Harrow COUNCIL LONDON

& our Partners,

Committed to Safeguarding Adults

London Borough of Harrow

Multi-Agency Protocol

"Working With Difficult to Engage Vulnerable Adults (including chronic hoarders)"

Harrow COUNCIL LONDON

in partnership with:

HAD – Harrow Association of Disabled People

mind For better mental health

Harrow mencap Providing opportunity : promoting change

harrow carers supporting family & friends

Royal National Orthopaedic Hospital NHS Trust

The North West London Hospitals NHS Trust

Central and North West London NHS Foundation Trust

London Ambulance Service NHS Trust

Ealing Hospital NHS Trust

Harrow Community Services NHS Harrow

Harrow age UK

LFB LONDON FIRE BRIGADE

METROPOLITAN POLICE Working together for a safer London

Local Safeguarding Children Board

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Acknowledgment

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1. Introduction

Across Housing and Adult Social Care, there are some people living in the community whose needs fall between the eligibility criteria of the older people, learning disability and mental health community care teams. Quite often these people have complex needs or present with particular behaviours that mean they are difficult to work with. This can often cause difficulties in planning resolutions to their particular situations.

This protocol sets out a framework for housing, adult social care and other relevant agencies to work in partnership using an outcome focused, solution based model. The protocol offers clear guidance to operational staff and managers on how the needs or presenting problems of difficult to engage vulnerable adults should be addressed.

The protocol includes reference to pieces of legislation that may be relevant and helpful in working with this group of people. Details of the legislative framework are covered in Appendix 1.

Self-harm is not included in the pan London safeguarding adults' policy and procedures, as the intention of those is to address situations caused by the actions or inactions of others. This protocol has been developed in that context i.e. where individuals are viewed as harming themselves.

2. Partners to the protocol

- Harrow Council: Housing; Environmental Health and Adult Social Care (including the Safeguarding Adults Service)
- Central and North West London Mental Health Trust
- North West London Hospitals Trust
- Harrow Clinical Commissioning Group
- Ealing Hospitals Trust (Harrow NHS Provider Organisation)

3. Rationale for the protocol

Vulnerable adults who are difficult to work with can have diverse needs that often fall between different agencies and in some cases their problems can be longstanding and recurring.

The work can be very time consuming and stressful for staff, largely because there are no straightforward and proven approaches available to follow.

The effects of the behaviours associated with this group of people e.g. chronic hoarders, can be very problematic and costly to rectify. For example, responding to concerns or complaints raised by neighbours or family/friends; housing repairs; deep cleaning and in some cases bespoke/unusual/innovative solutions.

Research in this area suggests that what works is a multi agency, multi professional and multi disciplinary approach. Therefore this protocol aims to ensure that there is as much coordination with this client group as possible in order to reduce duplication, prevent them being overlooked and wherever possible to get a positive outcome for the client themselves.

It aims to assist managers and staff to make the **best possible decision** in each case with a clear, transparent record as to how it was reached.

4. Aims of the protocol

- to improve the management of difficult to engage vulnerable adults with appropriate outcome focused solution-based support
- to improve the coordination of services between agencies in taking responsibility for the management and support of difficult to engage vulnerable adults
- to raise awareness of the full range of services available
- to establish best practice guidance
- to improve knowledge of the relevant legislation
- for all partners to fully cooperate in the implementation of the protocol

5. Who does the protocol apply to?

This protocol applies to all staff working in Housing, Adult Social Care (including the Safeguarding Adults Service), Environmental Health, the NHS and the partner agencies listed above who have agreed to its guiding principles.

There is an expectation that everyone engages fully in partnership working to achieve the best outcome for the service user whilst satisfying organisational responsibilities and duties.

6. Who are 'difficult to engage' vulnerable adults?

The term 'difficult to engage vulnerable adult' is applied to people who either choose to live in a situation that places themselves or others at risk, or people who have mental capacity but limited cognitive understanding. The individuals presenting problems can be wide ranging. For example:

- vulnerable people who 'hoard' excessively and this impacts on the living environment causing health and safety concerns for them and their neighbours
- signs of serious self-neglect regularly reported by the public or other agencies but no change in circumstances occur. The public /agencies become frustrated
- personal or domestic hygiene that exacerbates a medical condition and could lead to a serious health problem
- the accommodation becomes filthy and verminous causing a health risk or possible eviction
- the vulnerable person has no heating or water and refuses to move to alternative accommodation
- structural problems with the property and the vulnerable person cannot afford repairs or refuses to consider alternative accommodation
- health and safety issues around gas or electricity and the vulnerable individual refuses or cannot afford to get the appliances repaired
- anti-social behaviour that intimidates neighbours and causes social isolation
- the conditions in the property cause a potential risk to people providing support or services e.g. paid carers

NB. This list is not exhaustive and there may be other areas of concern or a mixture of the above that highlight a difficulty for the vulnerable person and those trying to assist them.

In most instances the individual is deemed to have mental capacity, but when presented with the risks or statutory actions that may be taken in response to their presenting issue e.g. chronic hoarding, refuses to engage in solutions to resolve them. The historical risk of a lack of engagement from vulnerable people has been social isolation, verbal abuse, homelessness and a risk to health and wellbeing. Some people are often difficult to engage because of presenting behaviours associated with diagnosed or undiagnosed mental health problems, cognitive impairments or other anti-social behaviours. Unfortunately when there is no clear diagnosis or people refuse treatment they often fall outside of the eligibility criteria of specific service areas.

These situations can often divide professional views into two perspectives - respect for autonomy and self determination, or duty of care and promotion of dignity. A duty of care (to secure dignity), even where mental capacity is present is valued and in some cases prioritised over autonomy. Communities can also be seen has having rights that counter-balance those of individuals.

Research has highlighted some emerging themes about the perspective of the individuals (that self neglect) themselves:

- 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:

- 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

Examples of disorders or cognitive impairments:

- Diogenes syndrome (chronic hoarding)
- Treatable/non-treatable personality disorders
- Aspergers syndrome
- Autism
- Mild learning difficulty
- Substance misuse
- Acquired brain injury
- Alzheimer's disease
- Dementia, including alcohol related dementia

The above list is also not exhaustive and the use of the protocol is designed to be situation based and not diagnosis or behaviour specific.

7. What triggers indicate a multi-agency case conference?

Most agencies have policies or procedures for managing the situations outlined in this protocol. There are also 'duties' laid down in statute for enforcing actions deemed to be in the individual or public interest and these are listed in appendix 1.

Although policies, procedures and statutory powers are useful in providing a framework, they can unfortunately encourage professionals and agencies to work within narrow boundaries. The guidance laid down in this protocol will encourage collective multi-agency working to achieve the best outcome for the individual.
By being outcome focused, the protocol looks at who is best placed to engage with the vulnerable person and how a coordinated multi-agency/multi-disciplinary/multi-professional approach could assist in achieving the best possible result.

Potential triggers for use of this protocol

- repeated problems of a nature outlined on page 4. When an agency's usual way of engaging with a vulnerable person has not worked and a) no other options appear available, or b) enforcement is been considered using statutory powers
- serious concerns for health and wellbeing that require an immediate response
- the individual's presenting behaviour is not understood and there maybe concerns about mental health or mental capacity

The potential situations agencies may be faced with are wide ranging and the examples in the protocol are a guide only. A pragmatic decision on whether to instigate the protocol will need to be made by each agency if a new situation occurs.
If a suggested trigger point is reached, the worker should discuss with their line manager who will advise whether a multi-agency case conference should be convened.

The vulnerable person should be informed by the worker that a meeting will be taking place and why and this communication should be followed up in writing.

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

When the worker and the manager (from any organisation) have agreed that the situation requires a multiagency/multi-professional/multi-disciplinary approach an 'alert' form should be completed and sent via e-mail or post to the respective managers and organisations to instigate an initial multi-agency meeting. If an urgent response is required key people should be invited by telephone.

A Service Manager, equivalent or delegated officer should chair the multi-disciplinary meeting.

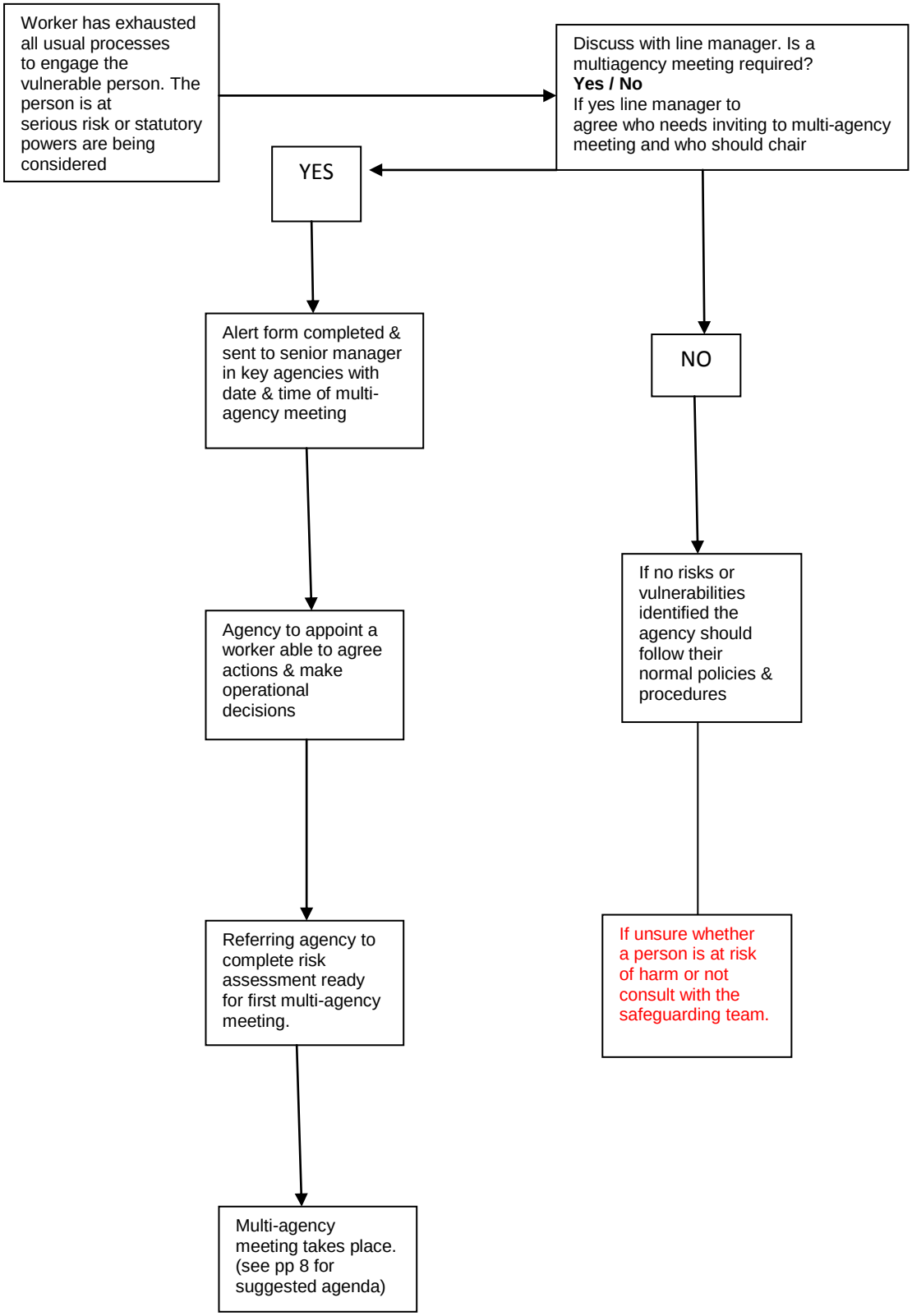
The meeting will aim to arrive at the "**best possible decision**" possible as it is acknowledged that in many circumstances there are no easy solutions. It is important that the meeting is accurately recorded so that the thinking and processes used in reaching the decisions made/action points are clear. Where a key person is identified to take the lead in engaging with the vulnerable person it is important that appropriate support is provided from relevant professionals when needed.

Coordinating information in relation to actions completed and future actions to be carried out in between multi-agency/multi-professional/multi-disciplinary meetings is a key part of the process. Careful thought should be given as to who takes responsibility for coordinating the sharing of information and what means and format is used for sharing information. This should be agreed at the multi-agency meeting.

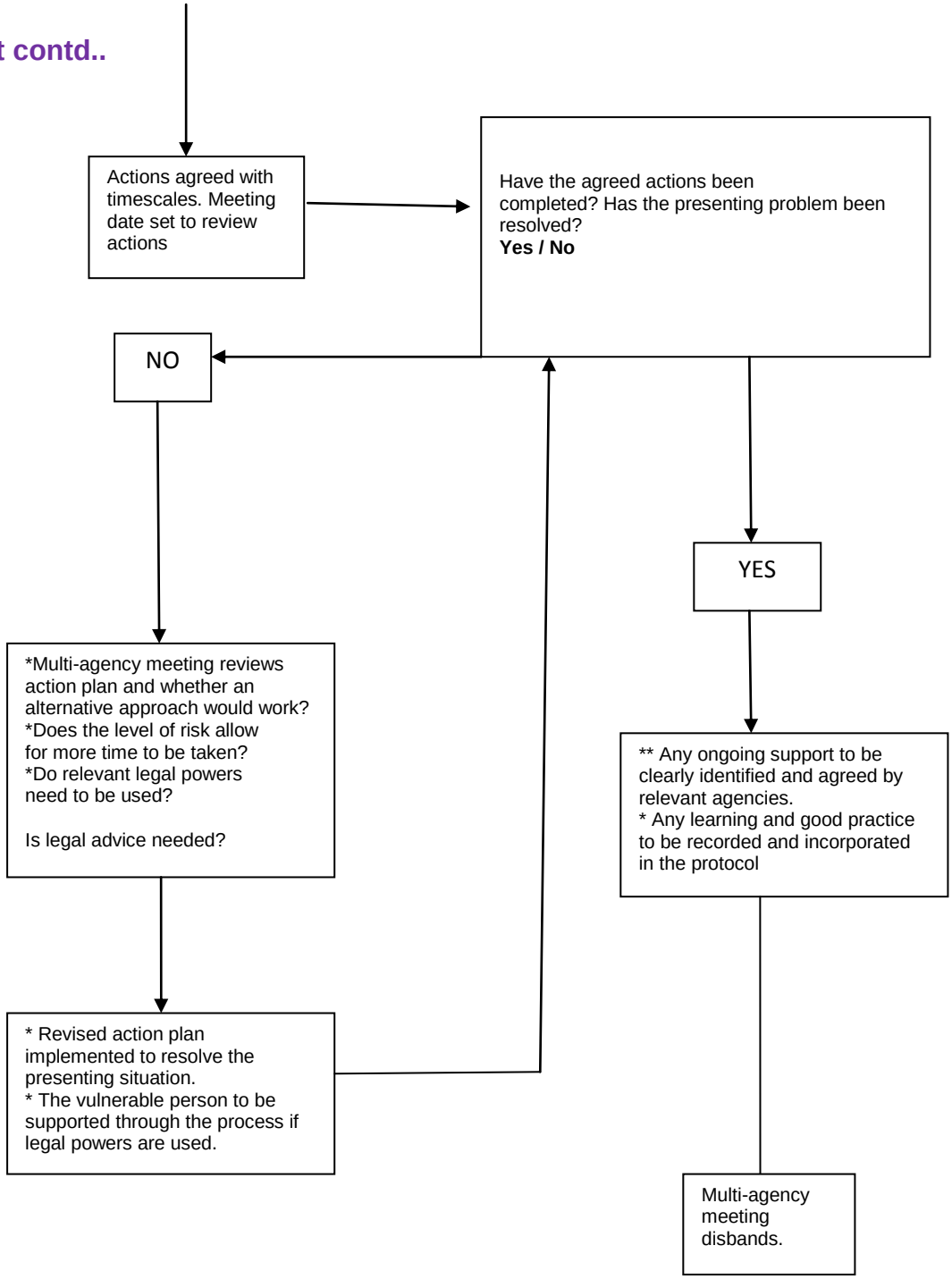
Agenda for the first multiagency/multi-professional/multi-disciplinary meeting

- *Introductions etc*
- *Up to date background information on the person causing concern (including medical advice where available)*
- *Clarification on concerns that have prompted the multi-agency meeting*
- *Results of formal mental capacity assessment (including "executive capacity" i.e. the ability of the individual to implement their decision)*
- *Multi-agency risk assessment completed or instigated*
- *Does the situation come under safeguarding adult's procedures?*
- *Are any children at risk?*
- *Are any animals at risk – do the RSPCA need to be informed?*
- *Identify 'challenges' to agency policy, procedure*
- *Relevant legal / Statutory powers to be identified*
- *Will legal / statutory powers be applied or used as a contingency? (refer to appendix 2)*
- *Information sharing protocol to be agreed*
- *Communication plan agreed*
- *Action plan and named lead officers*
- *Date of next meeting where required*

9. Flow Chart


Worker has exhausted all usual processes to engage the vulnerable person. The person is at serious risk or statutory powers are being considered
Discuss with line manager. Is a multiagency meeting required? Yes / No If yes line manager to agree who needs inviting to multi-agency meeting and who should chair
YES
NO
Alert form completed & sent to senior manager in key agencies with date & time of multi-agency meeting
Agency to appoint a worker able to agree actions & make operational decisions
Referring agency to complete risk assessment ready for first multi-agency meeting.
Multi-agency meeting takes place. (see pp 8 for suggested agenda)
If no risks or vulnerabilities identified the agency should follow their normal policies & procedures
If unsure whether a person is at risk of harm or not consult with the safeguarding team.

Flow Chart contd..



10. Financial considerations

The financial implications of any agreed actions should be kept out of the multiagency/multi-professional/multi-disciplinary case conference. This will allow the operational professionals to focus on the best outcome for the vulnerable adult and not be distracted by discussions around resources. Where possible the case conference will provide a provisional costing of the recommended actions and the relevant service managers or agencies will negotiate who is responsible for funding the actions. Debates and disputes around funding should be resolved outside of the meeting.

If the resource implications are substantial the service manager should escalate to their head of service for a decision before any actions are instigated. The urgency of decision-making will be based on the level of risk that has been identified.

11. Is a debrief required?

Working in a complex and demanding situation can be stressful for operational staff. As part of the final case conference, the staff involved in the work should be asked if a debrief is required. The multiagency/multi-professional/multi-disciplinary meeting will agree what form this should be in, individual, informal, formal etc.

12. Ongoing support for the vulnerable person

Before the multi-agency meeting concludes, any ongoing needs for the individual or their family and carers should be clearly identified and communicated to the relevant agencies. If the agency was not part of the intervention it is suggested that the chair of the meeting takes responsibility for conveying the ongoing needs to the relevant agency.

Appendix 1 Consideration of the statutory options

Possible interventions	Statutory grounds	Supporting factors	Possible consequences
Removal from home	s.47 National Assistance Act 1948 to remove to institutional care for up to 3 months people with grave, chronic conditions who are not receiving proper care and attention Powers of entry under the Environmental Protection Act 1990 and the Public Health Act 1936 to address conditions prejudicial to health		
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 Homeless Persons Act 1977. Eviction may be disputed by reference to the Disability Discrimination Act 1995		

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 in their 'best interests' Ensure "executive capacity" is fully considered		
Any other possible intervention?			

Appendix 2

Legislation

A. 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.

B. 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).

C. 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.

D. 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.

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

E. Environment 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.

F. 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.

G. Public Health (Control of Disease) Act 1984

Section 46 imposes a duty on the Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased.

H. National Assistance Act 1948

Section 47 allows the Local Authority to apply to a magistrate's court for removal of a person to suitable premises for the purpose of securing necessary care and attention if two conditions are met:

- the person is suffering grave chronic disease or is living in unsanitary conditions,

and

- they are unable to look after themselves and are not receiving proper care from others

The person must be given 7 days notice unless a doctor is of the opinion that immediate removal is necessary (National Assistance (Amendment) Act 1951). Detention is for up to 3 months and may be extended for similar periods.
Actions under a section 47 order may have serious consequences for the vulnerable adult and should only be used as a last resort.
Close co-ordination and communication between the Local Authority, the magistrates Court, Social Services, Environmental Health, the Primary Care Trust and secondary care is required to ensure that the implementation of the order, rehabilitation, cleaning the persons residence and subsequent placement are conducted smoothly.

The role of the Proper Officer is fulfilled by the Environmental Health Officers who will work in consultation with the Public Health team.

I. 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.

J. Anti Social Behaviour Orders

Anti social behaviour is defined as where there is persistent conduct which causes or is likely to cause alarm, distress or harassment or an act or situation which is, or has the potential to be, detrimental to the quality of life of a resident or visitor to the area. Questions about whether an application for an Anti Social Behaviour Order would be appropriate should be made to the Police Inspector responsible for Hate Crime and Anti Social Behaviour or the Anti Social Behaviour Officer.
Consider inviting the relevant Neighbourhood Policing Team to participate in multi agency work for individual cases.

K. 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

L. Mental Capacity Act 1995

"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.

M. 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.

Appendix 3

Background information on chronic hoarding

"Hoarding behaviour is defined here as the excessive collection and retention of any materials to the point that it impedes day to day functioning and creates a hazard or potential hazard for the individual……. in older adults it usually represents a complex set of psychological, physical and sociological factors that requires multi-level responses"

General characteristics

- long term behaviour pattern – decades of conscious collecting often following depression
- socially isolated – usually live alone, alienate family/friends, may have large number of animals that also cause problems with neighbours etc
- socially eccentric – not necessarily mentally ill
- mentally competent – often able to make decisions although social isolation can reduce awareness of impact on others
- lacking in self care – appears unkempt/dishevelled clothes
- sees nothing wrong with chosen lifestyle
- inability to differentiate rubbish from valuables
- more common in women than men

Background information on self neglect

(taken from the SCIE research 2011)

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 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 what can be attributed to self-neglect versus underlying illness or disease. Assessment, they suggest, should therefore be multi-agency 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.

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.

iii. risk assessment

It is important for staff to recognise that any 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.

One of the main reasons for the NHS & Community Care Act (1990) and the closure of large institutions was so that people with long term disabilities could have the same opportunities (and therefore take the same risks) as everyone else. User groups fought for many years for these rights. Personal budgets have increased choice and control even further in recent years.

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 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.

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
- 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
- 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.

Ultimately, the local authority has a statutory duty of care and a responsibility not to agree to support a care plan if there are serious concerns that it will not meet an individual's needs or if it places an individual in a dangerous situation.

London Borough of Harrow Appendix 4

Difficult to engage vulnerable adult ALERT form

DETAILS OF PERSON CAUSING CONCERN							
NAME					FWi/User ID		
Address							
DOB		AGE			GENDER		
USER GROUP	Learning Disability				Mental Health		
	Older People				Physical & Sensory		
	Substance Misuse				Other vulnerable people		
ETHNIC ORIGIN	White British		White Irish		Other White		
	White Traveller of Irish Heritage		White Gypsy/Roma				
	Black Caribbean		Black African		Other Black		
	Indian		Pakistani		Bangladeshi		
	Chinese		Other Asian		Mixed White and Black Caribbean		
	Mixed White and Black African		Mixed White and Asian		Mixed White and Chinese		

	Other					
DATE & TIME OF REFERRAL		DATE & TIME ALERT REPORTED				
TENURE	Home Owner			Leasee		
	Council Tenant			Private rented		
	Housing Association Tenant			Temporary Accommodation		
	Other					
SOURCE OF REFERRAL	Neighbour			GP		
	Estate Officer			Floating Support Worker		
	Social Worker/ Community Nurse			Police		
	Other					

DETAILS OF THE PERSON COMPLETING THIS FORM			
NAME	JOB TITLE / PROFESSION	CONTACT DETAILS	DATE
DETAILS OF THE TEAM MANAGER IF OPEN TO A TEAM			
NAME	JOB TITLE / PROFESSION	CONTACT DETAILS	DATE

Brief description of current issues causing concern: