research in practice for adults

OSAB
Oxfordshire Safeguarding Adults Board

Oxfordshire multi-agency Self-neglect policy

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Contents

1. Policy statement

The Care Act statutory guidance (DH 2016) states:

"*Within the context of the duties set out at paragraph 14.2, safeguarding partnerships can be a positive means of addressing issues of self-neglect. The SAB [Safeguarding Adults Board] is a multi-agency group that is the appropriate forum where strategic discussions can take place on dealing with what are often complex and challenging situations for practitioners and managers as well as communities more broadly.*" (14.141)

Oxfordshire's Safeguarding Adults Board recognises its role in taking ownership of the issue of self-neglect, with the aim of ensuring a strong multiagency commitment to appropriately responding to people who are self-neglecting.

This policy has been developed in collaboration with multiagency partners from Oxfordshire, and drafted by Research in Practice for Adults. It used the available evidence, and examples of policies from elsewhere in England to frame discussions local to Oxfordshire and develop a framework for working with people who self-neglect in line with the Care Act 2014.

Please note: Oxfordshire has a separate multiagency policy on hoarding. This can be found on the OSAB website and should be read in conjunction with this policy.

2. Partners to the protocol

This policy applies to all staff within the partner agencies of Oxfordshire's Safeguarding Adults Board who work directly, or manage people who work directly with people who may be self-neglecting.

Service managers and Safeguarding leads are responsible for implementing the policy, with the support of the Safeguarding Adults Board.

3. Aims of the policy

The aims of this policy are to:

- Ultimately, improve the wellbeing of the person and prevent serious injury and death of people who self-neglect
- Outline the principles that all staff should work within
- Support an effective multiagency model of working
- Ensure that staff from all agencies know where to go for support and advice about working with people who self-neglect
- Provide clarity over thresholds for referrals and outline a clear referral pathway, including escalation routes
- Provide a framework that empowers workers to act in a person-centred, creative and effective way
- Facilitate good information sharing and improve coordination between services
- Improve the recording of the numbers of people who self-neglect.

4. Definitions – what do we mean by self-neglect?

The Care Act guidance (DH, 2016) defines self-neglect as:

> "Self-neglect: this covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding" (DH 2016, s14.16)
>
> And
>
> "Where someone demonstrates lack of care for themselves and or their environment and refuses assistance or services. It can be long-standing or recent" (DH 2016: Annex J).

The research literature gives further detail, suggesting that self-neglect is made up of three elements:

- Lack of self-care (for example, neglect of personal hygiene, nutrition, hydration and/ or health) and/or
- Lack of care of the domestic environment (for example, squalor or hoarding) and/or
- Refusal of services that would mitigate risk to safety and wellbeing.

The person concerned may recognise the term, but may not use it to describe their own situation (Braye and Preston-Shoot, 2015).

Self-neglect may arise from an unwillingness, or an inability to care for oneself – or both. These are interlinked where unwillingness arises from a care and support need (e.g. undiagnosed pain prevents a person from be able to, or wanting, to clean their home).

5. The importance of mental capacity assessments

An important aspect of self-neglect is understanding of mental capacity. Capacity assessment must be time and decision specific (i.e. up to date, and related to a particular decision).

Braye and Preston-Shoot highlight the need for a broader understanding of capacity, to include the concept of 'executive capacity' when supporting people who self-neglect. This means checking whether people who self-neglect can both

- Understand, retain, use and weigh relevant information, including information about the consequences of any decision (mental capacity) AND
- Implement their actions (executive capacity).

Impairment of executive capacity can make it difficult for a person to make decisions *in the moment when the decision needs to be executed*; for example, they may recognise the need to eat and drink, but fail to act on that need.

'Articulate and demonstrate' models of assessment (tell me, then show me) can be effective in assessing both types of capacity (for more information see Naik et al, 2008).

The person should be supported to make an informed decision. This means that professionals may need to take time explaining the likely consequences of all courses of action.

Situations of self-neglect can lead to competing value positions – those of respect for autonomy and self-determination, and or duty of care and promotion of dignity. Evidence suggests that finding the right balance is a difficult judgement best achieved through multi-agency working and cooperation, and through a relationship where 'concerned curiosity' type questions are asked.

6. Referral and escalation routes

An update to the Care Act guidance in March 2016 (DH, 2016) gave further detail as to when self-neglect should be considered safeguarding.

> "It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support." (DH, 2016: 14.17)

Oxfordshire SAB are interpreting this statement to mean that safeguarding should be considered as an option where a person who is self-neglecting is refusing support that has been offered to them, and remains at high risk of harm to themselves or of presenting harm to others.

Following conversations on this issue, the referral and escalation flow chart below was devised by a group of multiagency colleagues at a workshop held in March 2016.

	Action	**Considerations or further detail**
1	Worker identifies a person who self-neglects who they are concerned about (i.e. because they are refusing services that could mitigate harm)	By 'worker' we mean a member of staff from any agency.
2	Contact agency safeguarding lead (see section 1) for signposting support (if needed), OR	The safeguarding lead will be able to signpost workers to the relevant contacts from other agencies who may be able to provide the required advice or support.
3	Contact other relevant agencies	
4	If colleagues are in agreement that they are working with someone who is self-neglecting, the case would only be referred to Adult Social Care (ASC) **if there was a need to undertake a formal assessment of need or if high risk a safeguarding alert.** The referral should include details of any of the following that are relevant: • High risk to personal safety and wellbeing • There is a public protection issue / risk to other people • Unmet needs outside of the remit of the worker (NB if person has unmet	Supporting people who self-neglect is a multi-agency responsibility. Adult Social Care may not always be best placed to lead work with individuals; workers from other agencies may already have a good relationship or rapport built up. Depending on the situation, the person may also be eligible for other input from ASC, starting with a social care assessment. Workers should bear in mind that people who self-neglect may experience abuse and neglect from

	care and support needs, they should be offered a care and support assessment from ASC). • If the person lacks mental capacity to decide whether to continue in their situation and is endangering self and/ or others. (Best interest process is triggered under the MCA 2005) • If the person is endangering others with their behaviour • If the person's mental capacity is unclear, and needs further (perhaps multidisciplinary) assessment • Whether the person is asking for help.	others. Evidence from research and Safeguarding Adults Reviews shows that this is not consistently spotted or responded to appropriately. Workers should discuss with the person whether they would like to initiate safeguarding for other types of abuse they may be experiencing.
5	• Continue work. Please refer to Appendix 1 for a checklist of actions to take. A suggested agenda for self-neglect multiagency meetings including 'defensible decision making' advice, guidance about what works in self-neglect cases, the legislative framework that can be used, are attached as appendices.	By work, we mean that the most appropriate agency will be leading efforts to support the adult who is self-neglecting to improve their safety and wellbeing. Routes such as ASC care & support needs assessment, fire safety measures, attention to health needs or support from environmental health may be necessary.
6	• If challenges are encountered with multiagency working, refer to safeguarding adults (add contact details).	Safeguarding adults can be used as a forum to bring together multiagency professionals. It should be used in cases of self-neglect where multiagency working is not working well – for example, where it is agreed that other agencies need to be involved, and requests for involvement are not being responded to or prioritised.

Figure 1: Escalation route for working with people who self-neglect in Oxfordshire.

7. Multi-agency/ multi-professional/ multi-disciplinary approach

The Care Act guidance outlines Making Safeguarding Personal as the preferred approach to safeguarding adults work. Although work with people who are self-neglecting may not always be taking into safeguarding, this approach is still relevant. The guidance states:

> "Making safeguarding personal means it should be person-led and outcome-focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety" (DH, 2016: 14.15).

The principles that colleagues should work towards are:

- To be person-centred, rather than process driven, with decisions underpinned by professional judgement
- To focus on the individual's wellbeing and involve them in decision making.
- To provide a 'team around the adult', where the most appropriate agency takes the lead role in coordinating support. By most appropriate, we mean the agency whose staff are most likely to be successful in building a trusted relationship with the person.
- To have a shared understanding of each other's roles, remit and responsibilities in working with people who self-neglect.
- To share risk as well as skills and expertise
- To share information, working within information sharing legislation and policy, and with the adult's permission wherever possible
- To be proportionate.

8. The role of safeguarding adults in self-neglect

The evidence shows that work with people who self-neglect is more effective where practitioners:

- "Build rapport and trust – showing respect, empathy, persistence and continuity
- Seek to understand the meaning and significance of the self-neglect, taking account of the individual's life experience
- Work patiently at the pace of the individual, but know when the make the most of moments of motivation to secure changes.
- Keep constantly in view the question of the individual's mental capacity to make self-care decisions
- Communicate about risks and options with honesty and openness, particularly where coercive action is a possibility
- Ensure options for intervention are rooted in sound understanding of legal powers and duties
- Think flexibly about how family members and community resources can contribute to interventions, building on relationships and networks
- Work proactively to engage and coordinate agencies with specialist expertise to contribute towards shared goals." (Braye, Orr and Preston-Shoot, 2015).

As outlined above, the Care Act guidance recommends using Making Safeguarding Personal when making safeguarding enquiries. While the points above do line up with a Making Safeguarding Personal approach, the timescales involved in self-neglect work may make a safeguarding enquiry an awkward fit. Therefore, situations of self-neglect should only be referred to safeguarding where

- support is needed to promote effective multiagency working
- the risks to the individual or others are deemed to be too high for the current support team to manage

As outlined in the flow chart (figure 1), it is important that even if the person is not referred to safeguarding, other routes of action are still explored.

9. Monitoring/quality assurance of the effectiveness of this policy

This policy can be seen as successful if it has met its aims (outlined in section 4). Measures which can be used, and reported on annually (for example in the SAB Annual Report) are:

- Reduction in numbers of serious injuries or deaths of people who are self-neglecting (data collection)
- Number of cases of self-neglect that are identified, and later escalated to safeguarding (data collection)
- Multiagency staff are aware of the policy and find it a useful reference (staff survey or other feedback mechanism)
- Multiagency staff know who their self-neglect lead is and feel confident to approach them with questions (feedback from agency leads on number of enquiries from staff; staff survey)
- Increase in the number of concerns raised to safeguarding for people who are self-neglecting that are progressed to safeguarding enquiries (denoting a valid concern), and decrease in the number of concerns raised to safeguarding which are not progressed to enquiries (data collection)
- Positive feedback from people who self-neglect on practice (interview at close of or throughout)
- Perception from senior and practitioner colleagues that the recording of self-neglect is more accurate (data collection)
- Perception from multiagency colleagues that information sharing and multiagency working in self-neglect is improved (staff survey).

10. Links to other relevant local policies

- Safeguarding (Making Safeguarding Personal)
- Information sharing
- Mental capacity and best interests assessments under the Mental Capacity Act 2005
- Care and support assessment under the Care Act 2014
- SAR protocol
- Pressure ulcers protocol
- Hoarding policy
- Use of Advocacy

11. Acknowledgements

Many thanks to Professor Suzy Braye and Professor Michael Preston-Shoot for offering guidance on the development of this policy. Thanks also to Harrow Local Safeguarding Adults Board for giving permission to draw from their multi-agency policy on self-neglect. Finally, thanks to the group of multi-agency practitioners who have supported the development of this policy with their time and comments.

12. References

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Harrow Local Safeguarding Adults Board (2015) Multi-agency protocol for self-neglect.

13. Appendix 1: Screening tool for self-neglect concerns

(Adapted from Harrow LSAB's policy)

Self-neglect cases require a multi-agency approach to ensure the best possible outcome for the individual, but not all need to be co-ordinated through the safeguarding adults policies and procedures. This screening tool aims to confirm that appropriate actions are being taken in each situation referred and to highlight those cases that have reached the threshold for safeguarding enquiries to be made.

1. An up to date and decision specific mental capacity assessment has been carried out and recorded

Yes (Dated……) No

2. An up to date risk assessment has been completed and recorded

Yes (Dated……) No

3. There is a risk management plan from the risk assessment which has been implemented

Yes (Dated……) No

4. A multi-agency self-neglect meeting has been held?

Yes (Dated……) No

5. The action plan arising from the meeting has been implemented and is proving to be unsuccessful

Yes (Dated……) No

6. Relevant legislation has been considered and applied

Yes (Dated……) No

7. Relevant services have been tried e.g. district nursing/home care and the case is active/allocated

Yes (Dated……) No

8. The allocated worker/s have presented the case to the Risk Enablement Panel (REP) and its recommendations have been implemented and unsuccessful

Yes (Dated……) No

All the above have been tried and unsuccessful – safeguarding "enquiries" to be made by the safeguarding team.

14. Appendix 2: Agenda for self-neglect multi-agency/multi-professional meetings

(Adapted from Harrow LSAB's policy)

- *introductions etc*
- *up to date background information on the person causing concern (including medical advice where available)*
- *clarification on concerns about self-neglect that have prompted the multi-agency meeting*
- *results of formal (recent/decision specific) mental capacity assessment (including "executive capacity" i.e. the ability of the individual to implement their decision and its implications)*
- *details of the risk assessment completed and risk management plan implemented*
- *are any children at risk – do Children's' Services need to be alerted?*
- *are any animals at risk – do the RSPCA need to be informed?*
- *is there a fire risk? is the local Fire Service aware/involved?*
- *relevant legal/statutory powers to be identified*
- *will legal/statutory powers be applied or used as a contingency?*
- *action plan agreed with named lead officers*
- *date of next meeting where required*
- *has the point been reached where another safeguarding "concern" needs to be raised?*

The meeting will aim to arrive at the "**best possible decision**", as it is acknowledged that in many circumstances there are no easy solutions. It is important that the meeting is accurately recorded so that the thinking and processes used in reaching the decisions made/action points are clear.

A **defensible decision** is one where:

- all reasonable steps have been taken to avoid harm
- a person's mental capacity (including executive capacity) has been taken into consideration and guided by the Mental Capacity Act Code of Practice
- reliable assessment methods have been used and information has been collected and thoroughly evaluated
- all legal powers and duties have been considered, and the reasons for acting/not acting under them recorded.
- decisions are recorded succinctly and in line with the agencies' recording policy, and decisions and related actions are communicated to all relevant parties with outcomes reported back to the lead agency
- practitioners and their managers adopt an approach that is proactive, investigative and holistic, taking into account all aspects of the individual and the wider family and any risks ("concerned curiosity")
- all appropriate services are arranged to mitigate identified risk and meet the assessed needs of the individual concerned as far as that person, with capacity to do so, is prepared to accept
- such services
- any occurrence of a risk event subsequently will require a review of the plan in relation to that risk

- policies and procedures have been followed and due adherence to statute and government and professional guidance is maintained

15. Appendix 3: List of local services that may be useful to draw on when working with people who self-neglect.

(To add – e.g.

Description	Name of service	How to contact them?
Safe drinking schemes		
Fire risk minimisation		
Adaptations and repairs		
Provision of equipment/ furniture		
Emergency respite		
Deep cleaning service		
De-cluttering		
Therapeutic activity (hoarding services through Mental Health?)		
Psychotherapy		
Peer support		

16. Appendix 4: Background information on self-neglect

(Taken from Braye, Orr and Preston-Shoot 2011 and 2014, and Harrow LSAB's policy)

What causes people to self-neglect?

Research has highlighted some emerging themes about the perspective of the individuals that self-neglect:

- pride in self sufficiency
- a sense of connectedness to place and possessions
- a drive to preserve continuity of identity and control
- traumatic life histories and events that have had life changing effects
- in some cases, shame and efforts to hide state of residence from others

Thus a wide range of explanations is offered, and there is no overarching model for understanding causation:

- self-neglect may be of physical and/or psychiatric aetiology - there is no one set of variables
- there may be underlying personality disorder, depression, dementia, obsessive-compulsive disorder, trauma response, severe mental distress, and/or neuropsychological impairment
- it may be associated with diminishing social networks and/or economic resources
- physical and nutritional deterioration is sometimes observed, but is not established as causal
- it may reflect once functional behaviours and personal philosophy (pride in self-sufficiency, sense of connectedness, mistrust)
- it may represent attempts to maintain continuity (preserve and protect self) and control

Mental Capacity

Capacity is a highly significant factor in both understanding and intervening in situations of self-neglect. Building good relationships is seen as key to maintaining the kind of contact that can enable interventions to be accepted with time and decision-making capacity to be monitored.

There are tensions between respect for autonomy and a perceived duty to preserve health and wellbeing. The former principle may extend as far as recognising that an individual who chooses to die through self-neglect should not be prevented from doing so; the latter may engage the view that action should be taken, even if resisted, to preserve an individual's safety and dignity. Human rights arguments are engaged in support of either perspective.

The distinction is not as stark in practice. Respect for autonomy must include a questioning of the extent to which apparent 'lifestyle choice' is really 'chosen' or whether it stems instead from a perceived lack of viable options, or demotivation from other life events and experiences, or difficulties with executive capacity. And even where autonomy is being exercised, respectful challenge may well be appropriate, particularly where others too may be at risk. This can require persistence rather than time-limited involvement: respect for autonomy does not mean abandonment. Equally, prioritising protection does not mean a denial of the person's wishes and feelings, or attempts to remove all risk.

The autonomy of an adult with capacity is likely to be respected and efforts directed to building and maintaining supportive relationships through which services can in time be negotiated. Capacity assessments, however, may not take full account of the complex nature

of capacity; the distinction in the literature between decisional and executive capacity is not found in practice and its importance for determining responses to self-neglect may need to be considered further. Strong emphasis needs to be placed by practitioners on the importance of interagency communication, collaboration and the sharing of risk.

Interventions

i. assessment

Sensitive and comprehensive assessment is of critical importance - an accurate assessment of the client's mental status, partly because lifestyle and personality traits are often involved, sometimes triggered or aggravated by a stressful event such as loss or physical illness. Assessment should include individual health status, family dynamics, depression and/or dementia, cultural beliefs and family coping patterns.

Assessment is crucial in evaluating the extent to which self-neglect may be attributable to underlying illness or disease. Assessment, the researchers suggest, should therefore be multiagency and multidisciplinary, and components should involve a physical examination, a detailed social and medical history, a historical perspective of the person and the situation, the person's perception of the position, willingness to accept support, observation and self-reporting. Interviewing family members and people in the individual's network may assist in gathering facts and gauging someone's decision making capacity.

Risk assessment should cover observation of the individual and the home, activities of daily living, functional and cognitive abilities, nutrition, social supports and the environment.

"Carefrontational" questioning will ensure that learned answers to questions do not convince a worker that someone who self-neglects is more independent and coping better than they are. In that context, a level of "professional (concerned) curiosity" i.e. asking why and seeking some demonstrable evidence of ability will provide a more reliable assessment picture.

Although for people assessed as having capacity it may be deemed to be a lifestyle choice to refuse support and services, a level of squalor should prompt the question "would anyone choose to live like this?" Impairment of executive brain function, or the negative symptoms of some forms of mental disorder, may interfere with the ability to be active in caring for oneself or for the domestic environment, without 'choice' having been exercised.

ii. building a relationship

There is some research evidence that in building a relationship with the person that self-neglects, they can be encouraged to accept some practical help. Equally, a relationship of trust may change their self-perception, and become the vehicle for achieving change in living conditions through consensual rather than imposed interventions.

iii. risk assessment

It is important for staff to recognise that any positive risk-taking approach must be balanced with their responsibilities in relation to safeguarding adults and children, care standards and health & safety legislation.

The fundamental principle is that support is provided to individuals to enable them to receive personalised care/support that meets their needs within a framework of risk assessment and management that is collaborative, transparent and enabling.

Most models of risk assessment accept that it is not possible to eliminate risk entirely. Unlike working with children, adults with mental capacity are able to take "unwise decisions". In the context of risk management, this makes the assessment of mental capacity even more

important. Even where people lack capacity, actions taken in their best interest must be least restrictive.

A risk assessment can only identify the probability of harm, assess the impact of it on a vulnerable adult and suggest intervention strategies which may diminish the risk or reduce the harm. Often the focus is upon risk assessment without consideration of risk management - however without a risk management plan the assessment will only identify the risk and not reduce it.

Social workers and health and care practitioners are expected to balance rights and responsibilities in relation to risk, regularly re-assess risk, recognise risk to self and colleagues and work within the risk assessment procedures of the Department.

A few principles to consider:

- risk assessment should be based on sound evidence and analysis;
- risk assessment tools should inform rather than replace professional judgement;
- all professionals involved in risk assessment should have a common language of risk and common understanding of the main concepts;
- information sharing for risk assessment should be based on clearly agreed protocols and understanding of the use of such information;
- risk assessment should not be seen as a discrete process but as integral to the overall management and minimisation of risk

Risk factors: Static risk factors may include age, gender, offence history, mental health/health record which can be viewed as more reliable indicators of risk as they remain constant.

Dynamic factors can include events which have occurred in an individual's life, such as traumatic events, changes in employment, housing, addiction, new illness/disability. These can often change and in most occasions be outside the control of the individual, and therefore viewed with less reliability in assessing future risk. NB. past risk factors are often a good indicator of possible future risk.

Risk Management: can be the process by which an organisation tries to reduce negative outcomes and also a means of maximising potential benefits in which the service user can also play an important role in managing the risk.

1. Appendix 5: Consideration of the statutory options (benefits and burdens)

(Adapted from Harrow LSAB's policy and Braye (2016))

Possible intervention	Statutory grounds	Benefits	Burdens
Removal from home	Powers of entry under the Environmental Protection Act 1990 and the Public Health Acts 1936 and 1961 to address conditions prejudicial to health. N.B. The Care Act 2014 abolished provision under s.47		

	of the National Assistance Act 1948 to remove a person in need of care from home.		
Eviction	Consider possible breach of the implied terms of a tenancy agreement i.e. not taking proper care of the property. Person may be declared intentionally homeless under the Housing Act 1996 and Homelessness Act 2002. Eviction may be disputed by reference to the Equality Act 2010. The Anti-Social Behaviour, Crime and Policing Act 2014 amends the Housing Acts 1985 (as amended by the Housing Act 1996) and 1988, introducing an absolute ground for eviction of a tenant where an Injunction to Prevent Nuisance and Annoyance (IPNA – see below) has been breached.		
Compulsory admission into hospital under the Mental Health Act 1983	The existence of defined forms of mental disorder, and for the individual's own health or safety or to protect other persons.		
Guardianship	Under s.7 of the Mental Health Act 1983. What short term or long term solutions would result, given the limited powers under guardianship provisions?		
Declaration of Mental Incapacity	The Mental Capacity Act 2005 enshrines the presumption of capacity. Incapacity must therefore be proved. Decisions and interventions in respect of people lacking capacity must be the person's 'best interests'. Ensure executive capacity is fully considered.		

Any other possible intervention?			

2. Appendix 6: Legislation

(Adapted from Harrow LSAB's policy and Braye (2016))

A. The Care Act 2014

The Care Act provides one of the statutory foundations for work with people who self-neglect (the other being the Mental Capacity Act 2005). Key aspects of the Care Act that are relevant include:

s.1: The local authority has a duty to promote the wellbeing of any individual in respect of whom they are carrying out any of their functions under the Act.

Chapter 2: an emphasis on preventing or delaying needs

Care Act guidance 2.1: It is critical to the vision in the Care Act that the care and support system works to actively promote wellbeing and independence, and does not just wait to respond when people reach a crisis point.

Section 6: Co-operating generally

1. *A local authority must co-operate with each of its relevant partners, and each relevant partner must co-operate with the authority, in the exercise of—*
    a. *their respective functions relating to adults with needs for care and support,*
    b. *their respective functions relating to carers, and*
    c. *functions of theirs the exercise of which is relevant to functions referred to in paragraph (a) or (b).*

Section 7: Co-operating in specific cases

2. *Where a relevant partner of a local authority, or a local authority which is not one of its relevant partners, requests the co-operation of the local authority in its exercise of a function in the case of an individual with needs for care and support or in the case of a carer, a carer of a child or a young carer, the local authority must comply with the request unless it considers that doing so—*
    a. *would be incompatible with its own duties, or*
    b. *would otherwise have an adverse effect on the exercise of its functions.*

Section 9: Assessment of an adult's needs for care and support

1. *Where it appears to a local authority that an adult may have needs for care and support, the authority must assess*

a. *Whether the adult does have needs for care and support, and*
b. *If the adult does, what those needs are.*

The Act goes on to give details of of eligibility criteria (s.13 and relevant regulations), the duty to meet needs (s.18), and the development of a care and support plan (s.25).

Section 11: Refusal of assessment

1. *Where an adult refuses a needs assessment, the local authority concerned is not required to carry out the assessment (and section 9.1 does not apply in the adult's case).*
2. *But the local authority may not rely on subsection (1) (and so must carry out a needs assessment) if –*
    a. *The adult lacks capacity to refuse the assessment and the authority is satisfied that carrying out the assessment would be in the adult's best interests, or*
    b. *The adult is experiencing, or is at risk of, abuse or neglect.*

Section 42: Enquiry by local authority

1. *This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—*
   a. *has needs for care and support (whether or not the authority is meeting any of those needs),*
   b. *is experiencing, or is at risk of, abuse or neglect, and*
   c. *as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.*
2. *The local authority must 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 (whether under this Part or otherwise) and, if so, what and by whom.*

Self-neglect is noted as one of the circumstances that constitute abuse and neglect in the Care Act guidance (s14.17). The guidance also notes:

"It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support." (s14.17)

Section 43 Safeguarding Adults Boards

3. *The way in which an SAB must seek to achieve its objective is by co-ordinating and ensuring the effectiveness of what each of its members does.*

Section 67 Involvement in assessments, plans etc

2. *The authority must, if the condition in subsection (4) is met, arrange for a person who is independent of the authority (an "independent advocate") to be available to represent and support the individual for the purpose of facilitating the individual's involvement; but see subsection (5).*
4. *The condition is that the local authority considers that, were an independent advocate not to be available, the individual would experience substantial difficulty in doing one or more of the following—*
   a. *understanding relevant information;*
   b. *retaining that information;*
   c. *using or weighing that information as part of the process of being involved;*
   d. *communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means).*

Section 68: Safeguarding enquiries and reviews

2. The relevant local authority must, if the condition in subsection (3) is met, arrange for a person who is independent of the authority (an "independent advocate") to be available to represent and support the adult to whose case the enquiry or review relates for the purpose of facilitating his or her involvement in the enquiry or review; but see subsections (4) and (6).
3. The condition is that the local authority considers that, were an independent advocate not to be available, the individual would experience substantial difficulty in doing one or more of the following—
   a. understanding relevant information;
   b. retaining that information;
   c. using or weighing that information as part of the process of being involved;
   d. communicating the individual's views, wishes or feelings (whether by talking, using sign language or any other means).

B. Mental Capacity Act 2005

"A person is not to be treated as unable to make a decision merely because he makes an unwise decision"

There are five underpinning principles of the Mental Capacity Act.

You must:

1) assume the person has capacity unless proved otherwise
2) do not treat people as incapable of making a decision unless you have tried all practicable steps to try to help them.
3) allow people to make what may seem to you an unwise decision (if they have capacity)
4) always do things, or take decisions for people without capacity in their best interest
5) ensure that when doing something to someone, or making a decision on their behalf you choose the least restrictive option

The two- stage test of capacity

You must use the following test to assess if the person has capacity:-

i. is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,
ii. is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at a given time (capacity is decision specific)

The person is able to make a decision and therefore has capacity if they:

a. understand the information relevant to the decision,
b. retain the information,
c. use or weigh that information as part of the process of making the decision, or
d. communicate his/her decision either by talking, signing, or any other means

It is very important to consider "executive capacity" – that is the ability of the individual to implement the action.

Best Interest Checklist

Where a person lacks capacity all decisions must be made in their best interest. The checklist below gives some common factors that you must always take into account where a decision is being made, or an act is being done for the person who lacks capacity.

- involve the person who lacks capacity
- be aware of the persons past and present wishes and feelings
- consult with others who are involved in the care of the person
- do not make assumptions based solely on the person's age, appearance, condition or behaviour
- is the person likely to regain capacity to make the decision in the future?

You must formally record your decision e.g. by completing the Mental Capacity Act Checklist template and store this within the service user's electronic or paper file.

Schedule A1: Deprivation of Liberty Safeguards

Where a best interests decision involves depriving someone of their liberty, there are additional legal safeguards that must be followed. A person is subject to a deprivation of liberty if they are subject to continuous supervision and control and are not free to leave.

Care homes and hospitals must apply to their local authority for authorisation to deprive a person of their liberty. Further information can be found in

The Law Society (2015) Deprivation of Liberty: A practical Guide. Online resource: http://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

C. Public Health Act 1936

Contains the principal powers to deal with filthy and verminous premises.

Section 83 - Cleansing of Filthy or Verminous Premises:

i. where a local authority (LA), upon consideration of a report from any of their officers, or other information in their possession are satisfied that any premises – a) are in such a filthy or unwholesome condition as to be prejudicial to health, or b) are verminous

ii. the local authority (LA) shall give notice to the owner or occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the condition of the premises.

The steps which are required to be taken must be specified in the notice and may include:

- cleansing and disinfecting
- destruction or removal of vermin
- removal of wallpaper and wall coverings
- interior of any other premises to be painted, distempered or whitewashed

There is no appeal against a Section 83 notice and the LA has the power to carry out works in default and recover costs. The LA also has the power to prosecute.

Section 84 Cleansing or Destruction of Filthy or Verminous Articles:

Applies to the cleansing, purification or destruction of articles necessary in order to prevent injury, or danger of injury, to health.

Section 85 Cleansing of Verminous Persons and Their Clothing:

The person themselves can apply to be cleansed of vermin or, upon a report from an officer, the person can be removed to a cleansing station. A court order can be applied for where the person refuses to comply.

The Local Authority cannot charge for cleansing a verminous person and may provide a cleansing station under Section 86 of the Public Health Act 1936.

The Public Health Act 1936 Section 81 also gives Local Authority's power to make bylaws to prevent the occurrence of nuisances from filth, snow, dust, ashes and rubbish.

D. The Public Health Act 1961

The Public Health Act 1961 amended the 1936 Act and introduced:

Section 36 Power to Require Vacation of Premises During Fumigation:

Makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation must be provided and there is the right of appeal.

Section 37 Prohibition of Sale of Verminous Articles:

Provides for household articles to be disinfested or destroyed at the expense of the dealer (owner).

E. Housing Act 2004

Allows Local Authorities to carry out a risk assessment of residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. If the hazard is a category 1 there is a duty by the Local Authority to take action. If the hazard is a category 2 then there is a power to take action. However an appeal is possible to the Residential Property Tribunal within 21 days.

F. Building Act 1984

Section 76 is available to deal with any premises which are in such a state as to be prejudicial to health. It provides an expedited procedure i.e. the Local Authority may undertake works after 9 days unless the owner or occupier states intention to undertake the works within 7 days.

There is no right of appeal and no penalty for non-compliance.

G. Housing Act 1985 (as amended by the Housing Act 1996) and Housing Act 1988

These provide grounds for eviction of a tenant, including:

- Where an individual has undertaken conduct which is, or is likely to cause, a nuisance or annoyance to a person residing, visiting or otherwise engaged in lawful activity in the locality
- Where an obligation of the tenancy has been broken.

H. Acceptable Behaviour Contracts

These are voluntary, non-legally binding agreements between an individual and the housing department, police or registered social landlord. They can provide an alternative or preliminary step towards injunctions or eviction proceedings.

I. Animal Welfare Act 2006

Where domestic pets are being neglected, it may be necessary to invoke animal welfare legislation.

The Animal Welfare Act 2006 makes an offence of causing an animal to suffer where that suffering is unnecessary, and also places a duty (s9) on people to meet the welfare needs of animals that they are responsible for.

Section 9. Duty of a person responsible for animal to ensure welfare

(2) For the purposes of this Act, an animal's needs shall be taken to include—

a. its need for a suitable environment,
b. its need for a suitable diet,
c. its need to be able to exhibit normal behaviour patterns,
d. any need it has to be housed with, or apart from, other animals, and
e. its need to be protected from pain, suffering, injury and disease.

There is further legislation that relates specifically to people – both the living and the deceased.

J. Environmental Protection Act 1990

Section 79(a) refers to any premises in such a state as to be prejudicial to health or a nuisance. Action is by a Section 80 abatement notice and the recipient has 21 days to appeal.

The local authority has a power of entry to deal with the statutory nuisance (which means a state prejudicial to health, smoke, fumes, gases, effluent, accumulation or deposits such as hoarded materials or noise), and must give 24 hours' notice unless an emergency or danger to life exists. The local authority may make a charge to the occupier.

K. Prevention of Damage by Pests Act 1949

Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice. They have a duty to ensure that its District is free from rats and mice.

L. Public Health (Control of Disease) Act 1984, amended by the Health and Social Care Act 2008

Section 2A outlines health protection powers. Where there is significant risk to human health, the local authority may apply for an order imposing restriction or requirements to protect against infection or contamination.

M. Mental Health Act

Admission for assessment (section 2)

Duration of detention: 28 days maximum.

Application for admission: by an Approved Mental Health Practitioner (AMHP) or the patient's nearest relative. The applicant must have seen the patient within the previous 14 days.

Procedure: two doctors must confirm that:

(a) the patient is suffering from a mental disorder of a nature or degree that warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; and

(b) he or she ought to be detained in the interest of his or her own health or safety, or with a view to the protection of others.

Discharge: by any of the following:

- Responsible clinician
- Hospital manager
- The nearest relative, who must give 72 hours' notice. The responsible clinician can prevent him or her discharging a patient by making a report to the hospital managers
- MHT. The patient can apply to a tribunal within the first 14 days of detention.

Admission for treatment (section 3)

Duration of detention: up to six months, renewable for a future six months, then for one year at a time.

Application for admission: by nearest relative, or AMHP in cases where the nearest relative does not object, or is displaced by County court, or it is not 'reasonably practicable' to consult him or her.

Procedure: two doctors must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that makes it appropriate for him or her to receive medical treatment in hospital; and

(b) appropriate medical treatment is available for him or her; and

(c) it is necessary for his or her own health or safety, or for the protection of others that he or she receives such treatment and it cannot be provided unless he or she is detained under this section.

Renewal: under section 20, the responsible clinician can renew a section 3 detention if the original criteria still apply and appropriate medical treatment is available for the patient's condition. The responsible clinician must consult another person of a different profession who has been professionally concerned with the patient's treatment.

Discharge: by any of the following:

- Responsible clinician
- Hospital managers
- The nearest relative, who must give 72 hours' notice. If the responsible clinician prevents the nearest relative discharging the patient, by making a report to the hospital managers, the nearest relative can apply to an MHT within 28 days.
- MHT. A patient can apply to a tribunal once during the first six months of his or her detention, once during the second six months and then once during each period of one year. If the patient does not apply in the first six months of detention, his or her case will be referred, automatically, to the MHT. After that, the case is automatically referred when a period of three years has passed since a tribunal last considered it (one year, if the patient is under 18).

Admission for assessment in cases of emergency (section 4)

Duration of detention: 72 hours maximum.

Application for admission: by an AMHP or the nearest relative. The applicant must have seen the patient within the previous 24 hours.

Procedure: one doctor must confirm that:

a) it is of 'urgent necessity' for the patient to be admitted and detained under section 2; and

b) waiting for a second doctor to confirm the need for an admission under section 2 would cause 'undesirable delay'

Note: the patient must be admitted within 24 hours of the medical examination or application, whichever is the earlier, or the application under section 4 is null and void.

Guardianship (sections 7-10)

Duration of guardianship order: up to six months, renewable for a further six months, then for one year at a time.

Application for reception into guardianship: by an AMHP or nearest relative.

Procedure: two doctors must confirm that:

(a) the patient is suffering from a mental disorder (see above) of a nature or degree that warrants reception into guardianship; and

(b) it is necessary in the interests of the patient's welfare or for the protection of others.

Note: the patient must be over 16. The guardian must a local social services authority, or person approved by the social services authority, for the area in which he or she (the guardian) lives. A guardian has the following powers

- to require a patient to live at a place specified by the guardian
- to require a patient to attend places specified by the guardian for occupation, training or medical treatment (although the guardian cannot force the patient to undergo treatment)
- to ensure that a doctor, social worker or other person specified by the guardian can see the patient at home.

Discharge: by any of the following

- Responsible clinician
- Local social services authority
- Nearest relative
- MHT. The patient can apply to a tribunal once during the first six months of guardianship, once during the second six months and then once during each period of one year.

Warrant to search for and remove patients (section 135)

Duration of detention: 72 hours maximum.

Procedure: if there is reasonable cause to suspect that a person is suffering from mental disorder and

(a) is being ill-treated or neglected or not kept under proper control; or

(b) is unable to care for him or herself and lives alone a magistrate can issue a warrant authorising a police officer (with a doctor and AMHP) to enter any premises where the person is believed to be and remove him or her to a place of safety.

Mentally disordered persons found in public places (section 136)

Duration of detention: 72 hours maximum

Procedure: if it appears to a police officer that a person in a public place is 'suffering from mental disorder' and is 'in immediate need of care or control', he or she can take that person to a 'place of safety', which is usually a hospital, but can be a police station.

Section 136 lasts for a maximum of 72 hours, so that the person can be examined by a doctor and interviewed by an AMHP and 'any necessary arrangements' made for his or her treatment or care.

N. Anti-Social Behaviour, Crime and Policing Act 2014

While previous legislation provided for Anti-Social Behaviour injunctions, the Anti-Social Behaviour, Crime and Policing Act introduces two different orders:

Injunction to Prevent Nuisance and Annoyance (IPNA).

This can be applied for by a local authority, housing provider or police.

The court may grant an injunction against a person aged 10 or over if two conditions are met:

1. (2) The first condition is that the court is satisfied, on the balance of probabilities, that the respondent has engaged or threatens to engage in anti-social behaviour.

1. (3) The second condition is that the court considers it just and convenient to grant the injunction for the purpose of preventing the respondent from engaging in anti-social behaviour.

The injunction may contain requirements and prohibitions, and a power of arrest for breach may be attached in cases with a significant risk of harm.

Community Protection Notices

These are available to the police and the local authority and can be issued to a person aged 16 or over, if they have been given written warned that they will be issued with one if their behaviour does not change.

43. 1

(a) the conduct of the individual or body is having a detrimental effect, of a persistent or continuing nature, on the quality of life of those in the locality, and

(b) the conduct is unreasonable.

The notice can impose requirements to stop or start doing specified things, or a requirement to take reasonable steps to achieve specified results.

O. Misuse of Drugs Act 1971

Section 8

A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises:

S8 (a)

Producing or attempting to produce a controlled drug

S8 (b)

Supplying or attempting to supply a controlled drug to another or offering to supply a controlled drug to another

S8 (c)

Preparing opium for smoking

S8 (d)

Smoking cannabis, cannabis resin or prepared opium

P. Protection of Property

This is a service for people who are known to adult social care services and who have no relatives or friends willing or able to look after their home and personal property during periods of admission to hospital or residential care.

Section 48 of the National Assistance Act 1948 places a duty on the local authority to protect moveable property when:

- the client is admitted to any hospital
- the client is admitted to a home provided under part III of the act
- the client admitted to any other place under section 47(3) of the act

- it appears to the local authority that the client is temporarily or permanently unable to deal with or protect their property and that no other arrangements have been or are being made to protect it

The council's duty to protect moveable property applies during the lifetime of the person. The section does not apply to a person whose death has occurred before action has commenced.

Q. Summary of powers of entry

The table below summarises powers of entry which can be used when working with people who self-neglect.

Police and Criminal Evidence Act 1984	The police may enter premises without a warrant in order to save a life or prevent injury, or prevent serious damage to a property.
Mental Health Act 1983, s115	An Approved Mental Health Professional (AMHP) may enter and inspect any premises (excluding a hospital) where a mentally disordered patient is living, if he has reasonable cause to believe that the person is not under proper care.
Public Health Acts 1936 and 1961	A local authority can apply for a power of entry if it believes that the state of the premises is prejudicial to health (see above).
Environmental Protection Act 1990	A local authority has power of entry to deal with 'statutory nuisance' (see section J above).

R. Court Jurisdiction

Complex cases may be the subject of an application to court.

Court of Protection

The Court of Protection makes decisions on matters relating to finance or welfare for people who lack the mental capacity to make a specific decision at a specific time. The Court can be asked to determine whether the person has the mental capacity to make a decision on a specific matter, and/or where they lack capacity, to decide what is in the individual's best interests. If the individual has mental capacity, the Court has no jurisdiction over that matter.

High Court Inherent Jurisdiction

The inherent jurisdiction of the High Court can be used to protect people who have the mental capacity to make decisions, but cannot exercise that capacity freely because they are:

- Under constraint
- Subject to coercion or undue influence
- For some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.