Aberdeen City Health & Social Care Partnership
A caring partnership

Multi-Agency Guidance for Managing Self-Neglect

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.

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Contents

1. Introduction

1.1 Self-neglect is a behavioural condition where an individual persistently neglects to care for one's 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; and
- 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.
- animal collecting 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.

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.

The Act defines an adult 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 that 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. 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.

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.
- 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 The ACHSCP 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.

2.4 The Adult Protection Unit 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.

2.5 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.

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 opened 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.

3.4 In 2009 the Scottish Government and COSLA issued guidance under 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 targeted on ensuring the most urgent needs were met in a timely manner.

3.5 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 1). 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.

3.6 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.

3.7 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 to others and their community.

4. Self-neglect assessment

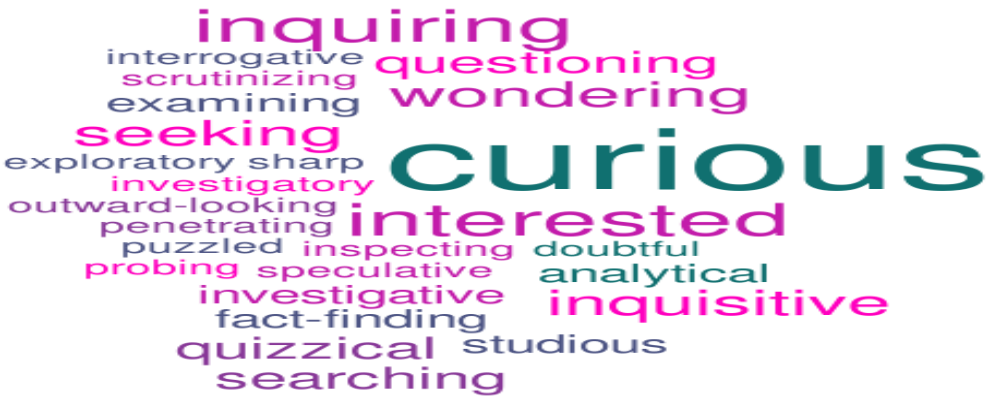
4.1 Sensitive and comprehensive assessment is important in identifying capabilities and risks. It is important to look further through a professional relationship possible significance of personal values, past traumas and social networks. Some research has shown that events such as loss of parents as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

4.2 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.

4.3 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 2) 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.

4.4 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.



4.5 The new Health and Social Care Standards: my support, my life is 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, be 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 - Bing

4.6 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; and
- life-changing events such as bereavement and loss
- fear, anxiety, or pride in self-sufficiency.
- age-related changes.

4.7 Every adult has the right to make his or her 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.

4.8 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 principals 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 their best interests and should be the least restrictive of their basic rights and freedoms.

4.10 The Decision-Specific Screening Assessment Tool (Appendix 3) 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.

4.11 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.

4.12 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.

4.13 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.
- 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.

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.

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].
- 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.
- 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 social worker / housing manager / health professional can chair the multi-agency meeting and use the agenda (Appendix 4) and aide memoire (Appendix?)

- 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.

5.2 The multi-agency meeting should agree the risk management support plan using the template provided in appendix 2. 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.

5.3 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.

5.4 How a case is monitored should be agreed with the lead agency practitioner & their Senior and any subsequent review meetings to monitor the situation or concerns should be scheduled. 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

6.3 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.
- 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	

6.4 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.

6.5 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 some beneficial approaches 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 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 ally such fears.
- make agreements to achieve progress can be helpful.
- regular, encouraging engagement and gentle persistence may help with progress and risk management.
- robust risk assessment may be the best outcome achievable if it is not possible to change the adult's behaviour.

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

Practical tasks may include:

- utilise local partners such as RSPCA, the fire service, environmental health, and housing.
- help with property management and repairs.
- some individuals may be helped by counselling or other therapies, including obsessive compulsive disorder or addictions.
- facilitate or co-ordinate doctors' appointments or provide practical support to attend appointments.

7.4 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.

7.5 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.

7.6 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.

7.7 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. Responses to non-engagement and service refusal

8.1 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 6).

8.2 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.

8.3 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.

8.4 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.

9. When no further interventions can be planned

9.1 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.

9.2 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.

9.3 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.

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

10. Support arrangements for professionals

10.1 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.

10.2 Appropriate and specialist self-neglect training where this is relevant to their role.

11. Unpaid carers

11.1 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.

APPENDIX 1

Eligibility Criteria (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.

Appendix 2

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……..

Appendix 3

DECISION SPECIFIC CAPACITY ASSESSMENT TOOL

DECISION-SPECIFIC SCREENING TOOL

To assist with assessment of capacity

Name of Adult		**CareFirst No.**		**CHI:**	
Worker Details		**Date**			

Capacity is the ability to understand information relevant to a particular decision or action; understand the benefits, risks and alternatives of the decision; ability to weigh up the possible outcomes in order to arrive at a decision; ability to communicate the decision to others, ability to remember the decision or show consistency in decision making and ability to act on the decision.

This tool aims to assist the practitioner consider the various elements involved in the decision making process. It may be used to gather evidence of an adult having or lacking capacity in relation to specific decisions and also to consider whether a more formal assessment is required in order to pursue measures under the Adult with Incapacity (Scotland) Act 2000.

Details of the Decision to be made	
Details of the adults views on the decision to be made or action to be taken	

Who was consulted in forming your opinion of the adult's decision-making ability?

Name	**Relationship with Adult**	**Contact Details**	**View**

Q: Does the adult have a mental disorder (diagnosed	**Yes**	**No**	**Not Sure**	*For example: dementia, learning disability, brain*	**Condition**

or suspected) or he/she is unable to communicate because of a physical disability?				*injury, personality disorder, neurological condition, mental illness etc.*	
If you have answered No to this question a capacity assessment is not applicable, however an adult may still be unable to safeguard themselves and appropriate Adult Support and Protection measures should be considered.					

Q1: Do you consider the adult **able** to **understand** the information relevant to the decision? Has this information been provided in way that he/she is able to understand?	**Yes**	**No**	**Not Sure**	*For example: a lady with learning disabilities who has never managed her own finances may need to receive information in an accessible manner. Information may need to be repeated.*	**Supporting Evidence**
Q2: Do you consider the adult **able** to **retain the information** for long enough to use it in order to make a choice or an effective decision?	**Yes**	**No**	**Not Sure**	*An adult may need to be asked on several occasions to confirm the consistency of their response. Where a person has difficulty remembering the decision but answers consistently this makes their decision valid.*	**Supporting Evidence**
Q3: Do you consider the adult **able** to **use or weigh** information about the decision as part of the process of making the decision?	**Yes**	**No**	**Not Sure**	*This may include understanding the consequences of the decision for themselves and others and weighing up the possible outcomes in order to arrive at a decision.*	**Supporting Evidence**
Q4: Do you consider the adult **able** to **communicate** the decision?	**Yes**	**No**	**Not Sure**	*Every effort should be made to facilitate communication including talking mats, sign language, interpreter, engaging Speech and Language Therapy etc.*	**Supporting Evidence**

Q5: Do you consider the adult **able** to **act upon** the decision?	**Yes**	**No**	**Not Sure**	*A person may show good reasoning and ability to understand and make the decision however when confronted with the situation, may not be able to use this reasoning to act, due to mental illness or cognitive impairment.* *For example: an adult with hoarding disorder may have shown capacity to understand and make a decision about others assisting with tidying however does not act on his/her decision by allowing entry to his/her home, due to emotional response associated with their hoarding disorder* *For example: an adult with brain injury and executive functioning difficulties may have shown capacity to understand and make decisions about day to day budgeting however when shopping in town spends a month's allowance on new clothes due to difficulties inhibiting response in the situation.*	**Supporting Evidence**
Q6: Overall, do you consider on the balance of probability that the impairment or disability is sufficient that the adult lacks the capacity to make this particular decision?	**Yes**	**No**	**Not Sure**	**Any additional supporting evidence**	
Any Further Comments					

If you have answered **YES** consistently to Q1-Q5, and **NO** to Q6, the adult is considered on the balance of probability, **to have the capacity to make this particular decision at this time**.

Sign/date this form and record the outcome within the adult's records

If you have answered **NO** please follow appropriate legislation

If you have answered NOT SURE to any of the questions **proceed to Q7 – Q8.**

Q7: Does the adult repeatedly make seemingly unwise decisions which place her/him at significant risk or serious exploitation? Is she/he making a decision which defies all notion of rationality and/or is markedly out of character?	**Yes**	**No**	**Not Sure**	*An unwise or eccentric choice doesn't necessarily mean the person is unable to make a decision – consider the person's views, values, preferences and previous decisions.*	**Supporting Evidence**
Q8: Do you consider the adult to have experienced undue pressure around the decision/ actions?	**Yes**	**No**	**Not Sure**	*Undue pressure involves one person taking advantage of a position of power over another person. This inequity in power between the parties can overrule one party's consent as they are unable to freely exercise their independent will. This can be due to trust or fear.*	**Supporting Evidence**

Q9: Have efforts been made to support the person to make the decision themselves?	**Yes**	**No**	**Not Sure**	*Interventions can be used to improve an individuals'* • *Ability to make decisions'* • *Memory or attention* • *Ability to organise and process information e.g. Speech and Language Therapy, Advocacy, Assisted Communication Aids, Translators and neuropsychology*	**Supporting Evidence**

If you have answered **YES** to Q7 or Q8, please follow appropriate legislation.

Signature		**Date Assessment Completed**	

Acknowledgement: Adapted from documentation in use in NHS Forth Valley, NHS Lothian and City of Edinburgh Council

Grampian Referral Guidance for requesting a Capacity Assessment

The GP or relevant team will consider referrals to assess capacity to make specific decisions, where there is uncertainty and/or complexity. We support multi-disciplinary and multi-agency groups of professionals considering questions of capacity in advance of such a referral, but where no consensus can be reached we would consider requesting a capacity referral for assessment.

Any referral for assessment of capacity should be:

- **Specific** with regard to a particular decision to be made
- **Focused**, rather than a number of questions we would encourage referrers to focus on one or two questions which need examined
- **Timely**, i.e., assessed at the time the person is required to make the decision
- With a **clear potential outcome**, such as considering Guardianship under the Adults with Incapacity (Scotland) Act 2000

It is important that a person has been given information regarding their choices to allow them the opportunity to make a fully informed decision. The Decision- Specific Screening Tool is to be completed by the referrer and will aid in providing clarity regarding the individual's capacity to make particular decisions.

Who would undertake a further assessment of capacity if an adult's decision making ability is still unclear following completion of Decision-Specific Screening Tool?

Each referral will be discussed and allocated to the most appropriate professional. Input may be multidisciplinary, requiring specific input from particular professionals e.g. speech and language therapy, clinical psychology. **Of note, assessments may take some time to complete, depending on the complexity and engagement of the person being assessed.**

Please note interventions that can be used to improve an individual's capacity e.g. engaging Speech and Language Therapy must be considered before requesting a Capacity Assessment.

Additionally, if you have answered YES to questions 1-5 and NO to question 6 and still have concerns regarding the adult's vulnerability follow appropriate Adult Support and Protection referral processes.

Adults with Incapacity (Scotland) Act 2000: Communication and Assessing Capacity: A guide for social work and health care staff https://www2.gov.scot/Resource/Doc/210958/0055759.pdf

APPENDIX 4

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

Appendix 5

SELF-NEGLECT AIDE MEMOIRE

Presenting problems

Assessment of need

Care and support have been determined using the eligibility criteria.

Mental capacity assessment

Assessment of heath 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.

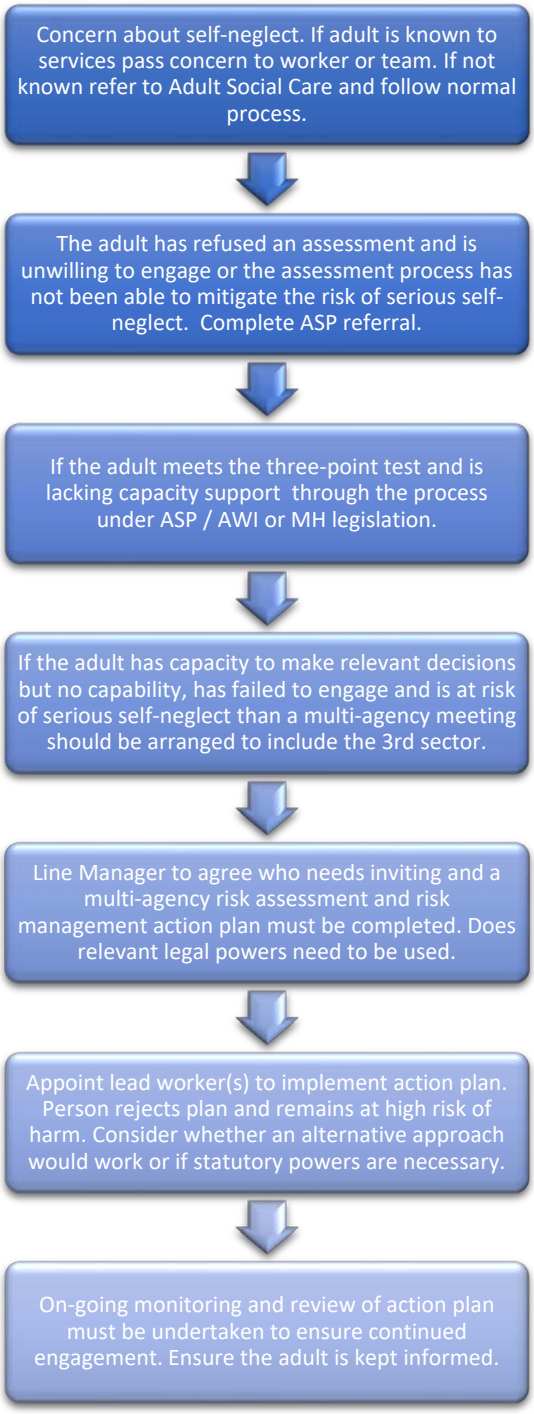
APPENDIX 6

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

APPENDIX 7 PATHWAY FOR REFERRALS



APPENDIX 8

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 criminalityotherwise, 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.

APPENDIX 9 **INFOGRAM**