



Self-Neglect Guidance

North of Tyne
January 2016

Concern about an adult with care and support needs self-neglecting.

In all cases:

- Attempt to manage any immediate risks.
- Consider (and assess where appropriate) mental capacity.
- Find out the adult's views and what they want to happen.
- Identify key individuals and agencies involved. Share information and work together.
- Record risks and actions taken.
- Be flexible.
- Be persistent.

Identify level of harm or risk. Refer to the [Risk Threshold Tool](#).

Low-level harm or risk.
(see page 9)

- Offer:
- Advice, information, sign-posting.
 - Assessment/review of needs.
 - Provision of services.

Significant harm or risk.
(see page 9)

- Decide if safeguarding adults referral appropriate.
- Offer:
- Advice, information, sign-posting.
 - Assessment/review of needs.
 - Provision of services.

Critical harm or risk.
(see page 10)

- Safeguarding adults referral must be made and a safeguarding adults enquiry coordinated.
- Strategy meeting must be held.

Ensure you consider any risks to others, including children and other adults with care and support needs. If you are concerned about the welfare of a child, please contact Children's Social Care:
Initial Response Service (0191 277 2500)

Contents

1. Introduction
2. The Care Act (2014)
3. Definitions of self-neglect
4. Understanding self-neglect
5. Mental Capacity
6. Prevention
7. Identifying level of risk/harm
 - 7.1 – Low-level risk/harm
 - 7.2 – Significant or very significant risk/harm
 - 7.3 – Critical risk/harm
8. Possible responses to self-neglect
 - 8.1 Responses applicable to all levels of risk
 - 8.2 Responses to low-level risk/harm
 - 8.3 Responses to significant/very significant risk/harm
 - 8.4 Responses to critical risk/harm
9. Ending involvement
- Appendix 1 Legal options
- Appendix 2 Hoarding
- Appendix 3 Drug and alcohol misuse and self-neglect
- Appendix 4 Case studies
- Appendix 5 Useful contacts

Thanks are given to Durham Safeguarding Adults Board for giving permission to use the Hoarding Guidance and Clutter Image Rating Tool.

1. Introduction

This aim of this document is to provide guidance for people supporting adults with care and support needs who are at risk of harm as a result of self-neglect.

Managing the balance between protecting adults from self-neglect and their right to self-determination is a challenge for professionals. The guidance aims to support good practice in this area.

2. The Care Act (2014)

Self-neglect and safeguarding adults

The Care Act (2014) was implemented in April 2015 and brought about a number of changes which impact upon how self-neglect cases are dealt with.

Within the accompanying statutory guidance for the Care Act (2014), new categories of abuse were added, with “self-neglect” specifically mentioned. As a result, self-neglect is now incorporated as a form of abuse and neglect covered by multi-agency safeguarding adults policy and procedures. The statutory guidance’s definition of self-neglect is as follows:

“self-neglect – this covers a wide range of behaviour neglecting to care for one’s personal hygiene, health or surroundings and includes behaviour such as hoarding”.

The statutory guidance identifies that it can be difficult to assess self-neglect. Specifically, that it may be difficult to distinguish between whether a person is making a capacitated choice to live in a particular way (which may be described as unwise) or whether the person lacks mental capacity to make the decision.

Other key changes (of relevance to how self-neglect is dealt with under the safeguarding adults framework) include the removal of a significant harm threshold and that the adult at risk does not need to be eligible for social care services for a safeguarding adults enquiry to commence.

Duty of cooperation

The Care Act (2014) now makes integration, cooperation and partnership a legal requirement on local authorities and on all agencies involved in public care, including, the NHS, independent or private sector organisations, housing and the Police. Cooperation with partners should enable earlier intervention - the best way to prevent, reduce or delay needs for care and support and safeguard adults at risk from abuse or neglect.

Wellbeing principle

The Care Act (2014) places significant emphasis on the wellbeing principle with decisions being person-led and outcome-focused. Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of an individual, including when carrying out safeguarding adults enquiries. The wellbeing principle will be an important consideration in responding to self-neglect cases. The definition of wellbeing as defined in the Care Act relates to the following areas:-

- personal dignity (including treatment of the individual with respect);

- physical and mental health and emotional wellbeing;
- protection from abuse and neglect;
- control by the individual over day to day life (including over care and support provided and the way it is provided);
- Social and economic wellbeing;
- Domestic, family and personal relationships;
- Participation in work, education, training or recreation;
- Suitability of living accommodation;
- The individuals contribution to society.

3. Definitions of self-neglect

Whilst there is currently no standard definition of self-neglect, in addition to the Care Act (2014) definition above, research has suggested that there are three recognised forms of self-neglect which include:

- Lack of self-care – this may involve neglecting personal hygiene, nutrition and hydration or health. This type of neglect would involve a judgement to be made about what is an acceptable level of risk and what constitutes wellbeing.
- Lack of care of one’s environment – this may result in unpleasant or dirty home conditions and an increased level of risk in the domestic environment such as health and safety and fire risks associated with hoarding¹. This may again be subjective and require a judgement call to determine whether the conditions within an individual’s home environment are acceptable.
- Refusal of services that could alleviate these issues – this may include the refusal of care services, treatment, assessments or intervention, which could potentially improve self-care or care of one’s environment.

4. Understanding self-neglect

Indicators of self-neglect

- Neglecting personal hygiene impacting upon health (including skin damage/pressure ulcers).
- Neglecting home environment, with an impact upon health and wellbeing and public health issues. This may also lead to hazards in the home due to poor maintenance. Not disposing of refuse leading to infestations.
- Poor diet and nutrition leading to significant weight loss or other associated health issues (including skin damage/pressure ulcers).
- Lack of engagement with health and other services/ agencies.
- Hoarding items – excessive attachment to possessions, people who hoard may hold an inappropriate emotional attachment to items.
- Substance misuse.

¹ See Appendix 3 for further advice and guidance around responding to hoarding.

- Large number of pets.

Factors that may lead to individuals being overlooked:-

- The perception that this is a “lifestyle choice.”
- Poor multi-agency working and lack of information sharing.
- Lack of engagement from the individual or family; challenges presented by the individual or family making it difficult for professionals to work with the individual to minimise risk.
- An individual in a household is identified as a carer without a clear understanding of what their role includes which can lead to assumptions that support is being provided when it is not.
- A de-sensitisation to/from well known cases, resulting in minimisation of need and risk.
- An individual with mental capacity making unwise decisions, withdrawing from agencies however continuing to be at risk of significant or serious harm.
- Individuals with chaotic lifestyles and multiple or competing needs.
- Inconsistency in thresholds across agencies and teams – level of subjectivity in assessing risk.

Contributing factors which may lead to or escalate self-neglect:-

- Age related changes, in physical health or mental health.
- Bereavement/ traumatic event.
- Chronic mental health difficulty.
- Alcohol or drug dependency/ misuse
- Social isolation.
- Fear and anxiety.

Learning from Safeguarding Adult Reviews

Over the years various local authorities have examined findings from Serious Case Reviews, now termed Safeguarding Adult Reviews. This is a summary of some of the findings:-

- The importance of early information sharing, in relation to previous or on-going concerns.
- The importance of thorough and robust risk assessment and planning.
- The importance of face-to-face reviews.
- The need for clear interface with safeguarding adults procedures.
- The importance of effective collaboration between agencies.
- Increased understanding of the legislative options available to intervene to safeguard a person who is self-neglecting.
- The importance of the application and understanding of the Mental Capacity Act (2005).
- Where an individual refuses services, it is important to consider mental capacity and ensure the individual understands the implications and that this is documented. Services/ support should be re-visited at regular intervals: it may take time for an individual to be ready to accept some support.
- The need for practitioners and managers to challenge and reflect upon cases through the supervision process and training.
- The need for robust guidance to assist practitioners in working in this complex area.
- Assessment processes need to identify who carers are (and significant others – the “whole family approach”) and how much care and/or support they are providing.

5. Mental capacity

The Mental Capacity Act (2005) (MCA) is crucial to determining what action may or may not be taken in self-neglect cases. All adults have a right to take risks and behave in a way that may be construed as self-neglectful, if they have the capacity to do so without interference from the state².

Mental capacity is a complex attribute, involving not only the ability to understand the consequences of a decision but also the ability to carry out the decision. Where decisional capacity is not accompanied by the ability to carry out the decision, overall capacity is impaired and ‘best interests’ intervention by professionals to safeguard wellbeing may be legitimate. Mental capacity assessments must be time and decision-specific - apparent capacity to make simple decisions should not result in an assumption that the person is able to make more complex decisions. All practicable steps should be taken to ensure firstly that the person understands what they are being asked and also enable the person to communicate their wishes.

² This is clear in Article 8, European Convention of Human Rights

Where it is felt intervention may be required due to a person's self-neglect behaviour, any action proposed must be with the person's consent where they are assessed as having mental capacity unless there are wider public interest concerns, for example, other people may be at risk of harm or a crime has or may be committed. Examples where other people may be at risk as a result of self-neglect include where there is a fire risk or where there are public health concerns (e.g. infestation affecting other properties).

Where there is a concern around significant self-neglect (see section 7), one of the first considerations should be whether the person has mental capacity to understand the risks associated with their actions/lack of action. As per the first principle of the MCA, a person must be presumed to have capacity to make their own decisions. However, a prior presumption of mental capacity may be revisited in self-neglect cases. This is confirmed by the MCA code of practice which states that one of the reasons why people may question a person's capacity to make a specific decision is "the person's behaviour or circumstances cause doubt as to whether they have capacity to make a decision" (4.35 MCA Code of Practice, p. 52).

Any capacity assessment carried out in relation to self-neglect behaviour must be time specific, and relate to a specific intervention or action. The professional responsible for undertaking the capacity assessment will be the person who is proposing the specific intervention or action, and is referred to as the 'decision-maker'. Anyone acting in a professional capacity for, or in relation to, a person who lacks capacity OR being paid for acts for or in relation to a person who lacks capacity, legally must have regard to the MCA. This covers a wide range of people including: healthcare staff; social care staff; paramedics; housing workers, or police officers (MCA Code of Practice, p1-2).

Although the decision-maker may need to seek support from other professionals in the multi-disciplinary team, they are responsible for making the final decision about a person's capacity.

If the person lacks capacity to consent to the specific action or intervention, then the decision maker must demonstrate that they have met the requirements of the best-interests "checklist".

In self-neglect cases where there is a risk of significant harm (or higher), it is best practice to demonstrate your assessment (or presumption) of capacity using the [MCA1 form](#) and where a best interest decision is required using the [MCA2 form](#).

In particularly challenging and complex cases, it may be necessary for a referral to the Court of Protection to make the best interests decision. Any referral to the Court of Protection should be discussed with legal services and the relevant Safeguarding Adults Manager. Due to the complexity of such cases, there must be a safeguarding strategy meeting to oversee the process.

If a person is assessed as having mental capacity this does not negate the need for action under safeguarding adults procedures, particularly where the risk of harm is deemed to be serious or critical. Where professionals foresee serious or critical harm

to a person and they have mental capacity, duty of care extends to gathering all the necessary information to inform a thorough risk assessment and subsequent actions even without the consent of the individual. It may be determined that there are no legal powers to intervene, however it will be demonstrated that risks and possible actions have been fully considered on a multi-agency basis.

6. Prevention

In the majority of self-neglect cases, early intervention and preventative actions will negate the need for safeguarding adults procedures to be used. The Care Act (2014) emphasises the importance of using local community support networks and facilities provided by partner and voluntary organisations. Please refer to Appendix 8 for a list of useful agencies with contact details.

Section 8 provides suggested responses to low-level harm and risk.

7. Identifying level of risk/harm

Responding to self-neglect will depend on the level of risk/harm that has been identified. Professionals should refer to the [Safeguarding Adults Risk Threshold Tool](#) which includes self-neglect as well as considerations about the vulnerability of the individual and the circumstances of the case.

- **Level 1: Lower Level Risk/Harm** - Identifiable risk factors that do not indicate imminent or significant harm to self or others
- **Level 2: Significant or Very Significant Risk/Harm** - Identifiable indicators of significant harm to self or others
- **Level 3: Critical Risk/Harm** - Imminent risk of serious harm to self or others, where the impact on wellbeing would be critical.

Level 1: Low Risk

This may include situations where existing information indicates that there are lower level risk factors present and that they are already being managed effectively by one or more practitioners. If a concern is identified as low risk, it is expected that the case is dealt with outside of safeguarding adults procedures and managed by the most appropriate practitioner. Circumstances could include, but are not exclusive to:

- Reports that self-neglect is occurring or possible, but where the potential impact and consequence is not considered to be significant or immediate.
- Unwillingness to engage with services, accept assessments or offers of support and/ or intervention, but where available information suggests little risk of significant harm;
- Non-compliance with medication, which is unlikely to result in significant harm;

Level 2: Significant or Very Significant

This may include situations where presenting circumstances indicate risks factors are present that place the adult at risk or others of significant harm through self-

neglect, but available information indicates that risk level is not immediate and/or critical. This can include but may not be exclusive to:

- Multiple reports of concerns of self-neglect from multiple agencies.
- Behaviour which poses a fire risk to self and others.
- Lack of care or behaviour (refusal to take prescribed medication, lack of personal care, unsanitary/unhygienic lifestyle or living conditions, substance misuse, dietary disorder) to the extent that health and wellbeing deteriorate significantly e.g. pressure sores, wounds, dehydration, malnutrition, infection.
- Where information indicates a history of risk taking behaviour or a prevalence of historical risk factors and there is a likelihood of reoccurrence;
- Unwillingness to engage with services, accept assessments or offers of support and/or intervention.

Level 3: Critical

This includes the most serious and challenging presenting circumstances, including but not exclusive to:

- Complex and high level risk, including the potential for or possibility of death and/or serious injury because of the presenting risks and situation;
- A failure to seek/accept lifesaving services or medical care where required;
- Apparent lack of options available to protect the individual from risk/harm;
- Ongoing behaviour which is likely to continue.
- Where the demands of managing the risk may involve the commitment of resources that will require senior management oversight and approval;
- Possibility of heightened public awareness, scrutiny or media attention due to the high profile nature of the circumstances.

8. Possible responses

8.1 Responses applicable to all levels of risk/harm

Find out what the adult's views are and what they would like to happen

In line with person-centred and outcome-focused approaches to safeguarding, details must be sought of what the adult at risk's views are and what they would like happen. Safeguarding adults plans and care plans are much more likely to succeed if the person has been involved in developing it.

Consideration should also be given to gathering the views of other people who are important in the person's life, where this is consented to by the adult at risk.

If a person lacks mental capacity, the views and wishes of the adult at risk (and their representatives) should be gathered as part of the best interest decision(s).

Find out if the adult at risk has mental capacity (refer to Section 5)

Decisions which could be assessed include:

In relation to accommodation (e.g. to remain at home);

In relation to care and treatment (e.g. to refuse care, support or medical treatment);

Keeping safe (e.g. to seek help/support).

Take a creative and flexible approach

Think about different ways of engaging the person in support to reduce the risks around self-neglect. This could involve thinking about who might be the best professional to get the best engagement with the person, or exploring different service options that may reduce risks.

Be persistent

Because of the nature of self-neglect cases, the likelihood is that the person may refuse services or support when this is first offered. In conjunction with being flexible and creative, professionals may need to repeatedly try to work with a person to reduce risks. Non-engagement at first contact should not result in no further action being taken at a later date or professionals going back to the person and offering further help or support (particularly where risks may have changed or increased).

Work on a multi-agency basis

There should be effective coordination of any actions that need to be taken across all agencies by the key professional involved. Information about risk and actions should be shared with relevant agencies, in most circumstances with consent of the adult at risk. Multi-agency action is not limited to that taken under safeguarding adults procedures.

Ensure you have made thorough and accurate recordings

Identification of risks and actions taken to manage or minimise risk should be fully documented in professional notes and, where appropriate, a risk assessment and risk management document should be completed. Recording should fully evidence and support any decision making and appropriate monitoring arrangements should be considered and implemented if necessary. This is particularly important where safeguarding adults procedures have not been used and therefore as a result safeguarding adults documentation will not have been completed.

Consider risks to others

You must consider whether anyone else is at risk as a result of the individual's self-neglect. This may include children or other adults with care and support needs. Whilst your actions may be limited in relation to the individual themselves, you may have a duty to take action to safeguard others.

8.2 Low-level risk/harm

Where presenting risks of self-neglect have been identified as low, the following actions should be considered by the most appropriate practitioner(s). An up-to-date assessment of the adult's needs should be obtained where applicable or where none exist, the need for appropriate assessments should be considered. Future monitoring should always consider escalation to higher risk categories and use of safeguarding adults procedures.

Information, advice, sign-posting

- Information/advice about risks and what options there are for reducing risks;
- Promoting self-help (asking for help if needed; keeping appointments);
- Information/advice about health or care needs;
- Financial information/advice;
- Sign-posting to universal services (e.g. GP, Fire Service, Leisure Services, Libraries).

Assessment and services

- Tenancy support;
- Floating support;
- Social care assessment/re-assessment/review;
- Provision of social care services (long-term or short-term reablement) including direct payment/personal budget;
- Health assessment/re-assessment/review;
- Health treatment/intervention (including action intervention under the Mental Health Act 1983);
- Fire alarm fitted, sprinkler system fitted;
- Change of accommodation.

Regular, low-level concerns can amount to a far higher level of concern which then require more in-depth investigation under safeguarding adults procedures. Where you are faced with repeated low-level concerns, please refer to the guidance below on responding to significant/very significant/critical risk/harm. In Newcastle, **if there have been four low level concerns in a six month period this should result in a safeguarding adults enquiry commencing, and progressing until at least Stage 2 "Information Gathering"** (see below).

8.3 Significant/very significant level of risk/harm

Where presenting risks of self-neglect have been identified as significant or very significant, safeguarding adults procedures should be used and a safeguarding adults enquiry should be coordinated subject to the consent (or appropriate over-riding of consent) of the adult at risk.

Making a referral into safeguarding adults procedures

Safeguarding adults referrals are made to:

Community Health and Social Care Direct (0191 278 8377).

A [Safeguarding Adults Initial Enquiry form](#) (or equivalent) should be completed.

Referrals should only be made out of hours where there is an urgent social care need (0191 278 7878).

Safeguarding adults procedures provide a much more formal, multi-agency, framework for sharing information, assessing and managing risk. As the level of risk/harm is deemed to be significant or very significant, **the safeguarding adults enquiry must progress to at least Stage 2 “Information Gathering”**.

The safeguarding adults enquiry should result in a Safeguarding Adults Plan being devised which could include any of the actions/interventions described above when responding to low level harm (refer to section 8.2). In self-neglect cases, the safeguarding adults enquiry should include specific consideration of:

- The mental capacity of the adult at risk in relation to specific decisions;
- Involvement of the adult at risk (and/or their family/a representative), including in the development of a Safeguarding Adults Plan;
- A review of current arrangements for providing care and support. Does there need to be an assessment/reassessment/review? This should include any informal carer arrangements;
- Options for encouraging engagement with the adult at risk (e.g. which professional is best placed to successfully engage? Who would the adult respond most positively to?);
- Any legal options available to safeguard the adult (see appendix 1). Legal advice should be sought;
- Whether there are any other people at risk (including children) and what action needs to be taken if this is case;
- A contingency plan, should the agreed Safeguarding Adults Plan fail;
- How agencies/professionals will keep in regular communication about any changes or significant events/incidents;
- Support for front-line staff delivering services to the individual (e.g. in responding to a refusal of services).

As with all safeguarding adults enquiries, it is important that details of actions and decision-making are clearly recorded.

Where the adult at risk does not consent to the action under safeguarding adults procedures, professionals will need to consider:

- Whether it would be appropriate to override consent; and/or
- Whether the individual has the mental capacity to consent; and/or
- Whether the individual would be accepting of any other support/intervention outside of safeguarding adults procedures (refer to section 8.2).

8.4 Critical risk/harm

Where presenting risks of self-neglect have been identified as critical, safeguarding adults procedures should be used and a safeguarding adults enquiry should be coordinated. Attempts should still be made to seek the adult at risk's consent for the safeguarding adults enquiry to take place, however where this is not provided consent should be overridden given the seriousness of the concerns. This is so that the concerns can be fully explored on a multi-agency basis and reassurance can be provided that all possible options to manage risk have been attempted.

Making a referral into safeguarding adults procedures

Safeguarding adults referrals are made to:

Community Health and Social Care Direct (0191 278 8377).

A [Safeguarding Adults Initial Enquiry form](#) (or equivalent) should be completed.

Referrals should only be made out of hours where there is an urgent social care need (0191 278 7878).

Safeguarding adults procedures provide a much more formal, multi-agency, framework for sharing information, assessing and managing risk. As the level of risk/harm is deemed to be critical, **the safeguarding adults enquiry must progress to at least Stage 3 "Strategy"**. Given the level of risk and likely complexity, a Strategy Meeting should be held as opposed to a Strategy Discussion. The Local Authority Safeguarding Adults Manager dealing with the initial concern or referral should seek advice from the Local Authority Safeguarding Adults Unit (0191 278 8156) at the earliest opportunity. A decision should be made as to whether the Strategy Meeting should be chaired by a Safeguarding Adults Manager from the Safeguarding Adults Unit.

The safeguarding adults enquiry should result in a Safeguarding Adults Plan being devised which could include any of the actions/interventions described above when responding to low level harm (refer to section 8.2). In self-neglect cases, the safeguarding adults enquiry should include specific consideration of:

- The mental capacity of the adult at risk in relation to specific decisions;
- Involvement of the adult at risk (and/or their family/a representative), including in the development of a Safeguarding Adults Plan;
- A review of current arrangements for providing care and support. Does there need to be an assessment/reassessment/review? This should include any informal carer arrangements.
- Options for encouraging engagement with the adult at risk (e.g. which professional is best placed to successfully engage? Who would the adult respond most positively to?);
- Any legal options available to safeguard the adult (see appendix 1). Legal advice must be sought;
- Whether there are any other people at risk (including children) and what action needs to be taken if this is case;
- A contingency plan, should the agreed Safeguarding Adults Plan fail;
- How agencies/professionals will keep in regular communication about any changes or significant events/incidents;

- Escalation/notification to senior managers of the case;
- Support for front-line staff delivering services to the individual.

9. Ending involvement

Ideally work will be carried out with individuals, which will result in their situation being improved to a situation where it is deemed to be safe enough. This will be based on decisions made with the individuals themselves, their families/carers (if appropriate) and any agencies involved.

There may come a point at which all options have been exhausted, and no improvement has been established. In cases where a critical level of harm has been encountered and it has not been possible to reduce risks, senior management must be informed and consulted.

Where safeguarding adults procedures have been used, a decision to end involvement must be made on a multi-agency basis and will be based on an individual risk assessment.

The shared decision will be recorded highlighting any monitoring that may be in place. It will also be clear that future concerns will be reassessed if the person is agreeable and motivated to become involved in the future or if risk increases.

Where safeguarding adults procedures have not been used (because the level of risk/harm is deemed to be low or due to a lack of consent) a decision to end involvement should be communicated with the other agencies/services involved.

Appendix 1 – Legal options

There are many legislative responsibilities placed on agencies to intervene in or be involved in some way with the care and welfare of adults who are believed to be vulnerable.

It is important that everyone involved thinks pro-actively and explores all potential options and wherever possible, the least restrictive option e.g. a move of the person permanently to smaller accommodation where they can cope better and retain their independence.

The following outline a summary of the powers and duties that may be relevant and applicable steps that can be taken in cases of dealing with persons who are self-neglecting and/or living in squalor. The following is not necessarily an exhaustive list of all legislative powers that may be relevant in any particular case. Cases may involve use of a combination of the following exercise of legislative powers.

Environmental Health

Environmental Health Officers in the Local Authority have wide powers/duties to deal with waste and hazards. They will be key contributors to cross departmental meetings and planning, and in some cases e.g. where there are no mental health issues, no lack of capacity of the person concerned, and no other social care needs, then they may be the lead agency and act to address the physical environment.

Remedies available under the **Public Health Acts 1936 and 1961** include:

- power of entry/warrant to survey/examine (sections 239/240)
- power of entry/warrant for examination/execution of necessary work (section 287)
- Enforcement notices in relation to filthy/verminous premises (section 83) – applies to all tenure.

Remedies available under the **Environmental Protection Act 1990** include:

- Litter clearing notice where land open to air is defaced by refuse (section 92a)
- Abatement notice where any premise is in such a state as to be prejudicial to health or a nuisance (sections 79/80)

Other duties and powers exist as follows:

- **Town and Country Planning Acts** provide the power to seek orders for repairs to privately owned dwellings and where necessary compulsory purchase orders.
- The **Housing Act 2004** allow enforcement action where either a category 1 or category 2 hazard exists in any building or land posing a risk of harm to the health or safety of any actual or potential occupier or any dwelling or house in multiple occupation (HMO). Those powers range from serving an improvement notice, taking emergency remedial action, to the making of a demolition order.
- Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice under the **Prevention of Damage by Pests Act 1949**.

- The **Public Health (Control of Disease) Act 1984** Section 46 sets out restrictions in order to control the spread of disease, including use of infected premises, articles and actions that can be taken regarding infectious persons.

Housing – landlord powers

These powers could apply in Extra Care Sheltered Schemes, Independent Supported Living, private-rented or supported housing tenancies. It is likely that the housing provider will need to prove the tenant has mental capacity in relation to understanding their actions before legal action will be possible. If the tenant lacks capacity, the Mental Capacity Act 2005 should be used.

In extreme cases, a landlord can take action for possession of the property for breach of a person's tenancy agreement, where a tenant fails to comply with the obligation to maintain the property and its environment to a reasonable standard. This would be under either under Ground 1, Schedule 2 of the **Housing Act 1985** (secure tenancies) or Ground 12, Schedule 2 of the **Housing Act 1988** (assured tenancies).

The tenant is responsible for the behaviour of everyone who is authorised to enter the property.

There may also be circumstances in which a person's actions amount to anti-social behavior under the **Anti-Social Behaviour, Crime and Policing Act 2014**. Section 2(1)(c) of the Act introduces the concept of "housing related nuisance", so that a direct or indirect interference with housing management functions of a provider or local authority, such as preventing gas inspections, will be considered as anti-social behaviour. Injunctions, which compel someone to do or not do specific activities, may be obtained under Section 1 of the Act. They can be used to get the tenant to clear the property or provide access for contractors. To gain an injunction, the landlord must show that, on the balance of probabilities, the person is engaged or threatens to engage in antisocial behaviour, and that it is just and convenient to grant the injunction for the purpose of preventing an engagement in such behaviour. There are also powers which can be used to require a tenant to cooperate with a support service to address the underlying issues related to their behavior.

Mental Health Act 1983

Sections 2 and 3 of the Mental Health Act 1983

Where a person is suffering from a mental disorder (as defined under the Act) of such a degree, and it is considered necessary for the patient's health and safety or for the protection of others, they may be compulsorily admitted to hospital and detained there under Section 2 for assessment for 28 days. Section 3 enables such a patient to be compulsorily admitted for treatment for up to 6 months, this can then be renewed for a further 6 months and then yearly if necessary.

Section 7 of the Mental Health Act 1983 – Guardianship

A Guardianship Order may be applied for where a person suffers from a mental disorder, the nature or degree of which warrants their reception into Guardianship (and it is necessary in the interests of the welfare of the patient or for the protection of other persons.) The person named as the Guardian may be either a local social services authority or any applicant.

A Guardianship Order confers upon the named Guardian the power to require the patient to reside at a place specified by them; the power to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training; and the power to require access to the patient to be given, at any place where the patient is residing, to any registered medical practitioner, approved mental health professional or other person so specified.

In all three cases outline above (i.e. Section 2, 3 and 7) there is a requirement that any application is made upon the recommendations of two registered medical practitioners.

Section 135 Mental Health Act 1983

Under Section 135, a Magistrate may issue a warrant where there may be reasonable cause to suspect that a person believed to be suffering from mental disorder, has or is being ill-treated, neglected or kept otherwise than under proper control; or is living alone unable to care for themselves. The warrant, if made, authorises any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove them to a place of safety.

Section 135 lasts 72 hours and is for the purpose of removing a person to a place of safety with a view to the making of an assessment regarding whether or not Section 2 or 3, or 7 of the Mental Health Act should be applied.

Section 136 Mental Health Act 1983

Section 136 allows police officers to remove adults who are believed to be “*suffering from mental disorder and in immediate need of care and control*” from a public place to a place of safety for up to 72 hours for the specified purposes. The place of safety could be a police station or hospital.

Community Treatment Orders (CTOs)

If a person has been in hospital under the Mental Health Act, a responsible clinician (usually a Psychiatrist) can arrange for a person to have a Community Treatment Order (CTO). This means the person will have supervised treatment when they leave hospital. The person will need to follow the conditions of a CTO. The conditions aim to make sure the person gets the appropriate treatment and can also be used to try and protect the person from harming themselves or other people. Conditions can include where the person will live or where they will go to get treatment. A person can be brought back to hospital if they break the conditions of their CTO.

Mental Capacity Act 2005

The powers to provide care to those who lack capacity are contained in the Mental Capacity Act 2005. Professionals must act in accordance with guidance given under the Mental Capacity Act Code of Practice when dealing with those who lack capacity and the overriding principal is that every action must be carried out in the best interests of the person concerned.

Where a person who is self-neglecting and/or living in squalor does not have the capacity (and this has been assessed) to understand the likely consequences of

refusing to cooperate with others and allow care to be given to them and/or clearing and cleaning of their property a best interest decision can be made to put in place arrangements for such matters to be addressed. A best interest decision should be taken formally with professionals involved and anyone with an interest in the person's welfare, such as members of the family.

The Mental Capacity Act 2005 provides that the taking of those steps needed to remove the risks and provide care will not be unlawful, provided that the taking of them does not involve using any methods of restriction that would deprive that person of their liberty. However where the action requires the removal of the person from their home then care needs to be taken to ensure that all steps taken are compliant with the requirements of the Mental Capacity Act. Consideration needs to be given to whether or not any steps to be taken require a **Deprivation of Liberty Safeguards** application.

Where an individual resolutely refuses to any intervention, will not accept any amount of persuasion, and the use of restrictive methods not permitted under the Act are anticipated, it will be necessary to apply to the Court of Protection for an order authorising such protective measures. Any such applications would be made by the person's care manager who would need to seek legal advice and representation to make the application.

Emergency applications to the Court of Protection - .

You can apply to the Court of Protection to get an urgent or emergency court order in certain circumstances, e.g. a very serious situation when someone's life or welfare is at risk and a decision has to be made without delay. You will not get a court order unless the court decides it's a serious matter with an unavoidable time limit.

Where an emergency application is considered to be required, relevant legal advice must be sought.

Power of entry

The Police can gain entry to a property if they have information that a person inside the property was ill or injured with the purpose of saving life and limb. This is a power under Section 17 of the Police and Criminal Evidence Act 1984.

Inherent Jurisdiction

There have been cases where the Courts have exercised what is called the 'inherent jurisdiction' to provide a remedy where it has been persuaded that it is necessary, just and proportionate to do so, even though the person concerned has mental capacity.

In some self-neglect cases, there may be evidence of some undue influence from others who are preventing public authorities and agencies from engaging with the person concerned and thus preventing the person from addressing issues around self-neglect and their environment in a positive way.

Where there is evidence that someone who has capacity is not necessarily in a position to exercise their free will due to undue influence then it may be possible to obtain orders by way of injunctive relief that can remove those barriers to effective working. Where the person concerned has permitted another reside with them and

that person is causing or contributing to the failure of the person to care for themselves or their environment, it may be possible to obtain an Order for their removal or restriction of their behaviours towards the person concerned.

In all such cases legal advice should be sought.

Animal welfare

The **Animal Welfare Act 2006** can be used in cases of animal mistreatment or neglect. The Act makes it against the law to be cruel to an animal and the owner must ensure the welfare needs of the animal are met. Powers range from providing education to the owner, improvement notices, and fines through to imprisonment. The powers are usually enforced by the RSPCA, Environmental Health or DEFRA.

Fire

The fire brigade can serve a prohibition or restriction notice to an occupier or owner which will take immediate effect (under the **Regulatory Reform (Fire Safety) Order 2005**). This can apply to single private dwellings where the criteria of risk to relevant persons apply.

Appendix 2 - Hoarding

Hoarding Disorder used to be considered a form of obsessive compulsive disorder (OCD). It is now considered a standalone mental disorder and is included in the 5th edition of the Diagnostic and Statistical Manual of Mental Health Disorders 2013. Hoarding can also be a symptom of other mental disorders. Hoarding Disorder is distinct from the act of collecting, and is also different from people whose property is generally cluttered or messy. It is not simply a lifestyle choice. The main difference between a hoarder and a collector is that hoarders have strong emotional attachments to their objects which 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.

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

- Clothes
- Newspapers, magazines or books
- Food and food containers
- Animals
- Medical equipment
- Collectibles such as toys, video, DVD, or CD's

Guidance Questions for Practitioners

Listed below are examples of questions to ask where you are concerned about someone's safety in their own home, where you suspect a risk of self-neglect and hoarding?

The information gained from these questions will inform a Hoarding Assessment (see page 27) and provide the information needed to alert other agencies.

Most clients with a hoarding problem will be embarrassed about their surroundings so adapt the question to suit your customers.

- How do you get in and out of your property, do you feel safe living here?
- Have you ever had an accident, slipped, tripped up or fallen? How did it happen?
- How have you made your home safer to prevent this (above) from happening again?
- How do you move safely around your home (where the floor is uneven or covered, or there are exposed wires, damp, rot, or other hazards)
- Has a fire ever started by accident?
- How do you get hot water, lighting, heating in here? Do these services work properly? Have they ever been tested?
- Do you ever use candles or an open flame to heat and light here or cook with camping gas?
- How do you manage to keep yourself warm? Especially in winter?
- When did you last go out in your garden? Do you feel safe to go out there?

- Are you worried about other people getting in to your garden to try and break-in? Has this ever happened?
- Are you worried about mice, rats or foxes, or other pests? Do you leave food out for them?
- Have you ever seen mice or rats in your home? Have they eaten any of your food? Or got upstairs and be nesting anywhere?
- Can you prepare food, cook and wash up in your kitchen?
- Do you use your fridge? Can I have look in it? How do you keep things cold in the hot weather?
- How do you keep yourself clean? Can I see your bathroom? Are you able to use your bathroom and use the toilet ok? Have a wash, bath? Shower?
- Can you show me where you sleep and let me see your upstairs rooms? Are the stairs safe to walk up? (if there are any)
- What do you do with your dirty washing?
- Where do you sleep? Are you able to change your bed linen regularly? When did you last change them?
- How do you keep yourself warm at night? Have you got extra coverings to put on your bed if you are cold?
- Are there any broken windows in your home? Any repairs that need to be done?
- Because of the number of possessions you have, do you find it difficult to use some of your rooms? If so which ones?
- Do you struggle with discarding things or to what extent do you have difficulty discarding (or recycling, selling, giving away) ordinary things that other people would get rid of?

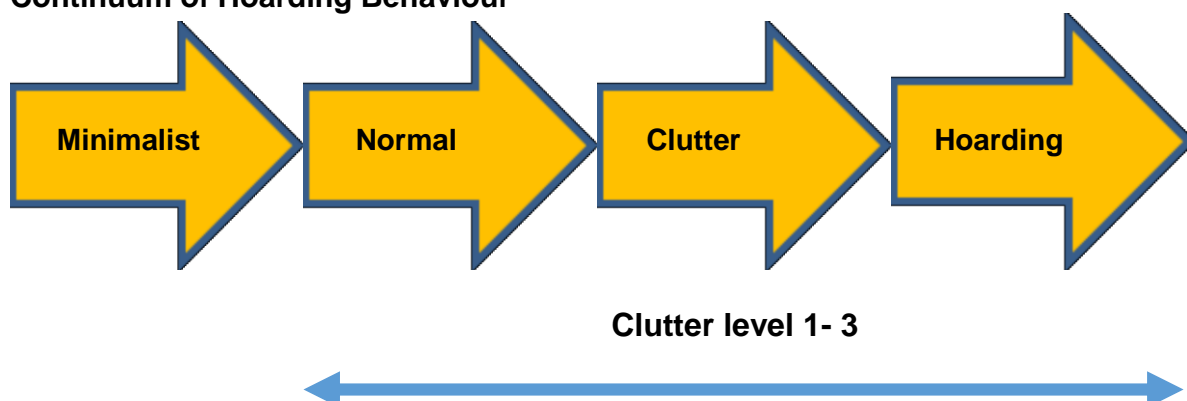
Multi-Agency Response

It is recognised that hoarding is a complex condition and that a variety of agencies will come into contact with the same person. It is also recognised that not all customers will receive support from statutory services such as Mental Health.

Any professional working with customers who may have or appear to have a hoarding condition should ensure they complete the Practitioners Assessment and use the clutter image rating tool kit to decide what steps to take.

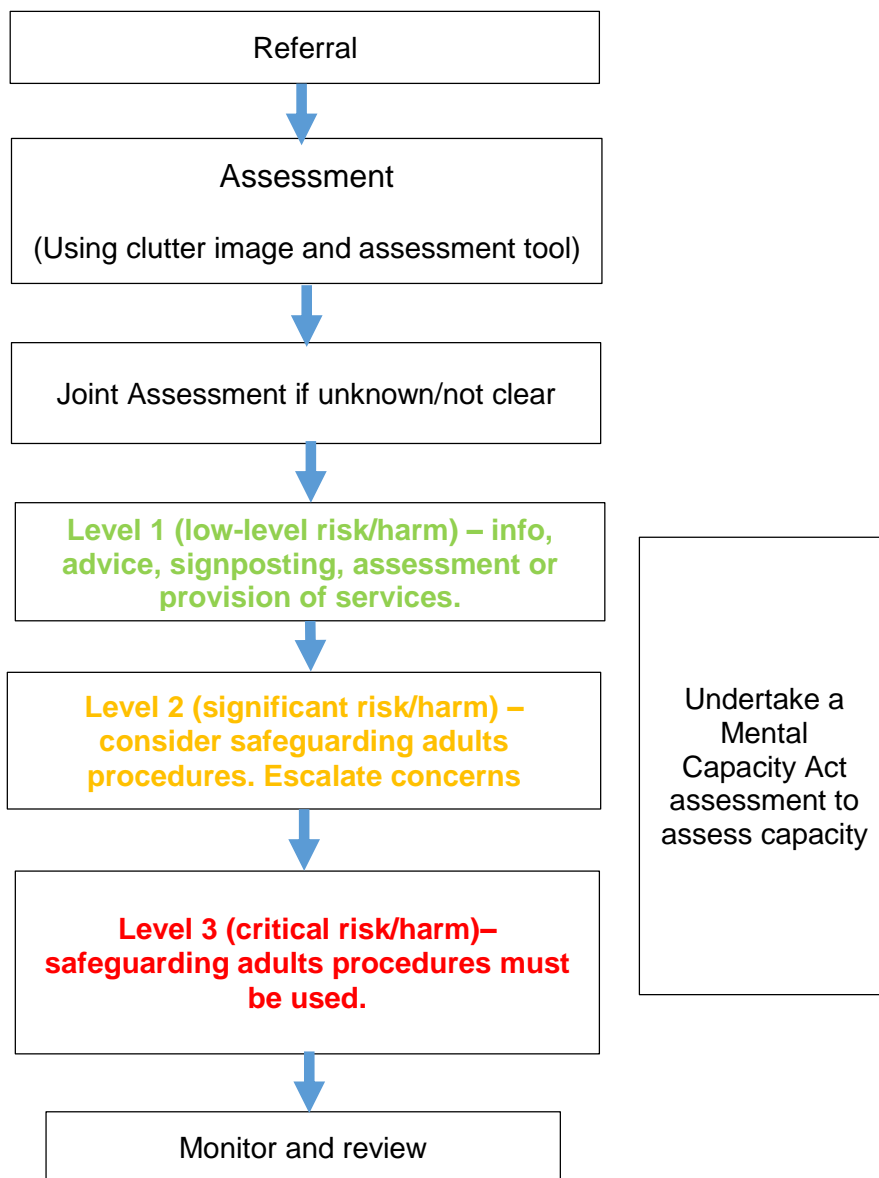
Evidence of animal hoarding at any level should be reported to the RSPCA.

Continuum of Hoarding Behaviour



Process for Clutter Image Rating Tool

The flow chart below sets out the process clearly. If in doubt, please ask your supervisor/manager for assistance.



Please use the clutter image rating to assess what level the customer's hoarding problem is at:

Images 1-3 indicate level 1

Images 4-6 indicate level 2

Images 7-9 indicate level 3

Then refer to clutter assessment tool to guide which details the appropriate action you should take. Record all actions undertaken in agency's recording system, detailing conversations with other professionals, actions taken and action yet to be taken.

Clutter Image Rating Scale - Bedroom

Please select the photo that most accurately reflects the amount of clutter in the room



Clutter Image Rating Scale - Lounge

Please select the photo that most accurately reflects the amount of clutter in the room



1



2



3



4



5



6



7



8



9

Clutter Image Rating Scale – Kitchen

Please select the photo that most accurately reflects the amount of clutter in the room



1



2



3



4



5



6



7



8



9

Practitioner's Hoarding Assessment

This assessment should be completed using the information you have gained using the Practitioner's Guidance Questions. Complete this review away from the client's property and in conjunction with the Multi-Agency Hoarding Protocol Assessment Tool. Text boxes will expand to allow further text. If it falls within your role/remit please attach photographic evidence of property.

Date of Home Assessment					
Client's Name					
Client's Date of Birth					
Address					
Client's Contact Details					
Type of Dwelling					
Freeholder	Yes/No		Tenant – Name & Address of Landlord		
Household Members			Name	Relationship	DOB
Pets – Indicate what pets and any concerns					
Agencies Currently Involved					
Non-Agency Support Currently in Place					
Client's Attitude Toward Hoarding					

Please Indicate if Present at the Property							
Structural Damage to Property		Insect or Rodent Infestation		Large number of Animals		Clutter Outside	
Rotten Food		Animal Waste in House		Concerns over the cleanliness of the Property		Visible Human Faeces	
Concerns of Self Neglect		Concerned for the Children at the property		Concerned for Other Adults at the Property		Concerning smell at property	
Using the Clutter Image Scale Please Score Each of the Rooms Below							
Bedroom 1		Bedroom 4		Separate Toilet			
Bedroom 2		Kitchen		Lounge			
Bedroom 3		Bathroom		Dining Room			
Please refer to the Multi Agency Hoarding Protocol. Provide a Description of the Hoarding Problem: (presence of human or animal waste, rodents or insects, rotting food, are utilities operational, structural damage, problems with blocked exits, are there combustibles, is there a fire risk? etc.)							
Please refer to the Multi Agency Hoarding Protocol Tool, based on the information provided above, what level is your case graded?							
Level 1 - Green		Level 2 - Orange			Level 3 - Red		
Name of the practitioner undertaking assessment							
Name of Organisation							
Contact Details							
Next Action to be Taken							
List Agencies Referred to with Dates & Contact Names							

Appendix 3 – Drug and alcohol misuse abuse and self-neglect

The term drug and alcohol misuse is defined as “drug and / or alcohol taking which causes harm to the individual, their significant others or the wider community”. It can sometimes be referred to as “substance misuse”. The term drug refers to “psychoactive drugs including illicit drugs, prescribed and non- prescribed pharmaceutical preparations.” The term misuse refers to the “illegal or illicit drug taking or alcohol consumption which leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence”³.

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

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

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

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

³ As set out within The National Treatment Agency for Substance Misuse Models of Care (The Framework for developing local systems of effective drug misuse treatment in England, D.O.H. 2002).

Specialist services and access points

The main access point into drug and alcohol support in Newcastle for over 18s is through Lifeline Integrated Service, which offers:

- **Early intervention and prevention** – including brief and extended advice for alcohol;
- **Recovery coordination** – providing a comprehensive asset based assessment, care planning and review; including 1:1s and group work;
- **Psychosocial interventions** – for example, motivational interviewing, skills training;
- **Recovery support** – for example structured day programmes, mutual aid, community integration.

Lifeline Integrated Service provide drug and alcohol specific care coordination for those individuals requiring specialist, structured support, working alongside other services as relevant offering range of tailored support packages and programmes. This includes a close working relationship with NTW Addictions (Plummer Court) who provide clinical assessment and pharmacological support (including prescribing interventions) within the care plan. You can contact Lifeline on 0191 261 5610. Access is through self-referral or referral by other professionals.

Other access points into Newcastle's system are as follows:

- **Lifeline harm reduction service** – an open access, confidential harm reduction service (which includes needle and syringe exchange) 0191 261 4719
- **PROPs family and carer support** – for those affected by a loved ones use or misuse - 0191 226 3440
- **DnA Young People's Service** – under 18s access to drug and alcohol related support and treatment - 0191 277 7377

Information for drugs and alcohol can be found at:

- www.talktofrank.com
- www.hiwecanhelp.com

Appendix 4 – Case Studies

Some case studies have been chosen to provide examples relating to self-neglect with varying levels of risk using the Safeguarding Adults Risk Threshold Tool:

Ms J - meets low level threshold

Ms J is 69 and lives alone in a council tenancy. She is known to adult social care and mental health services. She had a worker in mental health care coordination, until she was closed in the last month.

She was admitted to hospital following a fall which resulted in injury to her arm. She was reported to be under the influence of alcohol was reported to be covered in urine and faeces.

Ms J self- discharged herself from hospital. The Police did a welfare call to Ms J and submitted an Adult Concern to the local authority, reporting that she was still in the same condition as when she left hospital and that her home was also dirty and soiled, with lots of empty alcohol bottles and cans.

Helen and Karen from the adult social care visited Ms J. Ms J's ex-partner Mark had cleared the property and put the soiled bedding into the washing machine. Ms J's bed was very soiled and could not be totally cleaned. Mark said he had some money to buy a second hand bed, however the community resource he was to go to was now closed. Mark was signposted to a new furniture service to buy a bed. Helen also picked up bedding from the Foodbank to have in reserve.

Ms J did not want to attend formal services about her alcohol issues as she was too embarrassed and did not feel that there would be other people her age there. She did agree to a referral to a floating support service. It was agreed that the floating support service would see Ms J every Wednesday morning and they would look at local groups to keep Ms J busy during the day as well as strategies to manage Ms J's alcohol use. It was agreed that the floating support service would update ASC on Ms J's progress.

Elizabeth - meets low level threshold

Elizabeth is an 89 year old woman, with a physical disability, who normally resided with her sister in her own occupied home. Elizabeth was referred to an advocacy service by a Community Psychiatric Nurse for advocacy support around writing a formal letter in relation to the clearance of her home. The sisters were placed in emergency accommodation following concerns from emergency services regarding their home environment, after being called to the house when Elizabeth suffered a fall. This was a situation commonly referred to as 'extreme hoarding'. Elizabeth and her sister had agreed to their home being cleared, but items of furniture had been removed and disposed of without specific consent from Elizabeth or her sister.

In the first instance, the Older People's advocate made enquiries with the local authority Adult Services Dept. and also the furniture Removals and Storage Company, to identify missing items. The advocate also supported Elizabeth to

obtain a benefits check, following which a regular benefit has been paid to Elizabeth, to which she had been unaware of her entitlement.

The advocate continued to support Elizabeth, at meetings regarding her current placement and her expressed desire to return to home and in negotiations with Adult Services, around work that has been required on Elizabeth's home, to clear, clean, make safe and upgrade the utilities, fixtures and fittings. The house was finally ready for Elizabeth and her sister to return to after a year. Unfortunately her sister sadly passed away and Elizabeth decided that she would prefer to remain in residential care (fully funded due to her financial circumstances.)

The advocate continued to liaise with social work and health professionals in order to ensure the residential home was suitable for her needs on a permanent basis. Elizabeth expressed that she had been very grateful for the help she had received negotiating this difficult change in her life.

Mrs L - meets significant harm threshold

Mrs L was born in 1912, and lived in her owner occupied property with her husband; following the death of her husband (approx. 1993) she contacted adult social care several times for support.

Mrs L would ask for an assessment and would go through with the assessment and often accept services then would quickly disengage with services and take a dislike to care staff.

Mrs L's property was in a very unkempt state, she hoarded and her home was full to capacity with everything she declined to throw away. At one stage she refused to throw away left over food. She had always had dogs and she had two very large dogs who she adored.

The outside of her property was also unkempt, she put food down for birds and this attracted vermin. Her neighbours then became intolerant.

Involvement from Adult Social Care commenced in 2004. The property was not only unkempt it was unhygienic and becoming an environmental issue.

It soon became apparent that Mrs L would only accept support at her pace and often not at all. Visits would include supporting her to bag cardboard, newspapers at first and only if the Social Worker promised she would recycle. This may have seemed a small step but we were making some headway in at least making a clear pathway through her property.

The case was time consuming but she would not engage with an agency or a support worker.

Mrs L's health was deteriorating; she was getting frequent infections but did seek medical assistance.

A capacity assessment confirmed she did have capacity to understand the risk posed to her in relation to how she was living and the effect it had on her health.

Presenting Needs:

- Unkempt property/hoarding
- Isolation from her community
- Deteriorating health/personal care
- Environmental issues
- Disengaging with services including my intervention
- Suspiciousness
- Mrs L was diagnosed as having a personality disorder and Diogenes Syndrome (also known as Squalor Syndrome).

Having the diagnosis made it more understandable about how to continue to work with Mrs L.

The process of case management of Mrs L was lengthy and ongoing until she passed away aged 101. Mrs L continued living at home independently.

Steven – meets significant harm threshold

Steven is 62 and lives alone in a supported tenancy. He has multiple needs relating to a chest condition, depression, low motivation and obesity. He receives support from a Housing Support Worker to help with shopping and from a Home Care agency to help with domestic tasks and meal preparation.

He is admitted to hospital after he called an ambulance. There has been a significant deterioration in his health, he has developed a leg ulcer and his mobility has reduced. He meets the ambulance outside his property so paramedics do not see the inside of his home.

In hospital, he tells a Social Worker that his home is “in a state” and that he was embarrassed by it. He agrees that the Social Worker can visit his home prior to his discharge. The Social Worker described the property as “uninhabitable”. There was mould on the walls and on curtains which was due to a lack of ventilation. The kitchen and bathroom were filthy and there was a lot of rubbish all over the property. Steven’s bed did not have any sheets on it and was covered in faeces.

As a result the Social Worker made a safeguarding adults referral about self-neglect, but also querying possible neglect on the part of the Housing and Home Care agency.

The case progressed to a Stage 3 Safeguarding Adults Enquiry, with two strategy meetings being held. The Housing and Home Care agencies reported that Steven had mental capacity in relation to making decisions about his accommodation and his care. They advised that Steven could be difficult to work with as he would often refuse help and support. However, it was discovered that this had not been escalated to line managers, nor had the deterioration in his health or the condition of his property. As no concerns had been passed onto management, the Home Care

agency had undertaken a recent telephone review of Steven's care which had not highlighted any issues.

As a result of the safeguarding adults enquiry, the following safeguarding adults plan was agreed:

- Front-line staff were to report any issues around providing care/support to Steven to their line managers.
- The Home Care and Housing agencies were to communicate with each other about any issues or changes.
- Adult Social Care carried out an assessment of need and increased his care package to include a daily call around personal care.
- The Housing Support Worker (who assisted with shopping) was to encourage Steven to change his shopping habits which was felt to be contributing to his hoarding.
- A referral was made for a wheelchair to assist Steven in getting out and about.
- Emergency funding was sourced to get Steven some new clothes.
- The Home Care workers were to ensure the home was appropriately ventilated at each visit.
- The landlord (with Steven's permission) undertook a deep clean of the flat. This included replacing all the flooring, furnishings and appliances. Steven's fire was also subject to a safety check.

At the second strategy meeting, Steven had been home for a number of weeks and it was reported that all actions had been completed and everything was going well. The Housing and Home Care agencies would be responsible for monitoring the need to re-refer the case into safeguarding adults procedures. An annual face-to-face review would be carried out by Adult Social Care.

Robert – Meets Significant Harm Threshold

A safeguarding adults referral is made by the Police for Robert following a recent attendance at his property. The Police were called following concerns from neighbours.

Robert is 34 and known to misuse substances. He has a YHN tenancy and a tenancy support worker. No formal mental capacity assessments have been undertaken, however the Police have found evidence that suggest Robert is abusing solvents which Police felt were affecting Robert's ability to make decisions.

When Police arrived at the property they heard a disturbance from within but Robert refused the Police entry and so forced entry was required. On entering the flat, Police found squalid conditions; numerous flies in the property; there was an old mattress in the middle of the living room floor and numerous empty bottles and cans of alcohol. Robert's bedroom was ankle deep in rubbish and the whole property smelt strongly of waste.

This is the fifth safeguarding referral in 9 months outlining similar concerns from a number of different agencies. Every previous concern has progressed to a Stage 2 enquiry. The Safeguarding Adults Plan's have centred around addressing the fire risk within Robert's property; attempting to engage Robert in drug and alcohol

services; continuing to attempt to engage Robert with his tenancy support worker; and ensuring regular communication between agencies.

Due to the frequency of referrals and the fact that the previous safeguarding adults plans do not appear to have resulted in any change in Robert's circumstances, it is decided that the case needs to progress to Stage 3 and a multi-agency Strategy meeting held.

The Strategy Meeting ensured that all professionals involved with Robert were clear about his current situation and the level of risk. It was agreed that Mental Capacity Assessments needed to be undertaken in relation to Robert's ability to make decisions in relation to his accommodation (his tenancy was potentially at risk) and around his care and treatment. The Strategy Meeting discussed what had worked and what hadn't worked in the past in order to inform a safeguarding adults plan for the future (including contingency arrangements). The GP agreed to make a referral for a review of Robert's mental health. Legal Services were present at the meeting in order that the potential legal options could be explored.

It was also felt that this case would benefit from progression to Stage 4 of the safeguarding adults procedures in order that an evaluation could be made of how successful the safeguarding adults plan had been. The concerns at this stage did not suggest that Robert was at serious risk of harm but it was acknowledged that there could be the potential for risks to escalate. If this was to be the case and there continued to be a lack of engagement with no legal options available, the case would be escalated to senior managers.

Mr F – Meets Critical Harm Threshold

Mr F is 83 years old who has a medical condition that causes frequent bouts of diarrhea. He has refused medical treatment for this but agreed to try and manage the side effects. However, Mr F is repeatedly admitted to hospital (26 occasions over a 28 month period) to treat dehydration and low potassium levels. Mr F would often self-discharge from hospital against medical advice.

Mr F receives four calls per day from a domiciliary care service to help with personal care, shopping and domestic tasks. However, Mr F does not engage fully with the care package that has been arranged. He does not stop carers coming to his property but is very specific about what he will allow carers to do.

An Ambulance is often called when Mr F's condition deteriorates. Paramedics have submitted 16 Adult Concerns in the 28 month period related to Mr F living in squalid conditions and being emaciated. Concerns include: urine and faeces on furniture, walls and clothes; mouldy food; dirty incontinence pads in bathroom; rubbish bags piled up; and unsafe and unhygienic bathroom and kitchen.

Mr F's capacity has been assessed on numerous occasions in relation to decisions about: self-discharging from hospital against medical advice and refusing care and domestic tasks that were included within his care plan. He is assessed as having mental capacity as he does not have an impairment of the mind or brain. His mental

capacity is repeatedly revisited by various professionals given the seriousness of the concerns.

The case required multi-agency oversight and management via safeguarding adults procedures to ensure that all possible options to reduce risks to Mr F had been explored. The Social Worker involved in the case identified that it took time (and creativity) to build up a relationship with Mr F and to gain his trust. The domiciliary care service has to regularly communicate with Adult Social Care about any difficulties they have in delivering his care and any deterioration in his condition. There continued to be assessments of Mr F's capacity and the landlord considered taking action under the local Clean Homes Protocol (however the case was not felt to meet the threshold for action).

Appendix 5 – Useful contacts

Adult Social Care	<p>Community Health and Social Care Direct http://www.newcastle.gov.uk/social-care-and-health/care-and-support-adults/contact-adult-social-care 0191 278 8377</p> <p>Out of Hours Services (for emergency social care needs) 0191 278 7878</p>
Community Health Services	<p>Newcastle Hospitals Community Health 0191 282 6704</p> <p>GP surgeries in Newcastle</p> <p>Tissue Viability Team 0191 282 6336</p>
Mental Health Services	<p>Community Mental Health Teams (CMHTs) Newcastle West CMHT 0191 287 5060 Newcastle North and East CMHT 0191 287 5300 Referrals via GP, Primary Care Mental Health Teams, Local Authority</p>
Domiciliary care providers	<p>Care Services Directory (services commissioned by Newcastle City Council)</p>
Counselling or therapy services	<p>Newcastle Talking Therapies Service 0300 555 1115</p>
Advocacy	<p>Advocacy Centre North 0191 235 7013 Skills for People 0191 281 8737 Your Voice Counts 0191 478 6472</p>
Voluntary organisations	<p>Newcastle community and voluntary sector online database This online database holds information about Newcastle CVS's members, who are voluntary and community organisations working in Newcastle upon Tyne.</p>
Housing and Anti-Social Behaviour Team (HASBET)	<p>Your Homes Newcastle HASBET 0191 278 8740</p>
Housing Advice and Support Team	<p>Your Homes Newcastle Contact via online referral form or YHN Housing Services Office</p>
Environmental Health	<p>Newcastle City Council 0191 278 7878 and ask for 'Envirocall'.</p>
Falls	<p>Falls and Syncope Service</p>

	0191 282 5237
Children's services (including for child protection concerns)	Initial Response Service 0191 277 2500
RSPCA	Newcastle and North Northumberland Branch 0191 276 1560
Fire Service	Community Safety 0191 444 1002
Debt and money advice	Money Matters Team 0191 277 1050 Citizens Advice Bureau 0344 245 1288
Age UK Winter Warmth	Age UK 0191 232 6488
Police	Protecting Vulnerable Persons (PVP) 101