

Multi-Agency Self-Neglect Toolkit

Camden Safeguarding Adults
Partnership Board
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Introduction

The Camden Safeguarding Adults Partnership Board (Camden SAPB) ensures that all agencies in Camden work together to prevent and respond to abuse and neglect in adults at risk.

Learning from Safeguarding Adults Reviews (SARs) commissioned by the SAPB and other London Safeguarding Adults Boards suggests that the public and professionals require advice and guidance to support people who are at risk of or who are self-neglecting and/or hoarding. The definition of self-neglect used in the SCIE research was broad and centred on:

- a) lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing; and/or
- b) lack of care of one's environment – squalor and hoarding (see below); and/or
- c) refusal of services that would mitigate risk of harm.

Hoarding is the excessive collection and retention of any material to the point that living space is sufficiently cluttered to preclude activities for what they are designed for.

Why are there challenges in self-neglect work?

In part, it is because the factors that have led to the self-neglect are many and may be deeply rooted. Longstanding and complex problems are not easy to resolve, and social care practitioners are sometimes torn between their duty to care for people and protect them from harm, and the need to respect their choices about how they live (Braye et al, 2013)¹. This toolkit has been designed to provide practical support to those working hard to

support people who self-neglect and also supports priorities of the Camden SAPB to identify and reduce social isolation and promote Making Safeguarding Personal. The toolkit will be subject to on-going development and your feedback will be part of continual improvement. Please contact **camdenSAPB@camden.gov.uk** to give feedback.

¹ Braye, S., Orr, D., & Preston-Shoot, M. (2013). A scoping study of workforce development for self-neglect work.

Chapter 1

Overview of Self Neglect²

1.1 What is self-neglect and hoarding?

The important thing is to try to engage with people, to offer all the support we are able to without causing distress, and to understand the limitations to our interventions if the person does not wish to engage. Working in partnership with other services is usually key to a more effective approach.

What is self-neglect?

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

1.2 What causes self-neglect?

It is not always possible to establish a root cause for self-neglecting behaviours. Self-neglect can be a result of:

- a person's brain injury, dementia or other mental disorder, a learning disability
- obsessive compulsive disorder or hoarding disorder
- physical illness which has an effect on abilities, energy levels, attention span, organisational skills or motivation
- reduced motivation as a side effect of medication
- addictions such as drugs, alcohol or gambling
- traumatic experiences.

Sometimes self-neglect is related to deteriorating health and ability in older age

and people with mental health problems may display self-neglecting behaviours. There is often an assumption that self-neglecting behaviours indicate a mental health problem but there is no direct correlation.

Hoarding is now widely considered as a mental health disorder and appears in the US 'Diagnostic and statistical manual of mental disorders' (5th Edition). Hoarding can sometimes relate to obsessive compulsive disorder but hoarding and self-neglect do not always appear together and one does not necessarily cause the other.

1.3 Self-neglect: what are the issues?

People who neglect themselves often decline help from others; in many cases they do not feel that they need it. Family or neighbours can sometimes become frustrated and critical of professionals if they cannot improve the situation of the individual. But there are limitations to what others can do if the adult has mental capacity to make their own decisions about how they live. Sometimes, even when all agencies have done everything in their power to support an individual, they may die or suffer significant harm as a result of their own action or inaction. It is therefore vital that all efforts to engage with and support an individual are clearly recorded. The Camden SAPB have produced a leaflet for people who self-neglect and their families to provide some useful information.

1.4 Barriers to good practice

- Working with people who self-neglect can be alarming and very challenging.
- People who self-neglect may refuse support or fail to acknowledge the problem.
- The risks associated with self-neglect can be high and the options for intervention are limited.
- There can be pressure on professionals to take action, but often there is very little they can do.
- There is often a lack of clarity about who should take responsibility for supporting people who self-neglect.
- Poor and infrequent supervision can lead to increased stress on practitioners and lead to poor judgement.
- Work patterns and resources may not support long-term, relationship-based work.
- Individuals don't always have care and support needs – so safeguarding responses may not be appropriate.
- Uncertainty about how and where to escalate concerns.
- Information sharing is sometimes problematic, particularly when the person refuses help.
- Limited legal literacy – professionals may not have a good understanding of the law that can be utilised in relation to self-neglect.
- Application of the Mental Capacity Act can be very complex in relation to self-neglect.
- Lack of resources can prevent appropriate service responses.

1.5 Relevant legislation

It is essential that people working in health and social care are aware of the rights of individuals in law and of the duties, powers and responsibilities of the local authority and other, including their own, agencies. There is a raft of relevant legislation and guidance to support working with people who self-neglect but some key ones are

listed here:

- The Care Act (2014) statutory guidance – self-neglect is included as a category under adult safeguarding, although a safeguarding response is not always appropriate
- Article 8 of the Human Rights Act 1998 gives us a right to respect for private and family life. However, this is not an absolute right; it is a qualified right, meaning there may be justification to override it, for example, protection of health, prevention of crime, protection of the rights and freedoms of others.
- Mental Health Act (2007) Section 135 – if a person is believed to have a mental disorder and they are living alone and unable to care for themselves, a magistrate's court can authorise entry to remove them to a place of safety.
- Mental Capacity Act (2005) Section 16 (2) (a) – the Court of Protection has the power to make an order regarding a decision on behalf of an individual. The court's decision about the welfare of an individual who is self-neglecting may include allowing access to assess capacity – See Chapter 2.
- Public Health Act (1984) Section 31-32 – local authority environmental health could use powers to clean and disinfect premises but only for the prevention of infectious diseases.
- The Housing Act 1988 – a landlord may have grounds to evict a tenant due to breaches of the tenancy agreement.
- Rights of Entry (Gas and Electricity Boards) Act - 1954 a representative of a gas or electricity supply company can apply for a warrant of entry to premises to inspect or read the meter, to install a prepayment meter, or to disconnect the supply.

Inherent Jurisdiction of the High Court³:

- 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 person to 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.

Chapter 2: Positive engagement and best practice⁴

The research on self-neglect suggests beneficial approaches and a range of options, levers and practical measures that could help engagement with individuals. See Chapter 4 for resources that can help build relationships and assess need.

2.1 Approach

Research has shown that those who self-neglect may be deeply upset and even traumatised by interventions such as 'blitz' or 'deep cleaning'. When developing an approach it is important to try to understand the individual and what may be driving their behaviour. There are some general pointers for an effective approach to be read in conjunction with the Camden self-neglect directory of support:

- Multi-agency – work with partners to ensure the right approach for each individual and increased support for practitioners and agencies
- Person centered – respect the views and the perspective of the individual, listen to them and work towards the outcomes they want
- Acceptance – good risk management may be the best achievable outcome, it may not be possible to change the person's lifestyle or behaviour
- Analytical – it may be possible to identify underlying causes that help to address the issue
- Non-judgemental – it isn't helpful for practitioners to make judgements about cleanliness or lifestyle; everyone is different
- Empathy – it is difficult to empathise with behaviours we cannot understand, but it is helpful to try

- Patience and time – short interventions are unlikely to be successful, practitioners should be enabled to take a long-term approach
- Trust – try to build trust and agree small steps
- Reassurance – the person may fear losing control, it is important to allay such fears
- Bargaining – making agreements to achieve progress can be helpful but it is important that this approach remains respectful and professionally appropriate
- Exploring alternatives – fear of change may be an issue so explaining that there are alternative ways forward may encourage the person to engage
- Always go back – regular, encouraging engagement and gentle persistence may help with progress and risk management

2.2 Practical tasks

- Risk assessment – have effective, multi-agency approaches to assessing and monitoring risk
- Assess capacity – ensure staff are competent and supported in applying the Mental Capacity Act in cases of self-neglect
- Mental health assessment – it may, in a minority of cases, be appropriate to refer an individual for Mental Health Assessment
- Signpost – with a multi-agency approach people can be signposted to effective sources of support
- Contact family – with the person's consent, try to engage family or friends to provide additional support and consider the Family Group Conferencing approach
- 'Decluttering' and cleaning services – where a person cannot face the scale of the task but is willing to make progress, offer to provide practical help
- Utilise local partners – those who may be able to help include the RSPCA, the fire service, environmental health, housing, voluntary organisations
- Occupational therapy assessment – physical limitations that result in self-neglect can be addressed

⁴ Adapted from <https://www.scie.org.uk/self-neglect>

- Help with property management and repairs – people may benefit from help to arrange much needed maintenance to their home
- Peer support – others who self-neglect may be able to assist with advice, understanding and insight
- Counselling and therapies – some individuals may be helped by counselling or other therapies. Cognitive behaviour therapy, for example, may help people with obsessive compulsive disorder, hoarding disorder or addictions

2.3 Levers

Resorting to enforcement action should be a last resort with people who self-neglect. There are some options that can be used in extreme circumstances but often the threat of enforcement can encourage an individual to accept help and support. Levers may include housing enforcement options based on tenancy or leasehold breaches and environmental health enforcement based on a public health risk. Local authorities also have powers relating to anti-social behaviour that may be relevant in a minority of cases.

2.4 Safeguarding

London Multi-agency Adult Safeguarding Policy and Procedures state: Self-neglect may result from a behavioural condition in which an individual neglects to attend to their basic needs such as personal hygiene, or tending appropriately to any medical conditions, or keeping their environment safe to carry out what is seen as usual activities of daily living. It can occur as a result of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment or through personal choice. It can be triggered by trauma and significant life events. However, if self-neglect results from free and informed personal choice, where the adult is able to care for themselves but chooses not to, this is not a safeguarding issue.

London Multi-agency Adult Safeguarding Policy and Procedures guidance goes on to advise that ‘finding the right balance between respecting the adult’s autonomy and meeting the duty to protect their wellbeing may involve building up a rapport with the adult to come to a better understanding about whether self-neglect or hoarding are matters for adult safeguarding or any other kind of intervention’.

When you suspect or know an individual is self-neglecting in Camden you should consult with the Camden Multi-Agency Safeguarding Hub (MASH) on whether a safeguarding referral should be made or not.

All self-neglect referrals should be captured as a safeguarding concern but may not always be appropriate to progress to a section 42 enquiry in every instance.

Where a person is not currently receiving support and is unintentionally self-neglecting as a result of changes to their ability to self-care, a Care Act assessment and plan may be sufficient to address the concerns. In cases where the self-neglect is very severe, the person is at high risk, other approaches under care management have not worked, and/or the person is refusing support, the safeguarding concern should progress to a s42 enquiry and safeguarding plan, in order to support the multi-disciplinary response to the risks.

When the matter is not appropriate for a safeguarding response this should not deter the allocated worker from using the mechanisms of multi-agency discussion, risk assessment and supervision to evidence and manage risk that falls outside the parameters of the safeguarding pathway.

The Care Act places an emphasis on Making Safeguarding Personal and moves away from set timescales. In Camden we aim to comply with target timescales for the purposes of ensuring a timely intervention is carried out.

The referrer should report their concerns immediately if urgent but within 24 hours in other cases.

If a concern progresses to a formal enquiry, the intended timescales for the enquiry process would be the following:

- Initial conversation should be held on the same day the concern is received to decide on any immediate actions needed to ensure the person is safe
- Planning meetings should take place within 5 working days or sooner depending on urgency
- Enquiry actions should be completed within 20 working days
- Agreeing the outcome should happen within 5 days of the enquiry report being published.

The aim for the safeguarding plan and review should be the following:

- Safeguarding plan should be in place 5 days from the enquiry report.
- The review of the safeguarding plan should be within 3 months, although could be sooner dependent on risk.
- In terms of closing an enquiry the aim should be the following:
- Action immediately following a decision to close.

To discuss a safeguarding referral call **020 7974 4000** PRESS OPTION 1.

Download the referral form at

camden.gov.uk/safeguarding-adults

and email to

asc.mash.safeguarding@camden.gov.uk

2.5 Mental Capacity

Among adults who are vulnerable to self-neglect, the capacity to make decisions may remain intact. However, the capacity to identify and extract oneself from harmful situations, circumstances, or relationships may be diminished⁶. Building good relations can maintain a level of contact that enables support to be accepted over time and

with that, the monitoring of capacity⁷.

The Mental Capacity Act 2005 provides a legislative framework and a Code of Practice **www.gov.uk/government/publications/mental-capacity-act-code-of-practice** to support and protect the rights of people who may lack capacity to make some or all decisions.

The key principles are:

- Assume capacity
- Support people make their own decisions
- The right to make unwise decisions
- Best interests
- Least restrictive option

2.5.1 What is mental capacity?

Mental Capacity is the ability to make a decision e.g.

- Daily life decisions.
- Serious or significant decisions
- Decisions that may have legal consequences.

⁶ Naik, A. D., Lai, J. M., Kunik, M. E., & Dyer, C. B. (2008). Assessing capacity in suspected cases of self-neglect. *Geriatrics*, 63(2), 24.

⁷ <https://www.scie.org.uk/publications/reports/report46.pdf>

These decisions must be viewed as:

- Time specific – Capacity must be assessed at the time a decision needs to be made. Capacity and decisions must be reviewed at agreed times or it may even be possible to wait until a more appropriate time if that is better for the person.
- Decision specific – Capacity is assessed in relation to the ability to make a specific decision, not a general ability to make decisions. What is the decision to be made? Always keep going back to the decision in question, it's easy to drift away from the actual decision.
- Consider – does the decision have to be made now, can it wait if likely to regain capacity? Is this the best time of day for the person? Have you made all efforts to support the decision making before assessing capacity? Are the right people there to support the person? Do you need to ask someone with more experience in capacity assessments to support you?

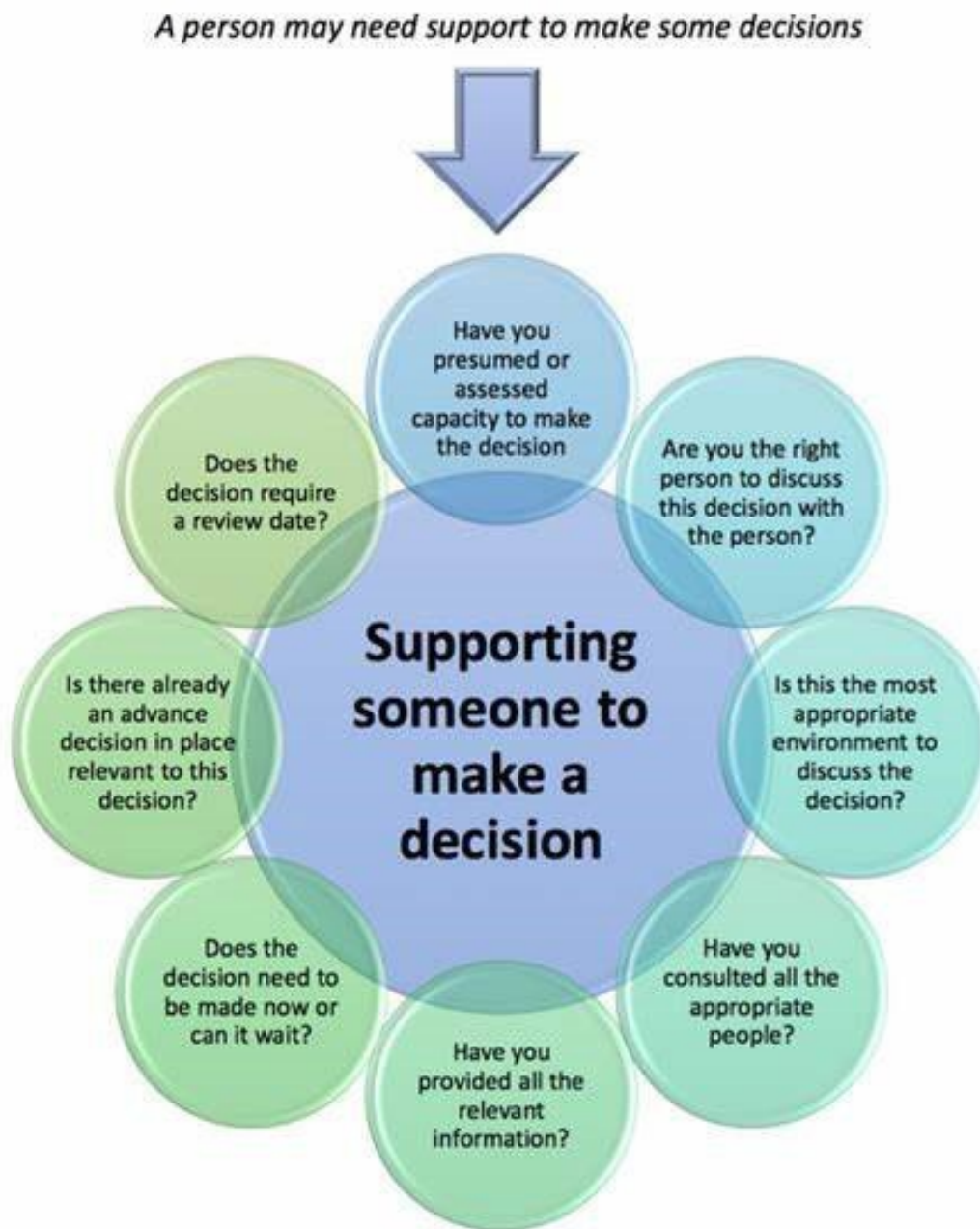
Figure 1 illustrates the principles from the person's perspective while Figure 2 provides some useful prompts to consider when supporting someone to make a decision about their life.

Figure 1: The MCA Principles



Figure 2: Supporting Decision Making

GP Toolkit: Supported decision making checklist



2.5.2 Assessing Capacity

If you have taken steps to fully support the person to make a decision but doubt their ability to make it then you should complete the capacity assessment.

Have you ensured:

- The person knows their capacity is being assessed
- You and they are clear on the decision to be made
- Any communication aids for example interpreters/signing, hearing aids, dentures and glasses are in place and working?
- The person has those present who make them feel safe and supported?
- This is the best time of day for the person? Are they at their best in the morning or evening?

- They have not had medication or drugs/alcohol that affects decision making?
- Anything that makes them anxious or distracted has been removed or reduced?
- The environment is helpful to making decisions e.g. not too noisy or uncomfortable?
- You are able to record your findings and share them with the person

Capacity assessment is comprised of a two stage test:

1. Does the person have an impairment or disturbance of the mind or brain? Examples of this could be dementia, a brain injury, a learning disability, effects of substance misuse or medication, acute illness/infection
2. Does the impairment or disturbance affect the ability to make THIS decision at THIS time? To establish this you must evidence the following components and ensure this is done in a way that maximises a finding of capacity:
 - Can P understand the information? Yes/No – evidence: can they explain back to you what is relevant to the decision? E.g. 'I have a urinary infection, antibiotics are needed for 5 days to clear it and without them it will probably get worse and I could end up in hospital'
 - Can P retain the information? Yes/No – evidence: They can demonstrate that they can remember the information long enough to be able to make the decision. This should be in proportion to the type of decision being made. E.g. information about a blood test for as long as the blood test takes, if it's to move to a new home this would be something the person should be able to remember as it has long term consequences.
 - Can P use and weigh the information – Yes/No - evidence: can the person tell you the pro's and cons of the decision? E.g. 'I know the antibiotics would make

my infection better quicker and prevent further serious complications but I prefer to wait and take home remedies to see if it improves first'

- Can P communicate their decision? – Yes/No – evidence: can they tell you their decision? This may be through various means and you may need a speech and language expert or interpreter to ensure you understand the person's wishes

Document your assessment and do not set the bar of understanding higher than would be reasonable for most people. Remember that the conclusion of your assessment is based on the balance of probabilities.

2.5.3 Top Tips

- A person should be fully supported to make a decision before deciding to assess capacity
- A person must be made aware their capacity is being assessed
- Make use of any templates your service has for documenting capacity
- The decision maker assesses capacity e.g. if it's a medical issue a clinician may assess, if it is about a social care issue, social worker would assess – be clear on what the decision is before assessing
- It is time and decision specific – it's not a mini-mental state exam. Inability to make one decision does not permit anyone to assume a general 'lacks capacity' for everything
- Be careful about constantly assessing capacity – to assess capacity is highly intrusive and must be justified, it is not repeat testing until we get the right answer!
- If a person refuses to engage, an assessment of capacity for a decision could be made based on ancillary information
- Capacity should not equate to abandonment, support should be offered with reasonable adjustments to suit the persons wishes

Chapter 3: Information Sharing

Key messages:

Adults have a right to independence and control over their lives including their information. There are circumstances in practice with adults where the right to confidentiality can be overridden.

The Care Act 2014 sets out general duties to cooperate between the Local Authority and other organisations providing care and support, including for the purposes of safeguarding adults at risk. It also outlines the responsibilities of others to comply with requests for information from the Safeguarding Adults Board, if such information is not forthcoming. More information can be found in the London Multi-Agency Safeguarding Adults Policy and Procedures. www.scie.org.uk/safeguarding/adults/practice/sharing-information

- Emergency or life-threatening situations may warrant the sharing of relevant information with the relevant emergency services without consent.
- The law does not prevent the sharing of sensitive, personal information within organisations. If the information is confidential, but there is a safeguarding concern, sharing it may be justified.
- The law does not prevent the sharing of sensitive, personal information between organisations where the public interest served outweighs the public interest served by protecting confidentiality – for example, where a serious crime may be prevented.
- Information can be shared lawfully within the parameters of the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).
- There should be a local agreement

or protocol in place setting out the processes and principles for sharing information between organisations.

- An individual employee cannot give a personal assurance of confidentiality.
- Frontline staff and volunteers should always report safeguarding concerns in line with their organisation's policy – this is usually to their line manager in the first instance except in emergency situations.
- It is good practice to try to gain the person's consent to share information.
- As long as it does not increase risk, practitioners should inform the person if they need to share their information without consent.

Information sharing can present professionals with uncertainty over the legal position and ethical dilemmas. Your organisation and professional body will have policy and guidance for you when you are unsure about sharing. It is important to consider the risk of not sharing information as well as the duty of confidentiality when weighing up your decision.

Information Requesting

An important point that can be overlooked, is how information about an adult at risk is requested. The request should be clear about the purpose, whether consent has been obtained and clear reasons as to why it has not. The request should also be very specific about who is requesting, the nature of the information required and the purpose for which it will be used. This can help the information holder to make an informed and defensible decision.

All information requests must be sent securely and provide a secure email to return them, if in doubt, check. If a request is not constructed in a way that enables you to cooperate, contact the sender and ask them to be more specific to guide your decision.

Find the link to the seven golden rules for information sharing here.

Adults sometimes refuse consent for their information to be shared, this is often due to fear of services interference or fear of an abuser. It is important that the adult is supported to discuss concerns they have and receive clear information about professionals concerns about risk plus any reassurance about their fears where it is possible to provide it.

It is possible to override the wishes of an adult not to share their information in the following circumstances:

- the person lacks the mental capacity to make that decision – this must be properly explored and recorded in line with the Mental Capacity Act 2005
- other people are, or may be, at risk, including children
- sharing the information could prevent a crime
- the alleged abuser has care and support needs and may also be at risk
- a serious crime has been committed
- staff are implicated
- the person has the mental capacity to make that decision but they may be under duress or being coerced
- the risk is unreasonably high and meets the criteria for a multi-agency risk assessment conference referral
- a court order or other legal authority has requested the information.

You must clearly document in the persons record, details of the request along with what you have shared and your reasons for doing so.

There are occasions it may be appropriate not to share information requested by another agency. This is when the adult does not consent and:

- Nobody else is at risk – always consider any children at risk as well as adults
- no serious crime has been or may be committed
- the person alleged to have caused harm has no care and support needs
- no staff are implicated
- no coercion or duress is suspected
- the public interest served by disclosure does not outweigh the public interest served by protecting confidentiality
- the risk is not high enough to warrant a multi-agency risk assessment conference referral
- no other legal authority has requested the information.

If you decide not to share information you must clearly record the request and your reasons for not sharing.

Chapter 4: The Camden Self-Neglect Directory of Services

4.1 What support can agencies provide?

Seminal research from Braye et al, 2014 found that service involvement for people who self-neglect is more successful when it draws on multi-agency working. It is sometimes challenging to know which agencies you can contact for support and what you can expect from those agencies when you do make contact. In response to this, agencies working in Camden have provided this practical information about what support services can provide.

Adult Social Care - London Borough of Camden

Adult social care can offer holistic and person-centred assessment and interventions where there are concerns about self neglect and hoarding, to support individuals to achieve positive outcomes. Adult social care practitioners can complete assessments under relevant statutory frameworks including the Care Act, the Mental Capacity Act and initiate safeguarding processes.

This may include co-ordinating a multi-agency approach and liaising with partner agencies to deliver joined up risk assessment and management, including health colleagues, care providers, housing, environmental health, the Fire Service and High Risk Panel. Concerns about self-neglect should be sent to Camden's Multi-Agency Safeguarding Hub (MASH). In the majority of cases the usual Care Act assessment procedures will be the best route to provide an appropriate intervention. If assessed as having mental capacity to make informed decisions on

the issues raised, then the person has the right to make their own choices. However, the assessor must ensure that the person has fully understood the risk and likely consequences if they refuse services. Involvement with the person should not stop at this point and efforts should be made to engage the person in the management of risks and to form a relationship with them to do this.

If the person is assessed as not having capacity to make the relevant decisions then care should be provided in line with "best interest" principles (Section 4 MCA). If any proposed care package might amount to a deprivation of liberty (DoLS), consideration must be given as to whether it would be necessary to obtain authorisation under the DoLS procedure or an order from the Court of Protection. Assessment of self-neglect should include assessment of any health issues such as impaired sight and mobility, pain issues, or long term conditions that may be contributing towards the self-neglect.

Housing

Under Part 1 of the Housing Act 2004, the housing department has powers to take enforcement action where there is any risk of harm to the health or safety of an actual or potential occupier of a dwelling or house of multiple occupation which arises from a deficiency in the dwelling or house of multiple occupation or in any building or land in the vicinity (whether the deficiency arises as a result of the construction of any building, an absence of maintenance or repair, or otherwise). The housing department can require access to residential premises in their district to assess if such a hazard exists.

The duty to inspect the property is restricted to where there is an official complaint made either to the Justice of the Peace or local council. However, where there is evidence that there is imminent risk of serious harm to the health and safety of the occupier, the local authority has emergency power to serve a remedial action notice or emergency probation notice prohibiting the use of the property.

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

Private landlords/housing associations/registered social landlords

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

Environmental Health Services

The Environmental Health Service (EHS) has a range of powers to intervene where a property is in a condition that is prejudicial to health, or where the premise is materially affecting neighbouring premises. EHS is a frontline agency in raising alerts and early identification of cases of self-neglect and hoarding. Where properties are verminous or pose a statutory nuisance EHS will take a leading role in case managing the necessary investigations and determining the most effective means of intervention.

Where the individual is residing in conditions that only pose a threat to their own welfare, the powers available to EHS may have limited or no effect. In cases involving persistent hoarders the powers may only temporarily address and/or contain the problem.

Therefore utilising powers under public health legislation in isolation may not be the most effective use of resources, particularly where a coordinated approach could provide immediate protection of the individual and others and also promote a long term solution.

Camden Learning Disability Service

CLDS can offer input for self-neglect or hoarding when the person is known to the service and has been assessed as being eligible for the service due to having a Global Learning Disability.

A Learning Disability is not necessarily a causal factor in self-neglect and hoarding. If there are indicators that the person may have a Learning Disability, then a referral can be completed to CLDS for a Learning Disability assessment. Please note that high functioning Autism can be associated with self-neglect and hoarding/collecting, however, this client group does not have a global Learning Disability and is not eligible for input from CLDS.

If a person is considered eligible for CLDS, then we can offer a multi-disciplinary service from a range of health and social care practitioners depending on need. This may include Psychology, Occupational Therapy, Psychiatry, Nursing, and Speech & Language Therapy. CLDS social care practitioners may complete an assessment under relevant statutory frameworks including Mental Capacity Act, & the Care Act and Safeguarding processes. This may include joint working, liaison and risk management with other local authority teams and partner agencies including Housing department, landlords, High Risk Panel, Fire Service etc., as appropriate.

Contact details – **020 7974 3737**

Multi-Agency High Risk Panel

The High Risk Panel (HRP) was established by the Camden Safeguarding Adults Partnership Board to provide a multi-agency way of supporting individuals with complex needs presenting with high risk in order to secure positive and person-centred outcomes. The various

partners of the HRP will support agencies in their work to reduce and manage risk for both individuals and their immediate neighbours. The panel has a consultative and advisory role.

The HRP aims to:

- Consider a variety of options for supporting individuals
- Improve support for practitioners
- Identify risk at an earlier opportunity
- Deliver a proportionate, coordinated, effective and timely response
- Improve outcomes for the adult with care and support needs
- Attempt to reduce risk, keep residents safe and combine knowledge, experience and expertise from different services to provide advice.
- Providing a support network of organisations and agencies.
- Developing better partnership working between the agencies to ensure a holistic approach to care.

Eligibility for the High Risk Panel

For cases to be accepted to the HRP, practitioners need to demonstrate a range of options have been considered or evidence of actions that have been tried to reduce the risks to the individual with no or little effect. Cases must:

- Deemed to be of high risk – serious harm to themselves or others. The risk will have maintained high despite interventions. The Risk Matrix (Appendix 1) can be used to help determine the level of risk, high risk being mostly orange or red. There may also be serious safeguarding concerns.
- Not a new case to the practitioner
- Not have immediate safeguarding risks, these should be managed under the London Multi-agency Adult Safeguarding Policy and Procedures.

Referrals from within the local authority should be made by completing a referral form and emailing it to the HRP (**HighRiskPanel@camden.gov.uk**). External referrers should refer via the

Camden Adult Social Care MASH (**asc.mash.safeguarding@camden.gov.uk**).

Health Services - General Practice

Advice for adult patients who are not registered with a GP and who are deemed to have capacity and decline to register⁹:

The reasons why these patients do not want to be registered should be fully explored by any professional in contact with the patient and any potential barriers considered and discussed/challenged as appropriate. If the patient is not registered with a GP, it may restrict their access to any hospital based services or community services outside of urgent and emergency care as these referrals are usually made via the GP practice. They may also not receive regular screening tests for things like cancer which are often co-ordinated via the GP. The following information may be useful for other professionals when discussing why to register with a GP and how to go about choosing a GP as well as your rights as a patient.

GPs are usually the first medical point of contact with the NHS. They are responsible for the comprehensive and continuing care of patients registered with them. GPs provide advice and treatment. If further treatment or investigation of a problem is required, the GP will co-ordinate this and ensure that it is provided. Further treatment might be provided by your GP, or by a member of their team such as a practice nurse, midwife or health visitor, or if required, by referral to a specialist doctor called a consultant or to other specialist services. GPs are also keen to promote good health amongst their patients.

They and their staff give advice on diet, exercise, healthy living and disease prevention. Most patients are looked after by the same GP for many years. This builds up a bond of trust between the GP and patient and enables the GP to build up a good knowledge of you and your health

⁹ www.nhsgrampian.org/nhsgrampian/files/GPBookletFeb07.pdf
www.nhs.uk/using-the-nhs/nhs-services/gps/how-to-register-with-a-gp-practice/
www.nhs.uk/using-the-nhs/nhs-services/gps/referrals-for-specialist-care/

Advice for health and social care staff who look after patients who lack mental capacity to decide about their care, and are at risk of self-neglect

In the case of a patient who is at risk of consequences of self-neglect, who lacks mental capacity to decide about his or her care, and who refuses to register with a general practitioner, another person may make the application on his or her behalf. This person may include:

- a relative
- the primary carer
- a lasting power of attorney
- a person appointed by a court under the Mental Capacity Act

This is stated in the GP contract, and practices that refuse to register patients must send their decision to the applicant in writing within 14 days. Practices may only decline to register a patient (whether as a temporary resident or permanent patient) if they have reasonable grounds to do so. These grounds must not be related to an applicant's race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition.

Once registered with a GP practice, the GP becomes the decision maker and will make a continuous assessment of someone's capacity through the Mental Capacity Act as appropriate.

Under the Mental Capacity Act, patients should also be provided with an independent advocate (IMCA) if they do not have an appropriate advocate who will support them to make decisions in certain situations, such as serious treatment or where the individual might have significant restrictions placed on their freedom and rights in their best interests.

It is not necessary for a patient to present formal identification or proof of address to be registered with a general practice. Furthermore, if a patient is homeless, they may register using the practice address.

If a health or social care professional has concerns about registering a patient with a general practice, please contact Camden Clinical Commissioning Group tel: 020 3688 1700 or email:

camccg.enquiries@nhs.net or to find your nearest GP you can do so by searching on the NHS Choices website.

Acute Hospital Services

Healthcare professionals provide holistic assessments of patients who present displaying characteristics of self-neglecting behaviours. They are crucial in raising concerns to the Trust safeguarding team, who will then refer to the relevant local authority for assessment and planning prior to discharge. A Datix (clinical incident reporting form) is completed for governance.

Of the potential multiple professionals that can be involved in self-neglect cases, the liaison psychiatric team may reveal underlying mental health issues, particularly regarding hoarding behaviours. This information can then be linked to community teams and/or the high risk panel.

Mental capacity assessments will be essential to identify intentional self-neglect where refusal of services in the community is a feature.

Some of the multi-disciplinary team (MDT) who may be involved within the Trust are: doctors; nurses; specialist teams such as drug and alcohol liaison, tissue viability, palliative care, dietician, therapists; liaison psychiatry. This is not an exhaustive list and will be tailored using a person-centred approach.

A key role for acute health is discharge planning involving the MDT both within and external to the Trust, and the patient in order to consider their wishes where possible, to plan for a safe departure from the acute health service.

Royal Free Hospital A&E, TREAT and Rapid Assessment Unit

On admission to the Trust, patients are assessed for mental capacity regarding their self-neglect/refusal of services/ hoarding behaviour (as appropriate), as part of their initial admission assessment pack.

If assessed to have mental capacity then previous admissions are examined through our electronic data recording mechanism (EDRM) system which holds patient records. These are looked at for any services that the patient had consented to being put in place.

The Trust holds a database of patients who have been referred to the frailty hubs in Camden and Barnet and these are checked for any care plans that may be in place already.

The Trust utilises two other specialist teams – triage rapid early assessment team (TREAT) and Rapid Assessment, who assessed for frailty, and a depression scale is used – if patient scores high they are referred to the mental health liaison team.

Occupational therapy (OT) assessment will be completed to review if any care provision in place, or if not, assessing whether the patient is able to manage their day-to-day activities.

If a patient consents, their GP is contacted to see if they are actively involved with their care in the community, or if district nurses are visiting.

Social services are contacted and asked to review the patient, and if they are known to have an allocated social worker they are notified.

A Datix (incident reporting form) is completed for the self-neglect, which is

reviewed by the safeguarding team, and if appropriate a concerns form which is sent to the local authority of the patient.

The Trust has a discharge policy which includes a section of advice on self-neglect.

If a person has capacity and refuses care and treatment, their wishes are respected and the decision documented.

If the person lacks capacity, a best interest decisions will be made including input from the multi-disciplinary team (MDT), family/friends, or independent mental capacity advocate (IMCA) if no known next of kin (NOK).

Mental Health Services - Hoarding disorder and Diogenes syndrome

Hoarding disorder or Diogenes is a relatively rare syndrome which describes an aggravation of eccentric and aloof/reclusive personalities, leading to isolation, severe self-neglect, extreme hoarding and squalid living conditions. The preferred term (coded in DSM-V) for people who hoard objects is 'hoarding disorder'. Hoarding and squalor can be due to dementia, frontal lobe damage from a stroke, depression, OCD and chronic schizophrenia. Many however do not have an additional psychiatric disorder and there is often a resistance to accept help. Research has shown that a cognitive behavioural treatment can be helpful for people who hoard.

For referrals, please contact Camden & Islington NHS Foundation Trust iCope Psychological Therapies Service via Switch Board Telephone: 020 3317 3500

District Nursing and Community Health Services

Central and North West London NHS Foundation Trust is one of the largest trusts in the UK, caring for people with a wide range of physical and mental health needs.

The Trust provides a wide range of services in Camden to treat people with a variety of health needs, including common physical health problems and long-term conditions.

Camden Integrated Primary Care is a 24-hours a day service for adults over the age of 18 who live in Camden and are registered with a Camden general practitioner (GP), who are housebound and cannot easily attend clinics.

As practitioners often visit patients in their homes, they are able to identify and raise concerns about self-neglect or hoarding, and play an important role in risk assessment and management.

The multi-disciplinary team encompasses district nursing, nursing care, rehabilitation, self-management and enablement for people in their own homes and other community settings.

The care can include the following:

- Complex wound care/tissue viability
- Continence care
- End-of-life care
- Falls services, including exercise groups
- Case management
- Medicines administration
- Continuing healthcare
- Home-based rehabilitation, including equipment loans
- The aim of the service is to provide high-quality care to support GPs in managing often complex housebound patients to live as independently as possible.

The service is not suitable for people:

- In need of social care but do not have a nursing need or rehabilitation potential
- Who need immediate admission to secondary care
- Who require administration of psychiatric medication or whose main presenting problem is a mental health issue (these should be referred to the appropriate mental health team)
- Who need help with tasks such as collection of prescriptions, delivery of incontinence equipment or purchasing equipment privately.

How to refer?

The service accepts referrals from GPs and other health and social care professionals, voluntary sector workers, patients, carers and families.

- To make a referral, telephone the Central Access Team on 020 3317 3400, or email **camdenreferrals.cnwl@nhs.net**
- Download Camden Community Services referral form
- Key Contacts in Camden
- https://www.cnwl.nhs.uk/wp-content/uploads/SERVENS0072_CamdenGP_CardA5_proof3.pdf
- Large print: https://www.cnwl.nhs.uk/wp-content/uploads/SERVENS0073_CamdenPatient_Posters3A4_proof.pdf

The Discharge to Assess model

The Discharge to Assess model comprises of four pathways, delivered by different services:

- Pathway 0 - delivered by Camden social services – The patient does not require any additional support compared to what was in place in their usual place of residence before admission.
- Pathway 1 – delivered by Camden Discharge to Assess - The patient has additional care or reablement needs that can safely be met at home.
- Pathway 2 – delivered by CNWL Camden Central Access Team -the patient is unable to return home for a short period of time as they require further rehabilitation or reablement,
- Pathway 3 – delivered by Continuing Healthcare -The patient requires intensive time limited support outside of the acute hospital whilst a comprehensive assessment of their complex and ongoing care needs is completed.

Discharge to Assess (Pathway 1) is an integrated health and social care community service which provides therapy and/or care for adults in Camden. The team consists of Single Point of Access occupational therapists, physiotherapists, social workers, therapy assistants and support workers. The service offers short-term intensive therapeutic intervention and care for up to five days.

Under Pathway 1 patients are safely discharged home where functional and care assessments can take place. Not only is this setting more appropriate as the environment is familiar to the individual, but it gives us a sense of functional capability. It also prevents decisions about long term care being made in crisis and gives insight into how patients cope and gives the professional an accurate assessment. Practitioners are therefore well placed to identify concerns about self-neglect and hoarding, and participate in risk assessment and planning.

Assessments that take place in the home environment include:

- Functional assessments
- Environmental assessments
- Medication review
- Care needs assessment with rapid access to reablement care, if required.

At the end of assessment the team will support the transition to long-term support (if required) as well as develop care plans with patients, and where appropriate their carers, to help alleviate the risk of crisis.

Therapists will also make sure referrals for ongoing therapy input are made prior to discharge from the pathway.

Eligibility criteria (who is the service for?):

The service is for adults over the age of 18 who live in Camden and available from 8am to 8pm, seven days a week.

How to refer?

The identification of patients is done by acute hospitals. A simple referral form is completed and sent to camdenreferrals.cnwl@nhs.net. Once accepted we aim to work with referrers to discharge patients from acute hospitals on the same day and assess their needs within two hours of them coming home.

- Telephone: 020 3317 3400/ 07714 597309
- Email: **camdenreferrals.cnwl@nhs.net**
- CNWL Camden Community Health providers work along the choice policy (North London Partners Supporting Patient' Choices To Avoid Long Hospital Stays and
- Delayed Transfer Of Care (Dtoc) Principles. Once someone is admitted which emphasises an integrated approach and positive risk taking.

London Fire Brigade

LFB carry out home fire safety visits to properties and focus on the most vulnerable people in the community. LFB crews can provide smoke alarms and fire retardant bedding. Crews can also signpost the vulnerable members of the public to Camden's more specialist staff. Often LFB can gain access to properties due to their trust in the community and LFB work with partner agencies to carry out joint visits to give a more holistic approach which benefits the community. Contact details by area are:

scwesthampstead@london-fire.gov.uk
sckentishtown@london-fire.gov.uk
sceuston@london-fire.gov.uk

Metropolitan Police Service

If you have a concern over a Vulnerable person please see below for advice on offences and Police assistance:

Cuckooing

Professional criminals are targeting the homes of adults with care and support needs so that the property can be used for drug dealing – a process known as 'cuckooing'

These criminals are very selective about who they target as 'cuckoo' victims and are often entrepreneurial. A lot of the time victims are lonely, isolated, frequently drug users themselves and are already known to the Police. Dealers often approach the victim offering free drugs to use their home for dealing.

'Cuckooing' means the criminals can operate from a discreet property, which is out of sight, making it an attractive option. They can use the premises to deal and manufacture drugs in an environment not under police radar.

When the criminal use the victim's property for criminal's enterprises, the inhabitants become terrified of going to the Police for fear of being suspected of involvement in drug dealing or being identified as a member of the group, which would result in their eviction from the property.

Anti-Social Behaviour

Anti-Social Behaviour (ASB) takes many forms and may be exhibited in or around the address of the Vulnerable adult.

General examples of ASB could be noise, rowdy behaviour, begging, street drinking, fireworks, nuisance calls, and abandoned vehicles.

Below are some important signs to look out for if you feel a property is being used to deal drugs, or if you are concerned about a property.

- Usually takes place in a multi-occupancy or social housing property
- An increase in the number of coming and goings
- Offenders will often have new vehicles outside the property, frequently use taxis or hire cars
- Possible increase in ASB activity in and around the property
- Professionals visiting may be aware of new unidentified persons in the property
- The property may become to appear almost sparse of valuable possessions inside and go into a state of disrepair.

Advice

Seek assistance from the police and local authority who are working in partnership to tackle Anti-Social Behaviour in the community.

Record evidence of what is happening by keeping an Anti-social behaviour diary recording the five Ws; Who, What, When, Where and Why.

Make the relevant landlord or housing officer aware as soon as possible.

Police have a range of tactics at their disposal including extra patrols, Dispersal zone powers, Community Protection Orders, Criminal Behaviour Orders and stop and search powers.

Welfare Checks

Police will only attend an address to carry out a Welfare check in an Emergency situation, if someone is believed to be in immediate danger such as collapsed. Police have a Power of Entry under Section 17 (1) (e) PACE 1984 in order to go into property to save 'life and limb' in such circumstances.

Police attending people's homes for welfare checks, following up on anti-social behaviour or cuckooing concerns, or called out for other reasons, often identify concerns about someone's living conditions or presentation and can alert other agencies to these concerns via Camden's Multi-Agency Safeguarding Hub (MASH).

When to call Police 999 v 101

Call 999 if:

- a serious offence is in progress or has just been committed
- someone is in immediate danger or harm
- property is in danger of being damaged

Call 101 for Non-emergency Neighbourhood Police.

Camden Borough is broken down into 'Wards' with each ward having its own postcode areas. Neighbourhood Policing Teams work in the local areas. Local Policing teams can be consulted about any individuals and vulnerable persons and will be able to offer advice and take action where required.

Email addresses for each Camden ward are listed below:

GospelOak@met.police.uk

Holborn&CoventGarden@met.police.uk

Bloomsbury@met.police.uk

Belsize@met.police.uk

RegentsPark@met.police.uk

St.Pancras&SomersTown@met.police.uk

WestHampstead@met.police.uk

Haverstock@met.police.uk

KingsCross@met.police.uk

FortuneGreen@met.police.uk

KentishTown@met.police.uk

Highgate@met.police.uk

Frogna&Fitzjohns@met.police.uk

CamdenTownwithPrimroseHill@met.police.uk

Kilburn@met.police.uk

HampsteadTown@met.police.uk

Cantelowes@met.police.uk

SwissCottage@met.police.uk

Camden MASH Police Team
9th Floor
5 St Pancras Square
London
N1C 4AG
EKMailbox-.PPD@met.pnn.police.uk

Hostel Services

Homelessness Services have a duty of care towards clients and have a duty raise any safeguarding or self-neglect concerns with Camden's Multi-Agency Safeguarding Hub (MASH). MASH will then ask the lead agency working with that client to look into the concern, who often then arrange a multi-agency meeting to discuss how all services involved can reduce any risk to the person or to others.

Camden homeless hostels are commissioned to provide support to homeless clients. Each client will be allocated a key worker who will carry out a support needs assessment and develop a support plan with the client. They will work with the client to address any safety concerns.

Housing Associations who provide support for homeless clients are obliged to complete a Fire Risk Assessment for their building and a Person Centred Fire Risk Assessment which identifies whether the person is at greater risk of a fire. The service then needs to set out how these risks will be managed in the project. All services will also have internal health and safety procedures they are required to follow. This may include how often they need to check the client's room and what access they require to the room.

Camden Carers Service

Camden Carers Service (CCS) offers free information, advice and support to unpaid adult carers (18+) living, working or studying in Camden, or caring for someone who lives in Camden. CCS work primarily with the carer but also with the person they care for and their wider networks both on a one to one basis and in group settings. This means that there are many opportunities for CCS staff to identify self - neglect and/or help carers recognise their self - neglect. CCS are able to support a carer with these issues via 1:1 and group counselling; holistic Health and Lifestyle Consultations in which goals

are set and follow up support offered to achieve these goals; sessions with a Nutritionist as well as groups to address anxiety, esteem, isolation and work on better self – care. Where the need is identified CCS are able to link carers into specialist and/or wider community services and activities

Website: www.camdens.org.uk
Email: referrals@camdencarers.org.uk
Contact number: 020 7428 8950
Opening hours: Mon, Tue, Thurs,
Fri: 9am – 5pm, Wed: 9am – 7pm

You can find more information on our webpage www.candi.nhs.uk/recoverycollege and our full course guide here: <https://www.candi.nhs.uk/sites/default/files/Documents/Recovery%20College%20Web%20View-compressed.pdf>

The Recovery College

The Recovery College welcomes everyone in Camden and Islington to our free educational courses on recovery and wellbeing. We were the first Recovery College in the UK open to all people aged 18 and over in our local community – this includes service users, their family and friends, carers, people working in mental health and other services, and members of the public. All our courses are co-created and interactive learning experiences which promote our core values:

- to inspire HOPE for living well and making positive changes despite life challenges
- to create OPPORTUNITY for people to find purpose and meaning, and to form positive relationships
- to help our students gain CONTROL by empowering them to make their own decisions and teaching them self-care tools

We believe that everyone is on their own unique journey of recovery. We hope that people will find our Recovery College a safe space to tell their story and share their experiences of their own recovery journey. No referral needed. Come in to see us to enrol or call 020 3317 6904 for more information.

¹⁰Lord Justice Munby: Local Authority X v MM & Anor (No. 1) [2007] EWHC 2003

¹¹Faulkner 2012, p.22). Faulkner, A., 2012. The right to take risks: Service users' views of risk in adult social care. London: Joseph Rowntree Foundation.

Chapter 5: Risk and Assessment Tools

The emphasis must be on sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks as the price appropriately to be paid in order to achieve some other good – in particular to achieve the vital good of the elderly or vulnerable person's happiness. What good is it making someone safer if it merely makes them miserable?¹⁰

We all manage risk in our daily lives and it is our right to take certain risks which is why the right to make unwise decisions is enshrined in the Mental Capacity Act 2005. Some people choose dangerous sports or to smoke cigarettes knowing this carries risk to safety and wellbeing. Determining what risks we are prepared to take is a skill developed over the lifespan, some people, for example with a learning disability, may not have been given the opportunity to develop skills in relation to risk. It is vital to exercising human rights that people are supported to develop and practice the skill to make independent decisions and weigh up risks¹¹

Enabling Risk

At the heart of the Care Act 2014 is the well-being principle, which assumes that the individual is the best judge of their own well-being, of what is important to them and the outcomes they wish to achieve¹². White (2017)¹³ offers three key questions to be answered in relation to any possible actions taken by professionals:

Can we promote the person's safety without interfering with the benefits they gain or infringing their rights?

Are there ways we can help change the situation or reduce risk to acceptable levels while still respecting their choices?

Accepting things could go wrong – what could go wrong and how could we respond if it did?

Assessment Tools

Assessment tools can be useful to support practitioners, they are designed to support assessment but are not a substitute for critical thinking, knowledge and experience. As with any professional assessment, knowledge is required to inform the conduct of the assessment is concerned, for instance, with determining the appropriate environment for conducting assessment; forming judgements about the kinds of contribution the service user seeks, and is able, to make; and timing the transition from assessment to intervention¹⁴.

If the practitioner is not experienced in working with self-neglect, they may require support and supervision to use assessment tools.

The involvement of the person and those they wish to be involved, is considered integral to the assessment process in all of the frameworks reviewed. Assessment should be about determining the service users' needs, but should not be a process that is 'done to' people.

Whichever tool is used, it must capture risk to enable a proportionate approach by helping to demonstrate what is to be gained from taking a particular risk as well as what could go wrong without oversimplifying the concerns.

Use of Photography

With agreement from the person, research conducted in the USA has shown using photography as a monitoring and reviewing tool to encourage service user participation in decisions relating to the decluttering of possessions and using a camera to create a photo album (at pre- and post-intervention) to support a service user to declutter¹⁵. This has also been used successfully in Camden.

Fire Safety Risk Assessment

Safeguarding Adult Reviews have highlighted insufficient attention is paid to the threat a person's behaviours may pose to others, particularly in relation to the accumulation of items and any propensity to start fires. Such circumstances should lead to a thorough assessment of mental capacity and if the risk is so significant it poses a wider risk this cannot be dismissed as personal choice. A more instructive intervention involving the person may be required. The London Fire Brigade have provided a copy of their fire safety assessment on page 27 and a smoke alarm check sheet with contact details if there are any issues with the check.

Home Fire Safety Visit, Smoke Alarms and Guidance Note

1. Maintenance and disposal of alarms
 - Smoke alarms fall under the WEEE Regulations (Waste Electrical and Electronic Equipment) category of the Monitoring and Control Instruments Regulations. Therefore, they should not be thrown out in general rubbish. Householders can:
 - Take old electrical equipment to their local Civic Amenity site (tip).
 - Arrange for their local authority to collect the equipment (some local authorities provide a free collection service and others charge).
 - Arrange for an electrical retailer delivering new equipment to take away the old alarms.
2. Selecting the best position for smoke alarms

It is essential to make sure that smoke alarms are correctly positioned within a room or area to give the optimum level of protection.

Flat ceilings

- This is the preferred location for smoke alarms. They should be mounted on a flat ceiling whenever possible. The ceiling covering should be checked for integrity. If the covering is flaky, damp or shows other signs of poor integrity, an alternative site may need to be found.
- Consideration must be given to how easily the occupant(s) will be able to access the alarms for testing. Ideally, do not place them directly over stairwells or other hazards and check that the resident will be able to reach the alarms before fixing them in place.
- Ideally, the smoke alarms should be positioned in the centre of the ceiling. Beams or other fixtures too close to smoke alarms can prevent or delay smoke reaching them and mean the alarms do not activate quickly enough.
- As a minimum, they should not be closer than 300mm to any walls, beams or light fittings. Where fluorescent light fittings are present, check the smoke alarm manufacturer's guidance, as some alarms are required to be positioned more than 300mm from such fittings.

Sloping ceilings

- In rooms with simple sloped, peaked or gabled ceilings, smoke alarms can be installed on the ceiling.
- Ideally ensure that alarms are positioned 900mm below the highest point of the ceiling.
- 'Dead air' at the peak of a ceiling may prevent smoke from reaching alarms in time to provide an early warning.
- As with flat ceilings, ease of reach for testing and the integrity of the ceiling should be considered.

Wall mounting

The best position to ensure smoke alarms activate quickly is on the ceiling. However, if a suitable site cannot be located on the ceiling, smoke alarms can be mounted on a wall provided that:

- The top of the detection element is between 150mm and 300mm below the ceiling.
- The bottom of the detection unit is above the level of any door opening.
- The manufacturer's instructions state that the smoke alarm is suitable for wall mounting.
- The area of the room does not exceed 50m. If this is the case, additional smoke alarms will be required in the room to ensure coverage of the whole space.
- Ease of reach for testing and the integrity of the wall covering should be considered.

In addition to the above points, care should be taken to avoid fitting alarms in the following locations:

1. In turbulent air from fans, heaters or windows to avoid disruption of smoke flowing to the alarm.
2. Laundry or boiler rooms or other areas of high humidity, as moisture particles are likely to cause nuisance alarms.
3. Near objects such as ceiling decorations, as these could impede the flow of smoke to the alarm.
4. Very dusty or dirty areas as these can build up in the sensor and impair the sensors.

To request a free home safety visit either go on LFB website

www.london-fire.gov.uk/safety/the-home/book-a-home-fire-safety-visit

or call **08000 28 44 28**



Smoke alarms should be tested once a month and in accordance with manufacture instructions

Date	Signature		Date	Signature

To request a free home safety visit either go on LFB website
london-fire.gov.uk/safety/the-home/book-a-home-fire-safety-visit/
or call - **08000 28 44 28**

Appendix 1: Camden Case Examples

These examples from a very experienced Integrated Care social worker may help you in your approach to supporting a person who is self-neglecting.

Peter's Story

Peter has multiple sclerosis. He was referred into the integrated care pathway because of serious concerns about his wellbeing and home environment. In particular, the room in which he resided.

Peter lived with his wife in a two bedroomed Camden Council flat. Peter has multiple sclerosis, diabetes, oedema of legs and ankles. The District nurses tried to visit him weekly to dress his venous leg ulcers but couldn't get into the room. Peter hadn't had a shower for years. When I first went there, I felt completely lost.

It was hard to describe the filthy chaotic and dangerous environment in Peter's room. It didn't help that Peter has had intensive health and social work involvement in the past with limited success. The GP, nurses, physiotherapist, all had escalated their concerns, his wife was distraught when I first visited saying that she would leave him. I was concerned as she was the main carer and Peter made it very clear to me that he wanted to be left alone and that he didn't want any care. Peter's multiple sclerosis meant that he had mobility problems, tried to use a stick and couldn't straighten up. The bed was covered with books. In fact, there were hundreds of books everywhere; his room was stacked high with piles of Hardback books and the stained sepia walls of his room were more reminiscent of a 1960s pub than a bedroom. Peter was a chain smoker. Usually the district nurses would stand at his door (unable to get in) and locate Peter puffing behind

piles of books and try to communicate with him before he sent them away. I talked to Peter's past social worker and read his thorough assessment which gave me lots of information. I located the Epidemiology of Neurology Disorders from the library and I read up on multiple sclerosis. I wanted to have a conversation with Peter about his diagnosis and I was determined to at least do it from an informed perspective. I was intrigued to learn that environmental factors are likely to influence risk of multiple sclerosis.

Then, I stepped back and thought about the books. They were hardbacks, good quality and Peter's choice was, in my opinion, pretty good. There was a lot of contemporary American fiction, Yates, Mailer, Ford, Anne Tyler with a large amount of new British fiction by McEwan, the problem was there were so many of them. I started to talk to Peter about his choices, his authors, what was good, what wasn't so good. I read lots to him and he read bits to me. It was great when I found a copy of 'Saint Maybe' by Anne Tyler. I found a great scene in this book where a sister concerned about her brother's hoarding calls in a professional clutter counsellor, Rita. I thought it pertained to Peter's situation and I read it out to him. Rita tells the hoarder in no uncertain terms to take anything he's not going to use in the next ten days 'Straight back out to the trash can'. Peter liked the ten-day rule. I also told Peter that I had an O' level in technical drawing (Grade C) and we drew up a plan for his room. Peter and his wife were intrigued that I did not (initially) want to get rid of anything I wanted to help him to make a library. I used photographs of the home environment in support of grant applications. We got five hundred pounds from Hampstead and Wells to redecorate the room top to bottom and a further individual support grant from the Multiple Sclerosis Society for six hundred pounds for shelves. Peter and his wife worked together with me getting prices from Argos, Habitat and even John Lewis (far too expensive). We were able to get a new hospital bed after the psychiatric nurse Christine did a referral. Importantly we helped Peter to select and edit his

Heart Foundation charity shop. The new shelves, clean books, re-decorated room really made a difference, for a start Peter's wife was able to get into the room, so were the district nurses, so was the physiotherapist and Peter can do his exercises. We worked around what mattered to Peter. He agreed to support once a week to assist him with a shower - after many years of not washing. I completed the carer's assessment for his wife and found out that she wanted to travel to Spain to visit her mother's grave. We arranged respite care and liaised with housing repairs to fix an electrical fault while she was away. Peter now lives in immaculately clean library which he is very proud of. He has a two-hour care package. Peter has stopped smoking. He still suggests books I might like to read.

The lady in the Crescent

It's quite difficult for me to think of Mary without confusing her with the character played by Maggie Smith in the Alan Bennett story 'The Lady in The Van'. There was of course the physical resemblance, the thin haggard beauty offset by the long tangled grey hair. There was also the fact that like Miss Shepherd in Bennett's story, Mary had been continually visited by a succession of support workers, health visitors and social workers who invariably got 'short shifted'. Mary had an 'expression of phrase' combined with an 'interesting' mixture of expletives that usually had the professional running for the door. Mary even lived near Alan Bennett's old house in Gloucester Crescent. In a third-floor bedsit of a Regency house that had seen 'better days'. Mary was a sitting tenant and predictably the relationship between her and the landlord had turned sour. Mainly because Mary neglected to pay the rent and the landlord realising that the bedsit could now be rented out for a fortune so wanted Mary out ASAP. The conditions in the bedsit were bad, possibly a nine or ten on the clutter scale. There was no hot water - the boiler had long since broken down.

There were only two places to sit down - an unsteady chair in the kitchen and Mary's

stained bed. When Mary had moved into the bedsit twenty years ago, she had neglected to unpack. The old accumulated dusty boxes were stacked to the ceiling. Whenever I sat next to Mary on the bed, I was always aware of small but distinct rustlings and shifting of papers as nested mice or even rats slid through holes in the boxes. The light was mottled, the windows stained with filth and established webs complete with caught flies. Mary was malnourished at 50kg. There was no air in the bedsit. There was that smell - a combination of decayed fruit, detritus and dust that I always associate with self-neglect and hoarding. In addition, Mary also suffered acute Diarrhoea.

For Alan Bennett the sound of a van door sliding shut takes him back to when his Miss Shepard lived in a van at the bottom of the garden.

For me my memories of Mary were of neatly stacked coins and notebooks. For despite, the chaos surrounding her, Mary was meticulous in making notes and keeping accounts of her money. Whenever I see a pile of coins or notes I am reminded of her hoard.

Mary was referred into the integrated care multidisciplinary team by my colleague Christine, a community Psychiatric Nurse. Christine was concerned over the living environment and the increased frailty of Mary. Very importantly, Christine had established trust and rapport with Mary. Christine had supported Mary to attend hospital appointments and talked Mary through her recent diagnosis of dementia. Mary was deeply distressed by her diagnosis and Christine's support was invaluable. Christine reflected that Mary so missed going outside, so by being proactive and taking the time to escort her to the shops we were able to build a relationship this way.

Her behaviour on outings and hospital trips was appalling, due to her inability to tolerate others or “suffer fools” as she so gallantly put it, resulting in much offence being caused to shop keepers, the public and professionals alike.

Despite this sharply reactive temper and vicious tongue, she also held a great sense of humour and insight into her unreasonable behaviour, so with some skilled work and lots of patience we were able to achieve multiple appointments to investigate a suspected cancer diagnosis, including many invasive procedures. There were also trips to the bank, shops and opticians all peppered with outbursts and tantrums but always lots and lots of laughs from us, as others around us were left aghast at her passing comments.

Due to building this trust and not judging or reacting to the behaviour, we were able to build a network of people who became used to Mary and her ways and see beyond the bad-tempered persona. So, she was able to access the medical services she so needed to maintain her health and wellbeing.

Christine sensitively introduced me to Mary. Initially we just talked. Mary told me that she had been a Mental Health Social Worker, that she had lived in a large house with a group of women that included her friend Hazel. With Mary's permission I subsequently contacted Hazel who was extremely worried about her friend. I also managed to find and contact Mary's relative. I explored Mary's exasperation. We concluded that Mary realised she could no longer go up the stairs to the toilet, had to write everything down because she forgot and did not know what to do with the stuff.

So, with Mary, Christine, Hazel, And the GP we formulated a plan. Mary was assessed by Gospel Oak Court extra care sheltered accommodation. We took Mary to view a flat and Christine and I worked closely with Hazel over the move. We placed Mary's wellbeing first and the stuff second, by that I mean that I politely but firmly kept inquiries about when we would move to the staff second to what was important to Mary. When Mary had been in a newly decorated and immaculate extra care sheltered flat for five weeks we worked with

Hazel, the relatives and the landlord to edit and clear the hoard. I also supported the relatives to get Lasting Power of Attorney..

Although Mary always resisted a shower, she was never malodorous, and her new flat remains immaculate. Mary was delighted when I brought her some old 35mm film canisters for her coins and when Christine and I set up an account with Wiltshire farm foods. Mary was impressed by the quality and quantity of the meal and would always insist that I look at the food in her freezer.

Christine and I were both pressurised to 'close the case' after a six-week cursory review. However, we both stayed with Mary for over two years and supported her through a series of hospital admissions and finally a move to nursing accommodation. By sticking by Mary, we avoided multiple referrals through duty and Mary had the support of two friendly faces. Mary was always pleased to see us, would hold our hands and invariably talk about politics. When Mary died recently her friend Hazel wrote to Jodi Pilling, the Acting Director of Adult Social Care. Hazel stated that Mary was supported and 'made to feel safe'.

When Mary died Christine and I reflected on the case. We came to the conclusion that when working with self-neglect, with hoarding clients, when there are deprived and damaged people - a style of friendly interest, consistent highly tuned long term social work and clinical expertise is needed, perhaps of a tenacious and imaginative kind and for people like Mary this might be the most helpful response. Such a response might be best arrived at by contemplating client inner worlds, histories, stories and how we acknowledge empower and make sense of them.

Appendix 2: Clutter Image Rating

Tool Guidance

The clutter image rating scale can be useful in objectively describing the environment a person is living in by selecting which level of 'clutter' is involved. Individual perceptions will differ to what constitutes 'clutter' or 'hoarding' so this is a helpful way to ensure a consistent and proportionate understanding of the level of concern, particularly when sharing information with other professionals or making referrals.

It should be noted the title 'Clutter Scale' is unlikely to reflect the feelings and values of the person who is living in the environment. People's property is often precious to them regardless of the opinions of those who have concerns about the way they are living. Language such as 'clutter' may be offensive to the person at the centre of the concerns and, therefore, should be avoided.

Use the Clutter Image Rating Scale and Guidance provided on the following pages to assess the level of the customer's hoarding problem and decide on the appropriate action you should take.

How to use this tool:

Using the 3 series of pictures (Bedroom, Living Room, and Kitchen), select the picture that best represents the amount of clutter in the house or individual rooms.

- Images 1-3 indicate level 1 (Green) – Signposting
- Images 4-6 indicate level 2 (Amber) – Escalate Concerns
- Images 7-9 indicate level 3 (Red) – Multi-agency response and consider mental capacity assessment

Alongside the practitioner's assessment, it is also useful to ask the person which pictures they think represents the state of their home, and then compare their perception with that of the practitioner's, to gain an understanding of their view of the problem and initiate discussion of changes they might like to achieve. Using the numbers that have been chosen, the practitioner and the person can look at whether they agree on the same level of clutter and if not, why not. An approach could be that they then together agree which room numbers the person would like their home to look like and how they are going to work together to achieve this. This may be done by prioritising one room at a time, or one type of item they wish to remove.

Appendix 3 also includes a range of assessment tools designed to support co-production and self-evaluation with individuals who may be self-neglecting or hoarding.

Clutter Image Rating (CIR) – BEDROOM

Please select the CIR which closely relates to the amount of clutter



1



2



3



4



5



6



7



8



9

Clutter Image Rating (CIR) – LOUNGE

Please select the CIR which closely relates to the amount of clutter



1



2



3



4



5



6



7



8



9

Clutter Image Rating (CIR) – KITCHEN

Please select the CIR which closely relates to the amount of clutter

**Please select the CIR which closely relates
to the amount of clutter**



Description of Risk - Level One

<p>Level 1 Clutter image rating 1 - 3</p>	<p>Household environment is considered standard. No specialised assistance is needed. If the resident would like some assistance with general housework or feels they are declining towards a higher clutter scale, appropriate referrals can be made subject to circumstances.</p>
<p>1. Property structure, services & garden area</p>	<ul style="list-style-type: none"> • All entrances and exits, stairways, roof space and windows accessible. • Smoke alarms fitted and functional or referrals made to London Fire Brigade and Rescue Service to visit and install if criteria met. • All services functional and maintained in good working order. • Garden is accessible, tidy and maintained
<p>2. Household Functions</p>	<ul style="list-style-type: none"> • No excessive clutter, all rooms can be safely used for their intended purpose. • All rooms are rated 0-3 on the Clutter Rating Scale. • No additional unused household appliances appear in unusual locations around the property. • Property is maintained within terms of any lease or tenancy agreements where appropriate. • Property is not at risk of action by Environmental Health.
<p>3. Health and Safety</p>	<ul style="list-style-type: none"> • Property is clean with no odours, (pet or other). • No rotting food. • No concerning use of candles. • No concern over flies. • Residents managing personal care. • No writing on the walls. • Quantities of medication are within appropriate limits, in date and stored appropriately.
<p>4. Safeguard of Children & Family members</p>	<ul style="list-style-type: none"> • No concerns for household members.
<p>5. Animals and Pests</p>	<ul style="list-style-type: none"> • Any pets at the property are well cared for. • No pests or infestations at the property.
<p>6. Personal Protective Equipment (PPE)</p>	<ul style="list-style-type: none"> • No PPE required. • No visit in pairs required.

Level 2 Clutter Image Rating 4 – 6	Household environment requires professional assistance to resolve the clutter and the maintenance issues in the property.
1. Property structure, services & garden area	<ul style="list-style-type: none"> • Only major exit is blocked. • Concern that services are not well maintained. • Smoke alarms are not installed or not functioning. • Garden is not accessible due to clutter, or is not maintained • Evidence of indoor items stored outside. • Evidence of light structural damage including damp. • Interior doors missing or blocked open.
2. Household Functions	<ul style="list-style-type: none"> • Clutter is causing congestion in the living spaces and is impacting on the use of the rooms for their intended purpose. • Clutter is causing congestion between the rooms and entrances. • Room(s) score between 4-6 on the clutter scale. • Inconsistent levels of housekeeping throughout the property. • Some household appliances are not functioning properly and there may be additional units in unusual places. • Property is not maintained within terms of lease or tenancy agreement where applicable. • Evidence of outdoor items being stored inside.
3. Health and Safety	<ul style="list-style-type: none"> • Kitchen and bathroom are difficult to utilise and access. • Offensive odour in the property. • Resident is not maintaining safe cooking environment. • Some concern with the quantity of medication, or its storage or expiry dates. • Has good fire safety awareness with little or no risk of ignition. • Resident trying to manage personal care but struggling. • No risk to the structure of the property.
4. Safeguard of Children & Family members	<ul style="list-style-type: none"> • Hoarding on clutter scale 4 -6. Consider a Safeguarding Assessment. • Properties with adults presenting care and support needs should be referred to the appropriate Social Care referral point. • Please note all additional concerns for householders.
5. Animals and Pests	<ul style="list-style-type: none"> • Hoarding is impacting the welfare of any pets at the property • Infestation may be beginning at the property
6. Personal Protective Equipment (PPE)	<ul style="list-style-type: none"> • Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent. • Is PPE required?

<p>Level 3 Clutter image rating 7 - 9</p>	<p>Household environment will require intervention with a collaborative multi-agency approach with the involvement from a wide range of professionals. This level of hoarding constitutes a Safeguarding alert due to the significant risk to health of the householders, surrounding properties and residents. Residents are often unaware of the implication of their hoarding actions and oblivious to the risk it poses.</p>
<p>1. Property structure, services & garden area</p>	<ul style="list-style-type: none"> • Limited access to the property due to extreme clutter. • Extreme clutter may be seen at windows. • Extreme clutter may be seen outside the property. • Garden not accessible and extensively overgrown. • Services not connected or not functioning properly. • Smoke alarms not fitted or not functioning. • Property lacks ventilation due to clutter • Evidence of structural damage or outstanding repairs including damp. • Interior doors missing or blocked open. • Evidence of indoor items stored outside.
<p>2. Household Functions</p>	<ul style="list-style-type: none"> • Clutter is obstructing the living spaces and is preventing the use of the rooms for their intended purpose. • Room(s) scores 7 - 9 on the clutter image scale. Rooms are not used for intended purposes or very limited. • Beds inaccessible or unusable due to clutter or infestation. • Entrances, hallways and stairs blocked or difficult to pass. • Toilets, sinks not functioning or not in use. • Resident at risk due to living environment. • Household appliances are not functioning or inaccessible. • Resident has no safe cooking environment. • Resident is using candles. • Evidence of outdoor clutter being stored indoors. • No evidence of housekeeping being undertaken. • Broken household items not discarded e.g. broken glass or plates. • Property is not maintained within terms of lease or tenancy agreement where applicable. • Property is at risk of notice being served by Environmental Health.
<p>3. Health and Safety</p>	<ul style="list-style-type: none"> • Human urine and excrement may be present. • Excessive odour in the property may also be evident from the outside. • Rotting food may be present. • Evidence may be seen of unclean, unused and or buried plates & dishes. • Broken household items not discarded e.g. broken glass or plates. • Inappropriate quantities or storage of medication. • Pungent odour can be smelt inside the property and possibly from outside. • Concern with the integrity of the electrics. • Inappropriate use of electrical extension cords or evidence of unqualified work to the electrics. • Concern for declining mental health.

4.Safeguard of Children & Family members	<ul style="list-style-type: none"> • Properties with adults presenting care and support needs should be referred to the appropriate Social Care referral point. • Please note all additional concerns for householders.
5. Animals and Pests	<ul style="list-style-type: none"> • Animals at the property at risk due the level of clutter in the property. • Resident may not able to control the animals at the property. • Animals' living area is not maintained and smells. • Animals appear to be under nourished or over fed. • Hoarding of animals at the property. • Heavy insect infestation (bed bugs, lice, fleas, cockroaches, ants, silverfish, etc.). • Visible rodent infestation.
6. Personal Protective Equipment (PPE)	<ul style="list-style-type: none"> • Latex Gloves, boots or needle stick safe shoes, face mask, hand sanitizer, insect repellent. • Visit in pairs required.

Appendix 3: Assessment Tools

The following pages include a range of assessment tools to help initiate conversations with individuals who may be self-neglecting or hoarding, encourage them to engage them in self-evaluation and identifying their priorities, and other ideas to support co-production. This supports a person-centred approach to the assessment and management of risks, which assumes that the individual is the best judge of their own well-being, of what is important to them and the outcomes they wish to achieve.

Please also find below a simple risk matrix which is commonly used by agencies and can be useful in articulating and monitoring risk both with colleagues and possibly the person being supported.

This includes:

- Tools for Co-Production with People Who Self Neglect
- A simple two-part quiz to find out how overwhelmed by clutter you are
- Practitioner’s Hoarding Assessment
- Using photography to support assessment
- Satisfaction with Life Questionnaire
- One Page Profile: a tool to help you work with someone to identify their priorities
- My Notes – prompts for practitioners
- Clutter’s Anonymous questionnaire
- Person-centred and strengths based approach
- SAPB leaflet on Self-Neglect Guidance

Likelihood	Impact				
	Insignificant	Minor	Moderate	Major	Severe
Almost certain	Moderate	High	High	Extreme	Extreme
Likely	Moderate	Moderate	High	High	Extreme
Possible	Low	Moderate	Moderate	High	Extreme
Unlikely	Low	Moderate	Moderate	Moderate	High
Rare	Low	Low	Moderate	Moderate	High

Some Tools for Co-Production with People Who Self Neglect

Social work with adults who self-neglect through hoarding presents a number of challenges for individuals, practitioners, organisations and communities. An integrated Care Social Worker has used some of the tools used below as prompts, resources and templates.

They have proved (at least partially) effective to prevent, protect and intervene with people who self-neglect and address the wide range of behaviours (such as neglecting to care for personal hygiene, health or surroundings) and including behaviour such as hoarding.

1. William Morris Wallpaper (1834-1896). William Morris was a socialist who sought to change the world with creative functional designs that were useful and beautiful. Use the Wallpaper designs to establish a dialogue. William Morris famously said: 'Have nothing in your houses which you do not know to be useful or believe to be beautiful'. Clients might start to talk about what they like/dislike about their own environment.
2. Getting to know the Person Grid: Use this tool to get to know the person, you can use or modify this template. You will get to know the person you are working with and perhaps draw out their strengths. Rather than focus on deficits have a conversation about what matters to the client.
3. First Thing Envelope: Introduce the idea of co-production with your client by asking them to write down the first thing they want to get rid of, clean or change in their life and 'post' it to you. The envelope has the address of the Recovery College on it you might want to discuss the Recovery College using the text from the tool kit?
4. Ten-Day Challenge. Use this tool to introduce the idea of removing one item – one day at a time. Change happens in steps. Indicate that you will stick to the client and help them one day at a time.
5. Myths and Truths Chart (All Answers are 'False'). Self-Neglect and Hoarding are not always presented accurately in the media. Hoarders, in particular, are presented as 'Folk Devils'. The person you are working with might be deeply ashamed even to be thought of as a 'Hoarder'. Use the Myths and Truths Chart to discuss and deconstruct the myths and indicate to the client that this time you are there to support them and understand the condition.
6. Van Gogh Painting Bedroom at Aries Winter Morning (1888). Use this picture by Van Gogh to start having a conversation about objects. Clearly for Van Gogh, his bedroom, the chairs, bed, table, mirror, paintings, water jug were important enough to paint. Throughout our life, possessions are increasingly a part of a reflection of what and who we are. It is helpful to discuss this as a human issue with your client. Sometimes it is harder and painful to throw away, for example, a soiled mattress, bed, chair or table, jacket that has been with us for a very long time. Like Van Gogh, the client might like to record (photograph) of her/his flat.
7. Wellbeing Rainbow: At the Heart of the Care Act 2014 is the Wellbeing Principle, which assumes that the individual is the best judge of their own wellbeing, of what is important to them and the outcomes they want to achieve. Use the Wellbeing Rainbow to discuss how so many domains are compromised by self-neglect and hoarding, Sustainability of Living accommodation and Person Dignity immediately come to mind.

8. World Health Organisation Announcement: Use the brief Guardian article on WHO to discuss how a diagnosis of a medical disorder can help the person to seek treatment for a condition such as Self-Neglect/Hoarding – which you are ideally equipped to support them with. Talk openly about other mental health diagnosis such as depression, medication and any therapeutic input.
9. Cheryl Strayed's Wild: Use the film/book to talk about Cheryl Strayed's journey along the South Pacific Trail, which runs from Mexico in the South through the United States to Canada in the North. After suffering from depression, bereavement and addictions, Cheryl sets out on the journey alone. She is so anxious that she over packs her rucksack (see the things she has with her), unable to lift it from the ground s a kind traveller she meets on the route shows her how to edit. Use the exercise to talk about editing and intentional life and letting things go. This has proved a very popular exercise at the Recovery Challenge.
10. Patterns of Expenditure: Use this tool to explore the link between expenditure (typically on items from Supermarkets and Charity shops) and hoarding loss of control. Many of the client's issues with self-neglect/hoarding start with overbuying and not taking an inventory.
11. Hoarding and Collecting Through Shower. Many clients will tell you that they are a collector or archivist. Use this Thought Shower to discuss the well-evidenced differences between hoarding and collecting.
12. Clutter's Anonymous. There is help out there – Encourage the client to reach out ,as they say: 'God, grant me the serenity to keep the things I need to keep, The courage to release the things I do not need, And the wisdom to know the difference!'
13. A life with less stuff. Use this clip of the Minimalists presentation to discuss an intentional life and positive change.

Quiz

Take this simple two-part quiz to find out how overwhelmed by clutter you are!
There is no scoring on this – it's just an aid to help you identify your areas of clutter and disorganisation.

Part 1 – How organised are you?

You have 10 minutes, how many of the following could you find?

- A bank statement from exactly six months ago
- Your P60 (if you are employed) or a completed tax return (if self-employed) for the last tax year
- A week's worth of clean underwear
- Vaccination certificate
- TV Licence
- Blank envelope and stamp
- Spare front door key
- Needle & black thread
- Candle & matches
- Passport

Part 2 - How cluttered are you?

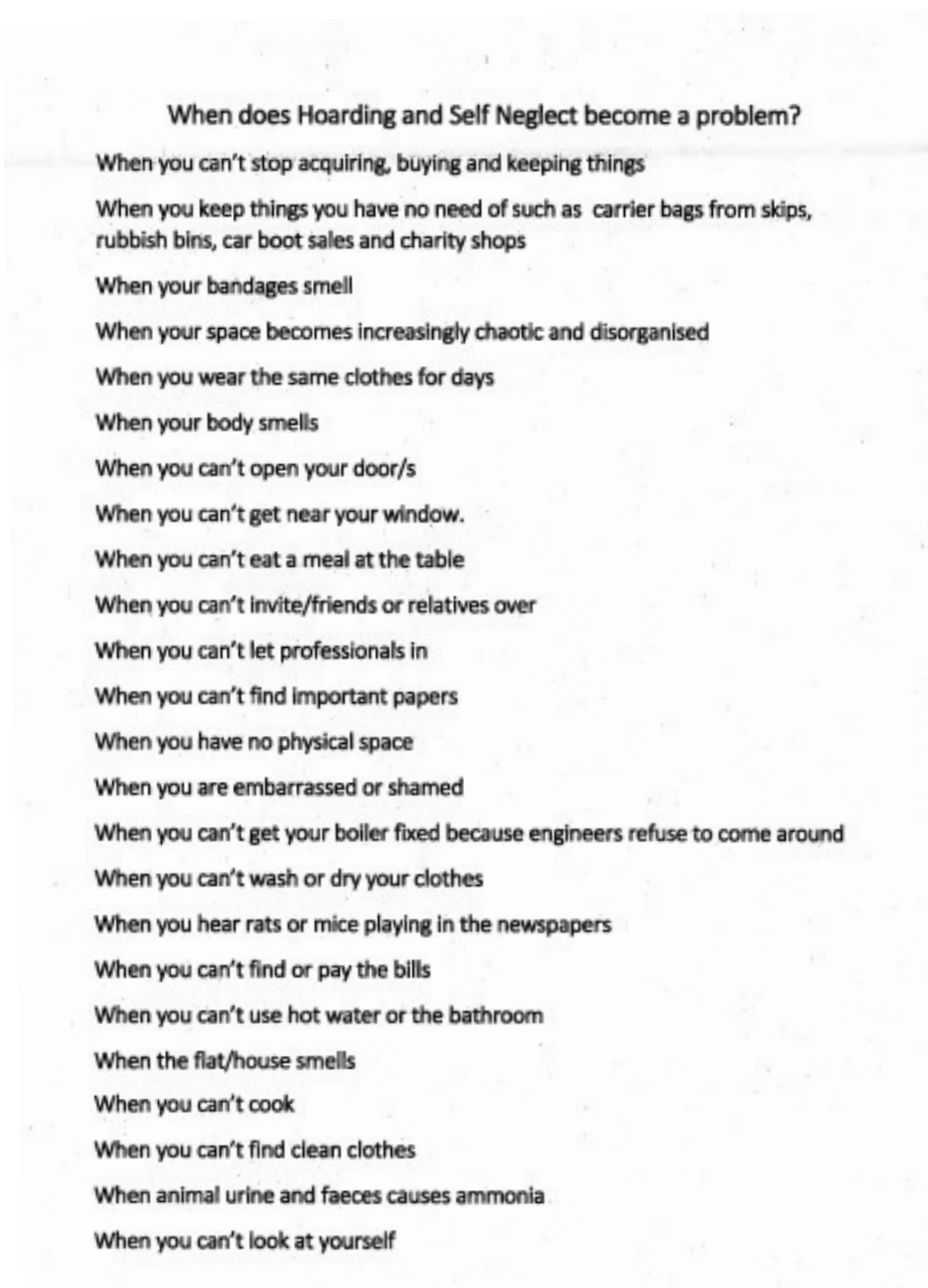
How many of the following do you have in the house?

- More than one basket of clean clothes waiting to be put away
- A free CD or DVD from a newspaper you will never play
- More than one set of gardening/decorating clothes
- Curtains from a previous home that you've never used
- A filing / storage system bought but never used
- A pile of magazines that has been there for months
- Christmas cards sent to you last year (excludes those that are very precious!)
- Several nearly empty notebooks, bought in an attempt to get organised
- More than three half-used bottles of shampoo
- A worn towel with a hole in it
- Clothes that make you feel fat or ugly
- A skirt or pair of trousers that haven't fitted for over 3 years
- Bed linen that doesn't fit any of the beds in the house
- More than four loads of laundry waiting to be washed
- A half-finished sewing project that you will never finish
- Drawers that are empty
- Pictures that you have never hung on the wall
- Creased, used wrapping paper
- A single earring (the other is lost or broken)
- A pair of shoes you've never worn because they are too tight
- An empty jewellery box
- Out of date prescription medicine
- Any of the following that you never use – bread maker, juicer, food processor or a sandwich maker
- Exercise video or equipment you have never used, or just once or twice
- Dead batteries
- More than five take-away menus
- More than one 'spare' pair of spectacles
- An ornament or picture given as a gift you dislike
- Expensive make-up you never use
- A pot from a dead houseplant
- Old Lampshades

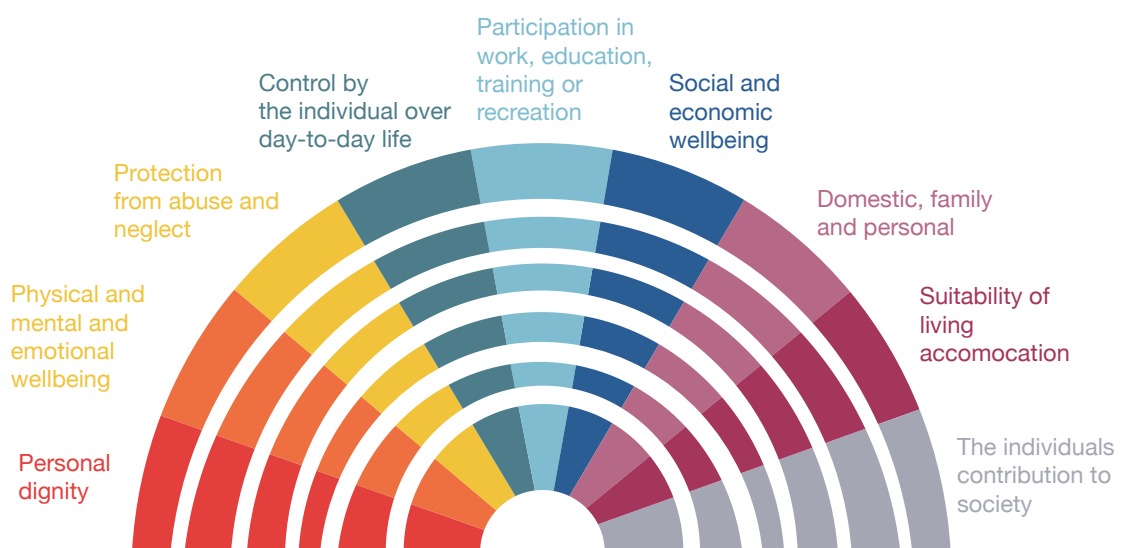
Practitioner's Hoarding Assessment

This page and the following two pages can be used together as a single comprehensive hoarding assessment tool, along with scoring from the Clutter Image Rating Tool. This hoarding assessment tool was developed by Martin Hampton, an Integrated Care social worker in Camden Adult Social Care, to bring together the key elements of such an assessment. These include supporting the individual to participate in reflection on the extent of their hoarding, prompts for practitioners regarding potential referrals to consider, and the use of photography to help the individual

capture their progress over time. It also includes the Wellbeing Rainbow, which highlights particular areas that are related to wellbeing as defined by The Care Act 2014, to encourage practitioners to consider the individual's wellbeing in relation to these.



<p>Have you had a family group conference? Is the landlord threatening you with eviction? Do you have a smoke alarm? Has your home had a fire safety check?</p>
<p>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.)</p> <p style="text-align: center;">Level 1 - Green ★ Level 2 - Orange 😊 Level 3 - Red 🚫</p>
<p>Name of Practitioner undertaking assessment Name of Organisation Contact Details Next Action to be taken</p>
<p style="text-align: center;">List Agencies Referred to with Dates and Contact Names</p> <p>Referred to The Recovery College? Referred to Integrated Care Borough Multi-disciplinary Team? Referred to High Risk Panel? Referred for Fire Safety Check?</p>



Wellbeing

‘Wellbeing’ is a broad concept, and it is described as relating to the following areas in particular (The Care Act 2014)



The use of photographs enables the client to map and assess their own progress over time encouraging hoarders to declutter and reclaim their living space. The client usually values the time spent by the social worker to produce these and the way that their property is treated with sensitivity and respect.

Satisfaction with Life Questionnaire

1. In most ways my life is close to ideal;
2. The conditions of my life are excellent;
3. I am satisfied with my life
4. So far I have got the important things I want in life;
5. If I could live my life over, I would change almost nothing.

Guidance notes

The person rates each statement on a seven point scale: from 1 = strongly disagree to 7 = strongly agree.

This questionnaire can be useful for using before and after any clearing out and change over time



One Page Profile

Name of Person:

Important things you need to know about me.
Including past history and significant life events.

What's most important to me?

How best can you support me?

My notes

What are the key risks I have identified?

What is the persons view?

Who is involved at present?

What improvements need to be made? List in order of importance

What support can I use to improve things?

What legislation and guidance is relevant?

What is my plan for escalation and supervision?

Clutterer's Anonymous

Am I a Clutterer? Do you have more possessions than you can comfortably handle?

1. Are you embarrassed to invite family, friends, health care providers, or maintenance workers into your home because it is not presentable?
2. Do you find it easier to drop something instead of putting it away or to wedge it into an overcrowded drawer or closet rather than finding space for it?
3. Is your home, or any part of it, unusable for its intended purpose, with a bed you can't sleep in, a garage you can't park in, a kitchen you can't cook in, or a table you can't use for dining?
4. Is clutter causing problems at home, at work, or in your relationships?
5. Do you hesitate sharing about this problem because you feel embarrassment, guilt, or
6. shame about it?
7. Do you have a weakness for discarded objects, bargain items, freebies, reading materials, or yard sales?
8. Do you use avoidance, distraction, or procrastination to escape dealing with your clutter?
9. Does your clutter create a risk of falling, fire, infestation, or eviction?
10. Do you avoid starting assignments, miss deadlines, or abandon projects because you can't find the paperwork or material you need?
11. Do you have difficulty making decisions about what to do with your possessions, daily living, or life in general?
12. Do you rent storage space to house possessions that you rarely use?
13. Do cleaning, organizing, follow through, upkeep, and maintenance all become daunting tasks, making the simplest of chores insurmountable?
14. Do you bring an item into your home without designating a place for it and releasing an equivalent one?
15. Do you believe that there is all the time in the world to clean your house, finish those projects, and read all those piles of old magazines or newspapers?
16. Are you easily side-tracked, moving from one project to another, without finishing any of them?
17. Are you constantly doing things for others while your own home is out of order?

18. Do you often replace possessions rather than And or clean those you already have?
19. Does perfectionism keep you from doing anything at all?
20. Does clutter cause you to have late charges added to your monthly financial obligations?
21. Do you feel a strong sense of emotional attachment toward your possessions, which makes it difficult to release them?
22. Do you consider all your possessions to be of equal worth, whether or not the objects have financial, functional, or sentimental value?
23. Do you waste your valuable time and talents by constantly rescuing yourself from clutter?
24. Does clutter keep you from enjoying quality leisure time?
25. Is the clutter problem growing?

If you have answered yes to some of these questions, CLA is here for you. Many of us have answered yes to most of these questions, while some of us have identified with only a few. However, the actual number of positive responses is not as important as how you feel inside about your clutter. Moreover, these questions may have shown you that your life is unmanageable or out of control.

Clutter may manifest in both blatant and subtle ways. The symptom* end patterns of our compulsion are as numerous as there are clutterers. The amount of clutter in our lives is not as important as the desire to stop Cluttering. If you want help, you can find It in the Clutterers Anonymous” fellowship.

**God, grant me the serenity to keep the things I need to keep,
The courage to release the things I do not need,
And the wisdom to know the difference.**

Graphic 17-Person Centred and strengths-based approach

Strengths Based Approach Practice Framework, Dept Health and Social care, p27

'The strengths perspective holds firm the idea that everyone who struggles learns something from their struggle, and develops capacities and traits that may ultimately turn out to be bountiful resources in moving towards a better life. It is to assert that everyone has dreams, visions and hopes even though they may currently be dashed

on the shoals of disease, oppression, poverty, or muted by a run of rotten luck'. Saleeby D (2000) *The Strengths Perspective in Social Work Practice* (2005).4th edition. London: Pearson.



Self-Neglect Guidance

Agencies That Offer Support:

- Camden Fire Service - Offer free fire safety checks which are particularly important when people are hoarding.
Please contact:
Keith Williams - scwesthampstead@london-fire.gov.uk
Keith Carmichael - skentishtown@london-fire.gov.uk
Rob Hazzard - scouston@london-fire.gov.uk
- Camden adult social care—who can carry out an assessment of need to support someone to remain at home (Telephone: 0207 974 4000, Option 1)

What Happens If You Make A Referral To Camden's Adult Safeguarding Team?

If you make a referral to the Safeguarding Team they will take basic details from you to determine if the referral meets the requirements to become a section 42 enquiry:

- A section 42 is where a local authority has reasonable cause to suspect that an adult in its area
- has needs for care and support (whether or not the authority is meeting any of those needs),
 - is experiencing, or is at risk of, abuse or neglect, and
 - as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must then make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

If it is considered appropriate for a section 42 enquiry, then a social worker will be allocated to carry out the enquiry and they will be in touch with you within 48 hours to look at carrying out the enquiry. The Safeguarding Team will provide advice and signposting if the case does not meet the requirements of a section 42 enquiry.

Self-Neglect Guidance

Can You Refer Someone Who Does Not Want To Be Referred?

People who self-neglect often say that they do not want help, and are reluctant to have the support of agencies due to the fear that things will be taken out of their hands.

However, you can still make a referral to the Safeguarding Team. You should of course inform the person that you are referring them and why you are doing this. However it is important that you make the referral as another agency may be able to offer help/support that the person will accept. It also offers an arena where your concerns and any identified risks can be shared with various agencies.

Camden Safeguarding Adults Partnership Board,
Camden Council, 5 Pancras Square, 5 Pancras Road, London N1C 4AG
Email: CamdenSAPB@camden.gov.uk

Self-Neglect Guidance



Help and Support for Self-Neglect

The aim of this leaflet is to assist people working in statutory services and partner agencies such as charities, housing providers, and the independent care sector who are working with people who self neglect. This leaflet should be read in conjunction with the Board's self-neglect tool kit which is available on our website.

Self-Neglect Guidance

What Is Self Neglect?

Self-neglect can cover a wide range of behaviours relating to when an individual neglects to attend to their basic needs.

This can include:

- Lack of self care—such as neglecting personal hygiene, nutrition and/or hydration, health and medical needs.
- Lack of care—relating to personal environment, such as hoarding or squalor.
- The refusal of services that may help/assist in relieving issues of self neglect.

An individual may be considered as self-neglecting and therefore at risk of harm where they are:

- Either unable or are unwilling to provide adequate care for themselves.
- Unable to or are unwilling to obtain necessary care to meet their needs.
- And/or decline essential support without which their health and safety needs cannot be met.

What Is Hoarding?

Hoarding is when a person acquires and stores an excessive amount of items. The items can be of little or no monetary value. The items acquired/selected are often stored in a chaotic manner, take up a lot of space, and create an unmanageable amount of clutter.

Hoarding is considered to be a significant problem if:

- The amount of clutter interferes with the persons everyday living activities

Self-Neglect Guidance

- The clutter is causing significant distress or negatively affecting the person's quality of life, or their families.
- It affects the health and safety of other people—i.e neighbors.

How Do You Recognize Self-Neglect?

Most people have come across someone who is self-neglecting either at work, through family or friends, or through watching a television program. However, self-neglect can present in various forms and levels.

If can often take many years before a person who self-neglects comes to the attention of services. Self-neglect can then be very difficult to address as behaviour may then have become very fixed. People can also self-neglect over a short period if they are unwell and unable to care for themselves.

Some signs of self-neglect which you can look out for:

- Living in unclean environments—such as rodent/insect infested areas, or with piles of waste food, etc.
- Living in a home which is unsafe, due to not being repaired, or hoards of items etc. which prevents people from accessing parts of their home (bedroom, bathroom, kitchen).
- Poor diet and nutrition or not taking medication for diagnosed health conditions.
- Refusing help from social care or health services which then affects their day to day lives, and may lead to a deterioration of their health.
- Having poor personal hygiene, poor healing of sores, etc., long toenails etc.

Self-Neglect Guidance

What Can You Do If You Think Someone Is Self Neglecting?

If you become aware that a person is self-neglecting and appropriate measures have not already been taken, then will you need to take additional steps to reduce the risk of further deterioration in the situation.

If there are immediate serious risks to life and limb, you should consider if it is necessary to call emergency services.

If you are in a paid role or are caring for someone who is self-neglecting then you have a duty of care to the person concerned to make a referral to the Adult Safeguarding Team at: CamdenSAPB@camden.gov.uk

If you have been working with the client for a while and are not able to make any significant progress then you can make a referral to the High Risk Panel who will provide advice and support to assist you in working with the person. You can access Adult Social Care on 0207 974 4000.



