidence that there is imminent risk of serious harm to the health and safety of the occupier, the local authority has emergency power to serve a remedial action notice or emergency probation notice prohibiting the use of the property.

There are also powers to serve a deferred action notice and take emergency remedial action. There is no requirement that the property is owned by the local authority, nor is the capacity of the inhabitant relevant to the exercise of these powers. However, use of these powers in isolation will have limited effect on those who have persistent behaviours. The Housing Act powers cannot be used to remove hoarded items or address any health and safety problems that are the result of the owner’s actions.

## Children’s Services

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

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

## Mental Health Services

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

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

In some cases of chronic or persistent self-neglect, individuals who are reluctant to engage with Adult Social Care Services or other agencies may engage with primary health care services such as their GP, district nursing service etc. GPs and district nurses often carry out home visits to people with care and support needs and may be the first people to notice a change in the person's home environment. Alternatively, failure to keep health appointments or to comply with medication may indicate self-neglect. As well as raising alerts and providing information, primary health services can be very effective in forming a relationship with the person and in addressing underlying concerns.

Primary health services should monitor those individuals who are engaged with their service and show signs of significant self-neglect. 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, a multi-agency response will be required.

## Private de-cluttering companies

There are a number of private companies and other organisations that offer specialist deep cleaning, decluttering and garden clearance services. Their staff should be specially trained to understand the complexities of hoarding and how to respond appropriately in sensitive circumstances. This option should be considered as part of a co-ordinated multi-disciplinary response, in cases where hoarding is apparent.

## Private landlords/housing associations/registered social landlords

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

## Royal Society for the Prevention of Cruelty to Animal (RSPCA)

Animal hoarders own a high number of animals for which they may be unable to provide adequate standards of nutrition, sanitation, shelter and veterinary care. Hoarders often care about their animals deeply but may not see or understand that the living conditions could result in animal neglect. This neglect can involve cramped, poor living conditions and in extreme cases, result in starvation, illness or death.

Animal hoarders are often in denial about their inability to provide appropriate care for their animals and typically believe that no-one else can care for their animals like they do. Sensitivity is vital as animal hoarders often hold the belief that if they seek help, or allow external intervention, their animals will be euthanised or taken away from them. Professionals can contact the RSPCA who can offer advice and assistance to improve animal welfare, including giving people time to make improvements to their standards of care. Where assistance is declined, or in extreme cases of neglect, the RSPCA can consider prosecution under laws such as the Animal Welfare Act 2006.

## West Midlands Fire Service (WMFS)

WMFS is best placed to work with individuals to assess and address fire risk and to develop strategies to minimise significant harm caused by potential fire risks in the home.

WMFS will also raise alerts when called to or visiting addresses where significant risk is identified or where homes have damage because of a fire and the individual continues to live at that address.

WMFS will carry out Safe and Well visits and offer advice to individuals assuring them of the necessity and principles of fire prevention in the home. The WMFS have on occasion managed to enter a home for a referral where home access is refused to other services due to the trusted nature of their work.

## West Midlands Police (WMP)

Each agency has responsibility to complete a welfare check where they are the main agency involved. Where, however, a crime is suspected or the person is missing,

despite attempts to find them/make contact, the concern with regard to immediate risk to life should be raised with the police.

## Utility companies/building and maintenance workers

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

## Support available in the community

There is a wide range of support and guidance available in the community. One of the difficulties of providing a list of such services is that it would not be exhaustive and would need regular updates and amendments to remain accurate and of value to practitioners.

An advice guide, community directory and marketplace can be found on the following website to which links are provided below:

Birmingham Connect to Support

The Waiting Room

Route2Wellbeing

## Key Legislation

While it is preferable to work with the consent of the adult, a balance has to be struck between negotiated and imposed interventions. Sometimes an agency's' legal duties will require it to impose an approach upon an adult (for example environmental health enforcement action to protect others).

There are a range of powers and duties that can or must be used in specific circumstances and by a variety of agencies.

Sometimes the possibility of imposed enforcement or other legal action being taken can serve; along with negotiated approaches to provide motivation to the adult to take action themselves to bring about change.

| | |
|---|---|
| • Animal Welfare Act 2006<br>• Anti-Social Behaviour 2003<br>• Care Act 2014<br>• Crime and Policing Act 2014<br>• Environment Act 1995<br>• Equality Act 2010<br>• Fire and Rescue Services Act 2004<br>• Homeless Reduction Act 2017<br>• Housing Act 1985, 1988 (and 1996), 2004<br>• Landlords - Housing Act 1985 & 1988<br>• Mental Capacity Act 2005<br>• Mental Health Act 1983<br>• Misuse of Drugs Act 1971 | • 6Public Health Act 1984 (and HSCA 2008)<br>• Human Rights Act 1998<br>• article 2 rights to life<br>• article 3 rights to be protected from inhuman & degrading treatment<br>• article 5 right to liberty and security<br>• article 8 right to respect for private and family life<br>• article 10 right to Freedom of Expression (underpins MSP)<br>• article 14 right not to be discriminated against (underpins equality & empowerment) |

**For more information on Key Legislation go to Appendix 3**

## Making Safeguarding Personal

The principles of Making Safeguarding Personal (MSP) should apply to work with people who are self-neglecting.

Safeguarding should be person-led, and outcome focused, engaging the adult at risk in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. Most importantly it is about listening and providing the options that support individuals to help themselves.

Whilst every effort must be made to work with adults experiencing abuse within the present legal framework, there will be some occasions on which adults at risk will choose to remain in dangerous situations. It may be that even after careful scrutiny

of the legal framework, professionals will conclude that they have no power to gain access to support or intervene positively because the adult at risk refuses all help or wants to terminate contact with the professionals. In these extremely difficult circumstances, professionals will be expected to continue to exercise as much vigilance as possible.

## Mental Capacity and Self-Neglect

The Mental Capacity Act (MCA) 2005[8] provides a statutory framework for people who lack the capacity to make decisions by themselves. The Act has five statutory principles:

- A person must be assumed to have capacity unless it is established that they lack capacity
- A person is not to be treated as unable to make a decision unless all practicable steps have been taken without success
- A person is not to be treated as unable to make a decision merely because he/she makes an unwise decision
- An act done, or decision made under this act for, or on behalf of, a person who lacks capacity must be done, or made in his or her best interests
- Before the act is done, or the decision is made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

When concerns about self-neglect are raised, there is a need to be clear about the person's mental capacity in respect to the key decisions in relation to the proposed intervention. Any intervention must be lawful, necessary and pursue a legitimate aim. If there are any doubts about the person's mental capacity, especially regarding their ability to 'choose' their living conditions or refuse support, then where possible a mental capacity assessment should be undertaken. In extreme cases of self-neglect and/or hoarding behaviour, the very nature of the environment should lead professionals to question whether the client has capacity to consent to the proposed action or intervention and trigger an assessment of that person's mental capacity.

The professional responsible for undertaking the capacity assessment will be the professional who is proposing the specific intervention or action and is referred to as the 'decision maker'. Although the decision maker may need to seek support from other professionals in the multidisciplinary team, they are responsible for making the final decision about a person's capacity.

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

Strong emphasis needs to be placed by practitioners on the importance of interagency communication, collaboration and the sharing of risk. The autonomy of an adult with capacity should be respected including their right to make what others

[8] Mental Capacity Act 2005

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.

Capacity assessments may not take full account of the complex nature of capacity. Self-neglect and adult safeguarding: findings from research, https://www.scie.org.uk/publications/reports/report46.asp 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.

It is good practice to consider or assess whether the person has the capacity to act on a decision that they have made (executive capacity). **See Appendix 2** for guidance on assessing executive capacity in relation to self-care.

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

It may be necessary for the organisation to seek legal advice in order to refer to the Court of Protection (COP) to make the best interest decision.

## Advocacy and Support

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

## Consent and Choice

Where an adult has mental capacity in relation to the relevant decisions, any proposed intervention or action must be with the person’s consent, except in the public interest where other people are affected or circumstances where a local authority or agency exercises their statutory duties or powers. (Appendix 2 Legislation)

If the individual refuses to participate or engage with agencies or provide access, information obtained from a range of other sources may 'hold the key' to achieving access or to determining levels of risk.

Where a self-neglecting individual chooses not to accept a positive change to their circumstances, professionals working with them have a responsibility to explore that choice through respectful challenge and tactfully expressing concerned curiosity. Professionals need to explore the extent to which "choice" is in fact chosen, taking into account potential contributory factors to the individual's situation which may shed light on their resistance. Examples could be undue influence by a third party being the reason that an individual declines intervention, a deep-seated fear of going into a hospital, or where the fear of losing one's pet(s) stops someone from accepting intervention.

The Care and Support statutory guidance (Care Act 2014) states that it is crucial to work alongside the person, understanding how their past experiences influence current behaviour. This is often referred to as trauma informed.

In the most high-risk, intractable cases where an adult has been identified as potentially self-neglecting, is refusing support, and in doing so is placing themselves or others at risk of significant harm, a referral should be made as outlined in the self-neglect pathway on page 27.

An adult at risk with no disturbance or impairment in the functioning of the mind may be entitled to the protection of the Inherent Jurisdiction[9] of the High Court if he/she is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other factors such as mental disorder or mental illness. They may also be reasonably believed to be, for some reason, deprived of the capacity to make the relevant decision, or disabled from making or expressing a free choice or genuine consent.

## Record keeping, information sharing and confidentiality

Sharing information is essential to safeguard adults who may be at risk of abuse or neglect. In safeguarding adult reviews across the country, failure to share information has often been identified as a significant contributory factor when things have gone wrong. The duty to share information can be as important as the duty to protect confidentiality. Workers should therefore have the confidence to share information in the best interests of the people they support, within their own organisational policy guidelines and local protocols.

Information should always be shared with consent wherever possible; but a person's right to confidentiality is not absolute - it may be overridden where there is evidence that sharing information is necessary in the public interest, is required by law, is necessary to protect personal safety, or where there are other legal reasons to do so.

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

In some instances, the individual will not have the capacity to consent to disclosure of personal information relating to them. Where this is the case any disclosure of information needs to be considered against the conditions set out in the Data Protection Act and must be in their Best Interests as per the Mental Capacity Act.

Decisions about what information is shared and with whom should be taken on a case-by-case basis. But whether or not information is shared, with or without the adult's consent, the information should be:

- Necessary for the purpose for which it is being shared
- Shared only with those who have a need for it
- Accurate and up to date
- Shared in a timely fashion
- Shared accurately
- Shared securely

The identified lead agency coordinates information gathering and determines the most appropriate actions to address the concerns. The key principles of information sharing and confidentiality are laid out in the Care Act Guidance section (14.151) which outlines the importance of obtaining informed consent, but if this is not possible and other adults are at risk of abuse or neglect, it may be necessary to override the requirement; and it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other adults may be at risk.

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

In certain circumstances, it will be necessary to exchange or disclose personal information which will need to be in accordance with the law on confidentiality and the Data Protection Act 1998 where this applies. The Home Office and the Office of the Information Commissioner have issued general guidance on the preparation and use of information. Information sharing within these procedures should be in line with the principle of information sharing contained in the Care Act Guidance[10] which will ensure information gathered at this stage is to inform:

- Decision making regarding whether further multi-agency information sharing is required;
- The completion of an initial Risk Assessment and ensuring any urgent actions are carried out.

E.g. Contacting emergency services, West Midlands Fire and Rescue Service, completing safety checks and where necessary seeking urgent medical intervention.

[10] The Care and Support Statutory Guidance (Issued under the Care Act 2014) Department of Health 2014 updated August 2021

Where there are concerns about the individual's ability to make informed decisions due to a mental disorder or ill health, consideration must be given to carrying out a Mental Capacity Assessment in relation to any decisions they may need to be made regarding their safety or the safety of others.

Information gathering will aim to build an understanding of:

- Any previous successful engagement with the individual.
- Approaches that appeared to disengage the individual.
- An insight into the individual's wishes and feelings including previous wishes or life experiences that may inform a Best Interests decision.
- The views of anyone who has or has had contact with the individual including relatives and neighbours.

When working with individuals who may be reluctant to communicate, the risk of miscommunication between agencies is greater than usual. It is important to ensure that all relevant information is available to those who undertake any assessments. Use information available on any previous successful engagement with the individual to facilitate direct communication with the individual if possible. This should be appropriate to the persons' needs such as making use of interpreters for those who speak English as a second language or British Sign Language signers when required. This should ensure that the assessment will inform any actions to be taken and include the wishes and feelings of the individual. The following key principles must be applied:

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

They will not be overridden other than where it is clear that the consequence would be seriously detrimental to their, or another person's health and wellbeing and where it is lawful to do so with the least restrictive option. The case record will include a complete and up to date summary record of the efforts and actions taken by all other agencies involved. Individual agencies will also need to keep their own records of their specific involvement. Accurate records that demonstrate adherence to this document and locally agreed case recording Policy and Operational Guidance must be maintained.

## Duty of Care

Safeguarding adults at risk of harm often creates a tension for professionals between promoting an adult's autonomy and their duty to try to protect them from harm. All professionals working with adults at risk should be aware of their duty of care in cases of self-neglect or hoarding, even when the individual has been assessed to have mental capacity in relation to the relevant decisions. Respect for autonomy and self-determination must always be balanced against the duty of care and promotion of dignity and wellbeing. The duty of care can be summarised as the obligation to exercise a level of care towards an individual, as is reasonable in all circumstances, by taking into account the potential harm that may reasonably be caused to thatn

individual or their property. It means supporting an individual to achieve their chosen outcomes while maximising safety as far as practicable.

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

Respect for autonomy does not mean abandonment. Working with self-neglecting adults often requires persistence over a long period rather than time-limited involvement.
NB This policy requires that all cases of self-neglect and hoarding assessed as high risk will not be closed prior to multi-agency agreement and a clear record of all protective measures and shared decision making should be kept.

## Approaches to Service Refusal

Due to the commonly compulsive nature of self-neglect and hoarding, professionals should not have an unquestioning acceptance of an individual's assurances that they do not need support or that they will implement plans to reduce risk, such as clearing the house. New strategies should be considered in the face of mounting evidence that the adult is not following through with those plans.

Where the level of risk remains high, professionals should remain proactively involved despite the difficulties and challenges of engagement. Professionals can focus on small improvements and changes that the person accepts while continuing to negotiate on larger, more contested issues. The focus should remain on building a relationship of trust through which consensual solutions can be offered.

As mentioned elsewhere in this operational guidance, it is good practice for professionals to recognise the root causes, triggers and reasons why the individual self-neglects or hoards. Only then can intervention be tailored appropriately.

Legal advice should be sought where required, to ensure the correct application of applicable legislation (Appendix 3). Legal processes should not stop the response to immediate risk and to making ongoing timely decisions.

Any concerns relating to the individual's mental health should be recognised and communicated to the GP and where relevant the Birmingham Mental Health Trust and the appropriate action taken. For further information see Appendix 5 - Practice Guidance

## Safeguarding Children

Safeguarding Children is about protection from maltreatment, preventing impairment of their health or development and ensuring that they are growing up in circumstances consistent with the provision of safe and effective care. A child who

resides with a carer who self-neglects can put a child at risk by affecting their development and in some cases, leading to the neglect of the child.

When addressing concerns of self-neglect and hoarding, professionals should determine whether there are children in the household who may need support or who are at risk. Where there are any child protection or child in need concerns, these must be referred to Birmingham Children's Trust Children's Advice & Support Service (CASS) as a matter of urgency;

**Monday to Thursday: 8:45am to 5:15pm**
**Friday: 8:45am to 4:15pm**
**Telephone: 0121 303 1888**

**Emergency out-of-hours number:**
**Telephone: 0121 675 4806**

**Online referral:**
https://www.birminghamchildrenstrust.co.uk/report-a-concern

# Process

# Self- neglect Pathway flowchart

**Key**
**ASC – Adult Social Care**

**Concern that an Adult with Care and Support needs is at risk of self - neglect**

In **Emergency** consider relevant support i.e: Police, Ambulance Fire etc

Professional/Agency speaks to person if appropriate and uses Multi-agency Self-neglect Risk Assessment to assist with considering level of risk.
If Mental Capacity is in doubt complete a mental capacity assessment and progress in best interests

**Yellow (low risk)** in all domains. Continue with your agency intervention as appropriate and continue to monitor changes in risk indicators. Offer advice, support and signpost as appropriate. **Hold multi agency meeting if needed.**

Consider review 6 weekly to monitor level

**NB: If the Multi-Disciplinary meeting determines higher or lower risk that when first referred, change to and follow appropriate pathway.**

**Orange (moderate risk) but NO red (high risk)** in any domain and no safeguarding concerns identified. Complete the Multi-agency Self-neglect Risk Assessment and email a copy to. CSAdultSocialCare@birmingham.gov.uk. Referring for support from ASC.

**Lead Agency** holds a multi-agency meeting with the person at the centre and all relevant parties (and/or carers) to determine levels of risk and agree self-neglect support plan.

Review 6 weekly to monitor level of risk and continue with multi agency response

Red (high/Critical risk) in any domain.
Complete self-neglect risk assessment and and Email it to: CSAdultSocialCare@birmingham.gov.uk. Telephone: 0121 303 1234

If **No** Safeguarding concerns are Identified ASC will confirm a **Lead Agency,** a multi-agency meeting with the person at the centre and all relevant parties (and/or carers) to determine levels of risk and agree self-neglect support plan the lead agency based on a case by case basis.

Review 6 weekly to monitor level of risk and continue with multi agency response

If there **are adult safeguarding concerns** identified, the concern will be referred to adult safeguarding team for S42 enquiry

Follow Joint Multi-agency Safeguarding Adults Policy and Procedure

If High risk continues for an Adult with Mental Capacity or increases following support, or multi-agency engagement is lacking, refer to a Risk Escalation Conference Email, risk assessment and plan as part of the referral to RiskEscalationConference@birmingham.gov.uk

## Self-neglect risk assessment

An assessment using the **M*ulti-Agency Self-neglect and Hoarding Risk Assessment Guidance Tool*** (Appendix 4) should be carried out by the most appropriate agency depending on the nature of the concerns. In most instances, this would be the referring agency. For example, where an individual is severely neglecting their health, the most appropriate lead agency may be a health partner such as District Nursing or Practice Surgery. Alternatively, Housing services or Environmental Health may be the most appropriate agencies to address hoarding and infestation while Adult Social Care would intervene where individuals grossly neglect their personal care and other daily living activities. Assessments can also be carried out jointly on an interagency basis. This must be informed by the views of individuals themselves, wherever possible and practicable as well as by the views of carers and/or relatives where appropriate to consider level of risk.

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

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

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

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

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

It is **NOT** enough or appropriate to solely write a letter offering intervention or asking the adult to make contact. People who self-neglect or hoard are unlikely to respond to written correspondence. Use a method of communication, which is best suited to the individual taking into account any and all of their communication needs.

## Self-neglect pathway

An assessment using the self-neglect risk assessment and referral tool (Appendix 4) should be used and informed by the appropriate pathway for Adults with Care and Support Needs who are self-neglecting.

If the screening scores yellow (low risk) in all domains, the referring agency should continue with intervention as appropriate and continue to monitor for changes in risk indicators. The agency may still lead and hold multi-agency meeting if they feel it would help with supporting the individual.

If the screening scores orange (medium risk) but no red (high risk) in any domain then the lead agency working with the person for whom there are concerns will ensure a person led assessment and comprehensive risk assessment is carried out. Once the assessments are completed to ensure that information and appropriate support from Adult Social Care is requested. The form should be emailed to csadultsocialcare@birmingham.gov.uk as a referral for support from Adult Social Care.

Adult Social Care will review the referral and provide the appropriate assessment or support

A lead agency should hold responsibility. A vehicle for coordinating this work will be a multi-agency self-neglect meeting with all relevant parties (and/or carers). There is no prescriptive list of which organisations should be involved. Involvement will be determined by the person's individual circumstances. The meeting will determine levels of risk and agree a self-neglect support plan. Where there are disagreements about any aspects of the plan, these should be resolved by consultation with a senior manager from the lead agency. **Any agency can hold a multi-agency meeting.**

Self-neglect support plans will be reviewed 6 weekly, to monitor level of risk and continue with multi-agency response.

If the screening scores red (high risk) in any domain then the lead agency working with the person for whom there are concerns will ensure a person led assessment and comprehensive risk assessment is carried out. Once the assessments is completed to ensure that information and appropriate support from ASC is requested from Adult Social Care via Birmingham City Council Contact Centre CSAdultSocialCare@Birmingham.gov.uk, tel: 0121 303 1234.

Adult Social Care (ASC) may speak to the referrer to gather more information and to determine if any adult safeguarding concerns are identified. **IF** adult safeguarding concerns are identified the concern will be referred to the City-Wide Adult Safeguarding Team (if no other ASC team is involved at the point of referral) or to the responsible constituency/specialist team for S42 enquiry and the Joint Multi-agency Safeguarding Adults Policy & Procedure will be followed.

If the multi-disciplinary meeting determines higher or lower risk than when first referred, change to and follow the appropriate pathway.

If no safeguarding concerns are identified ASC will confirm a Lead Agency, a multi-agency meeting with the person at the centre and all relevant parties (and/or carers) to determine levels of risk and agree self-neglect support plan.

If High risk continues for an Adult with Mental Capacity or increases following support, or multi-agency engagement is lacking, refer to a Risk Escalation Conference (REC).

## Multi–disciplinary Self–neglect Meeting

The multi-disciplinary meeting is an integral element of the self-neglect pathway. A multi-disciplinary meeting will be required when the risk has been identified as moderate or high/critical.

The principles for arranging a multidisciplinary meeting are to consider:

- Capacity and consent
- Indications of mental health issues
- The level of risk to the adult's physical health
- The level of risk to their overall wellbeing
- Risk of tenancy or mortgage breach
- Effects on other people's health and wellbeing
- Serious risk of fire
- Serious environmental risk e.g. destruction or partial destruction of accommodation
- Support planning

## Suggested membership (this list is not exhaustive):

- Adult at risk and their representative(s)/advocate(s)
- West Midlands Fire and Rescue Service
- West Midlands Ambulance Service
- Primary, Acute and Community Health Care Services
- Hospital Trusts
- Adult Social Care Services
- Children's Services
- Environmental Health
- West Midlands Police
- Housing
- Care Agencies
- Community/Voluntary Sector/ Community Networks
- Own organisation legal services

## Guidance for a multi-disciplinary meeting:

- The lead agency is responsible for convening the meeting and making arrangements such as venue, chairing and minute taking and will make arrangements to involve the individual concerned using the most appropriate agency to support them.

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

Outcomes of the meeting will include the following:

- An action plan - including plans and escalation process
- Agreement of monitoring and review arrangements and who will do this
- An agreement of a communication plan with the individual or other key people involved
- An agreement regarding which agency(s) will take the lead in the case, and
- Agreement of any trigger points that will determine the need for an urgent multi-agency review meeting or referral to the Risk Escalation Conference (REC).

The person at the centre of the concern will be informed, irrespective of the level of their involvement to date, using a method of communication which is best suited to the individual taking into account any and all of their communication needs. It will set out what support is being offered and/or is available and providing an explanation. Should this support be declined, it is important that the individual is aware, should they change their mind about the need for support, then contacting the relevant agency at any time in the future will trigger a reassessment. Careful consideration will be given to how this written record will be given; and where possible explained to the individual.

The multi-disciplinary meeting may decide to reconvene a further meeting for the purpose of revisiting the original assessments, particularly in relation to the individual's current functioning, risk assessments and known or potential rates of improvement or deterioration in:

- The individual,
- Their environment, or
- In the capabilities of their support system.

Decision specific mental capacity assessments will have been reviewed and are shared at the meeting. Discussion will need to focus on contingency planning based upon the identified risk(s).

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

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

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

If agencies are unable to implement support or reduce risk significantly, the reasons for this will be fully recorded and maintained on the individual's file, with a full record of the efforts and actions taken. In these circumstances, legal advice should be considered on a case by case basis.

## Self-Neglect Risk Escalation Conference

The Risk Escalation Conference (REC) provides a framework for Birmingham Safeguarding Adults Board (BSAB) partner agencies, working with people who have care and support needs, who have the mental capacity to make unwise choices and who are at risk of serious harm or death through self-neglect as a result of those choices.

The REC is collaboratively owned by participating agencies operating in Birmingham. It will be administered on behalf of the participating agencies by Birmingham City Council Adult Social Care and chaired by a nominated senior officer.

The REC will consider case presentations for situations which have already been considered within partner agencies risk assessment processes and/or the self-neglect multi-disciplinary meeting and significant risk remains. Reasons for referring to the Risk Escalation Conference may include:

- Lack of progress identified at the multi-disciplinary 6 weeks review meeting

- Public safety remains a concern
- Lack of partnership engagement
- Disagreement on deployment of resources

Partner agencies will remain responsible for delivering services to the people with whom they are in contact. This is not a means of handing over responsibility or closing down a case.

To access the Risk Escalation Conference, email the risk assessment and plan as part of the referral to RiskEscalationConference@birmingham.gov.uk

See Appendix 5 for the REC Terms of Reference

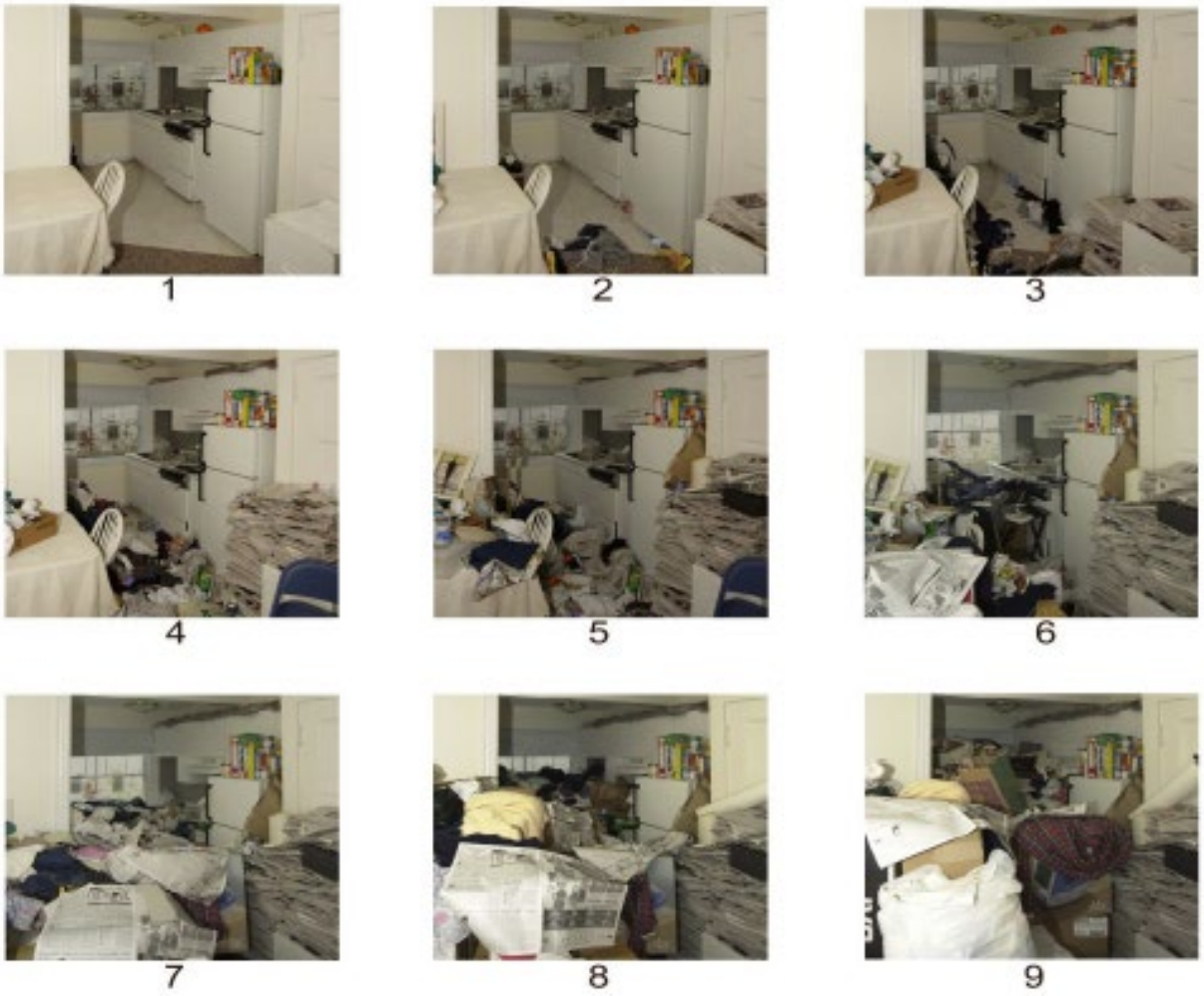
# Appendices

# Appendix 1 - Living Environment Assessment

*Score 1-9 for each room using the clutter scale illustrations as a guide*

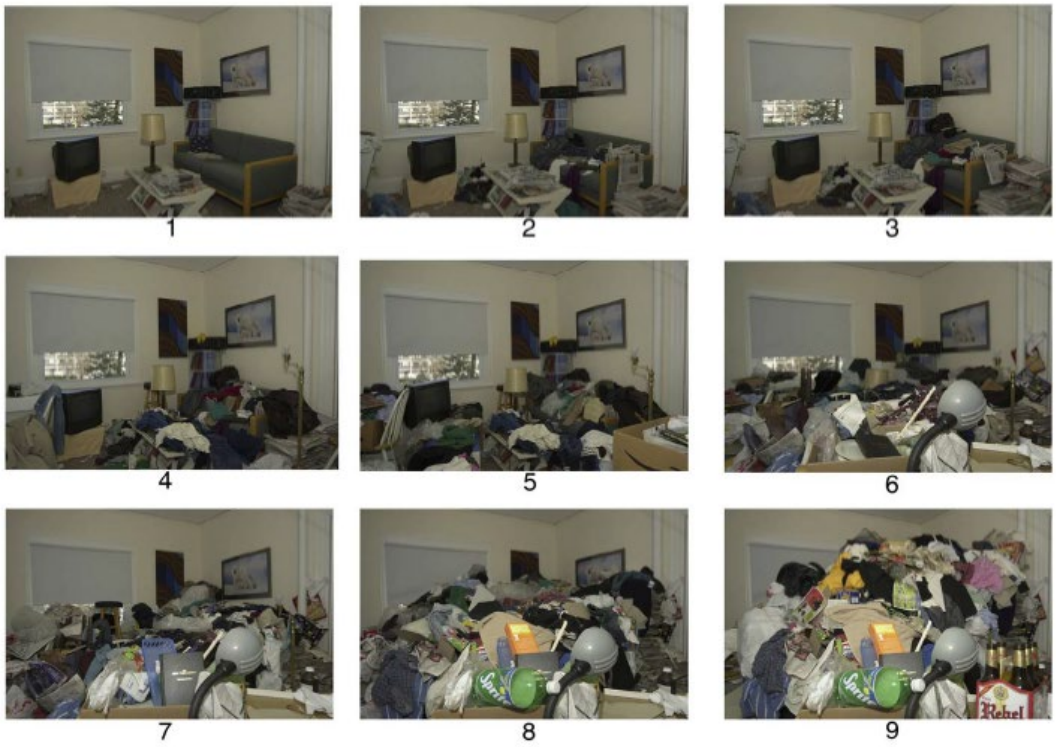
| | | | | | |
|---|---|---|---|---|---|
| Bedroom 1 | | Hallway | | Separate toilet | |
| Bedroom 2 | | Kitchen | | Lounge | |
| Bedroom 3 | | Bathroom | | Dining room | |
| Other areas | | | | | |

## Kitchen



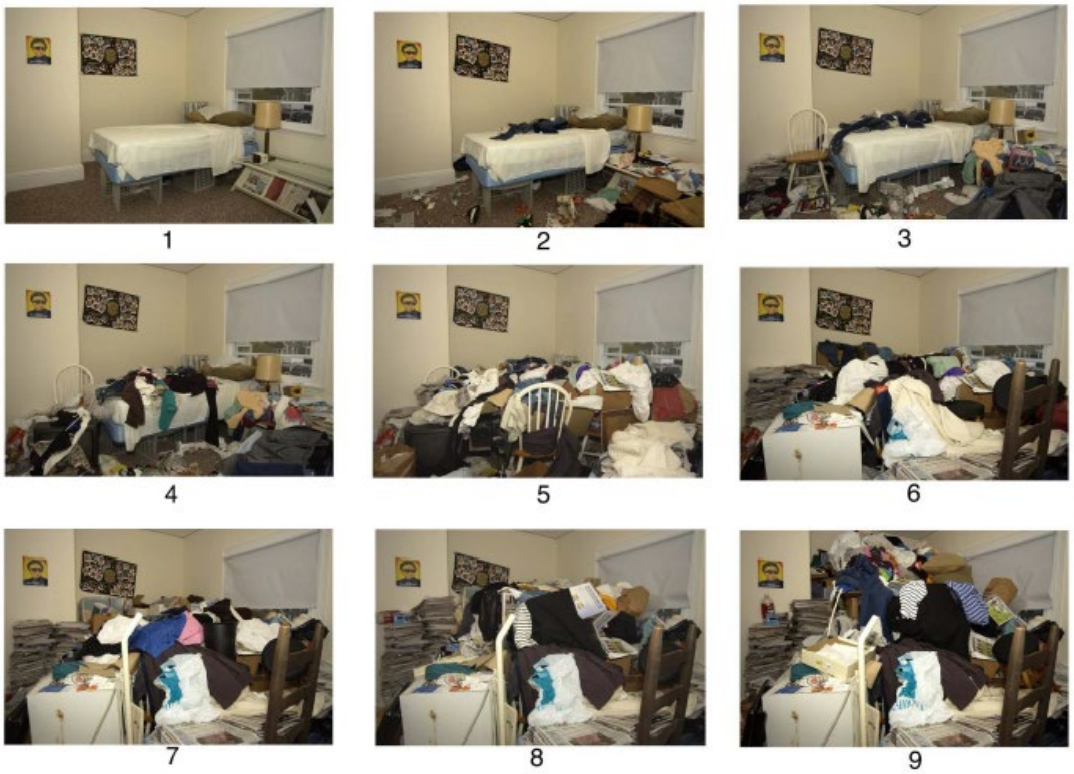

The above pictures show 9 varying degrees of clutter in a kitchen, on a sliding scale from 1-9, with 1 being the least amount and 9 being the worst.

## Living Room




The above pictures show 9 varying degrees of clutter in a living room, on a sliding scale from 1-9, with 1 being the least amount and 9 being the worst.

## Bedroom




The above pictures show 9 varying degrees of clutter in a bedroom, on a sliding scale from 1-9, with 1 being the least amount and 9 being the worst.

# Appendix 2 – Guidance on assessing Mental Capacity in connection to Self-neglect

When concerns about self-neglect are raised, there is a need to be clear about the person's mental capacity in respect to the key decisions in relation to the proposed intervention. Any intervention must be lawful, necessary and pursue a legitimate aim.

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

> ***The professional responsible for undertaking the capacity assessment will be the professional who is proposing the specific intervention or action and is referred to as the 'decision maker'. Although the decision maker may need to seek support from other professionals in the multidisciplinary team, they are responsible for making the final decision about a person's capacity.***

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

Strong emphasis needs to be placed by practitioners on the importance of interagency 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.

Capacity assessments may not take full account of the complex nature of capacity. Self-neglect and adult safeguarding: findings from research, SCIE Report 46: Self-neglect and adult safeguarding: findings from research 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.

**NB:** It is good practice to consider or assess whether the person has the capacity to act on a decision that they have made (executive capacity). See Appendix 2 for guidance on assessing executive capacity in relation to self- care.

Any capacity assessment carried out in relation to self-neglect and or hoarding behaviour must be time and decision specific and relate to a specific intervention or action. If the person is assessed as not having capacity to make decisions in relation to their self-neglect, then any decisions should be made following the best interests process, which includes taking into account the person's views and taking the least restrictive action. Due to the complexity of such cases, there must be a Best Interests Meeting, chaired by a manager or other senior or experienced professional from the appropriate organisation

and appropriately recorded in formal minutes. Additionally, consideration should be given as to whether an Independent Mental Capacity Advocate (IMCA) should be instructed. Fluctuating capacity should be considered and evidenced.

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

## Appendix 3 - Possible legal interventions

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| Birmingham City Council Environmental Health | **Power of entry/ Warrant:** **Public Health Act 1936 S.287** | Gain entry for examination/ execution of necessary work required under Public Health Act. Police attendance required for forced entry<br><br>Non-engagement of person. To gain entry for examination/execution of necessary work (all tenure including Leaseholders/Freeholders). In practise this is used as a last resort unless there is a risk to public health and/or a statutory nuisance (Environmental Protection Act 1990). However, all steps need to be taken to try to enter the premises; and a warrant will only be sought after a number of attempts and/or risk is imminent. |
| Birmingham City Council Environmental Health | **Enforcement Notice:** **Public Health Act 1936 S.83** | **Power to cleanse premises which are filthy or verminous.** Notice requires person served to comply. Failure to do so can lead to Council clearing out a property which is filthy or verminous and recovering expenses that were reasonably incurred.<br><br>Filthy or unwholesome condition of premises. Works undertaken to remove those items which are filthy or verminous where there is a public health risk to the occupier or neighbouring properties.<br><br>(All tenure including Leaseholders/ Freeholders/Empty properties). This process can be traumatic for the occupier and should only be considered in exceptional circumstances when all other informal and supportive efforts have been exhausted. |
| Birmingham City Council Environmental Health | Power to cleanse: **Public Health Act 1936 S.84** | Power to cleanse filthy or verminous articles within a dwelling. No provision to recover costs.<br><br>Typically used where a small number of filthy or verminous items are to be removed from one room of a property. Where a large number of items or several rooms are in filthy or verminous condition S.83 (Notice) is used instead. |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| Birmingham City Council Environmental Health | **Public Health (Control of Disease) Act 1984** | A justice of peace may make order under this section<br>Power to order health measures in relation to the person |
| Birmingham City Council Environmental Health | **Prevention of Damage by Pests Act 1949 Section 4** | The Local Authority (LA) has a duty to ensure all land within its area is free from rats and mice. Legal power is used where land is open to air, for example large amounts of rubbish in a garden which may attract pests. |
| Birmingham City Council Environmental Health | **Environmental Protection Act 1990 S.79(1)** | LA Power to require abatement of a statutory nuisance which includes:<br>(e) (e) any accumulation or deposit which is prejudicial to health or a nuisance.<br>(f) any animal kept in such a place or manner as to be prejudicial to health or a nuisance.<br>Power of entry and recovery of costs.<br><br>Power of entry and recovery of costs.<br><br>A nuisance is something which affects a person(s) at another property.<br><br>Prejudicial to health means injurious or likely to cause injury to health. |
| West Midlands Police | **Power of Entry Police and Criminal Evidence Act 1984 s17** | Person inside the property is not responding to outside contact and there is evidence of danger.<br><br>Information that someone was inside the premises was ill or injured and the Police would need to gain entry to save life and limb. |
| West Midlands Police, Housing Providers or BCC | **Anti-social Behaviour, Crime and Policing Act 2014**<br>See also statutory guidance (Home Office 2014) | Powers exist to address self- neglectful behaviour constituting severe nuisance and annoyance to others. |
| West Midlands Fire Service | **Powers of Entry – The Regulatory Reform (Fire Safety) Order 2005 Article 27(1)** | If any issues encroach on common areas (i.e. properties with shared access/areas, e.g. flats/HMOs? Write abbreviations in full. Not applicable to one family occupancy houses) of premises that WMFS believe comes under the Fire Safety Order, by virtue of the Order WMFS can act by inspecting the premises. |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| Birmingham City Council Housing | **Anti-social Behaviour, Crime and Policing Act 2014**<br>**Civil Injunction** | A Civil Injunction can be obtained from the County Court if the Court is satisfied that the person against whom the injunction is sought has engaged or threatens to engage in anti-social behaviour, and the Court considers it just and convenient to grant the injunction for the purpose of preventing the person from engaging in anti-social behaviour.<br>For the Court to grant an injunction, it must be satisfied both that ASB has occurred or is threatened AND that it is just and convenient to grant the injunction.<br><br>Conduct by the tenant which has caused, or is likely to cause, harassment, alarm or distress to any person; or is capable of causing nuisance or annoyance to a person in relation to the tenant's occupation of residential premises; or is capable of causing housing- related nuisance or annoyance to any person. "Housing-related" means directly or indirectly relating to the housing management functions of a housing provider or a local authority.<br><br>There are also powers within the Act to give the Court the ability to require the tenant to take certain actions. The aim of these "positive requirements" is to encourage the tenant to cooperate with a support service to address the underlying issues related to their behaviour. |
| Birmingham City Council Housing | **Anti-social Behaviour, Crime and Policing Act 2014**<br>**Premises Closure Order** | A Local Authority can apply to a Magistrates' Court for Premises Closure Order.<br>The magistrates' court may make an order if satisfied that:<br>• The occupant has caused disorderly, offensive or criminal behaviour on the premises, or the use of the premises is likely to result in serious nuisance to the public, or there has been disorder near the premises because of the way the premises have been used· and'<br>• An order is necessary to prevent the occurrence of such behaviour, disorder or nuisance. |
| Birmingham City Council Housing | **Housing Act 1985 (secure tenancies) or Housing Act 1988 (assured tenancies)** | The landlord has the right of entry to the property having provided at least 24 hours' notice to: inspect the premises and their state of repair.<br>As a last resort in severe cases and having already tried other options first to enable tenancy sustainment, a landlord can take action for possession of the property for breach of tenancy agreement, where a tenant fails to comply with the obligation to maintain the property and its environment to a reasonable standard. |
| Birmingham City Council Housing | **Housing Act 1985** | Ground 1: breach of tenancy<br>Ground 2: anti-social behaviour<br>Ground 3: waste/neglect of the property<br>Ground 4: deterioration of furniture |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| | **Possession Action Schedule 2 (for secure tenancies)** | Section 84A: mandatory ground for possession for breach of anti-social behaviour injunction<br>Ground 7A: mandatory ground for possession for breach of anti-social behaviour injunction<br>Ground 12: breach of tenancy<br>Ground 13: waste/neglect of property<br>Ground 14: anti-social behaviour<br>Ground 15: deterioration of furniture |
| Birmingham City Council Housing | **Housing Act 1985 Demotion order** | A County Court can make a Demotion Order, converting a secure tenancy into a Demoted Tenancy for a period of 12 months. The Court can make a Demotion Order if satisfied that the tenant has engaged in anti-social behaviour and that it is reasonable to make a Demotion Order. |
| Birmingham City Council Housing | **Housing Act 2004** | Allows enforcement action where either a category 1 or 2 hazard exists in any dwelling or land posing a risk of harm to the health or safety to actual or potential occupiers. Powers include serving a hazard awareness notice, an improvement notice, a prohibition order or in the case of a category 1 hazard - taking emergency remedial action. |
| Birmingham City Council (Adult Social Care and Health | **Care Act 2014 (Section 9 Needs Assessment)** | Needs or carers assessments must be carried out where it appears to a local authority that an adult may have needs for care and support. The assessment should be appropriate, proportionate, person-centred and ensure a focus on the duty to promote wellbeing.<br><br>• Where the adult at risk of self-neglect lacks mental capacity and carrying out a needs assessment would be in the adult's best interests, the local authority is required to do so.<br><br>• Where an adult at risk of self-neglect has mental capacity but refuses a needs assessment, the local authority must undertake an assessment so far as possible and document this. It should continue to keep in contact with the adult and carry out an assessment if the adult changes their mind and asks them to do so.<br><br>Once an assessment has been made there is a duty on local authorities to produce care and support plans and to offer a personal budget. This should focus on keeping people directly involved.<br><br>The Act also sets out a duty to review Care and Support plans to ensure that they continue to meet the needs of the person. |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| Birmingham City Council (Adult Social Care and Health) | **Care Act 2014 Section 42 Adult Safeguarding Enquiry** | Self-neglect is included in definitions of abuse and neglect, thus linking self-neglect to statutory safeguarding duties.<br><br>***N.B**. The statutory guidance states "It should be noted that self-neglect may not prompt a Section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adults' ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support."*<br><br>This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there).<br>a) Has needs for care and support (whether or not the authority is meeting any of those needs) and<br>b) is experiencing, or is at risk of, abuse or neglect and<br>c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.<br><br>The Local Authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.<br>If the adult has substantial difficulty in participating in their enquiry and they have no one else to support them with this, then the Local Authority must provide them with an independent advocate. |
| Birmingham City Council (Adult Social Care and Health) | **Care Act 2014 Section 11** | Refusal of assessment |
| Birmingham City Council (Adult Social Care and Health) | **Care Act 2014 Section 18** | Duty to meet needs for care and support<br>Meeting assessed eligible needs. |
| Birmingham City Council (Adult Social Care and Health) | **Chronically Sick and Disabled Persons Act** | The Chronically Sick and Disabled Persons Act 1970 received royal assent on 9 May 1970. The Act required local authorities to provide welfare services to disabled people who fell within section 29 of the National Assistance Act 1948 (those who were blind, deaf, people with learning disabilities or mental illness and |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| | | disabled people).<br>The 1948 act had already given local authorities powers to provide services. However, the 1970 act compelled local authorities to provide a range of services including:<br>• practical assistance<br>• home adaptations<br>• provision of or help with procuring access to recreational activities – such as outings, TV services or educational services, and the provision of meals at home. |
| **Animal Welfare agencies**<br>RSPCA, Dogs Trust and other animal rescue establishments<br><br>Birmingham City Council Environmental Health/ Dog Warden/ Enforcement Officers | **Animal Welfare Act 2006**<br><br>Further guidance:<br>**Animal welfare - Protecting pets** | Improvements to animal welfare, effected through education and support or enforcement in severe cases.<br>Escalation process:<br>• Verbal advice<br>• Support and re-visits<br>• Encourage voluntary rehoming of animals<br>• Provision of neutering vouchers to reduce overbreeding and hoarding issues and or assistance with transport to vets<br>• Issue of Improvement Notices of animals if animal is suffering<br>• Prosecution, in extreme cases (fine/ban on keeping animals/imprisonment)<br><br>**Cases of Animal mistreatment/ neglect.**<br>The Act makes it not only against the law to be cruel to an animal, but states that a person must ensure that the welfare needs of their animals are met.<br>Individuals have a duty to meet the welfare needs of their animals.<br><br>Advice and education may be followed by formal warnings and prosecution. Cruelty to animals is a criminal offence<br>See also legislation protecting pets. |
| Mental Health Services with Birmingham City Council (Adult Social Care and Health) | **Mental Health Act 1983**<br>**Section 135(1)** | This act provides for a Police Officer to enter a private premises, if need be by force, to search for and, if thought fit, remove a person to a place of safety if certain grounds are met. The police officer must be accompanied by an Approved Mental Health Professional (AMHP) and a doctor.<br><br>***NB**. Place of Safety is usually the Mental Health Unit but can be the Emergency Department of a General Hospital, or anywhere willing to act as such.* |

| Agency | Legal Power and Action | Circumstances requiring intervention |
|---|---|---|
| | | Evidence must be laid before a magistrate by an AMHP that there is reasonable cause to believe that a person is suffering from mental disorder, and is being<br>• Ill-treated, or<br>• Neglected, or<br>• Being kept other than under proper control, or<br>• If living alone is unable to care for self, and that the action is a proportionate response to the risks involved. |
| All | **Mental Capacity Act 2005** | A decision can be made about what is in the best interests of a mentally incapacitated person by an appropriate decision-maker under the MCA. It is important to follow the principles of the Act, to ensure any actions considered are taken in the persons' best interests and have given due consideration to the least restrictive options available<br><br>Where a person lacks capacity to make decisions and is at high risk of serious harm as a result. |
| All | **Mental capacity Act- Court of Protection Orders** | Court of Protection and the Public Guardian |
| All | **Inherent jurisdiction of the High Court:** See SCIE Guidance | The High Court has powers to intervene in extreme cases of self-neglect when adults have capacity, although the presumption is always to protect the individual's human rights.<br>Legal advice should be sought before taking this option.<br><br>In extreme cases of self-neglect, where an adult with capacity is at risk of serious harm or death and refuses all offers of support or interventions or is unduly influenced by someone else, taking the case to the High Court for a decision could be considered. |
| All | **Human Rights Act 1998** | Articles 2,3,5,8 (positive as well as negative duties) |

# Appendix 4 - Multi-Agency Self-neglect and Hoarding Risk Assessment Guidance Tool

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

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

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

**When using the risk tool below, consider whether the person has the mental capacity to understand the risk associated with their living condition. Also consider if the person has capacity to execute changes to reduce the risk.**

**Please note:**

**Whilst an aid to decision making, it is essential to recognise that the use of the key indicator list and risk assessment and referral tool are not eligibility mechanisms in their own right.**

**There should always be the overlay of a sensitive application of professional judgement.**

# Multi-agency Self-neglect Risk Assessment
## (document can support referral to BCC)

**This screening tool needs to be completed by the person who is concerned about possible risk of self-neglect. If self-neglect is identified as an issue by the person working with an individual, this screening tool can be used to identify the level of risk and may be used to support a referral into Adult Social Care.**

## Referrer Details:

| | |
|---|---|
| Date of Assessment | |
| Assessed by | |
| Organisation and Department | |
| Contact Details | |

## Client Details:

| | | | |
|---|---|---|---|
| **Name:** | | **Date of birth:** | |
| **Address including postcode:** | | **Telephone number:** | |
| **Other Residents:** *(**Note**: Consider Coercive and Controlling behaviour)* | | **Dependents:** *(if yes, please complete additional sheet on next page)* | **Yes/No** *(delete answer not appropriate)* |

| **A table to record consent** | |
|---|---|
| Yes | No |

| **If consent is not obtained, please fill in below boxes** (This box must be completed) | | | |
|---|---|---|---|
| Reason for referral *(**Note**: Is a Mental Capacity Act Assessment required)* | | Is the Adult who is at risk of self-neglect aware the concern will be reported to appropriate agencies? | **Yes/No** *(delete answer not appropriate)* |

# Dependent Details

***(please include any Adults that depend on them)*** **Think Family**

| | **Name** | **Address** *(if different from client address)* | **Age / Date of Birth** *(if known and relevant)* |
|---|---|---|---|
| **Dependent 1** | | | |
| **Dependent 2** | | | |
| **Dependent 3** | | | |
| **Dependent 4** | | | |
| **Dependent 5** | | | |

| **Agencies known to be involved with person** | |
|---|---|
| **Name** | **Contact Details** |
| | |
| | |
| | |
| | |

## Physical Wellbeing & Medication

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | The individual is accepting healthcare intervention | | |
| | The individual is taking prescribed medication | | |
| | No evidence of dehydration/weight loss | | |
| | No evidence of infection/diarrhoea/vomiting/other which is impacting on their health and wellbeing | | |
| | No evidence of untreated skin conditions such as ulcers, skin sores etc. which is impacting on their health and wellbeing | | |
| **Any other risks identified** | | | |
| **Low risk** | Sporadic acceptance of healthcare intervention - no identified impact on their health and wellbeing at this time | | |
| | Sporadic taking of prescribed medication - no identified impact on their health and wellbeing at this time | | |
| | The individual is not consistently eating and some evidence of dehydration/weight loss - no identified impact on their health and wellbeing at this time | | |
| | Some evidence of infection/diarrhoea/vomiting/other - no identified impact on their health and wellbeing at this time | | |
| | Some evidence of untreated skin conditions such as ulcers, skin sores etc - no identified impact on their health and wellbeing at this time | | |
| **Any other risks identified** | | | |
| **Moderate risk** | Sporadic acceptance of healthcare intervention which is having a negative impact on their health and wellbeing | | |
| | Sporadic taking of prescribed medication which is having a negative impact on their health and wellbeing | | |

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| | The individual is not consistently eating and some evidence of dehydration/weight loss which is having a negative impact on their health and wellbeing | | |
| | Some evidence of infection/diarrhoea/vomiting/ which is having a negative impact on their health and wellbeing | | |
| | Some evidence of untreated skin conditions such as ulcers, skin sores etc. which is having a negative impact on their health and wellbeing | | |
| **Any other risks identified** | | | |
| **High risk** | The individual is declining healthcare intervention which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm E.g. evidence of open wounds and refusing to consent to treatment. | | |
| | The individual is refusing to take prescribed medication which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm. | | |
| | Evidence of significant dehydration/weight loss which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm. | | |
| | Evidence of infection/diarrhoea/vomiting/other which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Evidence of untreated skin conditions such as ulcers, skin sores etc. which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| **Any other risks identified** | | | |

## Mental Health/Wellbeing

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | No concerns regarding mental health | | |
| | The individual is accepting health/support services | | |
| | The individual is attending health/support appointments | | |
| | Taking prescribed medication | | |
| **Any other risks identified** | | | |
| **Low risk** | Some concerns regarding mental health - no identified impact on their health and wellbeing at this time | | |
| | Attendance at health/other appointments is sporadic<br>- no identified impact on their health and wellbeing at this time | | |
| | Sporadic engagement with support services<br>- no identified impact on their health and wellbeing at this time | | |
| | Not consistently taking medication<br>– no identified impact on health and wellbeing at this time | | |
| **Any other risks identified** | | | |
| **Moderate risk** | Some concerns regarding mental health which is having a negative impact on their health and wellbeing | | |
| | Attendance at health/other appointments is sporadic which is having a negative impact on their health and wellbeing | | |
| | Sporadic engagement with support services which is having a negative impact on their health and wellbeing | | |
| | Not consistently taking medication which is having a negative impact on their health and wellbeing | | |
| **Any other risks identified** | | | |

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **High risk** | Concerns regarding mental health which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Attendance at health/other appointments is sporadic which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Sporadic engagement with support services which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Not consistently taking medication which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Risk of Mental Health Crisis | | |
| **Any other risks identified** | | | |

# Managing and Maintaining Nutrition

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | The individual is aware of own nutritional needs and is able to manage and maintain nutritional needs independently. | | |
| | No evidence of weight loss/weight gain | | |
| | Kitchen space is uncluttered, and the environment is kept clean | | |
| | Kitchen appliances suitable to persons needs are being used as and when required | | |
| **Any other risks identified** | | | |
| **Low risk** | The individual has some awareness of nutritional needs - no identified impact on their health and wellbeing at this time | | |
| | Some evidence of weight loss/weight gain (consider health related issues). No identified impact on their health and wellbeing at this time | | |
| | Kitchen space is becoming cluttered and evidence that the person is not able to keep the environment clean. No identified impact on their health and wellbeing at this time | | |
| | No usable appliances such as fridge freezer, cooker, microwave, kettle, toaster etc. No identified impact on their health and wellbeing at this time | | |
| | Food sometimes is not a priority compared to Alcohol or drugs which results in missing meals and or not having food available. | | |
| **Any other risks identified** | | | |

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **Moderate risk** | The individual has some awareness of nutritional needs, can access some food but this can be inconsistent which is having a negative impact on their health and wellbeing | | |
| | Some evidence of weight loss/weight gain (consider health related issues) which is having a negative impact on their health and wellbeing | | |
| | Kitchen space is becoming cluttered and evidence that the person is not able to keep the environment clean which is having a negative impact on their health and wellbeing | | |
| | No usable appliances such as fridge, freezer, cooker, microwave, kettle, toaster etc. which is having a negative impact on their health and wellbeing | | |
| | Food regularly is not a priority compared to Alcohol or drugs which results in missing meals and or not having food available. | | |
| **Any other risks identified** | | | |
| **High risk** | Evidence that food and drink is not a priority which is leading to concerns such as dehydration/malnutrition/significant weight loss etc. which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | No evidence of food in the property or evidence of mouldy and out of date food items which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Kitchen area is not usable due to unsanitary conditions or clutter which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | The individual is not able to use appliances (or no useable appliances) such as fridge, freezer, cooker, microwave, kettle and toaster independently and refuses support which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Food is rarely a priority compared to Alcohol or drugs which results in missing meals and or not having food available. | | |

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **Any other risks identified** | | | |

# Maintaining Personal Hygiene/Being Appropriately Clothed

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | Evidence that the person is maintaining their personal hygiene | | |
| | The individual is appropriately clothed for the weather. For example, the person is clean, bathed and groomed regularly with clean, weather appropriate clothes | | |
| **Any other risks identified** | | | |
| **Low risk** | Is unable to maintain regular personal hygiene<br>- no identified impact on their health and wellbeing at this time | | |
| | The individual is wearing inappropriate clothing for the weather - no identified impact on their health and wellbeing at this time | | |
| **Any other risks identified** | | | |
| **Moderate risk** | Is unable to maintain regular personal hygiene which is having a negative impact on their health and wellbeing | | |
| | The individual is wearing inappropriate clothing for the weather which is having a negative impact on their health and wellbeing | | |
| | Limited number of clothes available to change them according to the weather and or wash them. | | |
| **Any other risks identified** | | | |
| **High risk** | Consistently fails to maintain personal hygiene which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Wearing clothes inappropriate for the weather which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | No change of clothes available to change them according to the weather and or wash them. | | |
| **Any other risks identified** | | | |

# Managing Toilet Needs

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | The individual is able to manage and maintain own toileting needs | | |
| | No evidence of skin breakdown | | |
| | No identified risk to people providing support or services | | |
| | Has full access to bath/bathroom appliances | | |
| **Any other risks identified** | | | |
| **Low risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine - no identified impact on their health and wellbeing at this time | | |
| | Slight evidence of skin breakdown - no identified impact on their health and wellbeing at this time | | |
| | Some identified risk to people providing support or services as a result of individual's ability to meet toileting needs – no identified impact on their health and wellbeing at this time | | |
| | No usable and or accessible bath/bathroom appliances - no identified impact on their health and wellbeing at this time | | |
| **Any other risks identified** | | | |

| Risk level | Indicating factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **Moderate risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine which is having a negative impact on their health and wellbeing | | |
| | Evidence of skin breakdown which is having a negative impact on their health and wellbeing | | |
| | Evidence of faecal matter and urine which is having a negative impact on the health and wellbeing of others including people providing support or services | | |
| | No usable and or accessible bath/bathroom appliances which is having a negative impact on the health and wellbeing of others including people providing support or services | | |
| **Any other risks identified** | | | |
| **High risk** | Maintaining toileting needs is sporadic some evidence of faecal matter and urine which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Evidence of skin breakdown which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | Evidence of faecal matter and urine which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| | No usable and or accessible bath/bathroom appliances which is compromising and impacting on their health and wellbeing and resulting in significant or life-threatening harm | | |
| **Any other risks identified** | | | |

## Maintaining a Habitable Home

| Risk Level | Indicating Factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | Property is well maintained, usable and safe | | |
| | Amenities such as heating, electricity and water are all usable and in fully working order | | |
| | Fully usable kitchen and bathroom, appliances are safe and in working order | | |
| | Organisations with an interest in the property, for example, staff working for utility companies (water, gas, and electricity), housing services etc. have full access as required | | |
| | No evidence of infestations such as rats, vermin, flies, maggots etc. | | |
| | Animals in the property are well cared for and are not a concern for the individual | | |
| **Any other risks identified** | | | |
| **Low risk** | Some evidence of neglecting household maintenance with no identified impact on health, wellbeing and safety at this time | | |
| | Amenities such as heating, electricity and water may show signs of needing some maintenance or repair, no identified impact on their health and wellbeing at this time | | |
| | Evidence of hoarding - refer to Hoarding Framework for further guidance | | |
| | Not consistently allowing access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity), housing services etc. with no identified impact on their health and wellbeing at this time | | |
| | Some evidence that animals within the property are not being fully cared for, no identified impact on the individual's health and wellbeing at this time. (Contact RSPCA for advice) | | |

| Risk Level | Indicating Factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| | Risk of being made homeless. | | |
| **Any other risks identified** | | | |
| **MODERATE RISK** | Evidence of neglecting household maintenance and therefore creating hazards which is having a negative impact on their health and wellbeing | | |
| | Amenities such as heating, electricity and water need maintaining which is having a negative impact on the health and wellbeing of the individual and others including people providing support or services | | |
| | Evidence of hoarding - refer to Hoarding Framework for further guidance | | |
| | Refusing to allow access to other organisations with an interest in the property, for example, staff working for utility companies (water, gas, electricity), housing services etc., which is having a negative impact on their health and wellbeing | | |
| | Some evidence of infestations such as rats, vermin, flies, maggots etc. which is having a negative impact on their health and wellbeing (Contact Environmental Health) | | |
| | Failure to meet animal(s) needs which is having an impact on the individual's health and wellbeing (Contact RSPCA for advice 0300 1234999) | | |
| | Homeless but using services / hostels to prevent from sleeping rough. | | |
| **Any other risks identified** | | | |
| **High risk** | No essential amenities which is compromising and impacting on their health and wellbeing and result in significant or life-threatening harm. | | |
| | Evidence of hoarding which prevents safe use of any amenities within the home which could compromise and impact on health and wellbeing and result in significant or life-threatening harm. | | |

| Risk Level | Indicating Factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| | Evidence of infestations such as rats, vermin, flies, maggots etc. which could compromise and impact on the individual's health and wellbeing and result in significant or life-threatening harm (Contact Environmental Health) | | |
| | Possible risk of fire which could compromise and impact on the health and wellbeing of the individual or another person visiting, (including people providing support or services), and result in significant or life-threatening harm.<br>Contact WMFS who will visit the person and offer support, information and appropriate interventions.<br>Fire Safety Referral - West Midlands Fire Service (wmfs.net) guidance at: https://www.wmfs.net/our-services/safe-and-well/ | | |
| | Failure to meet animal(s) needs which is compromising and impacting on the individual's health and wellbeing and result in significant or life-threatening harm (Contact RSPCA) | | |
| | Living areas are not usable due to unsanitary conditions or clutter which is compromising and impacting on the individual's health and wellbeing and result in significant or life-threatening harm. | | |
| | Neglecting household maintenance to the extent that the property becomes dangerous e.g. unsafe gas, electric, water or structural damage (unsafe floorboards, roof etc.) which is compromising and impacting on the health and wellbeing of the individual or another person visiting, (including people providing support or services). The extent of which may result in significant or life-threatening harm. | | |
| | Homeless, sleeping rough and impacting on their safety. | | |
| **Any other risks identified** | | | |

# FINANCIAL/BENEFITS

| Risk Level | Indicating Factors | X if applies | Rationale behind this decision |
|---|---|---|---|
| **No identified risk** | The individual is able to manage and maintain own finances | | |
| | No evidence of | | |
| | No identified risk to people providing support or services | | |
| | Has full access to bath/bathroom appliances | | |
| **Any other risks identified** | | | |
| **Low risk** | Finding it hard to cope with finances, may require support but not impacting on wellbeing. | | |
| | Requires support in identifying and applying for any benefits that they may be intitled to. | | |
| **Any other risks identified** | | | |
| **Moderate risk** | Finding it increasingly hard to cope with finances, requires support as it is impacting on wellbeing. | | |
| | Requires support in identifying and applying for any benefits that they may be intitled to. | | |
| | Makes unwise financial decisions but not impacting significantly. | | |
| **Any other risks identified** | | | |
| **High risk** | Unable to cope with finances, requires support as it is having a significant impacting on their wellbeing. | | |
| | No current income and at extreme risk of exploitation. | | |
| | Makes unwise financial decisions and impacting significantly on ability to pay bills and buy food. | | |
| **Any other risks identified** | | | |

## Risk assessment and referral summary

**Please mark an 'x' below to indicate the highest level of risk recorded**

| | |
|---|---|
| | **No indicators higher than low risk** |
| | **No indicators higher than moderate risk** |
| | **ANY of the indicators are of HIGH RISK** |

| **Further comments/ Decision making Rationale** |
|---|
| |

| **Action to be taken** | **By who** | **Deadline** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

# Appendix 5 - Risk Escalation Conference Terms of Reference

## Background

The Care & Support Statutory Guidance (Issued under the Care Act 2014)1 states that (paragraph 14.2)2 safeguarding duties apply to those unable to protect themselves from either the risk of, or the experience of neglect and abuse and, within that context (paragraph 14.141) the Safeguarding Adults Board will have positive means of addressing issues of self-neglect. The guidance acknowledges self-neglect is challenging and needs to be addressed amongst professionals and the community more generally.

Partner agencies remain responsible for delivering services to the people with whom they are in contact. The Risk Escalation Conference (REC) will support agencies in their work to lower and manage risk for both residents and their immediate neighbours, where partners feel they have exhausted internal mechanisms for managing the risk or where formal consultation with colleagues from other agencies would enhance their response. It will report potential areas of shared learning to the Safeguarding Adults Board.

The REC will act in an advisory capacity and will make recommendations on what would be reasonable in terms of managing risk and balancing the rights of all concerned. The REC will offer a reflective space for consultation, reconciliation, problem solving and agreement in cases where the levels of risk raise concerns. The REC will not seek to change management or financial decisions although it may make recommendations that require alternative resources/further financial consideration. The conference does not replace the line management relationship but should supplement it. It is not a means of gaining “senior” agreement outside of Team or Service Management.

Information supplied to the conference will be managed by Birmingham City Council and be subject to the local authority’s data governance and information sharing procedures. The sharing of relevant information to safeguard adults and/or children at risk of harm or abuse will take place under these procedures.

Presentations to the conference should normally be made with the individual’s consent unless there is a vital or public interest, which makes it necessary to seek a multi-agency response.

## Terms of Reference

The REC is collaboratively owned by participating agencies operating in Birmingham. It will be administered on behalf of the participating agencies by Adult Social Care, Birmingham City Council and Chaired by a nominated Senior Officer from Adult Social Care.

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

Initiating the REC may be prompted by:

- Lack of progress identified at the Multi-disciplinary meeting
- Public safety remains a concern
- Lack of partnership engagement
- Disagreement on deployment of resources

## The REC core membership

The following will form the core membership of the REC:

- Birmingham City Council Adult Social Care
- NHS Birmingham and Solihull CCG
- The referring agency

The following will be additional members called upon to attend as required:

- Birmingham Community Health Care Foundation Trust
- Birmingham & Solihull Mental Health Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- Sandwell & West Birmingham Hospital NHS Foundation Trust
- Birmingham City Council Housing
- West Midlands Police
- West Midlands Fire Service
- Environmental Services
- Third Sector Organisations

REC members will be of sufficient seniority to commit their agency to the actions agreed and ensure they are implemented following the meeting. If they are unable to attend, they will brief a colleague who will deputise for them or if this is not possible, they will alert the Chair Person prior to the Conference.

A professional from the referring agency will normally make a case presentation, which will include a resume of actions already taken.

The person at risk of self-neglect may have an advocate who wishes to attend the meeting on their behalf.

## Role of the Risk Escalation Conference

The Conference will consider case presentations and will support partner agencies to work together with the aim to reduce and manage risks.

Suitable cases include those of greatest concern to the agency, which are particularly complex and have reached a "sticking point" through multi-agency action.

The Conference will discuss the cases presented to them with a view to determining next steps.

The Conference role is to challenge, advise and support the 'presenting agency' as well as identifying multi-agency solutions and action plans. The Conference may assist with the coordination of cases where there are multi-agency barriers.

Ownership of cases and responsibility for taking forward actions remains solely with the practitioner/Conference representative from the presenting agency.

It is assumed that each case will not need to return to the Conference.

A learning log of effective resolutions and other systemic learning, along with a record of the Conference outcomes, will be maintained. The Conference representative will be expected to share best practice or legal changes (especially within their specified field) with the rest of the Conference.

The Conference has no specific budgetary or official decision-making powers outside of each representative agency's legal duties.

## Referral and management of REC meetings

Referrals will be submitted by email to: RiskEscalationConference@birmingham.gov.uk. Please note e-mails should be sent from a secure e-mail account.

The referral will be completed by the lead agency involved with the person for whom there are self-neglect concerns/with the agreement of the Chair of the multi-disciplinary meeting.

The referral will include the following information:

- Personal details of the person (name, address, dob).
- Details of the referring officer (name, organisation, role, email/telephone)
- Does the person consent to the referral?
- If no to the above, why is the referral in the public/vital interest.
- Summary of multi-disciplinary meetings and actions taken.
- Outline the 'sticking point' that has prompted the referral. **NB**: the views of the person must be included.

In addition to the above the referrer will provide copies of the most recent risk assessment and risk management plans.

The responsible Adult Social Care Manager will review all referrals. If s/he has reason to believe that the referral does not meet the criteria for REC s/he will consult the representatives of the core group agencies before deciding whether or not to accept the referral.

Agenda, papers, and identifiable information will be sent to REC representatives **five working days** prior to the Conference. It is expected that the Conference will read the submitted referrals in advance of the meeting.

Minutes of the REC will be taken by Adult Social Care and distributed to participants.

REC meetings will be called on an ad hoc basis, where possible within 7 working days of the receipt of the referral. If more than one referral has been received within a working week the REC will consider all referrals held within that period (up to a maximum of five). The REC will usually meet no more than once monthly. **NB**: The focus of the REC process is people who self-neglect with capacity to make unwise decisions that result in high risk situations that have defied multi-agency efforts to resolve them. Consequently, there should not be high volumes of referrals to REC.

Consideration of a referral at the REC will consist of:

- 5-minute presentation of the case by the referring officer.
- the agency's own view of the risk and possible solution.
- the views of the REC representatives present.
- A statement of the conclusions/identified actions.

It is the responsibility of the REC Chair to manage the conference meetings and support efforts to move cases forward, where possible. The decision for the resulting actions is the collaborative duty of the REC and not any one individual. It is the responsibility of the presenting practitioner/Conference representative to ensure identified actions are implemented and followed up.

The REC meetings will be held virtually. In exceptional circumstances (e.g. a key participant is not able to access the required technology) the Chair can decide to call an actual meeting.

REC participants should always show respect and courtesy in their dealings with other members of the Conference and those presenting cases; and seek to take a collaborative solution focused, problem solving approach to find ways of improving each individual case.

# Appendix 6 - Practice Guidance

## The Challenge of Self Neglect

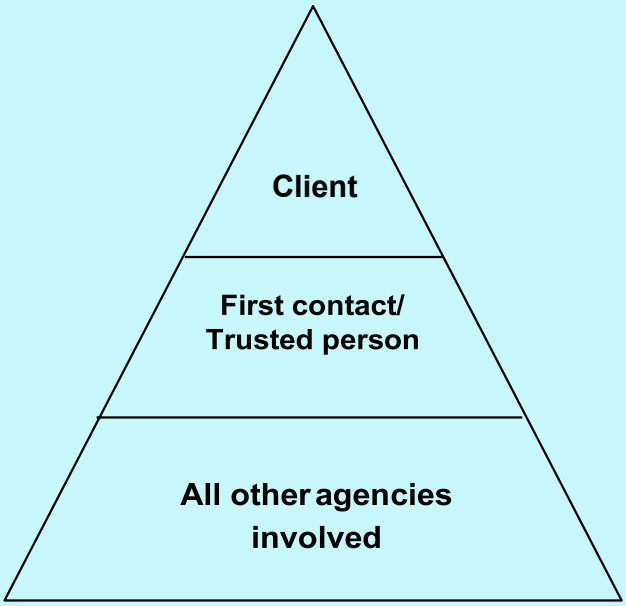
Self-neglect is challenging for Practitioners because:

- Every case is different, influenced by a complex mix of personal, mental, physical, social and environmental factors.
- The high risks it poses, both to the adults and sometimes to others (e.g. fire risk).
- The possibility that any outside intervention may not be welcomed by the individual, making engagement difficult.
- The complexities of assessing mental capacity.
- Ethical dilemmas between respecting the adult's autonomy and right to make choices and agencies fulfilling their duty of care.
- Limited resources that can lead to short-term, task-focused involvement rather than developing long-term relationships with adults.
- The need for coordinated interventions from a range of agencies and the difficulties involved in achieving this.

## Building a relationship with the adult

Because of these challenges and because all cases are different there is no one set approach that always works. However, a supportive approach based on building a trusting relationship with the adult has been shown to be more likely to achieve a positive outcome.

Supportive intervention relies on multi-agency co-ordination and risk management as illustrated below:




*The above diagram is of a pyramid, with 3 layers. The client is at the top, first contact/trusted person in the middle and all other agencies involved at the bottom.*

At the heart of good self-neglect practice is a complex interaction between knowing, being and doing:

- **Knowing**, in the sense of understanding the person, their history and the significance of their self-neglect, along with all the knowledge of resources that underpin professional practice.
- **Being**, in the sense of showing personal and professional qualities of respect, empathy, honesty and reliability, care, being present, staying alongside and keeping company.
- **Doing**, in the sense of balancing hands-off and hands-on approaches, seeking the tiny element of latitude for agreement, doing things that will make a small difference while negotiating for the bigger things, and deciding with others when enforced intervention becomes necessary.

## Knowing (understanding the individual's experience of self-neglect)

You are unlikely to build a trusting relationship and achieve a positive outcome unless you can gain an understanding of the adults' experience of self-neglect from their point of view.

Here are some points to consider helping you find out:

- Consider the person's own view of the self-neglect.
- Is the self-neglect important to the person in some way?
- Have you considered if the person has mental capacity in relation to specific decisions about self-care and/or acceptance of care and support?
- Is the self-neglect a recent change or a long-standing pattern?
- Has there been a recent significant life event such as bereavement?
- What strengths does the person have - what is he or she managing well and how might this be built on? What motivation for change does the person have?
- Are there links between the self-neglect and health (including mental health) or disability?
- Are there care and support needs that are not being met?
- Is alcohol consumption or substance misuse related to the self-neglect?
- Consider how the person's life history, family or social relations are interconnected with self-neglect?
- Does the self-neglect play an important role as a coping mechanism? If so, is there anything else in the person's life that might play this role instead?
- Are there any concerns for others in the property, i.e. other residents including children or animals?
- Who owns the property?

## Being (considering your own reactions when you interact with a person who self-neglects and the impact this could have).

Did you realise that when you enter a hoarded or neglected home you will have a very strong reaction, but you won't know you are having it as it happens subconsciously? You need to understand this in advance to prepare yourself because the adult may see this reaction, and this could damage your chances of building a positive working relationship.

When we enter any enclosed space, we look for symmetry as symmetry is memorable. We need to remember the layout since, if we feel threatened, we need to know how to escape. In hoarded properties there often is no escape route, and this can fuel your feelings of claustrophobia, discomfort or the desire to clear the property. This feeling can have a very negative effect on you and this effect might influence how you perceive the person you are working with; which will influence how you then work with that person. You may also have a strong physical reaction to strong smells that may be present.

## What you can do about it

If you know this normal reaction is going to happen; you can prepare yourself for this and think of strategies to help overcome it. For example, try imagining the environment is not cluttered and focusing your sight upon the person's face.

Noting your own feelings is helpful in reports and helps to build an understanding of the reactions of others that may have compounded a sense of isolation or helplessness about the individual's circumstances. The effect of strong smells can be reduced by carrying a strong counter acting smell e.g. using a cold remedy or having a mint.

## Doing (the things that tend to work best)

No one approach always works but there are a number of things that can be done that have been shown to be successful as below:

| The Approach | Examples of what this might mean in practice |
|---|---|
| **Building rapport** | Taking the time to get to know the person; refusing to be shocked. |
| **Moving from rapport to relationship** | Avoiding knee-jerk responses to self-neglect; talking through with the person their interests, history and stories |
| **Finding the right tone** | Being honest while also being non-judgemental; expressing concern about self-neglect, while separating the person from the behaviour. |
| **Going at the individual's pace** | Moving slowly and not forcing things; showing concern and interest through continued involvement over time. |
| **Agreeing a plan** | Making clear what is going to happen; planning might start by way of agreeing a weekly visit and developing from there. |
| **Finding something that motivates the individual** | Linking to the person's interests (for example, if the person is hoarding because they hate waste, link them into recycling initiatives). |
| **Starting with practicalities** | Providing small practical help at the outset may help build trust. |
| **Bartering** | Linking practical help to another element of agreement (for example, 'If I can replace your heater, would you go to see the doctor?'). |
| **Focusing on what can be agreed** | Finding something to be the basis of initial agreement, which can be built on later. |
| **Keeping company** | Being available and spending time to build up trust. |
| **Straight talking** | Being honest about potential consequences. |
| **Finding the right person** | Working with someone who is well placed to get engagement - another professional or a member of the person's network. |
| **External levers (Legal framework)** | Recognising and working with the possibility of enforcement action (See Appendix 3). |

BIRMINGHAM SAFEGUARDING ADULTS BOARD

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