Aberdeen City Health & Social Care Partnership
A caring partnership

Multi-Agency Guidance for Managing Self-Neglect, Hoarding and Non-Engagement

This guidance provides a framework to complement any single agency protocol or guidance with assessment and intervention in cases of self-neglect and hoarding across Aberdeen.

Changes Mar 24:

Added in reference to / extracts from the revised national ASP Code of Practice
Added in reference to consideration of gender based violence
Added in reference throughout the document to output from the Self Neglect and Hoarding Practitioner Forum workshop on 19th September (and added as new Appendix 1)
Capacity Assessment Tool removed as an appendix - replaced with a link in the doc (at 4.12)
Added a new Section 8 “Moving Forwards, Post Intervention – Self Management”
Added a new Appendix 2 - ‘Hoarding Ice Breaker’ Form
Added a new Appendix 11 – Hoarding Support Checklist
Added a new Appendix 12 – Additional Resources

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Date of Review / endorsement by APC	23rd April 2024

Contents

1. Introduction

1.1 Self-neglect is a behavioural condition where an individual persistently neglects to care for personal hygiene, health conditions or surroundings, including hoarding.

1.2 There are three broad approaches to addressing self-neglect cases depending on the individuals involved, the issues and the level of risk.

Single agency response
Formalised multi-agency
Section 53 of the Adult Support & Protection (Scotland) Act 2007

1.3 Potential indicators of self-neglect might include:

- persistently neglecting to care for one's personal hygiene, health conditions or surroundings, including hoarding;
- poor diet and nutrition or food that is mouldy and unfit for consumption;
- inappropriate and / or inadequate clothing;
- failure to seek help or access services which can reasonably be expected to improve the adult's quality of life;
- hazardous or unsafe living conditions which pose a fire risk, and access difficulties;
- unsanitary or unclean home environment, filthy and verminous causing a health risk;
- inability or unwillingness to manage one's personal affairs;
- self-endangerment through the manifestation of unsafe behaviours;
- social exclusion leading to a fear and uncertainty over asking and receiving assistance;
- the conditions in the property cause potential risk to people providing support or services; and
- Animal/s with potential insanitary conditions and neglect of animals' needs.

1.4 Extreme self-neglect can be known as **Diogenes syndrome**. It may, in a minority of cases, be appropriate to refer an individual for Mental Health Assessment. *[NB If a MH assessment is needed during office hours, a referral would need to be made via the individual's GP, unless they are open to a Community Mental Health Team, in which case this would be requested via that team. In order to establish if someone is open to a Community MH Team, a call should be made to medical records (01224 557275) to establish this. Medical records usually ask for a persons DOB and name in that order and will advise who the person is open to.]*

1.5 Section 53 of the Adult Support and Protection (Scotland) Act 2007 recognises self-neglect as a category of harm and under S4 of the 2007 Act we have a duty to inquire when a person who is self-neglecting meets the three-point test. See also the revised national Code of Practice for Adult Support & Protection (July 2022) (CoP).

The Act defines adults at risk as people aged 16 years and over who:

- are unable to safeguard their own wellbeing, property, rights or other interests; **and**
- are at risk of harm; **and**
- because they are more affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

1.6 The local authority is the lead agency under Section 4 of the Adult Support and Protection (Scotland) Act 2007, if adult support and protection is being considered.

1.7 However, the inclusion of self-neglect in statutory guidance does not mean that everyone who self neglects need to be protected under the legislation. Adult Support and Protection duties will apply where the adult has care and support needs **and** they are at risk of self-neglect **and** they are unable to protect themselves because of their care and support needs.

NB The CoP (p70) notes the following as an example of circumstances where a medical examination should be considered, as part of an ASP inquiry:

- the adult appears to have been subject to neglect or self-neglect and is ill or injured and no treatment has previously been sought.

1.8 There are two types of self-neglect:

- active - intentional neglect - occurs when a person when a person makes a conscious choice to engage in self-neglect; and
- passive – non-intentional - occurs because of health-related conditions that contribute to the risk of developing self-neglect.

While evidence of self-neglect may not prompt a formal Adult Support and Protection response, dismissing self-neglect as a 'lifestyle' choice is **not** an acceptable solution in a caring society.

2. Why do we need local guidance?

2.1 Self-neglect is a serious and complex problem requiring clinical, social and ethical decisions in its management and treatment. This guidance is required for understanding self-neglect and developing a consistent and common practice across all agencies that meet adults who are displaying self-neglecting behaviours whether they have mental capacity or not and who have care and support needs but who do not want help to change.

2.2 Aberdeen City Health & Social Care Partnership is committed to collaborative multi-agency partnership working to assist in increasing awareness of self-neglect and determine the most favourable approach for achieving engagement with the adult at risk in conjunction with a care and support plan to enable responses to be proportionate, appropriate and timely.

2.3 The Adult Protection Co-ordinator can offer advice and support around complex multi-agency work with adults at risk who choose to self-neglect. A failure to engage may have a profoundly detrimental effect on an adult's mental and physical health and wellbeing. It can also impact on the adult's family and local community.

2.4 Supporting operational staff and their managers to identify and respond to self-neglect is a key priority for multi-agency partners. While we are becoming increasingly better equipped to identify self-neglect, we are often challenged in how to respond to it effectively.

At a workshop on 19th September 2023, practitioners involved with self neglect and hoarding cases identified a range of challenges / barriers, including non-engagement / impact of trauma, lack of practitioner 'expertise' and capacity, and lack of a common approach. A summary of the findings of the workshop can be found at Appendix 1 to this Guidance.

The guidance aims to support good practice in self-neglect and non-engagement.

3. Definition and context

3.1 Self-neglect can be described as:

- an extreme lack of self-care to an extent that it threatens a person's health, wellbeing and/or living conditions; and
- may have a negative impact on other people's environments.
- it is sometimes associated with hoarding; and
- may be the result of other issues such as addictions.

3.2 Managing the balance between protecting adults from risk from self-neglect against their right to self-determination is a serious challenge for practitioners in the community. Part of the challenge is knowing when or how far to intervene when there are concerns about self-neglect and a person has mental capacity to make an informed choice about how they are living and the amount of risk they are exposing themselves too.

3.3 As self-neglect is often linked to disability and poor physical functioning, assistance with activities of daily living is often a key area for intervention. The range of interventions can include occupational therapy, housing, environmental health and welfare benefits advice.

3.4 Working with people who do not acknowledge there is a problem and/or are not open to receiving support to improve their circumstances, whether they have mental capacity or not, can be exceptionally time consuming and stressful for all concerned, and usually involves making individual judgements about what is an acceptable way of living, balanced against the degree of risk to an adult and/or others.

3.5 In 2009 the Scottish Government and COSLA issued guidance under Section 5(1) of the Social Work (Scotland) Act 1968 which required local authorities to adopt a common standard eligibility framework for older people. The guidance was intended to focus first on supporting those people who are in more urgent need and ensure that finite resources are targeted on ensuring the most urgent needs are met in a timely manner.

3.6 This Guidance was adapted for local use to ensure that those at greatest need are prioritised and where a person's risk is in the emergency / high category of risk our legal duty to provide care and support should be triggered (Appendix 2). Often, people who self-neglect do not want help to change and this could lead to assessors thinking more casually about a person's needs when determining eligibility, resulting in inconsistent approaches to support and care.

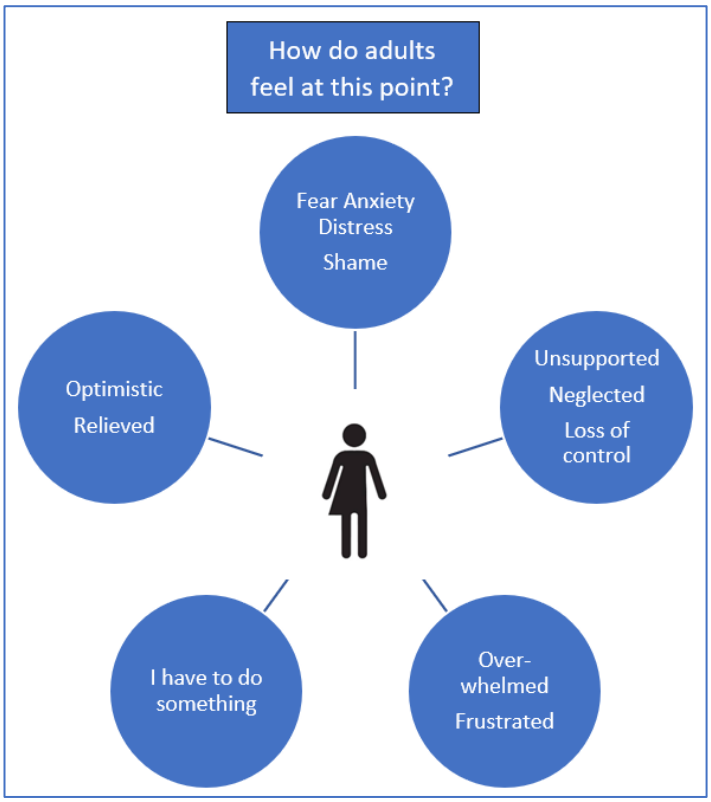
3.7 Self-neglect manifests in different ways and there is an expectation that every effort will be made to respond when neglecting to care for one's personal hygiene, health or surroundings is hazardous to the extent that people are living in extreme conditions of squalor with the potential for profound consequences for their wellbeing and safety.

3.8 Home visits are important, and practitioners should use their professional skills and observe for themselves the conditions of the person and their home environment. Any cause for concern over the person's health and wellbeing should be discussed with them as well as obtaining the person's views and understanding of their situation and perhaps even that of others and their community.

3.9 Situations where adults have been admitted to hospital and there is awareness of self-neglect and hoarding in their home environment can be challenging, given demands and pressures on hospitals that mean they need to move people on and out as quickly as possible. Close working between partners and services in both hospital and community will be required, in order to ensure the best possible outcome.

4. Self-neglect assessment

From SN&H Practitioner workshop on 19/9/23:



What works well?

- Visiting the adult to see what this looks like in practice
- Talking, communication, support, understanding, not being judgemental
- Investigation, building a relationship, trust
- Being curious – how long has the property been cluttered / issues been going on? (history)
- Recent ill-health / trauma?
- See the service user's view
- What would be the individual's ideal situation?
- Let the person keep their own agency to resolve issues
- Utilise positive social support network
- Depends on risk – initial call to partners, eg social work, SFRS, NHS 24 - if needed, raise an ASP
- Deep cleaning and ongoing weekly housing support to maintain home environment

4.1 Sensitive and comprehensive assessment is important in identifying capabilities and risks. It is important to look further through a professional relationship into the possible significance of personal values, past traumas and social networks. Some research has shown that events such as loss of parents as a child, abuse as a child, traumatic wartime experiences, and struggles with alcoholism have preceded the person self-neglecting. The Ice-Breaker Form at Appendix 3 might be a helpful conversation starter.

4.2 The CoP (p21) notes that practitioners should be alert to the need to view behaviours that compromise health, wellbeing and safety as adaptations that may have played a useful role in the individual's life in helping them to survive, and cope with, their experiences of trauma. Examples of such adaptations can include: maintaining contact with an alleged harmer; use of drugs or alcohol; self-harm; hoarding, and avoidance of places and people, including professional relationships and services, which may trigger reminders of prior traumatic experiences. In these circumstances, some people's ability to take and action decisions about safeguarding themselves may effectively be compromised.

There may be a complex intersectionality of physical, social, personal and environmental factors based on each individual's life experience. Practitioners should seek to understand any significance of self-neglect and harm based on the individual's diverse life experience especially where they may have experienced forms of discrimination, trauma and life changing events.

4.3 It should be borne in mind that societal expectations of women vs men as caregivers, homemakers and placing value in their appearance, may lead to increased shame/guilt and reluctance to access support. Interconnected vulnerabilities may lead to more complex trauma for women, amplifying the challenges they face and making accessing support even harder. In addition, traditional gender roles may discourage men from seeking help which is also a negative outcome of gender inequality.

4.4 The CoP (p22) states that it is also **essential** to move from a position of looking at substance dependency in isolation and, instead, to see it in terms of **relational causation and connection**, i.e. a shift from the view that dependency causes self-neglect, to one that understands such dependency as an outward symptom or sign of deeper challenges and of self-neglect itself. As above, considerations of the impact of trauma on the individual's ability to safeguard should be a thread throughout ASP activity [and any other intervention].

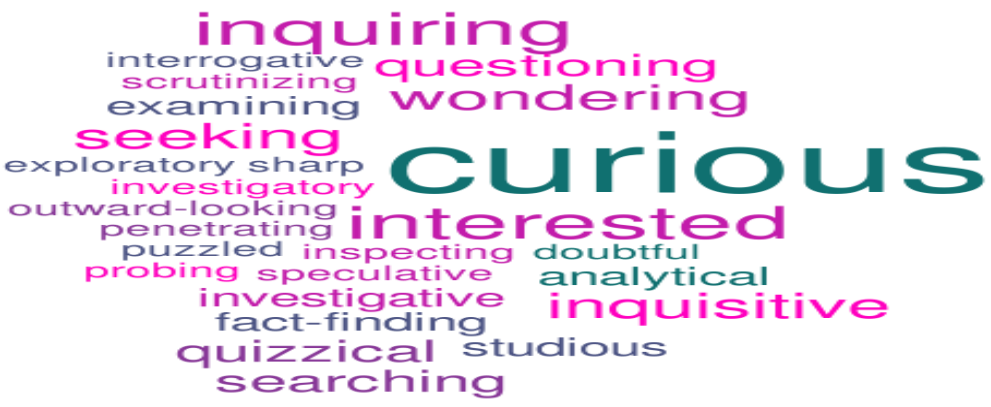
4.5 It is important to consider as part of the assessment if the individual has the skills and competencies, whether it is physical or mental, that can be applied and exploited. For example, an individual may be physically able to wash and dress and clean the house, but due to self-neglect they are not completing these tasks. Therefore, a significant risk to their health and wellbeing may arise. Where an individual may be able to do something for themselves but cannot due to self-neglecting behaviours, this may mean that they could be eligible for care and support.

4.6 The assessment process should include the person's understanding of the cumulative impact of a series of small decisions and actions as well as the overall impact. Risk assessment and risk management (Appendix 4) is an essential part of the process and risk enablement is a core part of placing people at the centre of their own care and support. The focus should be on a person-centred approach to engagement and risk management leading to outcomes for the individual wherever possible.

The possibility of Gender Based Violence should be considered as part of any assessment of an adult at risk. Professional curiosity is essential, especially given higher rates of self-neglect/hoarding in older adults who may have different views/values around some forms of gender-based violence. Information about support services can be found at: Services in Aberdeen - Aberdeen Protects (aberdeencity.gov.uk)

4.7 Professional curiosity and appropriate challenge should be embedded within an assessment:

- it is important that the practitioner does not make assumptions or accept the first, and potentially superficial response.
- do not accept things at face value.
- interrogate more deeply into how a person understands and could act on their situation.
- be honest about potential consequences while also being non-judgemental.
- separate the person from the behaviour.
- take time to get to know the person; and
- maintain contact and reliability.



4.8 The new Health and Social Care Standards: “my support, my life” are wide reaching and flexible and focused on the experience of people using services and supporting their outcomes. They are human rights based and underpinned by 5 principles: dignity and respect, compassion, being included, responsive care and support and wellbeing. They are no longer just focused on regulated care settings but for use in social care, social work, and health provision, and should be referred to when planning and delivering care. Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)

4.9 Assessing mental capacity and trying to establish a root cause for self-neglecting behaviours is often a complex phenomenon. It is important that staff are familiar with and recognise the risk factors associated with this condition. Some people have insight into their behaviour, while others do not.

There are various reasons why people self-neglect:

- brain injury, dementia, or mental disorder;
- obsessive compulsive disorder or hoarding disorder;
- physical illness or disability which influences abilities, energy levels, organisational skills or motivation;
- alcohol or drug dependency or misuse;
- traumatic event or childhood trauma;
- social factors and diminished social networks;
- life-changing events such as bereavement and loss;
- fear, anxiety, or pride in self-sufficiency; and
- age-related changes.

4.10 Every adult has the right to make their own decisions and must be assumed to have capacity unless it is proved otherwise. Just because an individual makes what might be seen an unwise decision, they should **not** be treated as lacking capacity to make that decision.

4.11 Mental capacity is a key determinant of the ways in which professionals understand self-neglect and how they respond in practice. Where individuals lack capacity and there are concerns about self-neglect then the principles within the Mental Health (Care and Treatment) (Scotland) Act 2003 become relevant and anything done for or on behalf of the adult must be done in their best interests and should be the least restrictive of their basic rights and freedoms.

4.12 The Decision-Specific Screening Assessment Tool must be completed if an agency is in doubt that the adult lacks the ability to use and understand information to make an informed decision and communicate any decision made. It is also important to understand the function-specific nature of capacity, so that the apparent capacity to make simple decisions is not assumed automatically in relation to more complex ones.

4.13 Sometimes it may be necessary to override the person’s right to choose in situations where the adult has capacity to make informed decisions on the issues raised but refuses to engage and concerns continue to escalate. Such situations might include:

- Serious concerns for physical or mental health and wellbeing are adversely affected daily, including weight loss & pressure ulcers;
- When a services usual way of engaging with the adult at risk has not worked and no other options appear available;
- Enforcement is being considered using statutory powers.

4.14 Overlooking or dismissing these degrees of risk is not an acceptable solution and does not absolve any agency from their duty of care or professional responsibility. The agency should risk-assess and determine what intervention needs to be considered.

4.15 When engaging with an adult who is self-neglecting, and who may have difficulty with their executive functioning (the ability to plan, organise and complete tasks) consider whether:

- they have information in a format they can understand;
- conversations take place over time and the building up of a relationship;
- consider who can support you to engage with the adult;
- always involve attorneys or representatives if the adult has one;
- check whether the person understands their options and the consequences of their choices;
- ensure the adult is invited to attend meetings, where possible; and
- arrangements should be made for monitoring and making proactive contact with the adult at risk and, if they exist, extended family and community networks.

5. Pulling together to find solutions

From SN&H Practitioner workshop on 19/9/23:

What works well?

- Good communication between agencies – opinions are valid – being able to discuss with partners what can be offered, and how to respond – what to say and what not to say
- Information sharing, informed case handover, shared experiences
- Collaboration / shared working & responsibility – all working to the same level of intervention / agreed action plans
- Concern identified and being addressed
- Support workers in Social Work – more time / capacity to work with people - flexible
- RSL – continued housing support once issue identified
- Therapeutic relationships are really critical
- Involvement and inclusion

5.1 Self-neglect is a real challenge in times of shrinking resources and ever-growing demands and most agencies cannot go it alone. What is required is a joint approach with both statutory and voluntary organisations working together to find solutions. Partnership working also supports evidence-based practice which is important within the complexities of self-neglect.

5.2 A co-ordinated approach by a range of organisations are likely to be more effective than a single agency response, and a co-ordinated action have led to improved outcomes for individuals. The message is that there does not need to be an adult support and protection investigation for different groups to work together. Self-neglect concerns are everyone's

responsibility and if self-neglect is significant and ongoing risks remain, it will be necessary to convene a multi-agency meeting. (List of partners / roles at Appendix 5)

5.3 Multi-agency meetings are often the best way to ensure effective information and communication, and a shared responsibility for assessing risks and agreeing an action plan.

Principles of a multi-agency meeting:

- A lead agency will need to be identified [if not considered under ASP, in which case a Council Officer will take the lead];
- The lead agency is responsible for convening the meeting and minute taking;
- Involve the adult as early in the process and if the adult does not wish to or is unable to attend, the lead agency will agree how information will be fed back to them;
- Advocacy support should be offered if required;
- The meeting will be formally chaired, and responsibilities recorded on a shared action plan; and
- Participants come prepared with required information and ensure any actions have been carried out.

5.4 When convening a multi-agency meeting, the practitioner must check with the Scottish Fire and Rescue Service whether the case is known, and a relevant member of that team should be invited to attend the meeting.

5.5 The adult at risk should be informed by the worker that a meeting will take place and why. An advocate should be offered if this is identified or if this is the wish of the individual. An appropriate 'lead professional' should be agreed at a multi agency meeting. This professional will coordinate the support around the individual, and chair multi agency meetings. The agenda (Appendix 6) and aide memoire (Appendix 7) templates can be used.

- Identify who will be responsible for coordinating actions.
- Determine when a further meeting will be required.

It is important that the meeting is accurately recorded, and action points are clearly identified. Timescales for achieving actions should be set at the meeting and will be specified within the shared action plan but remember that each adult's situation is unique. A date will also need to be set for a review meeting and any revised actions agreed.

5.6 The multi-agency meeting should agree the risk management support plan using the template provided in Appendix 4. [NB Where an individual is being supported and protected

under ASP, relevant ASP documentation would be used.] The multi-agency meeting should identify the level of risk by using the risk matrix and completing the risk matrix outcome, determining the current risk factors and completing the risk management plan. Members of the core group should be clearly identified in the plan along with the lead co-ordinator. This could be a social worker or other relevant professional.

5.7 Having established a risk management support plan, the adult's resistance and willingness to be supported should be tested through the implementation of the risk management support plan. The implementation of the plan should be coordinated by the person or agency most likely to succeed in further engagement with the adult to attempt to achieve the outcomes.

5.8 How a case is monitored should be agreed with the lead professional identified at a multi agency meeting, and any subsequent review meetings to monitor the situation or concerns should be scheduled. (Appendix 8). The level of risk should be reviewed at subsequent review meetings, if necessary. Where a key person is identified to take the lead in engaging with an adult who is self-neglecting, it is important that appropriate support is provided from relevant professionals when needed and the ability to reflect upon the case is managed through appropriate supervision, guidance and specialist self-neglect training where this is relevant to their role.

6. Information sharing

6.1 Practitioners and agencies must understand the following:

- when to share information;
- what information to share;
- how much information to share;
- who to share the information with; and
- the way in which the information should be shared.

Practitioners must also understand the possible adverse consequences of not sharing information.

6.2 Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under GDPR and Data Protection Act 2018 you may share information without consent if:

- it is required by law; or directed by a court;
- the benefits to an adult that will arise from sharing the information outweigh both the public and the individual's interest in keeping the information confidential.

6.3 You must weigh the harm will need to base your judgements on the facts of the case and when sharing or requesting personal information be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared. Guide to the UK General Data Protection Regulation (UK GDPR) | ICO

6.4 There will be many situations where it is necessary or desirable to share information with other practitioners and between agencies:

- where relevant and with the relevant people;
- limited to what is necessary, not simply all information held;

- is adequate and sufficient to properly fulfil your stated purpose for sharing; and
- where there is a specific need for the information to be shared at that time.

Legislation supports lawful information sharing and should not be seen as a barrier.

The legislation underpinning information sharing includes:	
The General Data Protection Regulation (GDPR)	GDPR is a legal framework that sets out guidelines for the collection and processing (sharing) of personal data (information) and special category data (information) of individuals within the European Union (EU).
	GDPR describes the principles which must underpin information sharing practice and the basis (formerly known as conditions) upon which information can be shared. All practitioners must understand the principles and basis for sharing information.
The Human Rights Act 1998	
European Convention on Human Rights (ECHR).	
The Data Protection Act 2018	

6.5 You must keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.

6.6 Practitioners should always refer to and comply with their own service / agency information sharing guidance and should always consider whether there is a legal requirement to seek consent to share information.

7 Developing an approach

7.1 The starting point for all interventions is to encourage the person to do things for themselves. Where this fails in the first instance, this approach should be revisited and all efforts and responses of the person to this approach should be fully recorded.

7.2 Research suggests that improvements to health, wellbeing and home conditions can be achieved by spending time building relationships and gaining trust. When people are persuaded to accept help, short-term interventions are unlikely to be successful - practitioners should be enabled to take a long-term approach.

7.3 Communicate to the adult regarding the timings of appointments and when these will take place to avoid drift and maintain momentum during which some action can be taken that will

achieve a desired outcome. We should make it easier for people to strengthen their networks or engage in existing or new hobbies and receive the opportunity to meet people and share interests. Make use where possible of any existing safe environment or someone the adult trusts when introducing the idea of support and/or services. Consider options for short-term respite if required, for example.

Positive engagement:

- identify the underlying causes that help to address the issue;
- it is not helpful for practitioners to make judgements about cleanliness;
- try and empathise even if it is behaviours you do not understand;
- agree small steps;
- the person may fear losing control, it is important to allay such fears;
- it can be helpful to make agreements to achieve progress;
- regular, encouraging engagement and gentle persistence may help with progress and risk management; and
- robust risk assessment may be the best outcome achievable if it is not possible to change the adult's behaviour.

7.4 Providing small practical help at the outset may help build trust.

Practical tasks may include:

- utilising local partners such as RSPCA, the fire service, environmental health, and housing;
- helping with property management and repairs;
- some individuals may be helped by counselling or other therapies, including obsessive compulsive disorder or addictions; and
- facilitating or co-ordinating doctors' appointments or providing practical support to attend appointments.

7.5 Where a person cannot face the scale of the task but is willing to make progress, offer to provide decluttering or 'deep cleaning' services. When significant risks are identified, and serious harm is implied gaining quotes for work needed to restore essential safety and hygiene to unsafe and unhygienic properties may be required.

7.6 If the person is refusing to have a non-residential financial assessment or pay for support, discussion should take place with relevant managers across social work and housing to consider the justification for suspending or wavering charges, even on a temporary basis, to allow critical support to be provided. This can sometimes be a way of engaging the individual and/or reducing a significant or immediate risk.

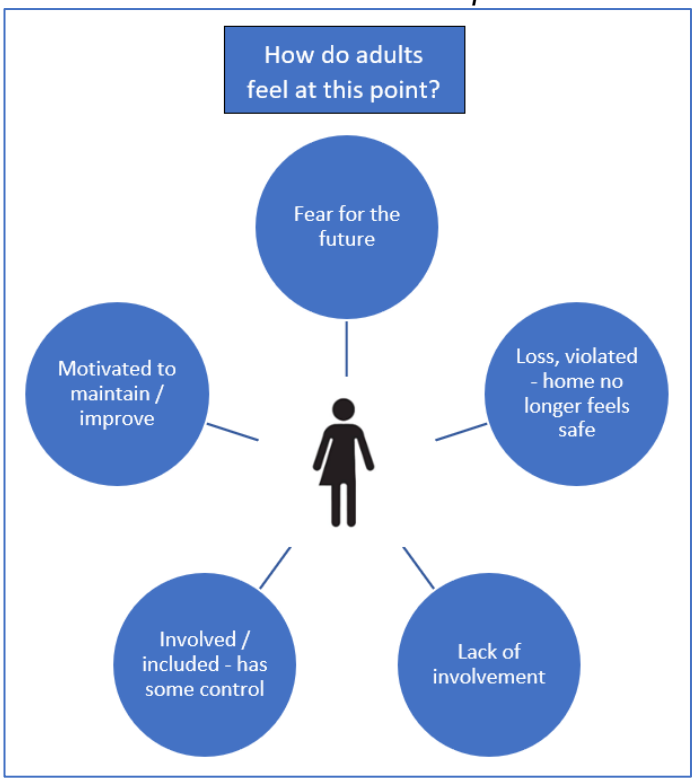
7.7 Each case will need to be assessed on an individual basis. It should also be remembered that children can be affected by adults who self-neglect. Where there are concerns for a child in the context of an adult who displays self-neglect, the Children's Reception Team should be contacted. [Tel: 0800 731 5520]

7.8 If the situation surrounding the adult at risk meets a significant level of risk, the worker should discuss with their line manager who should advise whether a multi-agency case conference should be instigated. **PLEASE CONSULT THE CLUTTER IMAGE RATING** https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf.

Ratings reaching scale 4 or above should be raising concerns and starting an intervention.

8. Moving Forwards, Post-Intervention – Self Management

From SN&H Practitioner workshop on 19/9/23:



What works well?

- Setting SMART goals
- Show people what is improving – praise to all
- Consistency in support
- Collaboration
- Communicating, building trust, working with the person's agreement and at their own pace, being person-centred and building a positive therapeutic relationship
- Ongoing support and reviewing of overall situation
- Build rapport as much as possible and with as many people as possible
- Use routine, return to normality – building back to normality

8.1 There are challenges for all services with providing ongoing long term support where this is needed in such cases, and it is recognised that there may come a time when consideration must be given as to how best to support an individual to 'self management', possibly with the support of other services or community / family supports.

8.2 The hardest thing for someone who is self-neglecting / hoarding is often deciding to address the issue. They may not see their behaviour as a problem and so struggle to find the motivation to change. Or they may see change as too overwhelming or scary a proposition. Investing in the right tools and techniques can help individuals develop their self-management skills that are essential if you want to stay organised and focused.

What is Self-management?

8.3 Self-management can be learned. It is key to putting people in the driving seat and instilling them with a sense of purpose and motivation that affects behaviour change.
The key question in self-management support shifts from 'What is the matter with you?' to 'What matters to you?'.

PROMOTING SELF-MANAGEMENT AND INDEPENDENT LIVING

APracticalGuideToSelfManagementSupport.pdf (health.org.uk)

8.4 Effective self-management requires a shared responsibility across health and social care systems and a common understanding of and commitment to self-management support.

8.5 Self-management support allows people to play a more active role in making difficult lifestyle changes by ensuring they receive:

- the full range of support they need to manage the physical, emotional and social impact of their long term health conditions at different times during their lives; and
- the care and support planning, which is often seen as the gateway to identifying the self-management support needs that individuals have.

8.6 Self-management support is an important component of person-centred care which has 4 principles:

1. Affording people dignity, compassion and respect
2. Offering co-ordinated care, support or treatment
3. Offering personalised care, support or treatment
4. Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

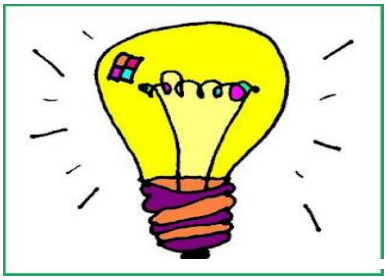
8.7 For people living with long-term health conditions, self-management support within services means:

- Involving the adult -being active partners in determining outcomes that are important to individuals and how to achieve them;
- Getting good information - people are given access to good quality information to develop their knowledge and resilience to tap into their strengths and support systems to overcome challenges and work through problems;
- Achieving self-confidence - to manage the impact of their symptoms and limitations so the adult can manage their own health and wellbeing, as effectively as possible;
- Behaviour change – having access to a range of the joined up support they need within and beyond health services provides direction to better manage their own health and wellbeing on an ongoing basis; and
- Technical skills – involves the practical knowledge individuals use in order to complete tasks e.g., learning basic skills

http://selfmanagement.kyoh.org

Each of these elements should be mixed and matched according to the specific needs of the individual to help them on the road to effective self-management.

The lightbulb moment



That moment of sudden insight when an individual realises they can do it and are confident and capable enough to reach their own goals and manage their own needs.

Some things an adult may want to consider to help themselves cope with hoarding

Not all of these suggestions might work for the individual but it is okay to try a few things before they find out what works best. Helping someone who is hoarding - Mind

Starting to manage your hoarding

8.8 It's not unusual for adults who are trying to cope with a hoarding problem to feel overwhelmed and that helping themselves will be too hard or take too long, or they don't know where to start. Taking small steps can help them make good progress. For example:

- setting small goals such as throwing away one thing per day;
- try to tidy one area by setting a timer, or listening to a set number of songs;
- schedule one hour a week for cleaning and try to plan where your items go such as in the bin or as a donation;
- make a rule that if the item hasn't been used in the last year it will be gotten rid of; and
- explore new activities that doesn't involve buying or saving things e.g., walking groups or condition-specific peer support groups.

Staying motivated

8.9 An adult who has been trying to manage a hoarding problem might feel like they are getting nowhere and need help to keep them motivated and notice how far they have come:

- track progress by taking before and after pictures of the space chosen to be cleaned;
- make things easier by using a litter picking tool to pick things up without touching them;
- find support for related issues to takes some pressure off such as money worries, addiction or housing problems;
- celebrate wins no matter how small they seem; and
- ask for help as sometimes just having someone to talk too before or after you clear can be useful.

Coping with difficult feelings

8.10 Trying to manage hoarding might bring up a lot of difficult feelings, which can make handling practical tasks harder:

- share feelings by talking to someone;

- try peer support - connecting with people with shared or similar experiences can be helpful;
- note down moods and feelings in a diary – can help spot patterns in what triggers hoarding behaviour and the reasons behind difficult feelings;
- taking time to relax as managing hoarding can be very hard work; and
- getting enough sleep and physical activity to look after general wellbeing.

Keeping safe

8.11 Hoarding can lead to a higher risk of fire spreading or escaping from a fire in an emergency. Make sure the place is safe. For example:

- ask the Scottish Fire and Rescue Service (SFRS) to do a safety check;
- help to stay safe around gas and electrical appliances;
- plan an escape route and know where to go; and
- visit the GP and consider whether there are any other health related problems related to the hoarding.

Supporting an individual's capacity for self-management

8.12 Self-management is a process and the challenges presented to adults and the techniques for overcoming these may change at different points in an intervention.

It is necessary for practitioners to:

- work with the adult to identify any challenges to effective self-management;
- help the adult identify goals that they find meaningful;
- apply self-management strategies to behaviours that they wish to change;
- plan appropriate levels of activity and identify incentives / self-reward;
- design bespoke action plans and help adult's review and revise goals over time; and
- reflect on the self-management techniques that they have found effective

As previously outlined, an ability to assess the adult's likely capacity to self-manage in terms of their:

- capabilities - physical and psychological resources e.g., physical skills, strength or stamina and the ability to engage in the necessary thought processes, comprehension and reasoning to perform the target behaviours;
- physical opportunities in terms of time or social opportunities in terms of relationships and local community assets and resources; and
- motivation or resources to build motivation such as reflecting on what they appreciate in their lives.

9. Non-engagement and service refusal

9.1 Concerns for self-neglect will follow the usual referral process in the first instance and self-neglect cases already allocated to a practitioner or a team should go directly to that worker or team to consider what actions are required to minimise risk to the adult or others (Appendix 9).

9.2 When attempting to work with people who are difficult to engage, and we are not being successful, it is important to give that person the impression you can help them. Find out what is important to that person and when engaging them in a conversation let them do most of the talking. Find something that motivates the adult and provide value to them first before expecting anything in return. (Appendix 10).

9.3 If the adult's ongoing refusal means that it has not been possible to undertake an assessment fully or the conclusion of the need's assessment is that the adult refuses to accept the provision of any care and support, multi-agency case recording should always be able to demonstrate that all necessary efforts and actions have been taken to carry out an assessment that is required, reasonable and proportionate in all the circumstances. This should include recording what steps have been taken to involve the adult and any carer and the outcomes that the adult wishes to achieve in day-to-day life and whether the provision of care and support would continue to the achievement of these outcomes.

9.4 **The case should not be closed simply because the person refuses an assessment or to accept a plan to minimise the risks associated with the specific behaviour(s) causing concern**. It should be demonstrated that appropriate information and advice has been made available to the adult, including signposting to alternative services or community resources, or contact with the adult's GP.

10. When no further interventions can be planned

10.1 There may come a point where all options have been exhausted and no further interventions can be planned. Where agencies are unable to implement services to reduce or remove the risks, the reasons for this should be fully recorded and maintained on the person's file. The efforts and actions taken by the agencies to assist the adult at risk should be fully recorded.

10.2 The adult at risk, carer or advocate should be fully informed of the support offered and the reasons why the support has not been implemented. The risk must be shared with the person to ensure they are fully aware of the consequences of their decisions, including the risk of death. There is a need to make clear that the adult at risk can contact the relevant agency at any time in the future for support and provide details of who to contact should be provided.

10.3 Before the multi-agency meeting disbands any ongoing needs for the individual should be clearly identified and communicated to the relevant agencies. It is important to ensure that meetings, discussion, actions and outcomes arising from each stage of the procedures are fully recorded on appropriate recording systems. This will highlight that partner agencies have exercised their duty of care in a robust manner and as far as possible.

10.4 In cases of significant risk, the role of monitoring the adult at risk, should be considered and legal advice should be sought.

11. Support arrangements for professionals

11.1 Working in a complex and demanding situation can be stressful for operational staff. Regular support and supervision from appropriate line management should be provided to support frontline staff involved. The Hoarding Support Checklist is a tool which may be used for this purpose (see Appendix 11).

11.2 Appropriate and specialist self-neglect training may be accessed, where this is relevant to the role.

12. Unpaid carers

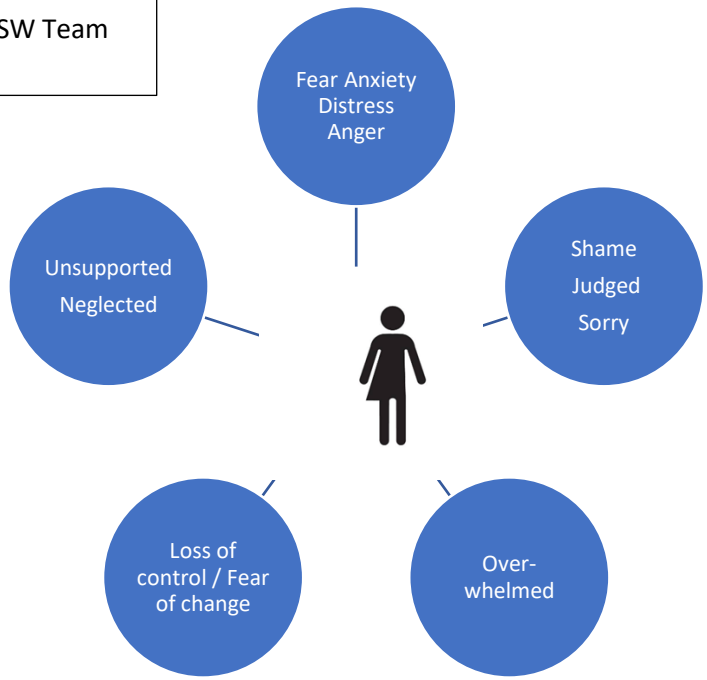
12.1 Unpaid carers may self-neglect because of their caring responsibilities. Workers should be aware of the impact that caring for a vulnerable person might have on the carer and ensure that an Adult Carer's Assessment is carried out and appropriate support offered.

Self Neglect & Hoarding Cases – Pathway: 1. Initial Awareness

How do services become aware of cases?
- Initial call to Police from a member of the public or a service, or could arise from a call for another non-related incident
- A concern from the community
- An ASP Referral or a drop-in to the Duty SW Team
- Public contact Environmental Health

What does this look like?
12. nhy gie

How do adults feel at this point?



What do services do at this point?
- Attempt to contact the adult to find out their knowledge of the risk of the situation
- Check systems for previous involvement, approaches taken, patterns of behaviour
- Risk-assess the situation
- iVPD (Police) to inform partners
- Communicate with other services
- Consider if ASP referral would be appropriate

What are the Challenges and Barriers?
- Difficulty in accessing a client to undertake initial assessment
- Capacity / Resourcing
- Risks not always seen
- Professional differences
- Capability / Lack of insight
- Professionals may feel they are 'above' lots of cleaning with individuals
- Consent
- Different 'standards' of those involved
- Expectations of service user, worker, line management
- People falling through the gaps
- Don't be tempted to "fix it" but work with the person to develop their agency within acceptable time frames

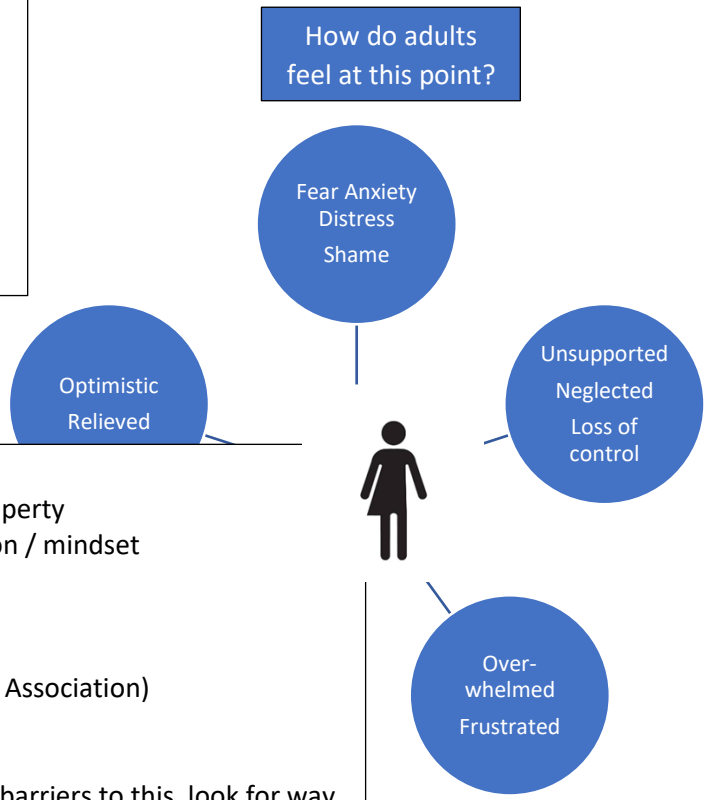
Even better if …
- Earlier intervention, recognising red flags – need to work these out!
- Working with and not doing for
- Multi agency discussion (including Psychology involvement)
- More time to work with the adult / Less paperwork
- More face to face / Consistent approach from an individual familiar with the client and their personal circumstances
- Education and better understanding re options / legal options
- Consideration of new learning / skills
- Where to go next / Follow-up

What works well?
1. Visiting the adult to see what this looks like in practice
2. Talking, communication, support, understanding, not being judgemental
3. Investigation, building a relationship, trust
4. Being curious – how long has the property been cluttered / issues been going on? (history)
5. Recent ill-health / trauma?
6. See the service user's view
7. What would be the individual's ideal situation?
8. Let the person keep their own agency to resolve issues
9. Utilise positive social support network
10. Depends on risk – initial call to

Pathway: 2. Single Agency Response

What does this look like?

- Positive - that the concern is being addressed
- Perceived expectation to solve the problem. (Feeling of powerlessness if non-engagement)
- Lack of understanding amongst colleagues / management as to how working in this situation has to be
- Lonely, unsupported, pressured



What works well?

- Building relationships / Understanding
- Time
- Communication / Involvement
- Ability to contact social work etc for their help / refer to ASP
- Raising VPD
- Identifying partners to involve, eg Housing, care management / OT / PT / District Nurse / GP / consultants etc / specialist nurses & practitioners eg mental health, MS, Parkinsons, drug and alcohol etc, third sector, SFRS, RSPCA

What are the Challenges and Barriers?

16. Restricted by the limitations of the property
17. The person's perception of the situation / mindset
18. Lack of training
19. Tick box exercise
20. GPs delays
21. Issues with access for repairs (Housing Association)
22. Personal tolerance
23. Feeling it's your sole responsibility
24. Lack of trusting relationships – look at barriers to this, look for way in
25. Non-engagement – long term work but risk of harm requires quick action
26. Bereavement keeps people in a time warp
27. Capacity / understanding of capacity
28. Lack of ability to help people who need it but can't see the risk

Even better if …

- More time / space to work effectively with the service user
- Having a better idea of available tools / resources / services
- Specialist service required
- Training and support to ensure have skills to deal with this
- Multi agency support
- Not to be in crisis

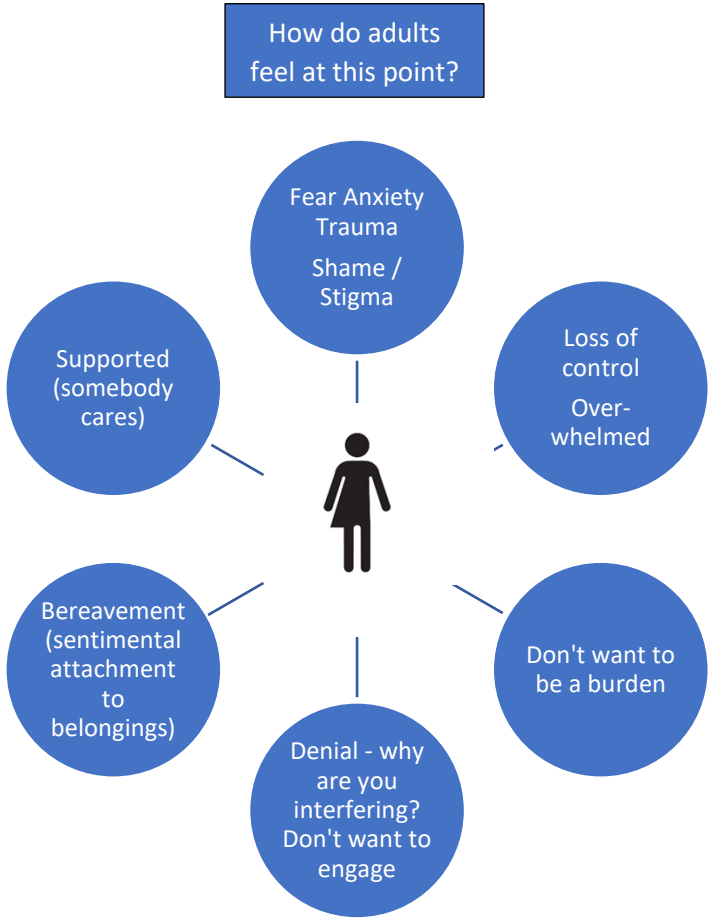
Pathway: 3. Multi Agency Response

What does this look like?

- Multi agency working / meetings (social work usually leads)
- Making appropriate referrals
- Refer for Home Fire Safety Visit / SFRS joint visits, mobility alarms, SFRS "vulnerable marker"
- Environmental Health – contact social work - can't give response to public queries
- Falls risk identified

What are the Challenges and Barriers?

- Housing – frustration, lack of understanding about their role – expectation that they can do more than they actually can
- Slow progress / time things take
- Lack of resource / availability / excessive caseloads
- Problems re engagement could be because someone else is controlling the engagement – eg domestic abuse
- Complexity – lots of different things driving it; trauma; cot death; miscarriage; care experienced; abusive relationships
- Not allowing those with the skills to do the work, ie Care Management, OT etc – support staff but without the training
- Physios: seeing patient as a one-off – difficult to resolve
- Private sector accommodation
- Knowing how to access support such as befriending – building belonging
- Not meeting criteria for certain services
- Trusting relationships are really key – issue when staff move on / holidays



What works well?

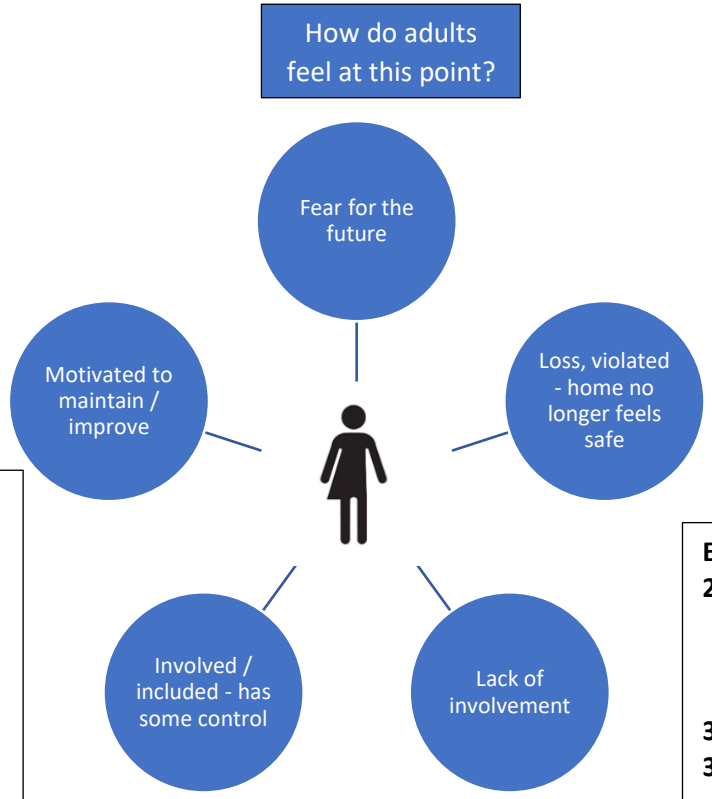
- Good communication between agencies – opinions are valid – being able to discuss with partners what can be offered, and how to respond – what to say and what not to say
- Information sharing, informed case handover, shared experiences
- Collaboration / shared working & responsibility – all working to the same level of intervention / agreed action plans
- Concern identified and being addressed
- Support workers in Social Work – more time / capacity to work with people - flexible
- RSL – continued housing support once issue identified
- Therapeutic relationships are really critical
- Involvement and inclusion

Even better if …
- Case discussions before crisis point reached
- People not coming with their own agenda
- SFRS referral form – add to the SN Guidance?
- Environmental Health: would be helpful to have updates re what is happening
- Having clear guidance re what referrals can be made / what services can be contacted / a list of professionals, organisations and roles, including third sector / better understanding of roles (eg Housing)
- More awareness and education re treatment options / shared training and reflection
- Complete the task – it does not stop when a property is cleaned – leave new skills and compensation strategies
- What service is best to lead? Best for the person – does it have to be SW led?
- Feedback from the client to improve the service
- Inclusion in university teaching
- A service to sell items for people?
- Use of language is important
- More 'visuals' for the client

Pathway: 4. Going Forwards

What does this look like?
- Identifying what supports are in place / funding – Welfare Fund
- Staying allocated for an agreed time
- Knowing when to hand over to the next service – which is the right service? How and 'fit'?
- How do we share learning about moving people on with colleagues, in a cross-agency way?

What works well?
- Setting SMART goals
- Show people what is improving – praise to all
- Consistency in support
- Collaboration
- Communicating, building trust, working with the person's agreement and at their own pace, being person-centred and building a positive therapeutic relationship
- Ongoing support and reviewing of overall situation
- Build rapport as much as possible and with as many people as possible



What are the Challenges and Barriers?

- Evidence-based approach – psychology – not feasible
- Lack of options
- Lack of resources / funding / capacity issues
- Undiagnosed mental health conditions
- Post trauma behaviour / mental health
- Denial / does the person want help?
- Lack of training and knowledge
- Not recognising root cause of hoarding / self neglect
- Keep people 'in the moment' – what's worrying you now? What's the best thing that can happen?

Even better if …

29. Identify who works best with an individual – let that person who has built up trust take the lead (supported by others with expertise to do this if necessary)

30. Value the individual

31. Understanding the motivations behind the hoarding, and working on the triggers

32. Ongoing progress reviews

33. Visuals for clients – to see the difference

34. Better informed services, to eliminate judgemental approaches

35. Consolidation of new learning, skills, compensation strategies

36. Having a specific 'go-to' team / colleagues who can offer advice

37. Cleaning companies / other services should be non-judgemental / trauma informed

Identifying High Risk Self-Neglect Situations (Aberdeen)

Emergency / Urgent need
• You are at risk of abuse. • You have a significant disability or health problem, which is or will be a serious threat to your safety or independence. • You are terminally ill and need essential non-medical services to support you at home. • You live alone and are housebound and essential daily personal care needs are not being met or are only being met by placing you at serious risk. • Essential daily care and support needs are being met by a carer whose health and wellbeing is seriously at risk. • Current care situation cannot continue because you have had significant difficulties in your present living conditions placing you at serious risk. • Due to a disability or health problem vital family and other social relationships are at serious risk of breaking down placing you at immediate risk.
High level of need
• You have a disability or health problem, which is or will be a significant threat to health, safety, or independence. • You live alone and are housebound and essential daily personal care needs are not being met or are only being met by placing you at significant risk. • Essential daily care and support needs are being met by a carer whose health and wellbeing is significantly at risk. • Current care situation cannot continue because you have significant difficulties in present living conditions placing you at significant risk. • Due to disability or health problems vital family and other social relationships are at serious risk of breaking down placing you at significant risk. • You are in hospital and cannot be discharged safely because of the circumstances described above.

Ice Breaker Form

CLUTTER, DISORGANISATION

& HOARDING BEHAVIOURS

www.hoardingicebreakerform.org

Ice-Breaker Form

Empowering people to start a conversation with their GP/doctor, clinician, professional or other trusted person, and get **practical advice**, **treatment,** and **support** to feel better

For instructions on how to complete the form, and information about please refer to our website preparing for the conversation with your trusted personwww.hoardingicebreakerform.org ,

Dear Trusted Professional

I have a problem which is affecting my health & wellbeing

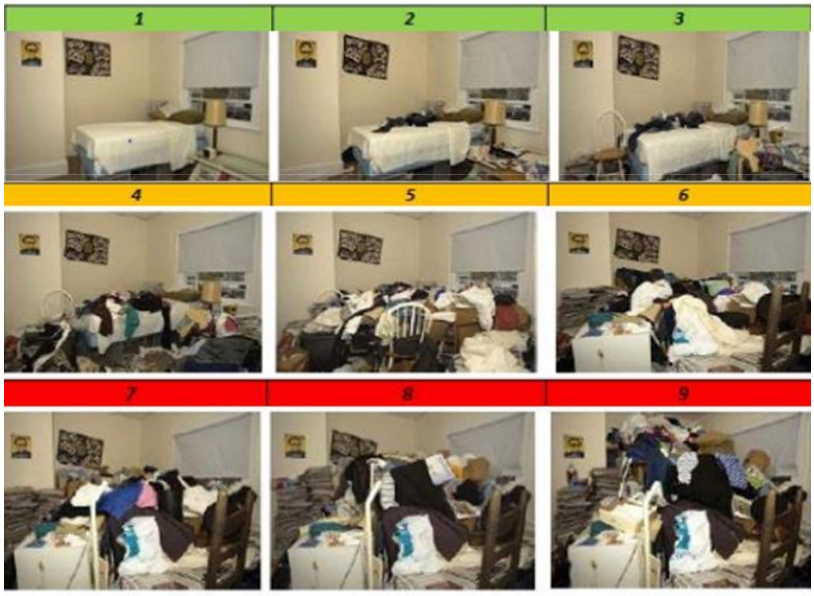
The problem applies to: Me ☐ Someone I live with ☐ A family member ☐ Other ☐

(Tick all the boxes that apply) I / they have:

A difficulty stopping acquiring things and accumulating them.	
Persistent difficulty or distress discarding or parting with personal possessions.	
Strong urges to save items.	
Areas full of possessions – eg. living areas, gardens, sheds, vehicles, etc.	
Areas where normal use of the space is difficult or impossible (eg. access to or use of toilet, kitchen, boiler, radiators, heating, hot water, lights, etc).	

Safety risks* inside or outside the home (eg. slip/trip/fall hazards; fire risks; blocked doors/windows/stairs; mould; faulty/broken electrical or gas equipment; rats/mice; overgrown garden, etc). Please explain your answer on the next page.	
Children, adults and/or animals that are not being looked after properly.	
Become overwhelmed and find making progress to reduce the problem difficult.	
Been reluctant to talk to people who say they want to help, and/or not permitted them to enter the property or the areas affected.	
Severe difficulty with things like timekeeping, prioritising, planning, organising (eg. paperwork or paying bills on time), making phone calls; making decisions.	
Been told to make changes (eg. by a family member, landlord, Environmental Health Officer, etc), and that action will be taken if nothing is done by a certain date.	

S A F E T Y I N F O R M A T I O N



The **Clutter Image Rating** (CIR)** shown here (in a bedroom) is a scale used to give an approximate measurement of levels of "clutter" in a room (1 to 9).

What number (level) on the **Clutter Image Rating** Scale is the most cluttered area that is affected, or you are concerned about?

Please show your trusted person photos or videos of the areas affected, so they can advise you better.

Click HERE to view, download or print a FREE version of the full set of Clutter Image Rating images (Kitchen, Bedroom, Living Room), devised by Jordana Muroff, Patty Underwood and Gail Steketee for Group Treatment for Hoarding Disorder: Therapist Guide, Appendices © Oxford University Press 2014 (the CIR is on the Treatments That Work section of the Oxford Clinical Psychology website).

I'm now at the stage at which I need to appeal to you to help me because:

(Tick all that apply)

I feel unwell because of this situation.	
I feel distressed, and/or indecisive about what to do to make things better.	
It's hard for me / them to talk about this.	
I feel alone and need support.	
Other people don't seem to understand.	

In what year did you first realise it had become a problem, and why?
***What safety risks are there?**
Who or what else is affected or involved (eg. young children, adult relatives, pets, friends, neighbours, Police, local authority, etc) and how?

Please add additional relevant information on other sheets of paper

INFORMATION FOR PROFESSIONALS

Not everyone who owns lots of possessions exhibits **hoarding behaviours** or has the diagnosable mental illness **Hoarding Disorder** (see the diagnostic criteria in ICD-11 for details)**.** For many people, living in a **chronically disorganised** home or where the **Clutter Image Rating (CIR) level is 1 - 4 can be as upsetting, overwhelming, incapacitating and disabling as CIR level 5 and above.

It's important to note that **safety issues** and **self-neglect** can occur at **ALL** levels.

In England **The Care Act 2014** recognises **hoarding behaviours** as one of the manifestations of **self-neglect**, and requires all public bodies to **safeguard people at risk**. To achieve the most sustainable and cost-effective results, managing hoarding behaviours and clutter-related issues usually requires a **person-centred, collaborative and integrated approach** between multiple agencies. Check local hoarding and self-neglect protocols for details (if available).

Various factors can result in "clutter" accumulating, someone becoming "**Chronically Disorganised**" or exhibiting **hoarding behaviours** – often a **COMBINATION of MULTIPLE factors** (such as, but **not restricted to**):

- Anything likely to impair **Executive Functioning** and/or **cognition** – ie. hinder a person's ability to plan; organise; prioritise; start/finish tasks; make decisions; be flexible with their thinking; remember things; control their impulses; self-monitor; manage their time-keeping and regulate their emotions, such as:
- **Neurodevelopmental conditions** – often undiagnosed - eg. **Learning Disabilities; Attention Deficit**
- Hyperactivity Disorder (ADHD);
- **Autism; Dyslexia; Developmental Coordination Disorder** - DCD, also known as **Dyspraxia**, etc
- **Acquired conditions** - eg. Acquired Brain Injury – ABI; viral infections – eg. COVID-19; Long COVID
- **Diseases of the nervous system** - eg. Migraine; Motor Neuron Disease; Multiple Sclerosis; Cerebral Palsy
- **Neurocognitive Disorders** - eg. Dementia; Parkinson's Disease; etc
- **Mental ill-health** - eg. Anxiety; Depression; **PTSD/CPTSD**; self-neglect; OCD; Bipolar Disorder; Schizophrenia; Hoarding Disorder
- **Misuse** of drugs, alcohol, etc
- **Other** – eg. Chromosome disorders (Klinefelter's; XXX; Down's Syndrome, etc)
- **Trauma - Adverse Childhood Experiences** (ACEs); adult **trauma**; **abuse; neglect**
- **Life/World events** and/or **changes in circumstances affecting self, family, others** - eg. bereavement; redundancy; relationship changes; domestic abuse, etc
- **Physical ill-health** - eg. mobility issues; **Fibromyalgia**; **Chronic Fatigue Syndrome**/ME; heart condition; hypermobility; cancer; etc
- **Overwhelm & exhaustion** - eg. due to carer responsibilities; age/infirmity; family issues; too much pressure; too many people to deal with; too much going on to cope with effectively, etc

Self-Neglect Risk Assessment Guidance Notes

Introduction

Risk is the possibility of harm occurring and the severity of that harm. Risk assessment is the process of identifying risk and enabling decisions to be taken about whether new or improved risk controls, or protective measures, are required. Effective person-focused risk assessment relies on the active participation of all agencies/teams involved. Legislation requires that risk assessment be "suitable and sufficient". This means that the degree of effort put into risk assessment needs to be proportionate to the risk involved.

Informal risk assessments are carried out every day upon both professional and personal experience, enabling risk to be recognised and necessary precautions to be taken. These everyday judgements and decisions are an individual's responsibility and a core professional competence which underpins everything we do. Formal risk assessments are a documented evaluation of risk including potential severity of consequences and the likelihood of such an occurrence along with the preventative and protective measures in place to control the risk. The aim is to weigh up whether existing support is adequate or whether more should be done to reduce the risk to an acceptable level through improved protective measures or contingency plans.

Risk assessments must be shared between all agencies/ teams involved to ensure the consistency of response and of care provided. A multi-agency risk assessment enables commitment of all involved to implement and comply with any protective measures agreed as essential to ensure the health and safety of the adult, staff, and any other persons who could be affected. In respect of environmental or low-level personal risks the risk assessment forms may be completed by one member of staff. The multi-disciplinary risk assessment must be completed by a multi-disciplinary group.

The Risk Assessment form should be used to identify and evaluate all significant risks associated with the adult, and to record all agreed protective measures necessary.

It is recognised that it can be a challenge to balance the positive benefits of taking risks with protection. The principles of the **Health and Social Care Standards** must be adhered to.

Self-Neglect Risk Assessment Form

This risk assessment form should be completed either prior to or during a multi-agency meeting by the lead agency. It is important that those who are aware of the risks are part of the risk assessment process. This may include professionals, hands-on carers, the police, legal advisers, family members, the adult themselves. The person organising the risk assessment should take time to consider who should be invited to ensure that an open and honest discussion takes place. They should carefully consider the pros and cons of having family members and the adult themselves present as this may impede full discussion or may cause the adult undue distress.
This Multi-agency Risk Assessment is a generic process which facilitates the sharing of concerns, the agreement of how risk can be managed and the acceptability or not of the presenting risks. It is possible, as part of this process, that the need for other specialist risk assessments may be identified.

Where a potential or actual risk has been identified on the Multi-agency Risk Assessment form this should then be transferred to the Risk Management Plan using the same issue number. In the "risk present" box where a risk is present, you should identify who is at risk using the following keys:

S = staff member; C = client; O = other.

The details of the risk should be noted. The existing control measures which are currently in place should then be recorded in the "existing control measures" column. In this column you should also evaluate and clearly record the effectiveness of these existing measures – are the measures:

effective, **partially effective** or **not effective** at all. Using the Risk Assessment Matrix identify the most predictable severity of the consequences of the event in question and note this. Similarly note the level of likelihood of the event occurring. You will then be able to identify the risk rating by finding where the "likelihood" column and the "consequences" row cross over. For example, an event which is **likely** to occur which has a **moderate** level of severity of consequences has a risk rating of **high.**

There may be times when the ability to reduce the risk is not possible e.g. when the maximum amount of support is already in place. This should be clearly recorded and if necessary escalated as per local processes.

Additional measures required to minimise risk should then be identified. It is perhaps helpful to think about what you can eliminate, reduce or further control the risk. Are there ways of improving monitoring, procedures, recording, communication, training, systems of work or organisational management. This will, along with existing controls, define how you will reduce and maintain the risk to a minimum.

The final risk rating completed using the same method as above by anticipating the impart the measures will have once they are put in place.

Where the final risk rating is **high or above** local escalation process will apply.

Self-Neglect Risk Management Plan

The Risk Management Plan can then be completed at the multi-agency meeting taking into account the Risk Assessment. This details the actions to be carried out to ensure the additional control measures are put in place, by whom, the target date for completion and the actual date completed. Some actions may be required on an ongoing basis.

The Risk Management Plan should also include who is responsible for reviewing the risk assessment and the target date for this.

When reviews are carried out, the date it was due to happen, the date it was actually carried out and by whom should be noted in the review table. The Risk Management Plan should be updated to take account of any changes necessary following the review. The Risk Assessment can be shared with other professionals/staff involved in an individual's care if appropriate.

Self-neglect can have physical, social, environmental and health consequences resulting in failure to engage in, or access, services. This can have grave consequences for individuals, families, and communities.

Risk Factors for Self-Neglect		
Features	**Risk factors**	
1. ADVERSE LIFE EVENTS	Traumatic chronic stressors e.g. surviving divorce or abuse.. Experiencing a medical crisis. Emotional blackmail. Sexual-physical-emotional abuse. Neglect. Parental separation.	
2. PERSONAL CARE	Poor personal hygiene or not washing at all. Poor dental care. Unchanged or inappropriate clothing due to weather conditions. Routinely soiled leading to potetial skin breakdown. Ability to contribute to daily living activities is affected. smelling of feaces or urine.	
3. ENVIRONMENT	Dirty or squalid home circumstances. See Clutter Image Rating. Inadequate heating, plumbing or electrical services disconnected. Pathways unclear due to large amounts of clutter. Animal faeces in the home. Residence filled with garbage.Smelling faeces or urine.	
4. HEALTH CONSEQUENCES	Utreated injuries & skin breakdown. Weight loss & malnutrition & dehydration. Non-attendance at appointments. Long-standing chronic medical conditions worsen due to self-neglect. Living with serious ungtreated medical conditions. Needing medical care but not seeking or refusing.	
5. INDEPENDENCE	Persistent fear of losing ones independence or privacy, or being the subject of harm.	
6. MENTAL HEALTH	Delay in seeking medical treatment or leaving the home due to anxiety or phobia. Memory-loss or poor judgement. Schizoprenia leading to suspiciousness, poor social networking & refusal of care. Depression leading to low self-worth, unable to enjot pleasurable activities & lack of motivation and energy. Personality problems limit social networking, leading to isolation and depression. OCD – can cause hoarding and infestation.	
7. NURTITION & HYDRATION	Lack of evidence of food in the house. Out-of date foodstuffs. Inapproprioate foodstuffs. Lacking fresh food, processing only spoiled food, or not eating.	
8. PHYSICAL	Physical disability limits the ability to seek care and maintain the environment. Unable to get out to the bank.	
9. SAFETY	Giving away money inappropriately. Living in hazardous situation. Fire safety risk. Unable to enter or egress property du eto clutter. Unsafe cooking methods. Overloading of electrical sockets.	
10. SOCIAL ISOLATION	Limited or no social interaction. Poor social networks, separation, divorce, living alone, bereavement and fear can all promote behaviouurs such as hoarding. Affected by mental health or adverse life events – see above. Refusing to allow visitors into residence.	
11. ALCOHOLISM	Malnutrition, dehydration, slow healing injuries, ulcers, financial hardship. Chronic health problems. Unintentional injuries. Depression and neglect of health. Isolaton from family and friends. Death.	
12. SENSORY IMPAIRMENTS	Poor vision and hearing can lead to sociak isolation and lead to risk of falls	

Please consider the following in any risk assessment / management plan.

Risk Assessment for Self-Neglect			
LEVEL OF RISK	**MINIMAL**	**MODERATE**	**HIGH/CRITICAL**
	The adult is accepting of care and support services.	Access to services is limited [eligibility criteria] but willing to engage	Refuses to enagage with necessary services
	Health needs are being addressed	Sporadic attendance at health care appointments.	Poor personal hygiene and deterioration in health care
	Willing to access services to improve wellbeing	Person is low of weight	Weight is reducing
		Wellbeing is partially affected	Wellbeing is affected on a dail basis
	Carers present	Limited social interaction	Isolated from family and friends
		Carers are not present	Care is prevented or refused
	Access to social and community activities	Limited access to social or community activities	Will not engage with social or community activities
	Can contribute to daily living activities with minimal support	Ability to contriute towards daily living activities is affected	Does not manage daily living conditions
	Personal hygiene is good with minimal support	Personal hygiene is becoming an issue	Hygiene is nonexistent causing skin problems
			Aids and adaptations refused or not accesssed.

Multi-agency Risk Assessment of Self-neglect / hoarding / non-engagement

In the “Risk Present” box, the person is identified by (S) = Staff, (C) = Client, (O) = Others

LEAD ASSESSOR: DATE OF ASSESSMENT: CLIENT ID:

No.	“Risk Present”	Details of Risk	Existing Control Measures Effective, partially effective, not effective	LIK	CONS	RR	Additional control measures required to minimise risk.	FRR
01.								
02.								
03.								
04								
05								
06								
07								
08								
KEY	LIK = likelihood		CONS = consequences			RR = risk rating		FRR = final risk rating

Risk Management Plan

Issue	Action/ Additional Control Measures	Implementation / Responsibility / By Whom	Target Date	Completion Date
	Escalation process followed for FRR assessed as High or above.			
	Organise review of Risk Assessment**, if required.**			

Lead Officer

Name……Signature……Date……..

Partner Roles

Organisations involved in supporting an adult who is self-neglecting may have a non-engagement policy. All professionals must refer to their own policies in addition to these procedures.

The roles / perspectives of some key partners in relation to self-neglect and hoarding can be found below.

The Scottish Fire and Rescue Service

(SFRS) is of importance where a person is hoarding items which may pose a risk of fire at the property. While a person's consent to involve SFRS should always be sought, it may be necessary to override the person's wishes if they are risk of serious injury or death if a fire occurs.

Police Scotland

Police have a statutory duty under the Adult Support and Protection (Scotland) Act 2007 to refer any adult who may be at risk of harm and to cooperate with council investigations, in line with local policies and procedures. This means accurately recording any concerns via iVPD under the category 'Adult Concern' so that reports and relevant information can be shared with relevant partners.

In cases of self-neglect, the safety and wellbeing of the adult concerned is paramount. If the adult concerned is believed to be at immediate risk, the Duty Social Work Team would be contacted so that action can be agreed. If there is no apparent criminality otherwise, officers will not necessarily be required to take any further action after the Concern Report has been submitted. If this occurs outwith office hours, Out of Hours Social Work and G-Meds should be considered.

Police may also be requested to attend an address, ideally with SW, for a safe and well check or due to SW being unable to access the property concerned and power to force entry should be considered where appropriate. Again, an iVPD should be compiled thereafter.

Officers can also seek advice and guidance from the Public Protection Unit or via the Adult Support and Protection SOP.

Landlord Services and Housing

Housing enforcement will focus on how the neglect is impacting on the fabric of the property or affecting the neighbours and will range from:

- housing officer visits, guidance and support to people who are in need to avoid them losing their tenancy alongside clear messages about what can occur if people do not cooperate, such as court applications.
- verbal warning, referral to housing support, referral to partner agencies, including ASP, request facilities to assist in clearing a property and recharge tenant (may not transfer tenant to temporary accommodation in instances where property is unsuitable for habitation)

Self-neglect – is not part of the tenancy agreement. Keeping the property in good, clean condition and disposing of rubbish appropriately is.

Environmental Health see council web pages – contact to report infestation

https://www.aberdeencity.gov.uk/services/environment/report-damp-water-penetration-dirty-houses

ASBIT

This type of thing is not their typical case, but I would be comfortable to bring a case to the hub meeting as a "scatter gun" approach to reaching out to several services. Police and Fire have referred cases where they have visited and found conditions which have caused concern.

Adult Community Safety Hub

An example of the way that partner agencies alert the hub of their concerns:

Can I ask that a task be raised for 1st Floor North, Marischal College, AB10 1AB? Occupier, Adult Protection Unit. DOB: 00/00/2007. Fire Service attended a false alarm where cooking fumes had actuated their detector. During the incident they were asleep in the breakout area. They presented as being under the influence of alcohol. Some of the detectors on the floor had been damaged. Their working conditions are very poor. Can you please issue a task to Fire Service and Housing to conduct joint visit? The attending Crews have submitted an AP1 form to social work. Thanks.

Scottish Ambulance Service

Ambulance staff report self-neglect to the APU as a vulnerable person concern - either on the relevant form or direct to the Social Work Duty Service. Appropriately trained staff might refer someone with a short-term issue to Penumbra as a DBI referral but that probably would not address longer term self-neglect.

It should also be noted on our Patient Report Form and if a patient was being admitted it would likely be part of the handover to hospital staff either as an explanation of an unwell patient presenting as unkempt/dirty/malnourished or as a reason for a possibly fairly "well" patient being admitted out of hours as more of a social admission or to a place of safety.

Our only other reporting option is G-MED or a patient own GP, but there is no agreed direct access to any other agencies.

AGENDA

Multi-Agency Risk of Self-Neglect Adults Professionals Meeting

1. Introduction and Welcome
2. Apologies
3. Confidentiality Statement
4. Background to the concerns about the adult at risk of self-neglect (Include previous agency support and interventions)
5. Agency involvement and assessment
6. Multi-Agency Risk Assessment
7. Relevant legal and statutory powers
8. Agree Risk Management Support Plan
9. Lead professional
10. Date of Case Review
11. Any Other Business

SELF-NEGLECT AIDE MEMOIRE / CHECKLIST

Presenting problems

Assessment of need

Care and support have been determined using the eligibility criteria - see Appendix 2

Mental capacity assessment

Assessment of health care

Risk assessment and agree actions within the risk management support plan and who is responsible for doing what and within what timescales.

Needs of the individual and what action is required to resolve/meet the needs.

Does the situation come under ASP Procedures?

Identify “challenges” to the agencies represented.

Relevant statutory / legal powers to be identified and a decision made whether they are applied or used as a contingency.

Identification of who is best placed to engage with the individual at risk (who has the best relationship or the most appropriate skills).

Agree communications plan and appropriate information sharing protocols.

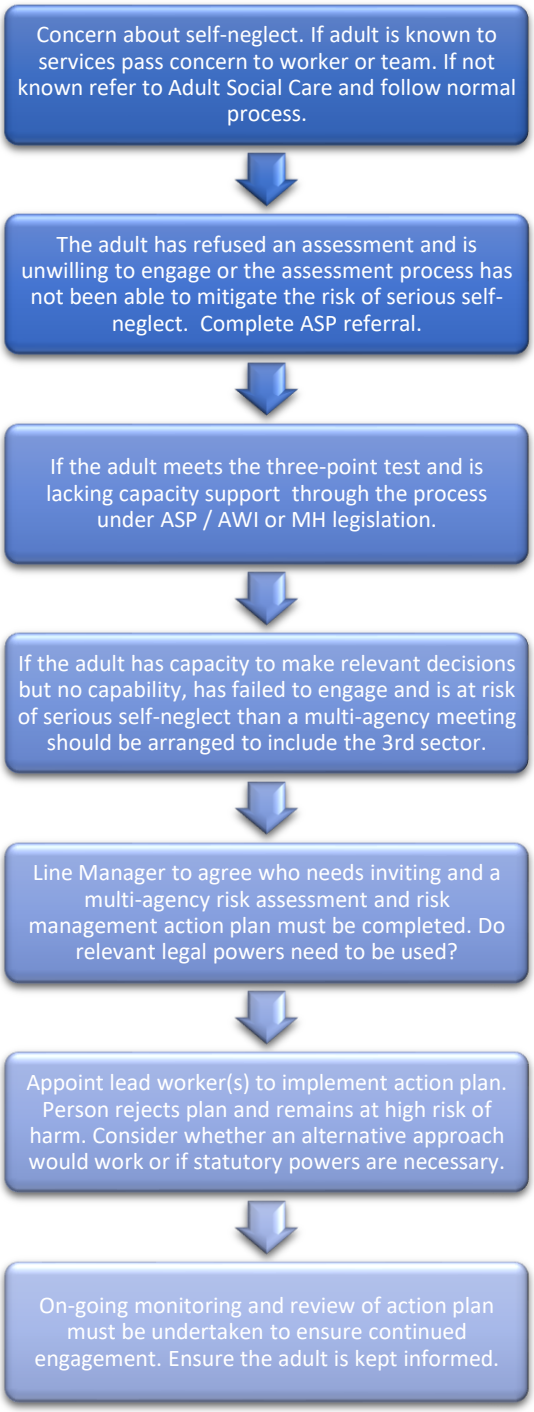
Agree who takes responsibility for communicating information.

AGENDA

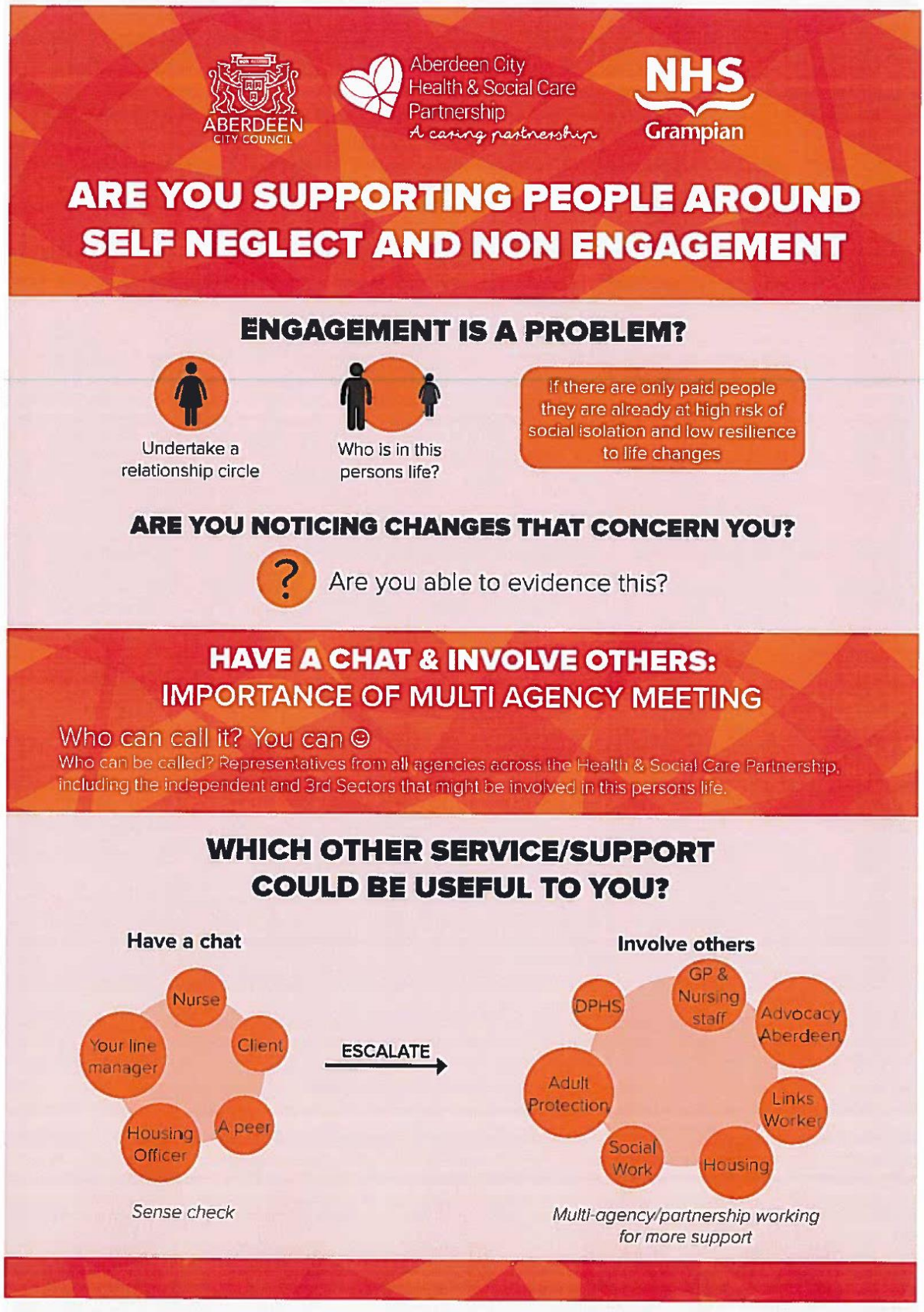
Multi-Agency Risk of Self-Neglect Adults Professionals Review Meeting

1. Introduction and Welcome
2. Confidentiality
3. Purpose of the Meeting
4. Minutes / review of actions from the last meeting
5. Current Situation
6. Review of Multi-Agency risk assessment
7. Relevant legal and statutory powers
8. Communication Plan
9. Agree Risk Management / Action Plan
10. Is this case ongoing or can it proceed to closure
11. Date of further case Review
12. Any Other Business

Referral Pathway – High Risk Cases



ENGAGEMENT INFOGRAM



CLOUDS END
We can sort it, together.

THE HOARDING SUPPORT CHECKLIST

A GUIDE TO STAYING ON TRACK WHEN SUPPORTING CLIENTS WITH HOARDING DISORDER/BEHAVIOUR

Understand trauma -
The causes & how it effects yourself and others.

Ensure you can reassure -
Recognising emotions in others (such as anxiety) and work to build trusting relationships.

Keep your own emotions/needs in check -
Situations can be triggering, work on controlling your emotional response.

Listen to understand each client -
Every case is unique and requires its own set of steps to follow.

Ask how you can help -
The client needs always come before your own expectations & agenda.

Other Agencies -
Consider other local support systems your client could be apart of.

Multi-Agency Approaches -
Engage with any other agencies involved to form ONE plan of action you all follow.

Slow and Steady -
Always work at the clients pace, it can be a slow process but provides the best outcome.

Reconnect -
Clients can suffer from isolation, how and who can you approach to create a support system?

Celebrate -
Keep track of clients journey's and make a point of celebrating milestones (In a way they are comfortable with).

ADDITIONAL RESOURCES

- 7 Minute Briefing which provides a useful overview: **Self Neglect and Hoarding 7 Minute Briefing-revised** 126.84 KB
- Adult Support and Protection (Scotland) Act 2007: Code of Practice (www.gov.scot)
- Adopting a Trauma-Informed Approach | Improvement Service
- Decision Specific Capacity Screening Tool 2.1 FINAL.docx (live.com)
- Watch the recording of our event held on 23rd June 2021 to launch our local Guidance: Lessons from a Case Review
- Keith's Story: a personal and touching film about hoarding
- **CLUTTER IMAGE RATING:** https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf
- Gender-based services in Aberdeen: Services in Aberdeen - Aberdeen Protects (aberdeencity.gov.uk)
- Health and Social Care Standards: my support, my life - gov.scot (www.gov.scot)
- Guide to the UK General Data Protection Regulation (UK GDPR) | ICO
- APracticalGuideToSelfManagementSupport.pdf (health.org.uk)
- http://selfmanagement.kyoh.org
- Helping someone who is hoarding - Mind