

**NORTHAMPTONSHIRE
SAFEGUARDING ADULTS BOARD**

**ADULT SELF-NEGLECT BEST PRACTICE
GUIDANCE**

Guidance and procedure for responding to self-neglect concerns and enquiries in Northamptonshire.

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With thanks to Gloucestershire County Council, whose guidance and procedures for self-neglect have been adapted to produce this document.

1. About this document

This document outlines the procedure and guidance for dealing with issues and concerns of self-neglect in relation to adults with care and support needs. This procedure and guidance follows the safeguarding procedure as outlined in the [Northamptonshire Safeguarding Adults Board \(NSAB\) Inter-agency Safeguarding Procedures](#), and should be read alongside that document. As with all safeguarding concerns, the 6 key principles (Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability) outlined in the Care Act Statutory Guidance should underpin all work with people in situations of self-neglect.

This guidance draws on the research published by SCIE on self-neglect:

[Self-neglect and adult safeguarding: findings from research](#)

[Self-neglect policy and practice: building an evidence base for adult social care](#)

[Self-neglect policy and practice: research messages for managers](#)

[Self-neglect policy and practice: key research messages](#)

This guidance does not include issues of risk associated with deliberate self-harm. If self-harm appears to have occurred due to an act of neglect or inaction by another individual or service, consideration should be given to raising a safeguarding adults concern with Adult Social Care.

2. Introduction

Self-neglect is a complex area. It is listed as an abuse type under the Care Act 2014, but it will not always be treated as safeguarding and there are other processes and agencies which will be better used or placed to manage cases of possible self-neglect. Previously self-neglect will have been managed outside of the safeguarding process, but the duties imposed by the Care Act mean that self-neglect must be incorporated into safeguarding procedures where enquiries are necessary. Mental capacity assessment, risk assessment and multi-agency working will all remain essential elements of professional work with self-neglect and where individuals refuse safeguarding interventions, as they may refuse assessment, practitioners will still need to find ways of working together, in partnership, to mitigate risk wherever possible and ensure robust recording and decision-making.

3. Legal framework

The Care Act 2014 places specific duties on the Local Authority relevant in cases of self-neglect. The main two areas are in assessment and safeguarding:

1. Assessment

[Section 9](#) of the Care Act outlines the Local Authority's duty with regards to assessment. Under [Section 11](#) of the Act there are 2 conditions under which an assessment must still take place **even if it has been refused**. These are; if the adult

lacks capacity and the assessment would be in their best interest, or **if the adult is experiencing, or at risk of, neglect and abuse**, and this includes self-neglect. How this assessment will be carried out despite this refusal will be covered later in this guidance.

2. Safeguarding

Under the latest Care Act Statutory Guidance self-neglect is listed as a type of abuse and neglect and safeguarding enquiries should be made under [Section 42](#) of the Act where appropriate. The Act outlines the three step test for safeguarding enquiries. To trigger an enquiry an adult must;

- have needs for care and support,
- be experiencing, or be at risk of, abuse or neglect (including self-neglect), and
- as a result of those needs be unable to protect themselves from either the risk of, or the experience of abuse or neglect (again including self-neglect).

The final step of this three step test is the most critical in self-neglect cases, whether as a result of a person's care needs, the person is unable to protect themselves from self-neglect, or the risk of it. In effect whether they are able to protect themselves from themselves. The most recent Care Act guidance explains:

'It should be noted that self-neglect may not trigger 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.'

Care Act: Care and support statutory guidance 14.17

The Safeguarding Adults Team can provide advice on whether a safeguarding enquiry should take place.

3. Advocacy

If the adult has 'substantial difficulty' in understanding and engaging with a social care assessment or safeguarding enquiry, the local authority must ensure that there is an appropriate person to help them, and if there isn't, arrange for an independent advocate. Further information on advocacy can be found in the inter-agency safeguarding procedures.

There are also further duties to provide information and advice and to prevent abuse and delay needs which can also apply in self-neglect cases.

Best Practice Guidance

4. What is self-neglect

Definition

The [Care Act statutory guidance](#) gives this definition of 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'

Care Act: Care and support statutory guidance 14.17

The Social Care Institute of Excellence in their [Self-neglect policy and practice: key research messages 2015](#), describe self-neglect as having three separate strands:

- Lack of self-care – lack of care over personal hygiene, health, nutrition or hydration leading to potentially severe harm or death.
- Lack of care of environment – leading to squalor or hoarding.
- Refusal of services which would mitigate harm.

Safeguarding, since the No Secrets guidance, has focused on adults whose vulnerability has put them at risk of abuse from others. Self-neglect, like neglect, is an act of omission but is unique in safeguarding in that there is no perpetrator. Additionally the harm, or risk of it, may not be due to one event but may gradually increase over time, although the behaviour causing it is the same. This can make it harder to intervene, as a behaviour that can appear harmless or eccentric in the short-term, may pose serious risks both to the individual and others in the longer term. Knowing when to intervene will be critical for professionals. The desire to allow people their freedom to make unwise decisions and the well-being principle to promote control over day to day decisions will need to be balanced with the risk posed by the outcome of those repeated unwise decisions for the adult and others.

For the purposes of this guidance self-neglect includes adults with or without capacity.

Models of self-neglect

Self-neglect will frequently reflect a complex individual history. Research finds it is often associated with conditions such as:

- Physical health – impaired physical functioning, pain, nutritional or dietary symptoms.
- Mental health – depression, anxiety, OCD, frontal lobe dysfunction, personality disorders.
- Substance misuse – alcohol and substance misuse.
- Psychological and social factors – lack of resources, lack of access to social and health services, traumatic histories and life-histories, personality traits and personal values.

Identification and intervention in potential situations of self-neglect is not dependant on any diagnosis of a physical or mental health condition e.g. Diogenes syndrome. It is often associated with older age, and in younger adults is more likely to be associated with mental health difficulties.

Characteristics of self-neglect

Self-neglect can vary from case to case, but there are some key signs to look for in identifying self-neglect in the community. Types of self-neglect include:

- Lack of self-care to an extent that it threatens personal health and safety (e.g. refusing to take medication)
- Neglecting to care for one's personal hygiene, health or surroundings
- Inability to avoid self-harm (e.g. alcoholism)
- Failure to seek help or access to services to meet health and social care needs (e.g. e.g. attending appointments, or accepting home visits)
- Inability or unwillingness to manage one's personal affairs

Indicators of self-neglect are:

- Very poor personal hygiene
- Unkempt appearance
- Lack of essential food, clothing or shelter
- Malnutrition and/or dehydration
- Living in squalid or unsanitary conditions
- Neglecting household maintenance
- Hoarding
- Collecting a large number of animals in inappropriate conditions
- Inability or unwillingness to take medication or treat illness or injury

Poor environmental and personal hygiene is not necessarily a result of self-neglect however. It can arise as a result of cognitive impairment, poor eyesight, financial constraints and other factors. In addition, many people, particularly older people, who self-neglect may lack the ability and/or confidence to come forward to ask for help, and may also lack others who can advocate or speak for them. They may then refuse help or support when offered or accept services that do not adequately meet their needs.

5. Mental Capacity

Five Principles

There are 5 key statutory principles outlined in the [Mental Capacity Act 2005](#), which determine responses in cases where there are doubts about capacity.

The key principles in the MCA are:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps have been taken to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.

5. Before the act is done, or the decision is made, regards must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The Act is very clear that mental capacity assessments are time and decision specific and mental capacity should always be assumed. If a professional believes there is a lack of capacity, the burden of proof lies in proving this, on the balance of probabilities, for the specific decision under consideration. This does not mean that capacity should be used to justify non-intervention in difficult cases however, and [post-legislation scrutiny](#) of the Mental Capacity Act has made this explicit:

'The presumption of capacity, in particular, is widely misunderstood by those involved in care. It is sometimes used to support non-intervention or poor care, leaving vulnerable adults exposed to risk of harm. In some cases this is because professionals struggle to understand how to apply the principle in practice. In other cases, the evidence suggests the principle has been deliberately misappropriated to avoid taking responsibility for a vulnerable adult.'

House of Lords, Mental Capacity Act 2005: post-legislative scrutiny, paragraph 105

This guidance and the Adult Risk Management (ARM) framework provide professionals with tools to support them when working with adults who are self-neglecting and not engaging with services. Further information on Capacity Assessment can be found in the Mental Capacity Act: Code of Practice, and in [NCC's Personalisation Core Procedures](#).

Establishing Mental Capacity

The MCA requires a two step test for capacity:

1. Does the person have a temporary or permanent impairment of, or disturbance in, the functioning of their mind or brain?
2. Because of this temporary or permanent incapacity, is the person unable to make a specific decision?

These two steps are known as the diagnostic and functional tests. For the second step the inability to make a decision is further defined by the Act as being composed of four elements, being:

- unable to understand information relating to the decision, **or**
- unable to retain the information **or**
- unable to use the information as part of the process of making the decision, **or**
- unable to communicate the decision.

All four of these elements need to be intact for an individual to be considered as having capacity.

When considering the functional test of capacity it is also useful to think in terms of **decisional capacity** and **executive capacity**. These are outlined in the [SCIE report](#) on self-neglect. Decisional capacity is the ability to understand and use information. This is commonly prioritised in much assessment practice. Executive capacity is the

ability to implement a decision once it has been made. The [MCA Code of Practice](#) is explicit about this:

‘For someone to have capacity, they must have the ability to weigh up information and use it to arrive at a decision. Sometimes people can understand information but an impairment or disturbance stops them using it.’

Mental Capacity Act 2005: Code of Practice, paragraph 4.21

So an individual may understand information and be able to make a decision, but be unable to use that information to implement the decision. The example given in the MCA code is of a person with anorexia nervosa, who may understand the information given to them, but is unable to use it to meet their own nutritional needs. When carrying out a mental capacity assessment practitioners need to be sensitive to the possibility that there are people who have decisional capacity but may be lacking executive capacity. To fully assess an individual’s capacity, the person being assessed will also need to be given all relevant information. This requires complete honesty from the professional carrying out the assessment, and includes sharing the consequences of taking, or not taking actions, and the likelihood of those consequences.

The capacity to make simpler decisions should not automatically be taken as meaning that someone will fully understand more complex decisions.

As mental capacity is time specific professionals need to think about the timing of the mental capacity assessment and any decision making. Where mental capacity may fluctuate, efforts should be made to ensure there is opportunity for the person to make a decision when they have every opportunity to demonstrate mental capacity.

Finally a third precautionary step should be included alongside the diagnostic and functional tests of capacity. This has been called the **causative nexus** in the most recent [MCA learning materials](#). This is to explicitly establish that the inability to make a decision is clearly due to the impairment of the mind or brain. It is important that this is made clear in the assessment. If the inability to make a decision is not due to the impairment, or failure of the diagnostic test, then further advice should be sought. Further information and guidance on the Mental Capacity Act can be found in the [Mental Capacity Act Code of Practice](#).

Where someone is assessed as lacking capacity then a decision will be made in their best interests and the lead agency will chair this meeting and appoint the decision maker. Who the decision maker is will depend on what the decision to be made is. Where the intervention is a medical treatment, then the consultant, doctor or anaesthetist should be the decision maker. Where there are decisions about care and support these can be made by a care manager. Some decisions will also require an Independent Mental Capacity Advocate (IMCA) to be present to advocate on behalf of the person lacking capacity. In urgent cases, where there is evidence that an adult lacks mental capacity (but this has not yet been satisfactorily assessed and concluded), and the home situation requires urgent intervention, the Court of Protection can make an interim order and allow intervention to take place. There may be occasions where professionals don’t have time to request an order from the Court of Protection. So long as professionals can demonstrate that they are acting in the individual’s best interests and their actions are reasonable and proportionate, then a

best interests decision can be made on the spot. These would only be situations where there is good reason to believe an adult lacks capacity, and there is an immediate need to make the best interests decision and this could not reasonably wait. A person who lacks capacity has recourse in law to the Court of Protection which would expect to see evidence of professional decision making and recording having taken place.

Where there are any doubts about mental capacity assessment or best interests decision making and professionals are facing challenges to their decision making, they should seek legal advice.

Unwillingness and inability

Mental capacity assessment must be sensitive to the distinction between being unable to do something and being unwilling to do so. The relationship is dynamic and people's wishes and intentions will change as their ability and confidence in their abilities changes. There may be times when someone claims to be making a decision to not do something, when this decision is being imposed upon them by their incapacity to do anything else. By limiting themselves to what they are able to do, or able to do easily, individuals can retain control of their situation, which is a key element in all cases of self-neglect. Being aware of this, and finding ways of empowering people to make the best decisions they can, and ensuring choices are available and credible, can help in these situations.

6. Assessment

Appropriate assessment and reviewing is at the core of effective working with adults who self-neglect. The responsibility to carry out assessments, where an individual at risk of harm or abuse refuses, can help to empower practitioners in working with self-neglect cases

As in other assessments, where there are other carers a carer's assessment should be carried out where these individuals have care needs of their own. Neglect and self-neglect may sometimes be intertwined, and practitioners should take steps to ensure they are clear what the caring arrangements are.

Robust assessment is especially important in cases of self-neglect where there are often histories of withdrawal from or refusal of services. Carrying out a needs assessment, without the consent of the individual being assessed, will inevitably be difficult and incomplete. Understanding that the assessment must take place, and the reasons for it, may encourage both the practitioner and the individual being assessed to engage in the process. Where this doesn't happen, the practitioner must still document the assessment process, and the decisions taken in terms of eligibility, needs and outcomes. Use of an advocate or appropriate adult should also be used where appropriate.

Practice Guidance

It is important to consider how to engage the person at the very start of the assessment process. If an appointment letter is being sent think carefully what it says. A standard

appointment letter is unlikely to be the beginning of a lasting, trusting professional relationship if it is perceived as being impersonal and authoritative.

Home visits are important and practitioners should not rely on proxy reports. Wherever possible it is important that the practitioner is invited into the person's house to observe for themselves their conditions. Practitioners should discuss with the person any causes for concern over the person's health and wellbeing and obtain the person's views and understanding of their situation and the concerns of others. The assessment should include the person's understanding of the overall cumulative impact of a series of small decisions and actions as well as the impact of each in the short term.

Professional curiosity and appropriate challenge should be embedded within assessments. It is important that when undertaking the assessment the practitioner does not accept the first, potentially superficial, response but interrogates more deeply into how a person understands and might act on their situation. Self-neglect cases are characterised by individuals who will often want minimal intervention or contact with health or care services and their answers may be motivated by this. There are different ways of managing this and Example 2 in Appendix 1 gives one example where a professional who already has a relationship with the adult, is able to discuss and review risks with the adult and manage their situation this way.

Sensitive and comprehensive assessment is important in identifying capabilities and risks. It is important to look further and tease out through a professional relationship the possible significance of personal values, past traumas and social networks. Some research has shown that events such as loss of parents or abuse as a child, traumatic wartime experiences, and struggles with alcoholism have preceded the person self-neglecting. If practitioners are able to 'find the person' rather than focusing on needs and symptoms, this can produce better outcomes for both the practitioner and the adult at risk.

Information can be collected and shared with a variety of sources, including other agencies, to build a picture of the person and their self-neglect and so partners can work together to support the individual and assist them in reducing the impact of their behaviour on their wellbeing and others. Consideration should be given in complex cases, and where there are significant risks, to convening a multi-disciplinary multi-agency meeting to share information and agree an approach to minimising the impact of specific risks and improving the person's wellbeing. Wherever possible the person themselves should be included in the meeting along with significant others and an independent advocate where appropriate.

In potentially complex situations where there is thought to be serious risk to the person's health, wellbeing or environment or to others, practitioners should use the ARM framework to evaluate the risks and where required, to assist in putting together a risk management plan to minimise the impact of the self-neglect. It is vital that there is clear ownership and responsibility where multi-disciplinary working takes place, and this is not diluted during the process.

A case should **not** be closed simply because the person refuses an assessment or refuses to accept a plan to minimise the risks associated with the specific behaviour(s) causing concern.

7. Interventions

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

Efforts should be made to build and maintain supportive relationships through which services, can in time, be negotiated. This involves a person-centred approach that listens to the person's views of their circumstances and seeks informed consent where possible before any intervention. It is important to note that a gradual approach to gaining improvements in a person's health, wellbeing and home conditions is more likely to be successful than an attempt to achieve considerable change immediately. Example 3 in Appendix 1 shows how this may work. Even small steps can be important, and small successes or negotiations can be helpful in building the relationship, and it is important that, wherever possible, change is at a pace the adult is comfortable with. This kind of intervention is much more likely to be effective, as the adult who is being identified as the problem will likely need to be their own solution.

Often concerns around self-neglect are best approached by different services pulling together to find solutions. Co-ordinated actions by housing officers, mental health services, GPs and DNs, social work teams, the police and other public services and family members have led to improved outcomes for individuals. Where specific practitioners, no matter their discipline or background, have a good relationship with the adult at risk, then it makes sense that they lead in working and negotiating with the individual where possible. There may be many reasons why individuals respond to professionals differently and it will not always be possible to change these attitudes in short timeframes. Example 1 in Appendix 1 gives an example of how this may work, where the relationship built up over many years with a GP gives agencies a doorway into the adult's world.

Research supports the value of interventions to support routine daily living tasks. Cleaning interventions alone however, where home conditions are of concern, do not emerge as effective in the longer term. The principal guiding intervention should be to reduce harm, rather than reducing symptoms. Symptoms will often be a kind of coping mechanism, and simply taking away these mechanisms is unlikely to help the individual in the longer term.

As self-neglect is often linked to disability and poor physical functioning, a key area for intervention is assistance with activities of daily living, from preparing and eating food to using toilet facilities. A range of interventions can be used, including adult occupational therapy, tissue viability nurses, domiciliary care, housing and environmental health services and welfare benefit advice.

Where agencies are unable to engage the person and obtain their acceptance to implement services to reduce or remove risks arising from the self-neglect, the reasons for this should be fully recorded and maintained on the person's case record, with a full record of the efforts and actions taken by the agencies to assist the person.

The person, carer or advocate should be fully informed of the services offered and the reasons why the services were not implemented. If a person who has previously refused an assessment changes their mind, then an assessment must be carried out. If there are changes to their circumstances, then a decision must be made as to whether an assessment is necessary due to this change, unless the person still refuses.

Where the risks are high, arrangements should be made for ongoing monitoring and, where appropriate, making proactive contact to ensure that the person's needs, risks and rights are fully considered and to monitor any changes in circumstances.

In cases of animal collecting, the practitioner will need to consider the impact of this behaviour carefully. Where there is a serious impact on either, the adult's health and wellbeing, the animals' welfare, or the health and safety of others, the practitioner should collaborate with the RSPCA and public health officials. Although the reason for animal collecting may be attributable to many reasons, including compensation for a lack of human companionship, considerations have to be given to the welfare of the animals and potential public health hazards.

Where the conditions of the home are such that they appear to pose a serious risk to the adult's health from filthy or verminous premises, or their living conditions are becoming a nuisance to neighbours, affecting their enjoyment of their property, advice from Environmental Health should be sought and joint working should take place.

If as a result of hoarding the practitioner thinks there may be a risk of fire they should seek advice from the local fire service.

In cases of alcoholism, services are typically postponed until the individual is ready to treat their addiction. Again it will be up to practitioners to determine the level of risk and what intervention, if any, would be appropriate.

8. Legal interventions

There will be times when the impact of the self-neglect on the person's health and well-being or their home conditions or neighbours' environmental conditions are of such serious concern that practitioners need to consider what legislative action can be taken to improve the situation when efforts to engage have failed. Such considerations should be taken as a result of a multi-disciplinary, multi-agency intervention plan such as an ARM, with appropriate legal advice. Understanding what legal options are available is helpful in working successfully with self-neglect cases.

Appendix 2 lists the types of legislative action that might be taken.

It is important to note that section 46 of the Care Act 2014 abolishes Local Authorities' power in England to remove a person in need of care under section 47 of the National Assistance Act 1948.

Procedure

9. Overview

Where an adult is engaging with and accepting assessment or support services that are appropriate and sufficient to address their care and support needs (including those needs relating to self-neglect) then the usual adult assessment and support service provision will be the most proportionate and least intrusive way of addressing the self-neglect risk. In these circumstances, the duty and need to undertake enquiries under section 42 of the Care Act may not be triggered or necessary. The procedure can be summarised as follows.

1. Concern is received

New or unallocated cases - Concerns relating to self-neglect will follow the usual local pathways in the first instance (e.g. needs assessment and/or safeguarding).

Allocated cases - Self-neglect concerns relating to cases already allocated to a practitioner should go directly to that practitioner.

Any concern received that indicates the duty to make enquiries under section 42 of the Care Act is triggered should be referred onwards to the relevant team. For new concerns these will be screened by the Customer Service Centre (CSC) and sent onto allocated teams where appropriate.

CSC, and local teams, will consider whether there is “reasonable cause” to suspect the adult is unable to protect themselves from self-neglect, or the risk of it, due to their care and support needs following the Decision Making Framework (DMF) and the supporting threshold guidance. If there is, the duty of enquiry under section 42 of the Care Act is triggered in addition to the duty to assess. If there is not, the needs assessment should continue if this is necessary. A section 42 enquiry can be triggered at any later point in the assessment process if information comes to light that does give “reasonable cause to suspect” the adult is unable to protect themselves from self-neglect, or the risk of it, due to their care and support needs.

There may be cases where the section 42 duty is not met, but a non-statutory enquiry is deemed appropriate. Teams will need to exercise discretion in these cases and can liaise with the central safeguarding team for further advice.

2. Safeguarding Enquiry

If a Care Act section 42 enquiry is triggered in self-neglect cases, or a non-statutory enquiry is triggered, the local team will follow the NSAB Inter-agency Safeguarding procedures which outline the detail of the safeguarding process and actions at each stage. The Making Safeguarding Personal principles will apply as for all safeguarding enquiries.

10. Undertaking assessments despite capacitated refusal

It will always be difficult to carry out an assessment fully where an adult with mental capacity is refusing. Practitioners and managers should record fully all the steps that

have been taken to undertake a needs assessment. This should include recording what steps have been taken to involve the adult and any carer, as required by section 9(5) of the Care Act, and assessing the outcomes that the adult wishes to achieve in day to day life and whether the provision of care and support would contribute to the achievement of those outcomes, as required by section 9(4) of the Care Act.

In light of the adult's on-going refusal or capacitated life-style choices, the result may either be that it has not been possible to undertake an assessment fully or the conclusion of the needs assessment is that the adult refuses to accept the provision of any care and support. However, case recording should be able to demonstrate that all necessary steps have been taken to carry out any needs assessment that are required, reasonable and proportionate in the circumstances.

As part of the assessment process, it should be demonstrated that appropriate information and advice has been made available to the adult, including information and advice on how to access care and support.

In cases where an adult has refused an assessment and services and remains at high risk of serious harm as a result, a section 42 enquiry should be undertaken and an ARM may be implemented.

11. Recording

General principles

It is important to record assessment, decision-making and intervention in detail to demonstrate that a proper process has been followed and that practitioners and managers have acted reasonably and proportionately. There should be an audit trail of what options were considered and why certain actions were or were not taken. At every step and stage in the process record the situation, what you have considered, who you have collaborated with and what decisions have been reached. This may appear a time consuming process, but it puts your activity into a framework of considerations and will encourage sharing with peers and seniors. It will also demonstrate why you have chosen a particular course of action, evidencing your decision making.

Mental capacity assessments

Recording should routinely reflect mental capacity considerations, including recording explicitly where there is no reason to doubt the adult's ability to make their own decisions and why this is. Formal mental capacity assessments need to be recorded fully in line with the Mental Capacity Act Code of Practice.

Appendix 1: Case examples

Example 1

Ms S is a 63 year old woman with mild learning disability. She has always lived with and was cared for by her parents until they both died over the last 5 years. She now lives alone in the former parental home. The house is in disrepair with no windows at the back of the house. The kitchen floor is always wet from the rain. The house is dirty. The house is cluttered with possessions such that it is difficult to walk through the house. Ms S is incontinent, her legs are ulcerated and weeping. Ms S has recently refused to let her sister into her house, but does still allow her GP to come into her house.

The Local Authority received a concern about risk of harm through self-neglect. The GP feels Mr S's capacity to understand the risks may be in question. The local authority decided there is reasonable cause to suspect Mrs S meets the criteria for a section 42 enquiry under the Care Act because there is reasonable cause to suspect that Mrs S has needs for care and support, is at risk of self-neglect, and there is reasonable cause to suspect Ms S is unable to protect herself from self-neglect or the risk of it.

The enquiries agreed were for the GP - as the person who knows Ms S best - to work with Ms S to understand what her views and wishes are about her care and support needs and to encourage her to accept input and assessment from the Local Authority, and for the Local Authority to undertake a needs assessment.

Example 2

Ms T lives alone. She has been diagnosed as having a severe compulsive disorder which manifests itself in hoarding. Ms T experiences high levels of anxiety which impacts on her ability to attend to personal care and eating. There are unopened bags of cooked food that Ms T says she has forgotten to eat. Ms T says she is aware of the risk to her health and environment and has noticed vermin droppings in the kitchen. She says she does not clean her home as it causes her anxiety to move things and throw things away.

Ms T gathers all her letters but doesn't open them. Ms T only goes out to familiar places where there are familiar faces.

The Local Authority received a concern about risk of harm through self-neglect. After checking with mental health services, it was found that Ms T had recently seen a psychiatrist. The psychiatrist was contacted and has a clear view that Ms T has full mental capacity to understand these risks, how her mental disorder affects these risks, and to make decisions about her care and support needs.

Although Ms T has been assessed as currently having the mental capacity to understand the risks to her from her behaviour and that she would be able to protect herself from self-neglect, the Local Authority still has a duty to undertake a needs assessment. The needs assessment was undertaken and Ms T expressed a wish to try to continue to manage her needs herself, as she feels this is the best way for her

to cope with her mental health in the longer term. The Local Authority provided information and advice on support services and how to access these. Outcomes were fed back to the psychiatrist who will continue to monitor Ms T's mental health.

Example 3

Mr M, in his 70s, lives in an upper-floor council flat, and had hoarded over many years; his own possessions, items inherited from his family home, and materials he had collected from skips and building sites in case they came in useful. The material was piled from floor to ceiling in every room, and Mr M lived in a burrow tunnelled through the middle, with no lighting or heating, apart from a gas stove. Finally, after years of hiding in privacy, Mr M had realised that work being carried out on the building would lead to his living conditions being discovered. Mr M himself recounted how hard it had been for him to invite access to his home, how ashamed and scared he was, and how important his hoard was to him, having learnt as a child of the war never to waste anything.

Through working closely together, Mr M, his support worker and experienced contractors have been able gradually to remove from his flat a very large volume of hoarded material and bring improvements to his home environment. It has taken time and patience, courage and faith, and a strong relationship based on trust. The worker has not judged Mr M, and has worked at his pace, positively affirming his progress. Both Mr M and his support worker acknowledge his low self-esteem, and have connected with his doctor and mental health services. The worker has recognised the need to replace what Mr M is giving up, and has encouraged activities that reflect his interests. Mr M has valued the worker's honesty, kindness and sensitivity, his ability to listen, and the respect and reciprocity in their relationship.

Appendix 2: Possible legal interventions

Agency	Legal Power and Action	Circumstances triggering intervention
Environmental Health	Power of entry/ Warrant (s. 287 Public Health Act) Gain entry for examination/execution of necessary work required under Public Health Act. Police attendance required for forced entry.	Non engagement of person. To gain entry for examination/execution of necessary work. (All tenure including Leaseholders/Freeholders)
Environmental Health	Power of entry/ Warrant (s. 239/240 Public Health Act) Environmental Health Officer to apply to Magistrate. Good reasons to force entry will be required (all party evidence gathering). Police attendance required.	Non engagement of person/entry previously denied. To survey and examine. (All tenure including Leaseholders/Freeholders)
Environmental Health	Enforcement Notice (s. 83 PHA 1936) Notice requires person served to comply. Failure to do so can lead to council carrying out requirements, at own expense, though can recover expenses that were reasonably incurred.	Filthy or unwholesome condition of premises (articles requiring cleaning or destruction). Prevention of injury or danger to person served. (All tenure including Leaseholders/Freeholders/Empty properties)
Environmental Health	Litter Clearing Notice (s. 92a Environmental Protection Act 1990) Environmental Health to make an assessment to see if this option is the most suitable.	Where land open to air is defaced by refuse which is detrimental to the amenity of the locality. An example would be where hoarding has spilled over into a garden area.
Police	Power of Entry (s. 17 Police and Criminal Evidence Act) Person inside the property is not responding to outside contact and there is evidence of danger.	Information that someone inside the premises was ill or injured and the police would need to gain entry to save life and limb.
Housing	Anti-Social Behaviour, Crime and Policing Act 2014 A civil injunction can be obtained from the County Court if the court is satisfied that the person against whom the injunction is sought has engaged or threatens to engage in anti-social behaviour, or if the court considers it just and convenient to grant the injunction for the purpose of preventing the person from engaging in anti-social behaviour.	Conduct by the tenant which is capable of causing housing-related nuisance or annoyance to any person. 'Housing-related' means directly or indirectly relating to the housing management function of a housing provider or a local authority.
Animal Welfare agencies such as RSPCA/Local Authority e.g. Environmental Health/DEFRA	Animal Welfare Act 2006 Offences (Improvement notice) Education for owner a preferred initial step. Improvement notice issued and monitored. If not complied can lead to a fine or imprisonment.	Cases of Animal mistreatment/neglect. The Act makes it not only against the law to be cruel to an animal, but that a person must ensure that the welfare of the animals are met.
Mental Health Service	Mental Health Act 1983 s. 135(1) Provides for a police officer to enter a private premises, if need be by force, to search for and, if thought fit, remove a person to a place of safety if certain grounds are met. The police officer must be accompanied by an Approved Mental Health Professional (AMHP) and a doctor.	Evidence must be laid before a magistrate by an AMHP that there is reasonable cause to believe that a person is suffering from a mental disorder, and is being: <ul style="list-style-type: none"> • Ill treated or • Neglected or • Being kept other than under proper control or

	N.B. Place of safety is usually a mental health unit, but can be the Emergency Department of a general hospital, or anywhere willing to act as such.	<ul style="list-style-type: none"> If living alone is unable to care for themselves and that the action is a proportionate response to the risks involved.
All	<p>Mental Capacity Act 2005 A decision can be made about what is in the best interests of a mentally incapacitated person by an appropriate decision-maker under the MCA. It is important to follow the empowering principles of the Act and ensure that any actions taken are the least restrictive option available.</p>	A person who lacks capacity to make decisions about their care and where they should live is refusing intervention and is at high risk of serious harm as a result.
Local Authority	<p>NB Where the decision is that the person needs to be deprived of their liberty in their best interests, a Deprivation of Liberties Safeguards (DoLS) authorisation will be required. In circumstances where a person is objecting to being removed from their home, or to any DoLS authorisation, referral to the Court of Protection may be needed and legal advice should be sought.</p>	

Other legal considerations:

Human Rights Act 1998: Public bodies have a positive obligation under the European Convention on Human Rights (ECHR, incorporated into the Human Rights Act 1998 in the UK) to protect the rights of the individual. In cases of self-neglect, articles 5 (right to liberty and security) and 8 (right to private and family life) of the ECHR are of particular importance.

These are not absolute rights, i.e. they can be overridden in certain circumstances. However, any infringement of these rights must be lawful and proportionate, which means that all interventions undertaken must take these rights into consideration. For example, any removal of a person from their home which does not follow a legal process (e.g. under the Mental Capacity or Mental Health Acts) is unlawful and would be challengeable in the Courts.

Inherent jurisdiction of the High Court: In extreme cases of self-neglect, where a person with capacity is at risk of serious harm or death and refuses all offers of support or interventions or is unduly influenced by someone else, taking the case to the High Court for a decision could be considered. The High Court has powers to intervene in such cases, although the presumption is always to protect the individual's human rights. Legal advice should be sought before taking this option.