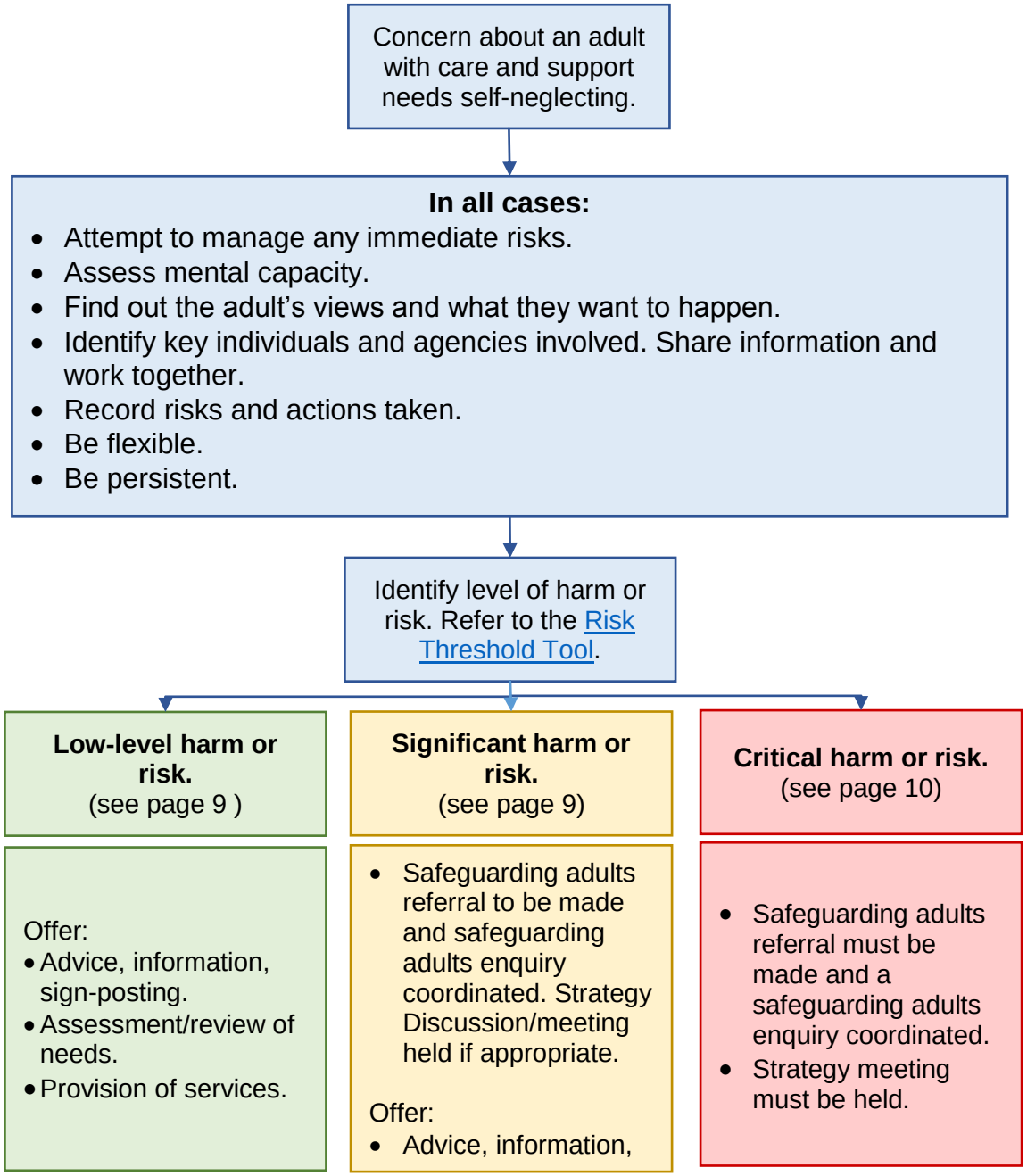
Self-Neglect Guidance

North of Tyne (North Tyneside and Northumberland)[1]
February 2016

[1] See www.newcastle.gov.uk for Newcastle version



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:
Northumberland Tel **01670 629200**
North Tyneside Tel **0345 200 0109**

Contents

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 hoarding[2]. 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.

- 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.

- 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.

- Large number of pets.

[2] See Appendix 3 for further advice and guidance around responding to hoarding.

Factors that may lead to individuals being overlooked:-

- The perception that this is a “lifestyle choice.”
- Poor multiagency 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 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 state[3].

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 decision-specific - apparent capacity to make simple decisions should not result in an assumption that the person is able to make more complex decisions.

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

[3] This is clear in Article 8, European Convention of Human Rights

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'. 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/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 of 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 through 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. If you are concerned that a self-neglecting parent may be neglecting children in their care also, you should report concerns to children's social care.
See also the **Northumberland Safeguarding Children's Board Neglect Strategy** at http://northumberlandlscb.proceduresonline.com/pdfs/neglect_strategy.pdf

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.

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 significant/very significant/critical risk/harm.

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
North Tyneside
Safeguarding adults referrals are made to:

- ☎ **Adult Social Care Gateway Team (0191 6432777)**
- ☎ **Out of hours (0191 200 6800) ONLY** where there is an urgent social care need

Provider agencies can use the Safeguarding Adults Initial Enquiry Form to report this information into Gateway.
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 be initiated and consideration be given to a Strategy Discussion or Strategy Meeting.**

http://www.northtyneside.gov.uk/browse-display.shtml?p_ID=533408&p_subjectCategory=421

Making a referral into safeguarding adults procedures
Northumberland
Safeguarding adults referrals are made to:

- ☎ **Adult Social Care** Foundry House **(01670 536400)**
- ☎ **Out of hours (0345 6005252) Emergency Duty Team**
- ☎ **For details of Northumberland Safeguarding Adults Procedure – see 10 steps document at**

http://www.northumberland.gov.uk/WAMDocuments/C323D23B-5344-417F-86CF-9841E7BDC7D2_1_0.pdf?nccredirect=1

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 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 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.

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Provider agencies can use the Safeguarding Adults Initial Enquiry Form to report this information into Gateway.
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 a Strategy Meeting.(**Given the level of risk and likely complexity, a Strategy Meeting should be held as opposed to a Strategy Discussion)

Making a referral into safeguarding adults procedures
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Safeguarding adults referrals are made to:

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- 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 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. Consideration should also be given to referring to the Risk Assessment Panel or Making Every Adult Matter (see below)
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

9.1 Risk Enablement Panel (REP) in North Tyneside

The REP is a forum for practitioners to seek advice, reflect on risk assessment, rehearse solutions and share the responsibility for risk management in complex situations. **In all cases referrals to the REP should be discussed / agreed with a Service Manager.**

Criteria includes:

- Where there remain **high / significant** risks requiring a decision / guidance on management by the REP i.e. where there are management of risk or compliance issues
- Where there is likelihood of a serious complaint and of reputational damage to the Council.
- Where an application to the court is being considered or contested

The following documents are required 2 weeks before the panel is due to meet:

- A recently completed Self Assessment Questionnaire
- A recently completed Support Plan
- A recently completed FACE Risk Assessment
- Completed REP 1
- Any other supporting documentation.
- Attendance is required for discussion

What will happen after the Panel Meeting?

- A completed REP 2 briefly outlining the discussion and recommendations will be shared with the social worker and their Service manager within 7 days

- The Senior Manager chairing the Panel will let the relevant Service Manager and Senior Manager have any constructive feedback on the case/documentation presented within 7 days of the Panel Meeting when required. ***This is not meant to be a complaint or a criticism; it is intended to support individual/team learning and development only.***

9.2 MEAM: - Making Every Adult Matters (North Tyneside only)

The MEAM approach in North Tyneside has been developed to coordinate multi – agency interventions that can transform lives.
The MEAM service is for adults who have multiple and complex needs who struggle to access both housing and support services and are at risk of chronic exclusion.
These adults do not always match the entrance criteria for services or have a history of non engagement. A multi- agency panel meets every two weeks and provides a forum for case discussion and for agreeing a shared action plan as well as signposting to appropriate community resources.

Referrals can be made by completing a North Tyneside Council single point of access referral form and New Directions Team risk assessment and sent to welfareprovision@northtyneside.gcsx.gov.uk

Or faxed to: 0191 643 2413

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.

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.

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 is 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 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 won't 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.

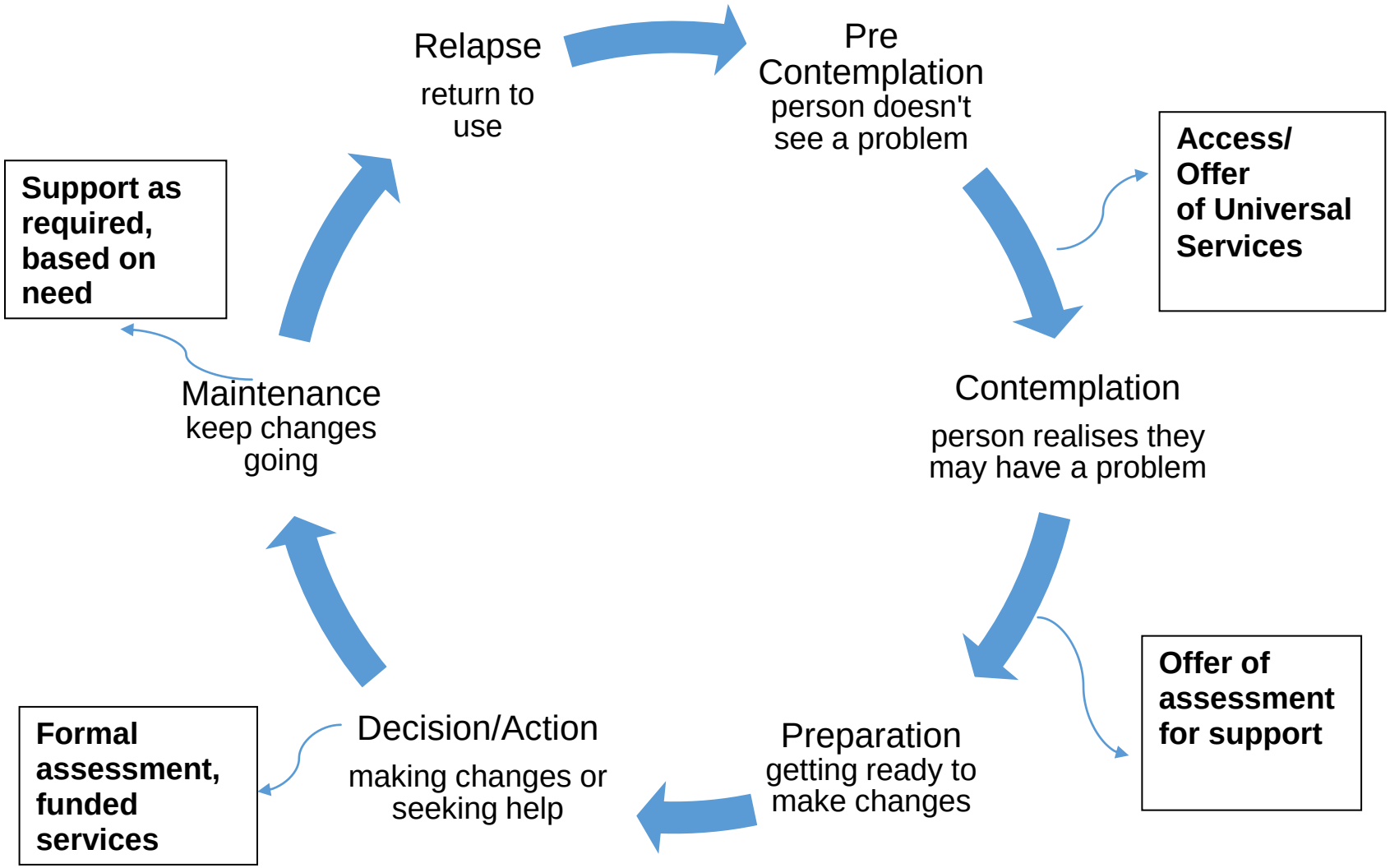
Where there is evidence that someone who has capacity is not necessarily in a position to exercise their free will due to undue influence then it may be possible to obtain orders by way of injunctive relief that can remove those barriers to effective working. Where the person concerned has permitted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



Appendix 3 - 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 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 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?

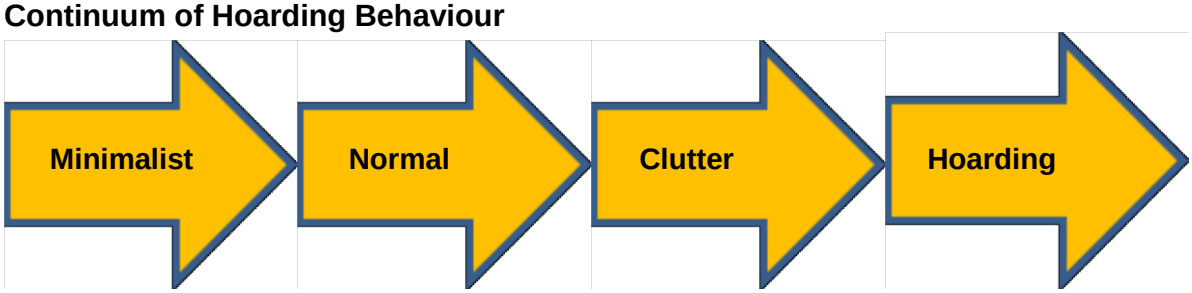
Multi-Agency Response

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 a 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.

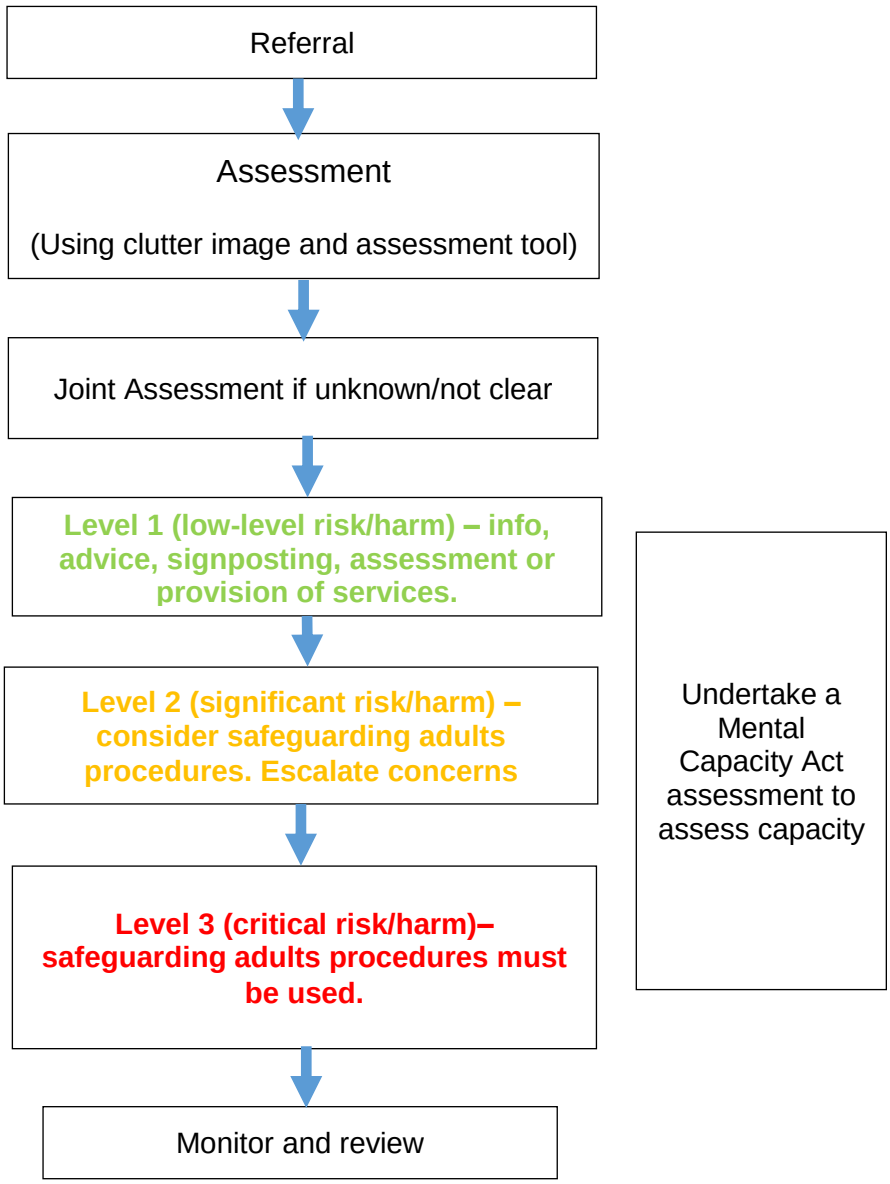
Continuum of Hoarding Behaviour



Clutter level 1- 3

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

1

2

3

4

5

6

7

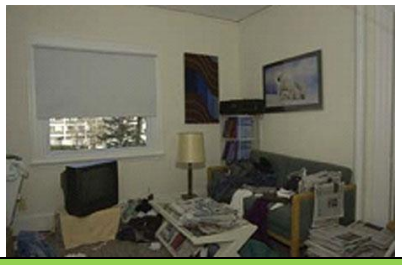
8

9

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

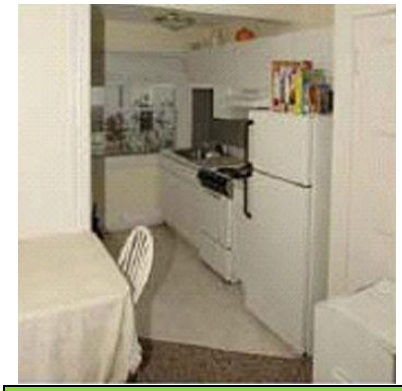
7

8

9

Clutter Image Rating Scale – Kitchen

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



1

2

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7

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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

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			

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 4 – Drug and alcohol 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” The term Drug refers to “psycho- active 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”*

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 but the cause of this is not directly a result of physical or mental impairment or illness but arises from acts of their own, such as drug and alcohol misuse and 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 impure substances if purchased on the street
- Risk of engaging in criminal activity to fund their lifestyle
- Exploitation by others, including sexual exploitation.

Certain people who misuse substances may have no diagnosable physical or mental impairment or have the ‘appearance of need’ but still present a significant risk to themselves and their own wellbeing. In such cases, it is important to give advice and guidance or signpost to other services. This should be documented to support evidence of an appropriate and proportionate response. It is widely recognised that cases involving those who misuse drugs and alcohol must often be dealt with outside usual prescribed timescales of the safeguarding adults processes. 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 but it is important not to sever contact with an individual who is displaying self-neglect / risk taking behavioural traits purely on the basis of refusal to engage with services or agencies regardless of capacity.

Models of intervention

The North Tyneside Recovery Partnership (NTRP) in North Tyneside and Northumberland Recovery Partnership in Northumberland is a dedicated service for anyone living in North Tyneside or Northumberland, 18 years old and over, who is experiencing problems with drugs and alcohol, delivered in partnership between Northumberland, Tyne and Wear NHS Foundation Trust, Changing Lives and Turning Point.

The service offers support which is tailored to help with a person's recovery journey:-

- Harm reduction – safer injecting support and needle exchanges
- Abstinence programmes – group and community-based 12 step programmes
- Medical support including prescription of substitute medications and supporting detoxification programmes
- Psychosocial Interventions – Motivational Enchancement Therapy (MET)
- Recovery support – ongoing services to help with next steps into employment, housing and health

Access to the service is either by self referral or via a GP/ other professionals. Referrals are also taken from carers of people experiencing problems with drugs and Alcohol, with their consent.

Contact details:

North Tyneside Recovery Partnership Tel: 0191 240 8122

Northumberland Recovery Partnership, Green Lane, Ashington NE63 8BL
Tel: 01670 396 303
Opening Hours
9am - 5pm, Monday to Thursday, 9am - 4.30pm Friday, with late clinics also

** 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).*

Appendix 5 – Obesity and Self Neglect

Introduction

The obese population in the UK is increasing and continues to be considerably over-represented in their use of health and social care services. Provision of care, support and manual handling of these patients presents a specific challenge partly due to individual factors but also due to the lack of policies, space, equipment, adequate staff numbers and vehicles for safe care, treatment and transportation.

The interaction between obesity and self-neglect has not been directly researched, but this section looks at some of the issues which may impact on a person's ability to care for themselves and some of the underlying causes of disengagement from care and support services which might lead to concerns about self-neglect.

"Bariatrics" is the branch of medicine that deals with the causes, prevention and treatment of the negative health consequences of being over-weight or obese. The term bariatric comes from the Greek root bar- ("weight"), suffix - iatr ("treatment"), and suffix - ic ("pertaining to").

This section refers to anyone, regardless of age, who has limitations in health and social care due to their weight, physical size, shape, mobility, tissue viability and/or environmental access.

Key issues for practitioners:

- In cases of self-neglect where the person is obese, staff should consider any possible underlying causes, or disabilities which may be interfering with the person's ability and or choice to engage with care and support
- Co-operation, collaboration and communication between professionals specialised in working with disability and those working in obesity can help lead to improved prevention, early detection, and treatment for people
- Health and social care providers need to identify and understand the barriers that people with disabilities and obesity may face in access to health and preventative services and make efforts to address them before assuming that the person is "refusing".
- Health and social care providers need to make adjustments to policies, procedures, staff training and service delivery to ensure that services are easily and effectively accessed by people with disabilities and obesity. This needs to include addressing problems in understanding and communicating health needs, access to transport and buildings, and tackling discriminatory attitudes among health care staff and others to ensure that people are offered the best possible opportunity of engaging with services.
- It may be that the person is able to engage in a conversation about a mental health or physical health problem when they do not feel able to talk about their obesity. This may be due to concerns about stigma, embarrassment or worries that professionals may seek interventions that they are not ready to access. Engaging the person to work on the problems they see as important is essential to developing a longer term relationship.

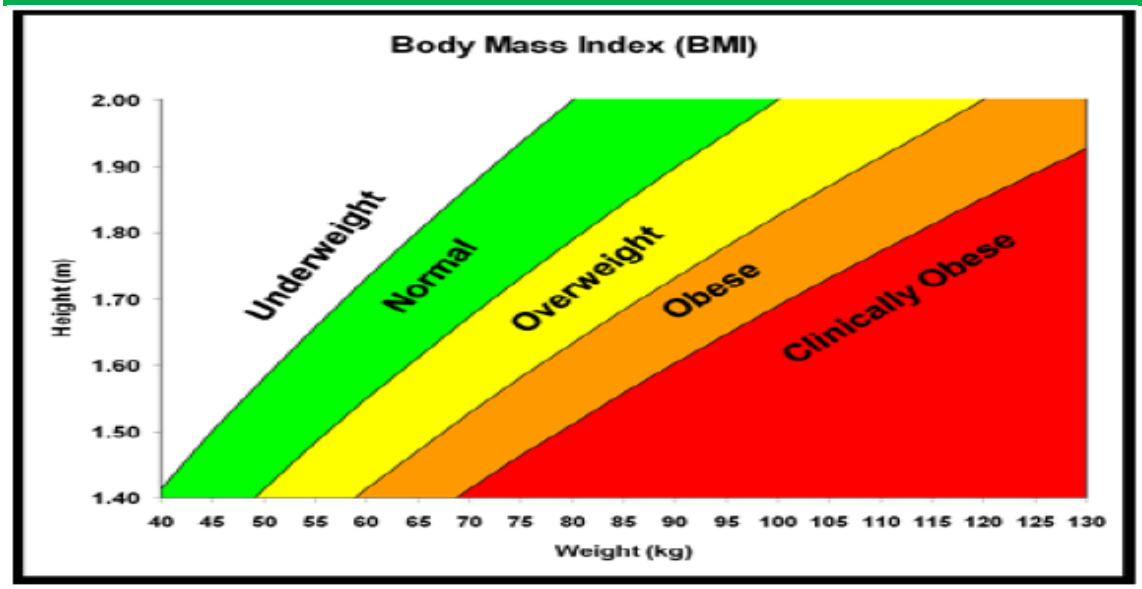
- There should be active support for obese people to live independent and healthy lives. It is important that health promotion initiatives recognise the limits of information-giving and the need for whole communities to be included in tackling discrimination to allow people to have the confidence to accept support and join in with community activities.

Body Mass Index

Degrees of obesity are calculated using Body Mass Index (BMI) (WHO 2000)

BMI ≥ 20 – 24.9 is normal
BMI ≥ 25 to 29.9 is overweight
BMI ≥ 30 to 34.9 is obese
BMI ≥ 35 to 40 is severe obesity
BMI ≥ 35 and experiencing obesity-related health conditions or ≥ 40–44.9 is morbid obesity
BMI ≥ 45 or 50 is super obesity

$$\text{BMI} = \frac{\text{mass (kg)}}{\text{height (m)}2}$$



Asian and African populations tend to experience health problems at a lower BMI than Caucasians; the National Institute for Health and Care Excellence (NICE) advises the use of BMI of 23 as a threshold for persons from ethnic minority backgrounds. (NICE, 2014)

The UK has the third highest rates of adult over-weight or obesity in Western Europe, with 67% of men and 57% of women classed as overweight or obese. (Ng, et al. 2014)

Obesity affects people in different ways due to their individual body characteristics and fat distribution varies accordingly. Fat distribution differs in men and women with men being predominantly apple shaped. Two body types, “apple” or android, and “pear” or gynoid are illustrated below.

Other terms for fat distribution

- Apple android – fat stored around waist area
- Apples ascites – weight carried high, abdomen may be rigid
- Apple pannus – weight carried high, abdomen (“apron”) is mobile, hangs towards floor, legs may be normal
- Pear gynoid – fat stored around hip area
- Pear adducted – fat carried below waist, tissue bulk on outside of thighs
- Pear abducted – fat carried below waist – significant tissue between knees

Impact of Obesity

The internal organs which may be affected by excess weight are:

- Apple or android – heart, liver, kidneys, lungs
- Pear or gynoid – kidneys, uterus, bladder, intestines

It is now commonly recognised that being significantly overweight can lead to a wide range of health problems, including heart and liver disease, high blood pressure and stroke, type-2 diabetes, some cancers, osteoarthritis, respiratory problems, mental health and psycho-social problems. (Public Health England, 2013)

Obese people are at very high risk of developing pressure ulcers, due to decreased mobility, increased pressure between the tissues and the support surface and poor blood supply to fatty tissues. There is also an increased risk of pressure ulcers if standard equipment such as commodes, chairs and beds and bed rails are used, causing e.g. compression on tissue from arms of chairs. Specialised equipment should be used where possible.

Staff should ensure that medication dosages are checked, as many drugs are metabolised differently in obese patients. Drugs affected include oral hormones, e.g. prednisolone, and oral contraceptives which have a higher failure rate in obese patients; injectable anaesthetics; antibiotics, e.g. vancomycin, daptomycin, gentamicin; and some beta blockers. Staff should seek further advice in the event of any queries.

In middle-aged and older adults, obesity is associated with a higher prevalence of falls and stumbling (Fjeldstad et al, 2008).

Obese people are typically sedentary and there is a close relationship between BMI and activity levels. An increase in BMI does not only suggest a low level of physical activity, it also associated with balance impairment. Consequently, obese people may get into the cycle of a fear of falling, which leads to further reduction in physical activity, and consequently greater risk of falling as they become less able to weight bear.

Obese adults may show signs of self-neglect as they experience decreased activity levels and subsequent change in their quality of life. Obesity interferes with all activities of daily living and physical functioning, such as bathing, toileting, showering, dressing, cooking, walking, parenting, bending, stooping and kneeling. Obese individuals may feel a sense of inadequacy or failure if they have to ask for assistance in such basic tasks which in turn may impact on their engagement with care and support services. Refusal of care and support may well damage their physical and/or mental health further.

Risk Assessment and admission to care or hospital

In 2007, the Health and Safety Executive published "Risk assessment and process planning for bariatric patient handling pathways".

The report revealed that:

- 40%-70% of health care trusts did not have a bariatric policy,
- policies are vital to lead the process planning, assessment and management of obese people's needs.
- Spatial risk factors were identified but seemed to have a poor management record for both building and vehicle design with over half of the Trusts with policies not considering space in the policy;
- almost 30% of ambulances did not have specialist vehicles and
- 33% of respondents reported inaccessible areas in their buildings.
- Even with good communication it was not always possible to manage all of the risks, and the provision of appropriate equipment and successful management of pain, safety, dignity and comfort all contributed to successful pathway experiences.
- Many of the equipment and furniture risks related directly to the weight, shape and size of the patient.
- The case studies suggested that the success of the pathway was determined by communication between and within the different agencies.

Planned hospital or care admissions should therefore, wherever possible, include pre-assessment of the patient's needs and clear lines of communication between

agencies – to include height, weight, BMI calculation, leg-length and waist-width (for appropriate seating), mobility, and specialist equipment requirements, alongside essential medical information.

Discharge/ transfer plans from hospital/care should be made early, i.e. starting at the time of admission, to allow Community Services sufficient time to engage with the person and organise appropriate staff, equipment and transport onwards.
Patient Transport Services, as far as is possible, should be notified 48 hours in advance of admission or discharge; a bariatric ambulance, wheelchair or stretcher, and extra crews may need to be booked.

If the patient is to be admitted for investigations, relevant departments, e.g. Radiology, need to be informed in advance. Some departments have limitations due to weight limits &/or size restriction of equipment.

Obesity and Disability

There is a two-way relationship between obesity and disability in adults Obesity is associated with the four most prevalent disabling conditions in the UK: arthritis, back pain, mental health disorders and learning disabilities

- One third of obese adults in England have a limiting long term illness or disability compared to a quarter of adults in the general population
- The prevalence of obesity-related disabilities among adults is increasing
- Adults with disabilities have higher rates of obesity than adults without disabilities
- For those adults who are disabled and obese, social and health inequalities relating to both conditions may be compounded. This can lead to socioeconomic disadvantage and discrimination (Public Health England 2013)

Obesity-related disability

Obesity can lead to disability as a consequence of increased body weight, associated co-morbidities, environmental factors, or a combination of these.

Obesity places mechanical stress on joints, increasing the risk of back pain and osteoarthritis which may in turn limit mobility. Some obese people may face difficulties in performing tasks such as walking, climbing steps, driving or dressing. This in turn can lead to physical inactivity, pain and discomfort, functional limitation and mental distress. Older people who are obese are at particular risk of joint pain and arthritis and may be less motivated to engage in physical activity if they are concerned about falls and bone fracture.

These factors can all impact on a person's ability to self-care, or accept care from others.

Disability-related obesity

The association between obesity and disability varies by age and sex, and by level and type of disability. Physical inactivity and muscle atrophy, as well as secondary

conditions (such as depression, chronic pain, mobility problems and arthritis) have all been found to contribute to the development of obesity among people with physical disabilities. For those with learning disabilities, obesity is linked to lower levels of physical activity, poor diet and the side-effects of medication.

A higher BMI can present a greater risk of secondary conditions and people with disabilities may face a range of barriers in relation to health screening and health promotion, primary and secondary health care as well as rehabilitation services which may lead to an inability or refusal to engage with health and social care services resulting in self neglect.

Arthritis

Arthritis is the leading cause of disability in many older adults. Common arthritic symptoms include joint pain, stiffness, inflammation and restricted movement. In the United States, the prevalence of obesity among adults with arthritis is on average 54% greater than among adults without arthritis. Obese adults with arthritis are 44% more likely to be physically inactive compared to obese adults without arthritis. (Public Health England 2013). Therefore, pain or the fear of pain may result in people refusing care, social activity or health interventions.

Mental health disorders

Mental health disorders are the second greatest cause of disability in the UK. According to the Office for National Statistics, 16.2% of people in England have a common mental health problem such as depression or anxiety (19.7% of women and 12.5% of men), and 0.5% of people experience psychotic or bipolar disorders (0.3% of men, 0.5% of women).

Obesity has been linked to common mental health problems such as depression and anxiety. Luppino et al 2010 found people who were obese had a 55% increased risk of developing depression over time, while people who were depressed had a 58% increased risk of becoming obese. Possible risk factors affecting the direction and/or strength of the association between the two conditions included severity of obesity, socioeconomic status, level of education, age, sex, and ethnicity.

Rates of obesity of up to 60% have been found in people with schizophrenia or bipolar disorder. Many antipsychotic, mood-stabilizing, and antidepressant medications commonly used to treat severe mental illness are associated with weight gain (McElroy et al 2006)
Obese people found to be self-neglecting may therefore be doing so due to an underlying (possibly undiagnosed) mental disorder and this may well be the direction that their support needs to take in the first instance.

Learning disabilities and obesity

Around 2% of the UK population has a learning disability and less than a quarter of this group are known to local health and social services (Emerson and Hatton 2004)
People with learning disabilities are more likely to be either underweight or obese than the general population (Emerson et al 2014)

The Sainsbury's Centre for Mental Health 2005 found that the rate of obesity among people with a learning disability was significantly different to those without such a disability (28.3% compared to 20.4%).

The reasons for this higher prevalence of obesity in people with learning disabilities are a complex mix of behavioural, environmental and biological factors. Women, people with less severe disabilities and those living independently or with less supervision are at increased risk of developing obesity.(Emerson et al 2012 and Robertson et al 2000)

Disability, Poverty and Obesity

A substantially higher proportion of households with one or more disabled member live in poverty compared to households where no one is disabled.(Office for disability issues 2012) Disabled people are far less likely to be employed than non-disabled people (46.3% compared to 76.2%) and around twice as likely to have no qualifications.(Office for National statistics 2012).

A report on disability and health inequalities for WHO Europe found extensive evidence that people with disabilities experience significantly poorer health outcomes than their non-disabled peers (Emerson et al 2012). Reasons for this include:

- exposure to socioeconomic disadvantage increases the risk of health conditions or impairments associated with disability and poor health
- some health conditions or impairments associated with disability involve increased risk of secondary health conditions such as pressure ulcers and urinary tract infections
- disability discrimination reduces access to timely and effective health care.

Obesity is associated with social and economic deprivation across all age ranges and puts adults and children at greater risk of secondary conditions such as type 2 diabetes, cardiovascular disease, osteoarthritis, cancers, mental health disorders and liver disease (Kopelman 2007)

Being obese can generate additional stigma for people who may consequently become socially withdrawn or refuse care and support services. Whether obesity is the result of disability or a contributing factor to disability, a variety of social, environmental, biological, psychological and behavioural factors may be involved. These factors include chronic disease, medication side-effects, genetic factors, mental health problems, lifestyle factors (related to both physical inactivity and diet), stigma and reduced social contact.

It is difficult to measure the relationship between obesity and disability ie whether a cause or a consequence of factors associated with both conditions. Age, sex, ethnicity, level of obesity, type and severity of disability, socioeconomic status and living arrangements all appear to impact on the relationship between the two but it is difficult to tease the factors out. People with disabilities may be at a greater risk of obesity because they are more likely to have lower socioeconomic status than those without disabilities, whilst older people with arthritis may be at a greater risk of obesity because arthritis becomes more prevalent as we age.

Obesity exacerbates difficulties for people with disabilities and their carers, whilst those who are severely obese experience significant physical problems just in coping with daily life. Social and health inequalities relating to obesity and disability may be compounded leading to socioeconomic disadvantage and discrimination, fewer

opportunities for community participation, employment and leisure and poor access to healthcare services and increased stigmatization (Public Health England 2013)

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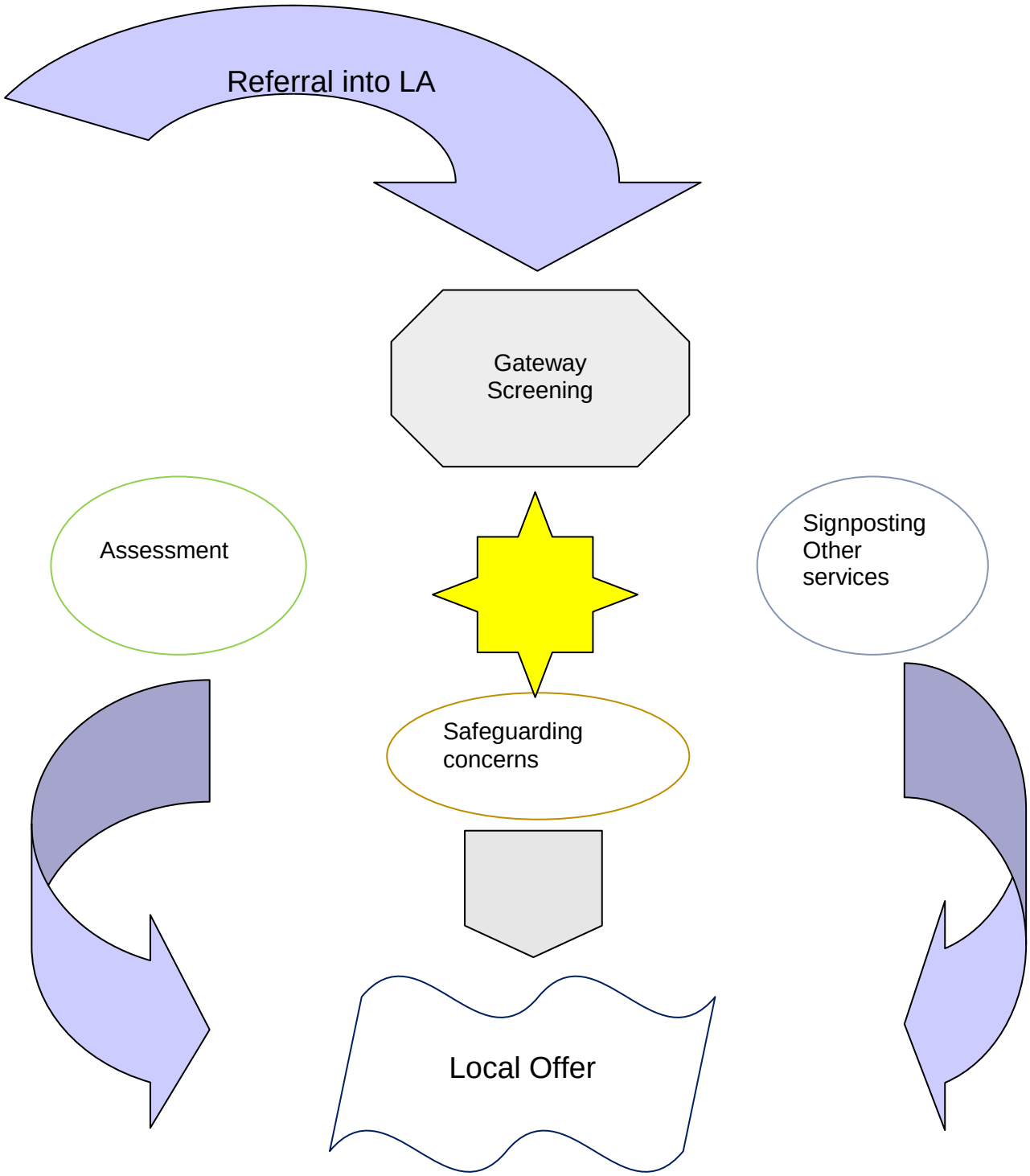
Appendix 6:

Pathway for people with complex needs and difficult to engage
LA duty of care
Local offer



Local Offer Options

Formal Assessment Funded services
Social Work Assessment
NTRP
Funded rehab
Northumbria Community Rehabilitation Company
National Probation service
CMHT

Unmanaged Risk of harm and/or abuse
Safeguarding Adults Process

Your responsibility
Help yourself as much as you can
Open Lines of communication
Speak to people
Engage
Keep appointments
Pay bills
Motivation

Semi formal non chargeable services
Budgeting support
Welfare assistance
Housing applications
Supported accommodation
Tenancy support
Floating support
Multi agency working together - MEAM process

Informal
Advice and information
Signposting to other agencies
Universal services
GP
CAB
Leisure services
Libraries

Your Views/Needs

Appendix 7 – 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 vey 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 owner 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.

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 8 – Useful contacts

Adult Social Care- referral to MEAM; Adult Social Care screening; referral for floating support.	Adult Social Care Gateway Team North Tyneside– **Tel 0191 6432777** **http://www.northtyneside.gov.uk**
	Adult Social Care Single Point of Contact Northumberland **Tel 01670 536400** Email Socialcare@northumbria.nhs.uk
Safeguarding Adults Team	**North Tyneside** **http://www.northtyneside.gov.uk** **Tel 0191 643 7079**
	Northumberland safeguardingadults@northumberland.gcsx.gov.uk **Tel 01670 622683**
Community Map	North Tyneside only ASC practitioners can access **Community Map** with a list of local activities in North Tyneside Via:-ASC General share drive/ Community Map
Mental Health Services	Community Mental Health Teams (CMHTs) North Tyneside **Tel 0191 643 7352** Referrals via GP, Primary Care Mental Health Teams, Local Authority
	CMHT's Northumberland via Adult Social Care **Tel 01670 536400**
Care and Connect North Tyneside	**Care&connect@northtyneside.gov.uk** **Tel 0191 6437474**
Advocacy	North Tyneside **Skills for People** **Tel 0191 281 8737** **Your Voice Counts** **Tel 0191 478 6472**
	Northumberland Adapt (North East) Burn Lane Hexham Northumberland

	Tel: 01434 600599 **Fax: 01434 605251**
Good neighbours scheme – Voda Project	**North Tyneside only** **Tel 0191 643 2631**
Safe and Healthy Homes	**North Tyneside only** **Tel 0191 643 7585**
Safer Estates – Tackling Anti- Social Behaviour	North Tyneside Via on line reporting system at **www.northtyneside.gov.uk** OR Adult Social Care Gateway Team - **0191 6432777** OR Northumbria Police- **101**
	Northumberland See www.Northumberland.gov.uk or http://www.northumberland.gov.uk/Protection/Neighbourhood.aspx#antisocialbehaviour Adult Social care Tel 01670 536400 Or Northumbria Police on 101
North Tyneside Homes Support Gateway	Referral to be completed and submitted to Gateway at: **welfareprovision@northtyneside.gov.uk** Or fax: **0191 643 2413**
	Northumberland Housing support through Homefinder http://www.northumberland.gov.uk/Housing/Homefinder.aspx#applyforahome
Environmental Health	**environmental.health@northtyneside.gov.uk** **0191 643 6635/6**
	Northumberland http://www.northumberland.gov.uk/Protection.aspx
Children's services (including for child protection concerns)	Front Door Service - **0345 2000 109** Or Out of hours Service – **(0191) 200 6800** Fax: **0191 6432409** or Email: **MASCT@northtyneside.gov.uk**

	Northumberland Tel **01670 629200**
RSPCA	North Tyneside **http://www.rspca.org.uk** **0191 2531395**
	Northumberland http://www.rspca.org.uk/home West branch Tel 07872 041733 North branch Tel 0191 2 761560 see also http://www.northumberland.gov.uk/Protection/Animals.aspx#animalwelfaredogcontrol-contactus Telephone: 0345 600 6400
Fire Service	North Tyneside East Community Fire Station **0191 444 1216** **www.twfire.gov.uk/yourarea/north-tyneside**
	Northumberland http://www.northumberland.gov.uk/Fire/Info.aspx#firerescueinnorthumberland or Fire safety checks Telephone: 0800 731 1351 •Email: NFRSHFSCReferral@northumberland.gov.uk
Debt and money advice	**welfareprovision@northtyneside.gov.uk** www.**ageuk**.org.**uk**/money-matters/money-man**age**ment/**debt-advice** www.citizensadvice.org.uk **2635395 / 0844 499 1198**
	Northumberland Contacts available through http://www.northumberland.gov.uk/Tax/Debt.aspx#advicefordealingwithdebt
Age UK Winter Warmth	North Tyneside **Age UK** **0191 232 6488**
	Northumberland Single Point of Access for Social Care Tel 01670 536 400 or email Socialcare@northumbria.nhs.uk

	For help with bills and benefits. Ring Northumberland County Council on 0845 600 6400 or the Age UK helpline on freephone 0800 009 966 for further information. For more information about organisations and charities which can help older people, visit the following websites: • NHS Choices: www.nhs.uk/Livewell/winterhealth/Pages/KeepWarmKeepWell.aspx • Independent Age: offers friendship to the lonely via one to one visits and telephone calls. www.independentage.org/media/625279/winter-wise_final.pdf and http://www.independentage.org/befriending • Silverline: a confidential, free charity helpline offering information, friendship and advice to older people. www.thesilverline.org.uk
Police	**North Tyneside and Northumberland** Protecting Vulnerable Persons (PVP) **101**