Adults

June 2026

Adult Guidance

Self-Neglect Practice Guidance

Safeguarding Partnership Jersey

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Contents

PART ONE: INTRODUCTION

'Balancing choice, control, independence and wellbeing calls for sensitive and thought through decision making. Dismissing self-neglect as a lifestyle choice is not acceptable in a caring society'. (Kay Murray – The Guardian).

1.1 Self-neglect guidance

This guidance has been developed to support practitioners working across all services in Jersey to recognise the implications of self-neglect and hoarding on the health and wellbeing of people who may be at risk. Within the scope of this guidance, we include the wider considerations of others, such as family members and children who may also be affected.

Services are encouraged to work in partnership with individuals, communities and other organisations to raise awareness of both self-neglect and hoarding by sharing information appropriately, providing advice and tailored support as required.

1.2 The aim of this guidance

This guidance aim is to promote a preventative culture, with the intent of identifying timely and proportionate interventions that respect an individual's right to self-determination, balancing empowerment and the practitioner's duty of care.

Professionals are encouraged to recognise and respond accordingly to people who are experiencing or at risk from self-neglect or hoarding, and for proposed interventions to be person-centred, proportionate, trauma informed and handled with the utmost sensitivity. It is imperative that multiagency responses to self-neglect are effective, and that each agency upholds their own respective duty of care.

Please refer to our 7Minute Briefing on Self-Neglect as a quick guide.

PART TWO: DEFINITIONS AND INDICATORS

2.1 Self-neglect

Self-neglect is the inability (intentional or unintentional) to maintain a socially and culturally accepted standard of self-care, with the potential for serious consequences to the health and wellbeing of the person, and potentially to their community.

In brief self-neglect relates to **three things:** a lack of self-care, and/or a lack of care to the environment **and** a refusal of services (or help).

1. **A lack of self-care** may include neglect of personal hygiene, medical needs, nutrition and hydration, or health, to an extent that may endanger safety or wellbeing.
2. **A lack of care of a person's environment** includes situations that may lead to domestic squalor or elevated levels of risk in the home environment (e.g. health or fire risks caused by disrepair or hoarding).
3. **Refusals** might include access of care services, or health assessments or interventions, even if previously agreed, which could potentially improve self-care or the home environment.

2.2 Indicators of self-neglect

- ✓ **Poor diet and nutrition, leading to weight loss, or associated health issues**
- ✓ **Poor hygiene, unclean attire**
- ✓ **Unmet medical or health needs, (e.g. unmanaged medications, refused treatments|)**
- ✓ **Lack of engagement with health services or other support services**
- ✓ **Refused offers of support**
- ✓ **Refused assessments**
- ✓ **Isolation and disengagement**
- ✓ **Changes in behaviour (e.g. mistrust, not seeing friends/family)**

It is helpful to **separate the issues of self-neglect and hoarding**, as they are often conflated. Self-neglect can relate to a lack of self-care, or lack of care to the person's environment or both. A lack of self-care can impact on the person's health, wellbeing or welfare **without hoarding being evident**.

2.3 Hoarding

Hoarding is the **persistent accumulation** of possessions that results in cluttering living areas, or difficulty in parting with items and causing significant distress or impairment in daily life.

Living in unsafe conditions and having clutter accumulated in a person's home can affect the person's quality of life, their safety and their wellbeing.

Hoarding (unlike collecting) is characterised by impulsive acquisition and a **strong emotional attachment** to items. This can result in difficulties in using living spaces safely (e.g. toilets, bathrooms, kitchens and associated appliances).

In simple term, there are three types of hoarding:

1. **Inanimate objects**: e.g. papers, containers, books, clothing. This is the most common form of hoarding, and most **significant in terms of fire risk.** We have provided a clutter rating tool in this guidance (appendix 2), which can help identify the risks.

2. **Animal hoarding**: e.g. cats/dogs other, this becomes problematic when the animals and/or person are at risk from neglect, from poor care, or insanitary conditions. In such scenarios the JSPCA have a role to play Contact Us – JSPCA to protect the animals concerned, alongside agencies working together to support the adult occupant.

3. **Data hoarding**: includes a need to store data, and to amass equipment such as computers, various devices and paperwork. (This type of hoarding is less likely to require a self-neglect response)

IMPORTANT: Excessive hoards can present a physical danger to the person, and to others who share the same household (‘think family’ and intergenerational risk).

2.4 Indicators of hoarding include:

- ✓ **Excessive accumulation of items, with no space for them to be stored safely**
- ✓ **Difficulty parting with items (irrespective of perceived value)**
- ✓ **Compulsion to save items**
- ✓ **Distress at suggestions to sift, and discard**
- ✓ **Clutter rendering rooms unfit for purpose: e.g. kitchen for cooking etc.**

2.5 Hoarding disorders

Based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a hoarding disorder is characterised by a persistent difficulty discarding possessions, which results in a significant accumulation of items that clutters and compromises the use of living areas. The condition became a distinct diagnosis in 2013 with the publication of the DSM-5, having previously been considered a symptom of obsessive-compulsive personality disorder.

According to the DSM-5, a diagnosis of hoarding disorder involves a persistent difficulty discarding or parting with possessions regardless of their value, leading to clutter that compromises the use of living spaces, unless cleared by others. This behaviour causes significant distress or

impairment, such as maintaining a safe environment, and is not attributable to another medical or mental condition.

Problematic hoarding can affect people of **any age, sex or socio-economic group**. As such, people affected by hoarding can often live alone and live isolated lives, however, some have children or partners, and as such these people can be significantly impacted.

For more details about hoarding, please see links: About Hoarding | HoardingUK; Hoarding disorder - NHS

2.6 Risks associated with self-neglect & hoarding include:

- Health and nutritional risks.
- Medical problems (from poorly managed medications or non-compliance).
- Unsanitary home, attraction of vermin, infection.
- Loss of tenure.
- Environmental risk to others. (Public safety).
- Disrepair.
- Structural damage.
- Anti-social targeting or exploitation.
- Loneliness and isolation.
- Serious illness, injury or death.
- Fire spread, smoke inhalation.
- Intergenerational risks.

Please refer to our 7Minute Briefing on Hoarding as a quick guide.

PART THREE: UNDERSTANDING THE PERSON

Self-neglect involves the complex interplay of physical, social, psychological, personal and environmental factors, **all of which must be explored** to understand the meaning of self-neglect in the context of the person's individual experience. This meaning will assist professionals to both recognise and address the root causes of the person's difficulties. The underlying causes of a person's self-neglect may be attributable to the following areas:

- **Physical health issues;** pain, impaired functioning, nutritional deficits
- **Mental health issues;** depression, psychotic disorders, impaired cognition, dementia
- **Substance misuse;** alcohol, drugs

- **Psychosocial factors;** trauma, life histories, diminished social network, loss, economic restrictions

A lack of care for one's environment or personal hygiene *may not* always be attributable to self-neglect. The person may have developed difficulties with their eyesight, balance, or physical health or mobility. It may be that the person is experiencing a cognitive decline, or financial hardship.

Braye et al 2014 Self-neglect and adult safeguarding: findings from research identified 5 overarching themes in their self-neglect research;

1. Demotivation stemming from other factors.

2. Other priorities.

3. Different standards.

4. Maintaining self-care

5. Uncertainty about reasons and inability to self-care.

'Often the reasons for self-neglect are complex, multiple and varied. It is important that we pay attention to mental, physical, social and environmental factors that may be affecting the situation' (Braye et al 2014).

Homelessness, health difficulties, loss and social isolation are repeated themes. There needs to be distinction between **unwillingness** and an **inability** to care for oneself. **Capacity** to understand the consequences of a person's action (and inactions) are crucial in determining the right response.

Executive dysfunction – the inability to perform essential activities, even though the need for them is understood is seen (from this research) as significant when accompanied by an inability to recognise unsafe living conditions. Self-neglect may often be the result.

By engaging, working alongside and continuously assessing the needs of the person it may be identified that the person's presenting self-neglect derives from their previously unidentified or unmet needs. We need to take care when labelling someone as self-neglecting or as a hoarder, as this can be unhelpful, and be a barrier to positive relationship building.

PART FOUR: AREAS FOR PRACTITIONER'S CONSIDERATION

4.1 Chronic disorganisation

What can sometimes appear to be a hoard, may in fact be attributable to the person's **inability** to organise their homes and affairs. Hoarding behaviour is positively driven by the person's desire to acquire and accumulate items. Whereas **chronic disorganisation differs**, in that there is no emotional attachment to the collected items, and the person would invariably like to live with more order, but lacks the organisational skills, or motivation to achieve this alone.

Chronic disorganisation may lead to clutter in the home, car or office (as picture below). Chronic disorganisation has a strong link to ADHD, dementia, or uncontrolled pain management.

People affected by chronic disorganisation, often:

- **Will be running late, or behind schedule.**
- **Have clutter, papers, boxes, bags stacked in their home, office, car, and garage.**
- **Try to organise, but fail to achieve this.**
- **Are unable to focus on long term planning, due to inability to deal with issues in the present.**

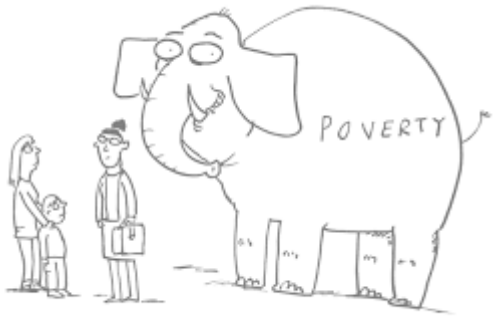
The clutter rating scale in Appendix 2. of this guidance will help practitioners view the severity of someone's chronic disorganisation, or their hoarding risk.

4.2 Poverty

Poverty and self-neglect can be significantly intertwined, with financial hardship increasing the risk to individuals who are struggling to meet their basic needs. These needs could relate to food intake, nutrition, heating, accessing health care – including medications.

Whilst capacity and personal choice are factors for additional consideration in self-neglect cases, it should not be assumed that the person can afford to prioritise essential services, or repair work to their accommodation. Practitioners should routinely consider maximising a person's income and ensure they have up to date advice on their right to access benefits and local grants.

'Poverty – the elephant in the room - Harry Venning'



"People are relatively deprived if they cannot obtain, at all, or sufficiently, the conditions of life – that is, the diets, amenities, standards and services which allow them to play the roles, participate in the relationships and follow the customary behaviour which is expected of them by virtue of their membership of society. If they lack or are denied the incomes, or more exactly the resources... to obtain access to these conditions of life they can be defined to ***be in poverty****".* (Townsend P – Poverty in the UK)

See: BASW Anti-Poverty Guide

4.3 What Serious Case Reviews (SCR's) tell us about self-neglect

Complexity and Interconnectivity: Self-neglect often features a complex interplay between physical, mental, psychological, and social factors. SCRs frequently identify links with prior **trauma**, loss, substance misuse, or domestic abuse, where self-neglect may serve as a coping mechanism.

'Capacity' Challenges: A recurring finding in SCRs is the failure to properly assess a person's capacity, particularly **executive functioning** (the ability to carry out a decision in practice, even if

the person can verbally describe what they should do). Professionals often incorrectly assume "lifestyle choice" or "unwise decision" without deeper investigation.

Importance of Relationships: SCRs consistently emphasise that effective intervention relies on building long-term, trusting relationships rather than short-term case management. Persistence, 'finding the person', 'taking time to build rapport, and trust' as vital but time-consuming practices.

Multi-Agency Coordination: Failures often occur due to poor information sharing and a lack of joint risk management between different agencies (e.g., housing, health, and social service depts). SCR's advocate for strong multiagency cooperation, and to flexible and imaginative solution finding. SCR's have frequently identified that **failings in multi-agency co-ordination** have contributed to negative outcomes for the adult's concerned.

Organisational Support: Because self-neglect work can be emotionally demanding and high-risk, SCRs stress the necessity of robust **supervision** and management oversight to support practitioners.

Common Barriers: SCRs identify that individuals who self-neglect often refuse services (found in roughly 76% of analysed cases) and may live in squalid conditions that pose fire or public health risks. They often lack a social network or advocate to speak for them.

Professional Curiosity: Reviews highlight a need for "professional curiosity"—proactively questioning the status quo rather than taking things at face value. This includes exploring the reasons behind the self-neglect and not accepting superficial refusals of help. (see 4.4: Applying Professional curiosity).

Serious Case Reviews both locally and nationally outline the importance of:

- Early and ongoing information sharing.
- Ongoing need for multiagency working and collaboration.
- Robust face-to-face assessment and home visits.
- Regularised reviews.
- Legal literacy and the careful application of the capacity and self-determination legislation.
- Assessment of needs of the person, their informal carers and risks to significant others (e.g. family members, children, affected neighbours).
- The use of professional supervision.
- Robust guidance and training for staff.
- Escalation routes for casework that is deemed high risk or where workers are stuck.

See team around the person, single agency and multiagency approaches via link.
https://www.proceduresonline.com/jersey/adults/files/agency_approaches.pdf

4.4 Applying professional curiosity

'Professional curiosity is key to safeguarding' (Laming report)

Professional curiosity is particularly relevant when working with someone you suspect is at risk from self-neglect. The term is used to describe an in-depth interest in the adults you are working with by exploring and understanding what is happening, or may be happening in their lives, rather than making assumptions or accepting things at face value.

A person who is at risk from self-neglect may not want others to know what they are experiencing. People may struggle to share information or acknowledge they are unable to fully manage their needs, due to shame or stigma. Practicing professional curiosity helps to prevent abuse and neglect from happening or worsening.

See chapter from our multi-agency guidance: professional_curiosity.pdf

4.5 Children and other occupants

There must be full consideration of whether there are other people at risk because of an individual's self-neglect. This includes any children, or adults with care and support needs and informal carers.

If the adult (parent) is neglecting themselves, it is a strong possibility that their child and the needs of others will also be neglected.

Children and young people can assume adult responsibilities. Such as trying to manage the home situation, or risks to their siblings or parents – and often take on 'carer' responsibilities.

Children affected by hoarding often experience isolation, feel embarrassed, shame and being devalued – this can lead to social stigma, and psychological distress. A child living in a full home, may have little space for self-expression, room to play, room to dance, or a safe space to invite friends. The child's education may be impacted, and homework will likely be severely impacted.

A child living in a state of anxiety and shame can experience lasting trauma throughout their lives. For many people hoarding behaviours begin in childhood, and for children growing up in hoarded homes this likelihood is significantly greater.

As well as thinking about a child's safety from fire, or accidents it is these more **hidden harms** that affects the **emotional wellbeing** of the child, and lead to poorer outcomes for their futures.

We can apply this same lens to other adults who share accommodation in a hoarded home.

Adult and children's safeguarding services must work together to ensure the needs of all occupants are being communicated and addressed.

Additional reading

Children of Parents with Mental Illness (Parenting Capacity)

Respecting and Capturing The Voice of the Child

How HD Affects Families - Hoarding with video link

4.6 Trauma informed practice

Trauma can influence the way a person relates to their situation and to others. Without the right support, trauma can have enduring negative effects on a person's physical and mental health, as well as their wellbeing and life's outcomes. It is important to understand that people react to trauma in different ways, and that the effects of trauma are personal and individualised.

Taking a purely risk-based approach or an authoritarian enforcement angle, is unlikely to yield a positive and trusting relationship. Similarly, a care management approach and onward referral process may fail to understand and address what trauma has happened in a person's life – that leads them to struggle to self-care. Trauma has been shown to impact on a person's inability to

cope, their sense of safety, ability to self-regulate, sense of self, perception of control and interpersonal relationships.

Six principles of trauma informed practice:

1. Safety
2. Trustworthiness
3. Choice
4. Collaboration
5. Empowerment
6. Cultural considerations

Substance use, mental ill health, homelessness, self-harm, domestic abuse, or being in the criminal justice system may all contribute to trauma experienced by an individual.

For a person who has experienced trauma, a lack of supportive relationships can result in emotional and learning difficulties, engagement in health-harming behaviour, experience of ill health, disrupted nervous, hormonal, and immune systems, being involved in violence, or a victim or survivor of violence.

Experience of trauma can manifest in many ways, including angry outbursts, distrust, anxiety, poor impulse control, hypervigilance, feelings of guilt and shame or perceived hostility in others.

Chronic trauma can lead to chemical and structural changes in the brain, affecting the regulation of emotions, and stress. After experiencing trauma (or harm) a person's brain learns to see the world as a dangerous place, which may result in avoidance, or perceiving threats or imagining worst-case scenarios. This can make connecting with others more difficult, especially figures of authority. Trauma can cause the brain to remain in a state of hypervigilance, suppressing memory and impulse control, and trapping the person in a constant state of emotional reactivity.

Trauma informed practice for self-neglect involves building trusting relationships, working at the person's pace, and making decisions collaboratively to restore a sense of control. This often requires longer term engagement, rather than focusing on finding short term solutions.

See link Working definition of trauma-informed practice - GOV.UK

Read: Making trauma-informed practice a reality | Research in Practice

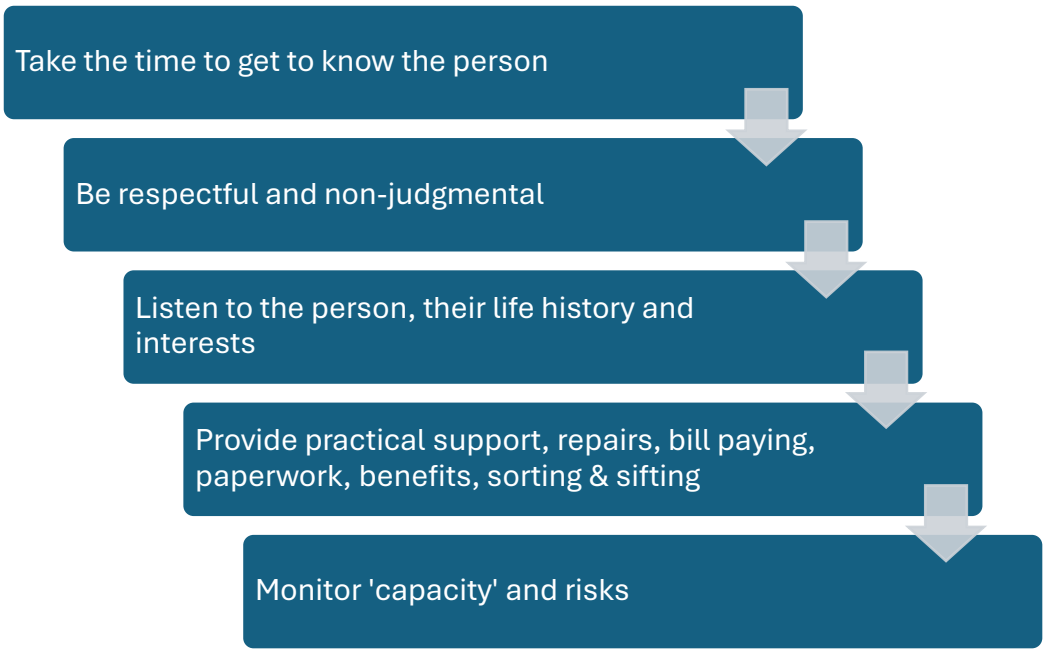
PART FIVE: WHAT WORKS? A LOOK TOWARDS FINDING SOLUTIONS

5.1 Building rapport

Blitz cleaning, or sudden, forced removal of items is highly discouraged, as it can cause profound trauma, anxiety and erosion of trust. Implementing gradual, person-centred, compassionate care and support is crucial when working with people at risk of self-neglect and hoarding.

There is no tried and tested way of resolving self-neglect matters, and invariably there's no quick win. Whilst professionals may look at promoting services, highlighting and sharing risks; the essence of solutions invariably lie **in building a trusting relationship** and getting to know and understand the person. It is important to explore with the person their history; **listen** to the way they talk about their life, difficulties and strategies for self-protection.

The following graphics help define steps that could be taken to build rapport.

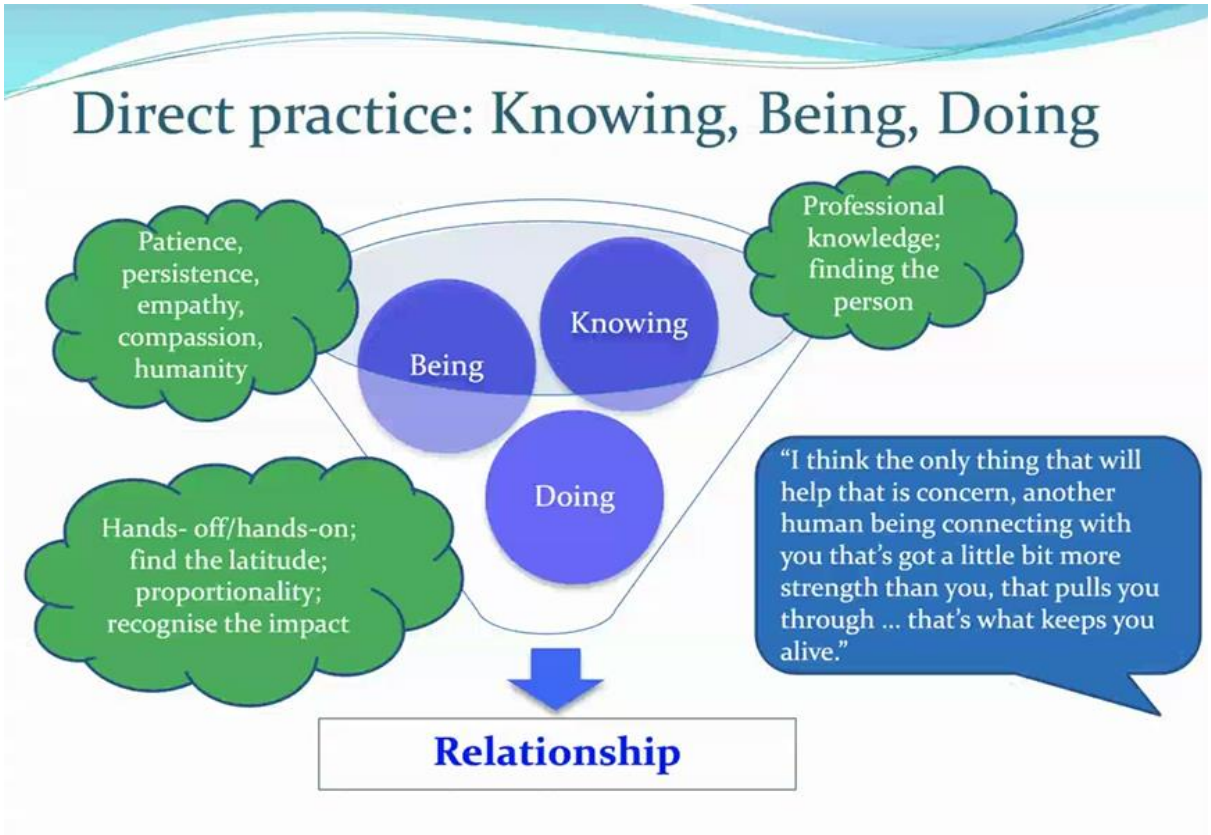


Engage person's family and social supports (with consent)	Be honest with the person, about your concerns and what you can offer, scenario plan - consequences	Facilitate any appointments, (e.g. GP, benefits,
Attempt to reduce harm: e.g. fire risk, unhealthy substance misuse	Seek person's agreements thoughout and record with care in-line with your agency's standards	Be reliable, follow up on agreements and keep the person informed as you go

5.2 Knowing, being, doing

Research has shown an effective way of working with adults who self-neglect combines aspects of **knowing, being and doing.**

- **Knowing:** This relates to professional knowledge and understanding of self-neglect, including recognising its signs and causes, such as mental or physical illness affecting a person's abilities or motivation. It involves "finding the person" and understanding their situation and needs.
- **Being:** This encompasses the qualities a practitioner brings to the relationship, such as patience, persistence, empathy, compassion, and humanity. These qualities are crucial for building trust and rapport with individuals experiencing self-neglect, which is often rooted in complex psychological and social factors.
- **Doing:** This refers to the actions taken in practice, which can be "hands-off" or "hands-on." It involves finding appropriate interventions, recognising the impact of self-neglect, and working towards positive change. *Research in Practice* working_with_people_who_self-neglect_pt_web.pdf



When you enter a person's home and are met with signs of hoarding, animal excreta or strong odours – you are likely to visibly demonstrate a reaction to what you experience. By being prepared for what you may encounter and rehearsing maintaining a neutral expression, this is more likely to foster a positive first impression with the person at risk.

5.3 Harm reduction

People who self-neglect may resist traditional services, so professionals may need creative approaches to reduce risk. For example, someone mistrustful of health services might engage better with other agencies, which can act as a vital link to support wellbeing and encourage engagement. MDT's and safeguarding planning meetings should be collaborative spaces for creative problem-solving, not just task allocation. Individually tailored solutions usually achieve the best outcomes. This involves understanding and recognising the limitations of what is possible, with practitioners needing to **focus on reducing harm** in the first instance rather than achieving the ideal outcome

Harm reduction is grounded in justice and human rights, in that it focuses on working with people **without judgement** or discrimination. The model aims to **minimise** negative impacts of risk, rather than look to eradicate all risk. This has echoes of Making Safeguarding Personal, whereby we work alongside the individual in a facilitative way, supporting their wishes where appropriate, but using our professional skills in offering both practical and emotional help, and in being honest where we see risk/difficulties. This model of working is based upon methods successfully employed in the drug and alcohol field; however, this approach is supported in practice for cases relating to hoarding particularly.

The approach advocates for incremental changes, rather than quick wins, or enforced actions. Furthermore, '*harm reduction interventions are inexpensive and easy to implement and have a strong positive impact on individual and community health*'. *(Harm Reduction International)*.

Remember - our aim is to reduce the negative risks and impact of self-neglect and hoarding, we are not looking for perfection, or sterile homes.

5.4: Engaging family, friends and community support

With the person's consent, trying to engage the person's own network of support can provide a level of both support and challenge to the person, which may have a positive impact on their choices. Such informal supports can also be helpful around organising, sifting /sorting, bill paying, shopping, cleaning, gardening etc.

If working in a person's best interest (because they lack capacity) then gaining the views and supports of relevant others should be part of the decision-making process.

PART SIX: RISK – AND RAISING CONCERNS

6.1 All agencies responsibility

For **ALL** cases all agencies should:

- Make attempts to reduce immediate risks.
- Build rapport through positive engagement (rather than overreliance on assessments and risk mitigation).
- Assess and monitor capacity (to establish if needing to work alongside or in the *Best Interests* of the person).
- Listen to the person – and be professionally curious.
- Work at the person's pace.
- Strengthen engagement to build trust.
- Foster relationship building as a priority.
- Be genuine and provide continuity.
- Be flexible, persistent and use a trauma informed approach.
- Be reliable – follow through on what you say you'll do (e.g. I'll be back to see you tomorrow, or let's meet for coffee at café XYZ).
- Don't be alarmist or use language that could act as an unhelpful barrier (e.g. threats, eviction, dirt, filthy, verminous, infestation).
- Share concerns with your own organisational safeguarding lead.
- Record all concerns and actions.
- Raise a concern following matrix below (where appropriate, e.g. **orange, red** or professional judgement)

6.2 Risk assessment table:

Non reportable (low risk)	**Requires consultation (medium risk)**	**Reportable (high risk)**
engage person advice and information, signposting assessment or review of needs	care needs assessment multi-agency meeting to discuss and share concern consider team around the person	raise safeguarding concern (adult/child/both) multiagency meeting to decide upon actions legal advice where required

6.3 Basis for risk assessment – judgment

Low risk non-reportable	Requires consultation – medium risk	Reportable – high risk
The adult is accepting of care and support services	Access to services is limited	Refusing to engage with necessary services
Health needs are being addressed	Sporadic attendance to health needs or medical appointments	Poor personal hygiene and marked health deterioration
Person is willing to access services to improve safety/wellbeing	Person is of low weight	Isolated from family, friends and support network
Carers are present	Wellbeing is at risk	Care offers repeatedly refused or access prevented
Person can access community and social activity	Limited social interactions	Not managing activities of daily living
Hygiene needs can be met with support or prompts	Personal hygiene at risk of deterioration	Poor hygiene affecting skin integrity
Person can contribute to daily living activities with support	Activities of daily living are affected	Severe weight loss/gain
Property neglected, but home is functional	Signs of disengagement are emerging	Significant disrepair
There is a low risk to the person or other occupants	Lack of food, hydration	Significant risk to person or other occupants
Low level evidence of hoarding	property neglected, and is becoming dysfunctional	Child(ren) in premises
Person is contemplating advice	There is a medium risk to occupants, and potential risk to others direct neighbours	Malnourishment in evidence
	Animal neglect is suspected	High level of clutter (see clutter rating scale)
	Person's insight is in question	

At all levels of risk assessment, practitioners should seek advice and guidance within their own organisations, access supervision as appropriate, and consider risk escalation. Also, all are encouraged to think of other occupants within the household, or premises e.g. children, adults with care and support needs, informal carers, or other occupants in shared accommodation who may be at risk of fire spread, or health risks.

6.4 The importance of risk assessment and multiagency working

Risk is part of everyday life, so safeguarding principles should promote empowerment, proportionality, and prevention. A thorough risk assessment requires conversations with the adult and professionals to understand risks and their impact. Risk assessment is ongoing throughout safeguarding processes and must be recorded according to each agency's procedures. Self-neglect concerns are often complex and may need multi-agency collaboration.

To ensure effective multi-agency working, please consider the following:

- Is there appropriate involvement from all professionals, agencies & networks that could contribute to the adult's care and support?
- Are all involved parties clear on their own, and each other's, roles and responsibilities?
- Is there an identified lead professional – who has a clear coordinating role?
- Are communication and information sharing appropriately effective, and done so in a timely way?

6.5 Early coordination

Early, coordinated multi-agency interventions with the adult can prevent issues from escalating and reduce the need for intrusive statutory actions. Where an adult engages with appropriate support services, usual assessment and provision remain the most proportionate way to address self-neglect risks. Agencies should work collaboratively in the client's best interest, and some may need to hold cases where engagement shows positive progress. Initial low-level support can be built upon over time—our aim is not perfection, but good enough to ensure safety and wellbeing. No agency should unilaterally withdraw support for an adult at risk, and all agencies are accountable for working collaboratively in the spirit of Jesey Partnership.

6.6 Assessment of needs

If there are concerns about an adult who may need care and support and is at risk of self-neglect, refer them for assessment via SPOR/Adult MASH. If the person already has a care coordinator, share concerns directly with them. The coordinator should keep the referrer informed and may seek management advice, consult adult safeguarding, or raise a safeguarding concern if necessary.

6.7 Safeguarding responses

If a needs assessment has been offered and either the assessment or the proposed care provision has been **exhaustively declined** *and* it is considered that the adult remains at a high risk of harm, then the concerns may be considered under adult safeguarding procedures.

Safeguarding should be considered as an option where a person who is self-neglecting is repeatedly refusing support that has been offered to them and remains at **high risk of harm** to themselves or of presenting harm to others.

Safeguarding is not however a magic wand that will alleviate all risks – or take on the burden of concerns of all agencies. **Multiagency safeguarding requires ongoing cooperation** and tenacity in building a circle of support for people most at risk.

What safeguarding can achieve is in bringing services together to create a team around the person under an overarching framework and **hold agencies to account** for providing ongoing support and follow-up. This can help counteract any unhelpful silo working. However, multidisciplinary working is encouraged outside of safeguarding responses, as well as within and the team around the person approach can be equally effective – providing a lead agency is identified.

Where the self-neglect or hoarding behaviour poses a **risk to a child** then a referral to the Children and Family Hub is required and **MUST** be made, alongside a referral to adult safeguarding.

Decision-making as to whether actions are needed under adult safeguarding procedures will be based on the following threshold definition:

a) ***The adult has needs for care and support (whether these are being met by formal services or not).***

b) ***The adult is experiencing, or at risk of abuse, neglect (including self-neglect).***

c) ***As a result of the adult's care and support needs the adult is unable to protect themselves from the risk of abuse or the experience of abuse or neglect. (includes self-neglect)***

Regarding C) above, if a person has capacity and refuses to pay for services, this may not be a failure to protect themselves from the risk of abuse and neglect. The focus should be on whether the person is making the decision freely and is not subject to pressure or coercion from another

person. In such cases, even those with capacity cannot protect themselves, given their inability to make a free choice.

If the person at risk of self-neglect is also an **informal carer** for an adult in need of care and support - this is a matter for adult safeguarding.

Sometimes there will be a lack of surety as to whether to raise a concern or not. All referrals should be made based upon the professional judgment of the referrer.

Information gathering will take place to identify which of the relevant agencies know the adult or could have information to share as part of the decision-making process for agreeing next steps.

6.8 Mental health responses

If there are concerns that the individual has unmet mental health needs (and they are not under a care coordinator), there should be initial engagement with the person's GP to determine if those needs can be met by the GP. If the mental health needs are greater than the support the GP can provide, they can make a referral to the Mental Health and Crisis Team.

PART SEVEN: RISK – SELF-NEGLECT IN THE CONTEXT OF JERSEY'S CAPACITY LAW

7.1 Notes to reader

Please note this section relates to cases of self-neglect and should be read alongside the CSDL Capacity and Self-Determination (Jersey) Law 2016 and Code of Practice ID Capacity and Self Determination (Jersey) 2016 - Code of Practice.pdf . This chapter is not meant to be a reworking of the CSDL or its meaning in any sense.

Please also see our chapter on **Adult Safeguarding and the Law** safeguarding_and_law.pdf from our multiagency procedures.

7.2 A rights-based approach

Adults have the general right to live their life as they choose, and to take risks in accordance with their wishes. All agencies must bear in mind these fundamental rights when considering intervening in someone's life, even if they are at risk from self-neglect.

Adults have the right to choice and control – and as a general principle no action should be taken for or on behalf of an adult without obtaining their consent. **Consent is an enduring process**, not a single event, and consent should be revisited with appropriate regularity, bearing in mind that people need time to reflect on decisions that may affect them.

If someone with capacity says you cannot share their personal information, you can still raise a safeguarding alert if you consider the person is at serious risk of abuse or neglect, the person is being threatened or coerced into not giving consent and a serious crime has been committed or is being planned. You should escalate any concerns to line managers/ DSL/MDT where a person with capacity refuses to allow you to share confidential information with other agencies given the presumption that their wishes should be respected. You may wish to obtain legal advice as to the extent of the information which can be shared.

There may be other occasions where an adult safeguarding referral about self-neglect should be made, such as when there is a concern that people or organisations who ought to have supported the person have failed to, or where someone is blocking the person from getting the support they need. Each case needs careful consideration and risk appraisal, and a blanket interpretation of this guidance should be avoided.

7.3 Purpose of capacity assessments

Robust capacity assessments are vital in determining the approach to be taken by professionals when working with someone who is at risk from self-neglect.

If working with a person who has capacity to make decisions about their care and support – then we are **working alongside** the person to support the person's decision making.

If working with a person who lacks capacity to make decisions about their care and supports, then we need to be demonstrably working in the person's **best interests**.

The undertaking of a capacity assessment is to determine the **approach required** to assist the individual at risk. Should the person, after the assessment be deemed to have capacity, this is not the end of the matter, and **cases should not be closed merely because of 'capacity'** being established. If risks persist then ongoing relationship-based interventions need to be attempted and revisited.

7.4 When should capacity assessments be completed?

Recording should routinely reflect capacity considerations, including explicitly recording where there is no reason to doubt the person's ability to make their own decisions, and why.

It is important to carry out a formal assessment when a person's 'capacity' is in doubt. For example:

- The person's behaviour or circumstances causes doubt as to whether they have capacity to make a decision.
- Someone else has indicated they are concerned about the person's capacity, OR
- The person has previously been diagnosed with an impairment or disturbance which affects the way their mind or brain works and it has already been shown that they lack capacity to make other decisions in their life.

Capacity assessments are likely to focus on the following points in cases relating to self-neglect:

1. The nature of the person's self-neglect, e.g. relating to a lack of self-care, lack of care for the person's environment, or both
2. The reasonably foreseeable consequences of the person's self-neglect:

    - e.g. for the person this may be risk of infection, pressure damage, malnutrition/dehydration, deteriorating health conditions, risk of hospitalisation
    - for the environment, risk of fire, risk to neighbours, risk of falls, risk of enforcement action, risk of disrepair, devaluation of property, increasing costs
    - the proposed interventions that may reduce risks of harm, such as home care, safety devices, negotiated cleaning, sifting & sorting etc.

7.5 Executive functioning

Executive dysfunction may be evident when a person gives coherent answers to questions, but it is clear from their actions that they are **unable** to carry into effect the intentions expressed in those answers. It may also be that there is evidence that the person cannot recall relevant information at the point when they might need to implement a decision that they have considered in the abstract.

This will be relevant to assessments of capacity as it raises the question as to whether someone can 'understand' and 'use or weigh relevant information' in the moment when a decision needs to be enacted.

Assessments of capacity may need to be supplemented by observation of the person's functioning and decision-making ability to provide a complete picture of an individual's decision-making ability. It can also be helpful to not only ask the person to articulate what they would do, but to demonstrate how they would do something in practice. ***Show me, instead of telling me.***

Where a person is unable to carry out their expressed intentions, a key question in the capacity assessment is whether the person is aware of their own deficits – in other words, whether they are able to use and weigh (or understand) the fact that that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete situations.

"Executive functioning is an umbrella term used to identify a wide range of cognitive functions commonly thought to be situated in the frontal lobes of the brain. This includes, for example: insight, attention, planning, organisation, initiation, generating ideas, inhibition, control of behaviours and emotions, problem-solving, evaluation, judgment and decision-making skills.

If these executive functions do not develop normally, or are damaged by brain injury or illness, this can cause something called 'executive dysfunction'. Cognitive impairments associated with executive dysfunction can cause significant challenges for the person, but also for individuals offering that person support, as they are typically more subtle than other impairments and so can be hard to evidence.

As someone with executive dysfunction will not have all of the myriad of difficulties noted above, this means that a person might have good insight or awareness into a particular problem that you are talking about and plan in conversation around it – but might not be able to organise themselves to initiate this plan or control their behaviour in the moment.

If the person has good language skills and can talk around the issue competently, then without a performative aspect to the capacity assessment, we might wrongly assume that the person has capacity when they cannot in reality 'walk the walk.' Community Care 28/10/20" When mental capacity assessments must delve beneath what people say to what they do - Community Care

Self-neglect can be a complex area, and practitioners should seek advice from their lead practitioners, and legal advisers as and when required.

Where there is a significant dispute between what professionals consider to be in a person's best interest to those views held by family members or Lasting Powers of Attorney/Delegates – legal advice could be obtained as the matter may require a Royal Court application, if the dispute cannot be resolved. However, a best interests meeting should be convened in the first instance, where professionals and family members are invited to actively participate.

Also, if an LPA is deemed to not be acting in a person's best interest – a report should be made to the Viscount's Office.

7.6 Refusals

Due to the usually compulsive nature of self-neglect, practitioners should not unquestioningly accept service refusals, or people's assurances they do not want help. By focusing on small improvements and changes the person finds acceptable, a trusting relationship may be formed, which may impact on larger more contestable issues in the longer term.

Practitioners are prompted to seek guidance from their managers and DSL, and to seek further help from other agencies in the partnership – the solutions to these complex issues can invariably be found in multiagency working

Where situations necessitate, Health Care Jersey staff can carry out assessments of need, and make attempts to involve the person, and seek their consent to approach other agencies. If this is not possible a desktop assessment can be undertaken, but staff may not be able to access external agencies health records/care plans without the relevant person's consent. If they lack capacity, that is a different matter, unless they have a Lasting Power of Attorney, or Deputy under the CSDL.

Legal powers are also extended to Jersey Fire and Rescue and Environmental Health; these can range from persuasive compliance through to enforcement actions as a last resort. See PART 8: agency roles.

There will be occasions where **all attempts** to support and engage are **rebuffed**, and legal remedies will not apply. But you will have tried, revisited, negotiated, held multi-agency meetings and involved line managers where appropriate. It may be the person is not ready to accept help at

this time. Your records should reflect all discussions, and the person told (and written to) that they can seek help in the future, with appropriate contact details.

PART EIGHT: AGENCY ROLES

8.1 Who does what?

No.	Agency	Role
1	**Environmental Health**	Environmental Health can form part of the safeguarding response when self-neglect is **impacting on the person's environment**. An officer can conduct a visit to the home to assess hazards and concerns with the person's living conditions. When the concern surrounds an owner occupier this is purely advisory. Collaborative work is often undertaken with other agencies to support hazard reduction in the home. If a concern relates to a tenant, Environmental Health have various powers under Public Health and Safety (Rented Dwellings – Minimum Standards and Prescribed Hazards) (Jersey) Law to compel the Landlord to take appropriate action to reduce the hazards present in the property. This includes minimum standards such as the presence of working smoke alarms, Electrical Condition Reports, Carbon monoxide detection (where appropriate) and Gas Safety Checks (where appropriate). Environmental Health Officers also investigate matters of Statutory Nuisance, this can include issues surrounding odour, noise, premises in such a state to be prejudicial to health, etc. Statutory Nuisance can arise when self-neglect behaviours begin to impact others in the neighbouring environment. For adults at risk, issuing of any notices relating to nuisance is a **last resort**. Multi agency work to achieve abatement of the nuisance is the most empowering and effective response. Environmental health officers do not assess the care and support needs of individuals.
2	**Adult Social Care**	ASC Provide an assessment and care management service for adults that follows, as best practice, the requirement to provide an assessment in the UK Care Act (2014). The service is generic for anyone not requiring the more acute input of Mental Health or Learning Disability Services. There is no Community Care Law in Jersey, so UK law is used to guide practice. The most relevant law in Jersey would be the Capacity and Self Determination Law (2016). The service is consent led.

3	**Safeguarding Adults Team (SAT)**	SAT will oversee the safeguarding enquiry for any self-neglect case in line with the current multi -agency safeguarding policy WHEN THE ADULT AT RISK (a) has needs for care and support (whether Health and Care Jersey are meeting any of those needs or not), (b) is experiencing, or is at risk of, self-neglect, and (c) because of those needs is unable to protect himself or herself against the experience of self-neglect or the risk of it. • The SAT will work with adults at risk as per the guidance tool if 'Amber' or 'Red' and risks cannot be reduced by any other means - e.g., Fire Service involvement, Case Management.
4	**Jersey Fire and Rescue**	Under Clause 6 of the Fire and Rescue Service (Jersey) Law 2011 the Fire and Rescue Service must promote fire safety in Jersey. This includes the provision of information and the giving of general advice in respect of the steps needed to prevent fire and the importance of always maintaining a means of escape from a property. Although general and not specific to matters of self-neglect this responsibility under law demonstrates why the Fire and Rescue Service are involved in cases of self-neglect where there is often a greater risk of fire and obstacles obstructing an individual's "Means of escape".
5	**States of Jersey Police**	States of Jersey Police will often have contact with an adult, either at their home address and/or come within the community whereby concerns of Self Neglect are raised. Police Officers and Staff have no direct role in assessing the adults needs and/or concerns but have a moral duty (in the absence of current laws) to report concerns via an Adult Protection Notification (APN) and/or Safeguarding Referral via the Single Point of Referral (SPoR). SOJP will need to be mindful of relevant legislation such as Human Rights (right to private life) if the adult is not wanting to seek support, along with Data Protection (Jersey) Law 2018 in regards to sharing information without consent where there is a perceived safeguarding risk.
6	**Andium Homes**	Andium Homes is a wholly States-owned, but independent company with our own Board of Directors. Jersey's largest landlord, managing approximately 5,000 properties, which provide homes for around 11,000 Islanders. Oversees a mixed portfolio of rental homes and assisted sale schemes.

		To access social rent accommodation applicants must meet the be Residentially Entitled and meet the criteria to access social housing via the Affordable Housing Gateway or the Partnership Pathway. Clients residing in our homes are expected to adhere to the obligation set out within their tenancy agreement. Both Andium Homes and their clients are required to adhere to the Residential Tenancy (Jersey) Law 2013 There are a range of services provided by Andium Homes to support clients in have a safe, successful, and sustainable tenancy
7	**Family Nursing & Home Care**	Family Nursing and homecare provide services in the community ranging from pre-birth to the end-of-life. This includes health visitors, school nurses, and children's community nursing teams in child and family services. FNHC also deliver district nursing and rapid response and reablement services in adult services. Adult nursing teams receive referrals from a range of professionals for people with a nursing need to reduce the risk of deterioration in their health and the need for admission to hospital. The nursing teams undertake an initial holistic assessment and will then work with the person to agree a care plan to meet their health needs with a focus on helping them to recover from an acute health issue or manage their long-term condition and continue with self-care where this is appropriate. Adult nursing services visit house-bound patients to provide palliative care, wound management, catheter, continence care and medication support and provide timed appointments in clinics for patients who are not housebound.
8	**Health Safeguarding Team**	The Health Safeguarding Team provides advice, support, supervision, training, and quality assurance to promote positive safeguarding outcomes. The Team develops and implements safeguarding policies, procedures, and guidelines, aiming to embed a culture of "Safeguarding is Everybody's Business- It is not a Choice "across Health and Care Jersey. The team ensures that staff are equipped with the skills and knowledge specific to their roles, enabling them to recognise and respond effectively to signs of abuse and neglect, keeping patients, service users, and colleagues safe.
9	**Mental Health Services**	Mental Health services will provide an assessment of mental health and social care needs (utilising the Care Act 2014) as Best Practice) and care co-ordination for adults or older adults. The team will work in line with Capacity and Self Determination Law

		(2016). If an individual has complex mental health needs and there are risks to the individuals' health or safety or risks to other people, they can request that a Mental Health Law (2016) assessment which may result in admission to hospital.
10	**SPOR/ Adult MASH**	The SPOR team act as a centralised hub for managing referrals into Health and Care Jersey (HCJ). The main purpose is to streamline and coordinate the referral process so that patients, clients, or service users get directed to the right service quickly and efficiently.
11	**ESSH (Soc Sec)**	ESSH work collaboratively alongside agencies to ensure access to benefit, review of information and appropriate support and communications is in place. ESSH assist in ensuring all appropriate funding within the ESSH framework is explored and exceptional funding request reviewed and applied as appropriate.
12	**Children's social care**	Children's Social Care have a statutory responsibility to safeguard and promote the welfare of children living in or visiting households where self-neglect or hoarding is present. Where an adult's self-neglect impacts on the care, safety, or living conditions of a child, this should be viewed as a potential indicator of neglect and/or emotional harm. Children's Social Care will: • Assess the impact of the home environment on the child's health, development and wellbeing • Ensure the voice of the child is seen, heard and recorded, including their lived experience of the home conditions • Undertake a Child and Family assessment where threshold is met • Consider whether the child is experiencing: o Neglect (basic care, hygiene, nutrition) o Emotional harm (shame, isolation, anxiety) o Role reversal (young carer responsibilities) o Lead or co-lead multi-agency planning where a child is at risk of significant harm o Work jointly with Adult Services to ensure a whole family approach

PART NINE: STAFF SAFETY

When working with individuals living in hoarded environments, staff safety must be a key consideration. Hoarded homes can present a range of hazards including restricted access and exit routes, fire risks, structural instability, vermin, biohazards, and reduced visibility, all of which may increase the risk of injury.

Staff should ensure that a dynamic risk assessment is undertaken prior to and during any visit, considering environmental risks as well as the individual's presentation and behaviour.

Lone working procedures must be followed, including informing colleagues of visit details and expected return times. Where risks are identified, visits should be planned and, where necessary, undertaken jointly with other professionals or agencies.

Staff should not enter environments where they feel unsafe and must escalate concerns to a manager. Appropriate personal protective equipment (PPE) should be used where required, and consideration should be given to infection prevention and control. The safety of staff must always be balanced with the need to engage the individual, ensuring that interventions are both safe and respectful.

Meeting with people in neutral environments (cafes, library etc) is encouraged and may be preferable to all parties.

APPENDIX ONE: THE PERSON'S PERSPECTIVE

Practitioners should be prepared to see the adult's perspective, and to answer their questions and concerns.

- Consider how you can work at the adult's pace through continued involvement over time but consider if there is anyone else at risk and if you need to escalate concerns.

- Contact other agencies to see if the adult is known to them already to help inform risk assessment and improve multi-agency working.

- Consider that the adult may have a very different view of their current situation and may not agree with the level of concern being raised about them.

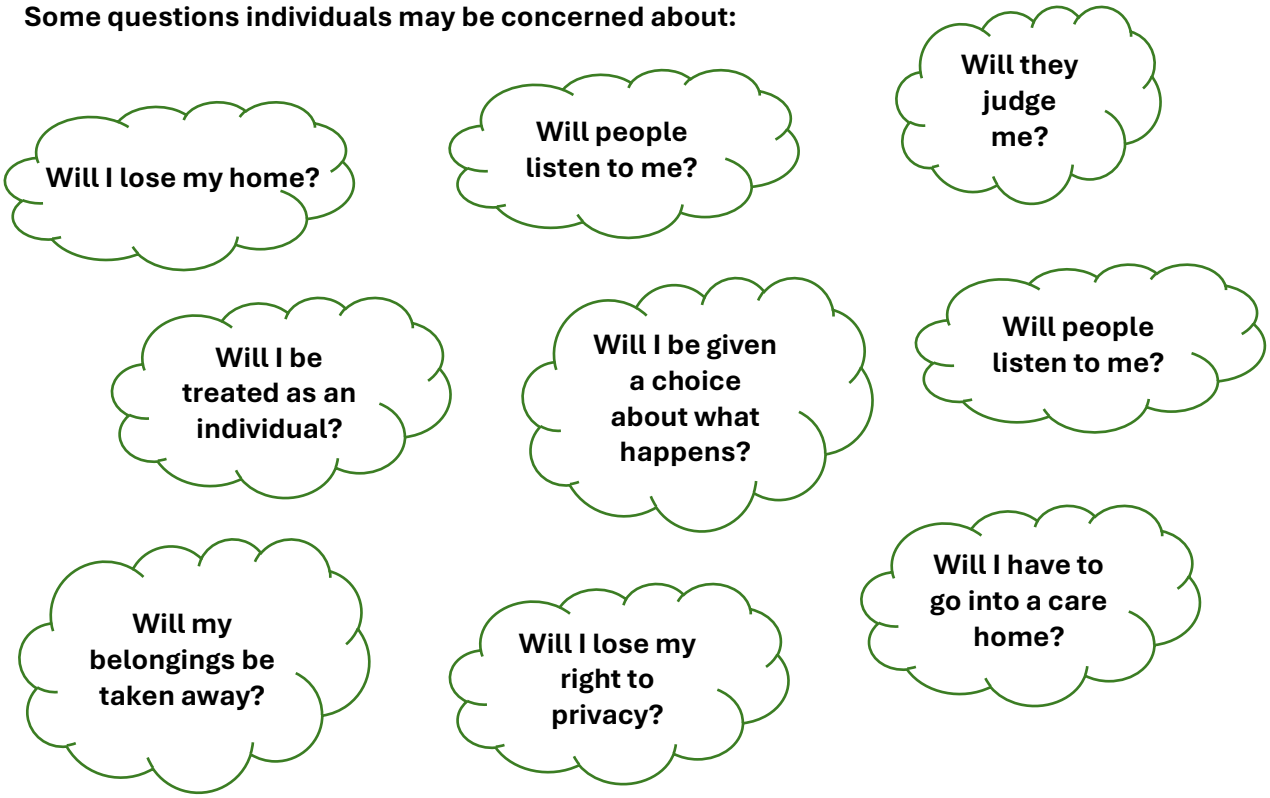
- Consider that there may be a reason why the adult is fearful or resistant to being contacted by services. This could be related to previous trauma or abuse, issues of equality and diversity, or neurodiversity. It may also be related to feelings of shame about their situation.

- Consider and establish the adult's preferred methods of communication and their preferred times for contact/visits for example, some adults may feel less anxious in the afternoon in comparison to the morning.

- Take the time to get to know the adult and learn about their interests, history, and stories. Finding something that motivates the individual linked to their interests can help to build the relationship.

- Developing a chronology of the adult's history, previous referrals and interventions helps practitioners to understand their situation and to know what has worked and what has not worked in the past.

Some questions individuals may be concerned about:



Build trust by gaining an understanding of self-neglect from the adult's point of view and considering the possible worries and concerns they may have about you or other agencies contacting/visiting them, you are more likely to find a way to build a positive relationship with the adult and work together.

Before you visit or meet with the person, think about:

- ✓ Are you the 'preferred professional' for this person? If not, who is?
- ✓ Checking the preferred methods of communication for the adult and whether any alternative formats or languages are required for information to be shared and understood.
- ✓ Is it necessary to meet at home? Where else do they go? Can you meet them outside the home in a neutral non-threatening place, e.g., GP surgery?
- ✓ Would they like to bring a friend or have a friend present when you visit?
- ✓ Can a family member or neighbour introduce you?
- ✓ Texting/emailing/telephoning people in advance of your visit to re-assure them.
- ✓ Being discreet because the person does not/may not want their neighbours to know you are visiting.
- ✓ Joint visits with referrer or someone they trust.

- ✓ Think about what other services are likely to have contact with the person, such as the Fire Service, Housing. Can you enlist the help of faith, voluntary and support services, church leaders? Can you do a joint visit?
- ✓ Can you make an appointment - rather than just turning up?
- ✓ Can you build rapport before the visit over the phone?
- ✓ If the person is known to your service find out what has worked or failed before?

When you go out:

- ✓ Plan what you are going to say taking a positive approach where possible.
- ✓ Consider whether wearing a uniform will help or hinder the visit.
- ✓ Consider what can be offered to the adult to make their situation better?
- ✓ Be open and honest about why you are there but try not to show your opinions or be judgemental. Be aware of your body language and verbal language and so that you do not make people feel uncomfortable.

If you are unsuccessful in engaging the individual:

- ✓ Revisit all the points above.
- ✓ Be approachably persistent.
- ✓ Put a note through the letterbox, giving another time when you will call back.
- ✓ Put a note through the letterbox asking the adult to call you.
- ✓ Try calling at a different time of day.
- ✓ Contact the police if there are immediate concerns about the adult's safety.
- ✓ Consider escalating through internal processes or through adult safeguarding procedures.

Practical support for the adult:

- ✓ Offer support on a trial basis as this may seem less overwhelming.
- ✓ Consider any other sources of help such as family members.
- ✓ Are there actions that can be quickly agreed?
- ✓ Work with the adult to establish their priorities in terms of needs.
- ✓ Work at the adult's pace when supporting them to move or remove items.
- ✓ Remember that there may be meaning attached to hoarded items.
- ✓ Educate the adult in relation to their health, safety, support.

- ✓ Emphasise the positives.
- ✓ Escalate to your manager obstacles of ongoing intervention due to the adult's financial contributions

APPENDIX 2: Clutter rating tool

Self-Neglect Tool

Buckinghamshire SAB Safeguarding Adults Board

Tool Two: Household Images (Clutter Rating)

Clutter Image Rating: Kitchen Please select the photo that most accurately reflects the amount of clutter in your room


1


2


3


4


5


6

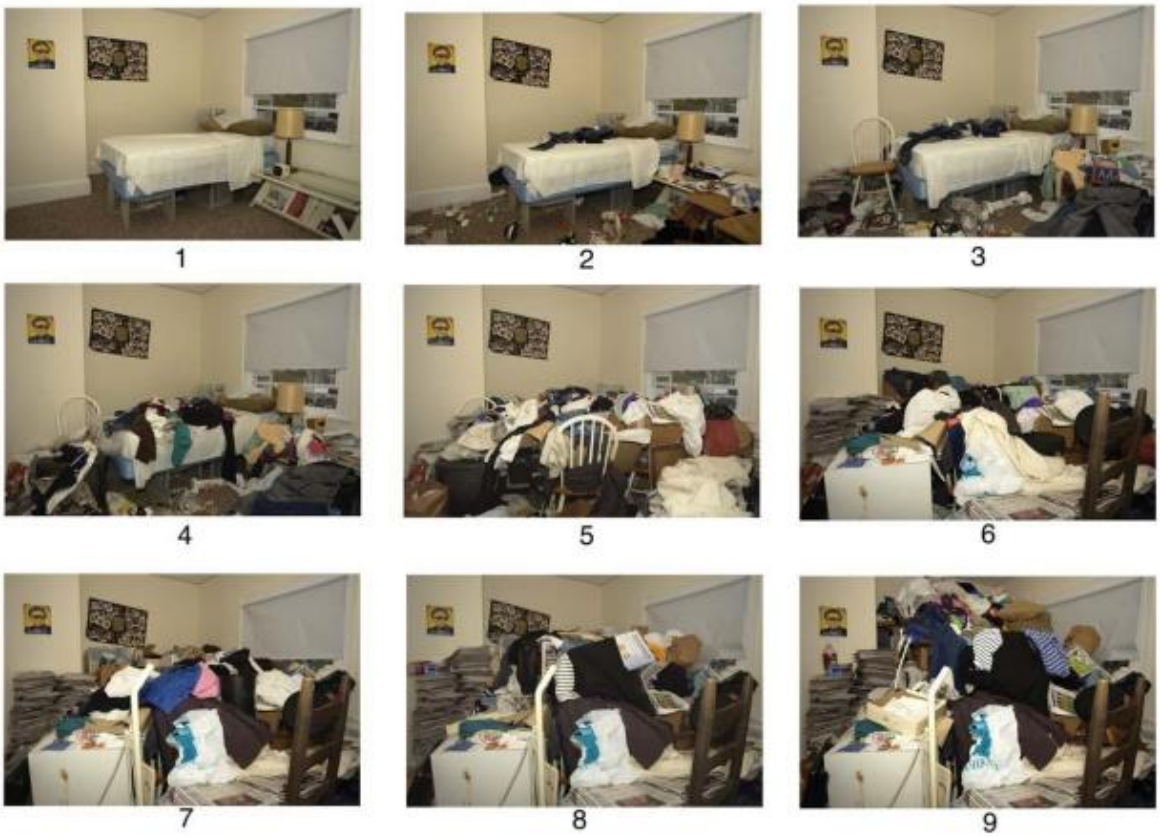

7


8


9

Clutter Image Rating: Bedroom

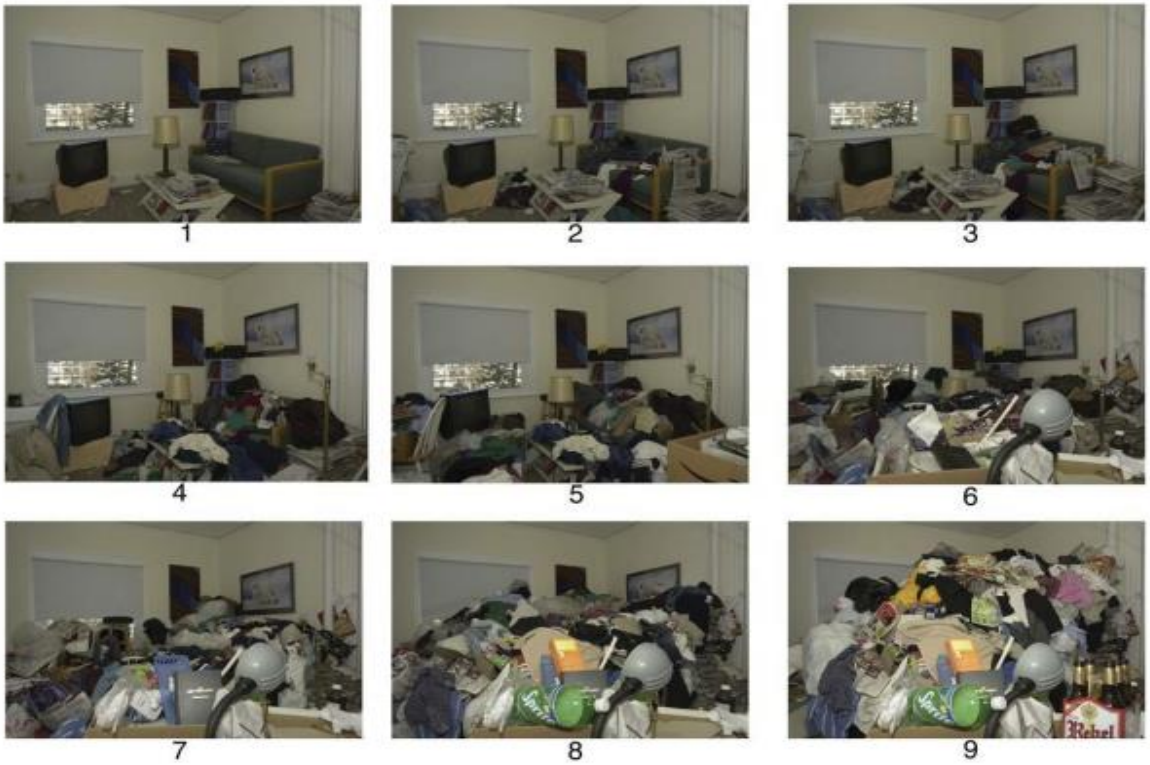
Please select the photo that most accurately reflects the amount of clutter in your room



Images and forms courtesy of TreatmentsThatWork™

Clutter Image Rating: Living Room

Please select the photo that most accurately reflects the amount of clutter in your room



Images and forms courtesy of TreatmentsThatWork™

APPENDIX 3: RISK ASSESSMENT ADDITIONAL GUIDANCE (to Part 6.2& 6.3) This is intended as a general guide only and is not meant to depict a list of all possible scenarios.

GREEN RESPONSES

- Agencies should keep a record of concerns and their offers to intervene
- Staff should discuss the concern with their own safeguarding lead
- Any unmet health needs should be reported to the person's GP
- An assessment of need may be required
- Continuing monitoring and engagement with the individual should carry on
- If there are other concerns, or repeated concerns then these should be reviewed and kept in check
- If there's suspicion that the person may not be making decisions freely then this may be a matter for adult safeguarding, otherwise the matters identified in this green risk section are unlikely to trigger a formalised safeguarding response
- A referral to other agencies may be needed, e.g. fire service re smoke detector, housing provider (if in rented property) GP

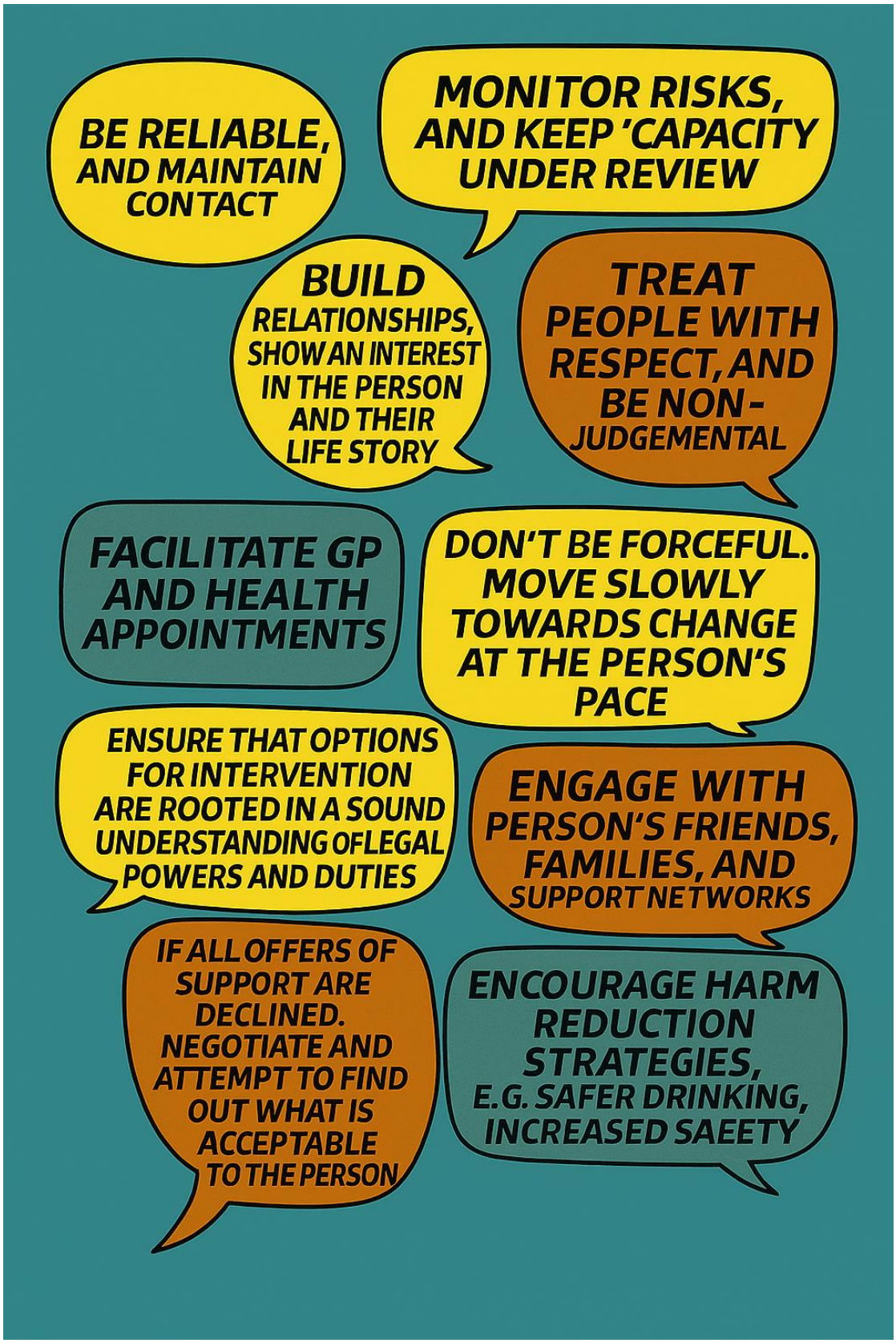
AMBER RESPONES

- Staff to discuss with their own safeguarding lead without delay.
- The immediate safety of the person should be prioritised.
- The consent of the person should be ascertained, or overridden if person's vital interest is at risk, or there is a risk to other people (public safety).
- A referral for an assessment of needs can be made to SPOR/ Adult MASH.
- Adult services can consider if a safeguarding response is required.
- The referrer has the right to refer to adult safeguarding if they believe this to be the right course of action, and in turn adult safeguarding can engage other adult services.
- A team around the person approach may be indicated, and agencies should not end their relationship or close a case based on merely raising their concerns to adult social care.
- A referral to other agencies can be actioned, e.g. fire service, housing provider, GP, environmental health as required.

RED RESPONSES

- Staff to discuss with their own safeguarding lead without delay.
- The immediate safety of the person should be prioritised.
- If person's vital interests are at risk, or if there are other people at risk of harm (public safety) or children are at risk.
- A formalised concern should be raised with adult safeguarding without delay.
- Stay involved, agencies are not to close cases because of merely referring to adult safeguarding.
- If a child is living in the same premises the referrer **MUST** notify children & family hub directly and tell adult safeguarding this has been actioned.
- Referrals to other agencies can be actioned, e.g. fire, GP, environmental health, housing, other as required.

Appendix 4: TOP TIPS



- ✓ **Relationship building is crucial.**
- ✓ **Work at the adult's pace wherever this is possible.**
- ✓ **Persistence and commitment require time and patience.**
- ✓ **Find out what the adult wants and expects, and what is worrying them; see if they feel able to manage or resolve some things for themselves.**
- ✓ **Use professional curiosity to understand the history of the adult, how their self-neglect started.**
- ✓ **Consider how trauma, diversity, neurodivergence, bereavement, or loss may have impacted on their life and show empathy.**
- ✓ **Be open and honest with the adult, particularly in relation to the concerns about them.**
- ✓ **Reinforce the positive aspects of the adult's life.**
- ✓ **Offer choices, but do not make promises you cannot keep.**
- ✓ **Involve other relevant agencies early in the process. This will help to identify the collective support available for the adult and which agency staff member might be accepted by the person in working with them.**
- ✓ **Liaise with and involve close family and friends where appropriate.**
- ✓ **Remember that the use of language is important, and the term 'self-neglect' may not be recognised or welcomed by the adult you are working with.**
- ✓ **Work on shared goals, not goals based on how you or others think the adult should live.**
- ✓ **Be persistent, do not give up, but make sure your involvement is lawful.**
- ✓ **Think creatively about the best way to enable the adult to work with you. This may mean adapting your communication style or the timing of your calls and visits.**
- ✓ **Co-ordinated interventions and responses from agencies could help prevent the need to escalate to more intrusive support such as statutory actions.**

APPENDIX 5: CHECKLIST TOOL

Task	Completion comments
Understanding and involving the adult at risk	
Do you know and understand the person's views, wishes and desired outcomes? Has your approach taken these into account?	
Is the adult in need of representation of a friend, relative, or representative to facilitate their involvement?	
Have you considered the person's communication and support needs to enable them to manage support arrangements?	
Have you gathered information about the person's personal and cultural background? Does your approach actively take these into consideration?	
Has the person experienced adverse childhood experiences or adult trauma that impacts on their ability to maintain their safety? Are you taking a trauma informed approach where relevant?	
Adopting a strength-based approach	
Are you building upon the person's strengths and their social and community networks? Are you focused on what people can do, rather than what they cannot?	
Using professional curiosity	
Have you read previous records held in relation to the person?	
Are you questioning assumptions? Considering alternative explanations?	
Is what they say consistent with what you see?	
Are you seeking to understand the underlying issues?	
Ensuring the right people and services involved	
Are all key services engaged?	
Is there an agreed lead person/agency to coordinate actions?	
Where an agency is not involved, have you sought to escalate concerns to gain involvement? You might need help from a manager in your service to do this.	

If there are differences of views, have you actively sought to resolve disagreements?	
Have you considered contact with the adult's relatives, do you have the consent of the person at risk, or is it proportional to do so even without the adult's consent?	
Have you considered involving an agency or service that has a role that enables them to befriend and get alongside the person, for example a community group or specialist service?	
Having a multi-agency approach	
Are the right organisations involved?	
Have you escalated your concerns if you have not received the response, you feel you should?	
Has there been a multi-agency meeting about these concerns?	
Has there been a formal multi-agency risk assessment?	
Has a multi-agency plan for intervention been tried?	
Has there been a review of this multi-agency approach? Are there other things you can try?	
Is information sharing being carried out with appropriate cooperation?	
Refusing support with essential services	
Have you sought to build relationships? You may need to build relationships and trust before the person is gradually able to accept support.	
Have you sought to understand and find the person you are concerned about? Do you know why they decline support, and what is important to them?	
Have you tried to develop plans alongside the adult, starting with where they are and with what is important to them?	
Have you sought to be creative, addressing their particular needs, issues and concerns?	
Are you working with the person's strengths, at their pace?	

Have you considered if further interventions are proportionate to the risk, and in accordance with Human Rights obligations	
Legal options to be considered	
Is there evidence to indicate an assessment of capacity is required?	
Is your practice in accordance with the Capacity & Self Determination (Jersey) Law	
Does the adult have fluctuating capacity?	
Do you need to seek advice from the Capacity Lead or Capacity Champion for your organisation?	
Has legal advice been considered?	
Have legal powers of intervention been considered? This may involve considering the legal powers of agencies other than your own.	
Is there a risk to others?	
If there is a risk to a child? Have you informed Children's services via Family Hub?	
If there is a risk to other adults, have you considered how to manage those risks?	
Is an informal carer at risk, or posing risks?	
Supervision	
Have you used supervision to gain advice from a manager, to reflect on progress or lack of progress made in supporting the adult, or to rethink your formulation of the person's needs and your approach?	
Have you consulted your lead professional DSL?	
If significant risks have been identified, have you escalated your concerns within your organisation? Are your managers fully aware of the issues and concerns?	
Have you referred to relevant policies, procedures or guidance?	
Have you accessed the multi-agency guidance or procedures?	

APPENDIX 6: INDICATOR GRAPHIC

Safeguarding
Partnership
Jersey

safeguardingpartnership@gov.je