Adult Protection lead officers and practitioners have noted an increase in the work being done with people experiencing self-neglect and hoarding. This paper has been produced to support the adult protection community consider these issues in terms of practice, training and strategy. It draws upon existing research, guidance and practice tools to provide Adult Protection Committees with an outline upon which to base the development of practice and guidance.

NAPC

National Adult Protection Coordinator

supporting those protecting others

Self Neglect and Hoarding

Practitioner and Strategic Briefing

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Contents

Introduction

The issues of self-neglect and hoarding may share some commonalities with regard to how they can be addressed but it is important to recognise the differences and be clear on what basis any interventions are being taken forward. On this basis this paper draws on materials from both areas of work and presents them in a way that practitioners can consider whether they are appropriate for the person and situation with which they are working. This paper is not intended to be a definitive guide but provides an outline of some of the materials available which may be useful to inform local practice and the development of local guidance. In this regard it considers issues around prevalence, definition, assessment, intervention, capacity, ethical dilemmas, multi-agency working and other guidance available.

Definitions and common characteristics

Below are some definitions which may be useful in considering whether an intervention is appropriate but this does not detract from any definitions your agency may already work too. Also, whilst the issues are now being defined in terms of illness classification, research highlighted later will demonstrate the issues that may arise in relying solely on this approach.

Self-Neglect

> The inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of the self-neglecters and perhaps even to their community (Gibbons, 2006)

Wellbeing

The Oxford English Dictionary (OED) defines wellbeing as a state of being healthy, happy, or prosperous in relation to a person's physical, psychological, or moral welfare.

Hoarding

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (American Psychiatric Association) defines hoarding as an enduring issue regarding the disposal of belongings regardless of value, where attempts to do so causes distress which is not explained by other organic or psychiatric conditions. This in turn leads to living spaces being obstructed unless cleared by others, impacting upon social functioning and ability to maintain a safe environment. (Diagnostic Criteria 300.3 [F42])

Interestingly the classification system used in the UK known as the ICD-10 (International Classification of Diseases) (World Health Organization [WHO]) does not appear to currently specify hoarding though it does make some specific references to self-neglect in relation to a lack of food or fluid intake. However it has been stated that in the UK hoarding has only recently been recognised as a distinct medical issue (Royal College of Psychiatrists, 2016). The current draft of ICD-11 (the update to ICD-10) does however provide a definition of hoarding (noting this may be subject to amendment) which appears to be similar to the DSM 5 definition. It is described in terms of excessive gathering of belongings coupled with difficulties in disposing of them, again regardless of value. They relate this to, *'repetitive urges or behaviours related to amassing or buying items'* [WHO ICD11). This definition also includes a need to retain things and distress related to disposal as well as the impact upon living spaces whereby they become obstructed to the extent that safety is a concern. In

addition this causes notable distress or impairment in terms of social or occupational relationships/activities. (ICD-11, 6B24 Hoarding disorder)

Self-Neglect and Hoarding

Early work on self-neglect identified common characteristics which included; isolation, poor self-care, high intelligence and older age. Later work also identified that some of the drivers of these characteristics may be due to psychiatric disorders, organic disorders and alcohol use (McDermott, 2008). Research throughout the 1990s added other factors such as; being over 60, low income and physical impairments (McDermott, 2012).

There is limited evidence that self-neglect is due to biological dysfunction (McDermott, 2012) and therefore in terms of Adult Support and Protection it may not be helpful to base the need for intervention solely upon a medical diagnosis, though seeking diagnosis and treatment of other issues should form part of the work. Within their assessments practitioners may therefore wish to consider some of the definitions noted in this paper and make their initial decisions regarding the need for interventions and supports based upon social need as opposed to medical diagnosis. This would appear to be in line with the models outlined in this paper where other issues may require addressing but a formal diagnosis does not necessarily prevent work commencing around self-neglect or hoarding. The assessment may then highlight undiagnosed or untreated medical needs and addressing these could form part of the broader work.

In the USA the National Adult Protective Services Association (NAPSA) defines self-neglect as involving*, 'seniors or adults with disabilities who fail to meet their own essential physical, psychological or social needs, which threatens their health, safety and well-being. This includes failure to provide adequate food, clothing, shelter and health care for one's own needs'* (NAPSA). In Australia one study indicates professionals use three categories of self-neglect which they view differently. These are neglect of the self, neglect of the environment (referred to as squalor) and the inability to dispose of items, referred to as hoarding. Self-neglect was seen as not maintaining sufficient food and liquid perhaps accompanied by incorrect self-management of medication or not following medical advice. Squalor was seen as the presence of vermin and animals, rubbish and waste with associated odours. Hoarding was seen as the collecting of items which would not have value to others in society. However some blurring and cross overs between these definitions was noted. Finally some Australian research appears to dispute assumptions that self-neglect is more frequently an issue for older people (McDermott, 2008).

Section 47 of the National Assistance Act 1948 (NA Act) defined the circumstances under which interventions may have previously been undertaken. These included the person experiencing; chronic disease; infirmity, physical incapacity within the context of insanitary conditions where they or others were not meeting the needs of the person. This section of the NA Act was repealed by the Adult Support and Protection (Scotland) Act 2007 (ASPA) and the related Code of Practice makes specific reference to self-neglect. On this basis perhaps Section 3 of ASPA offers the basis of a threshold when drawing up local criteria or assessment tools as to whether interventions should be offered. This could perhaps emphasise consideration of mental and physical infirmity based upon one of the broader definitions offered by the OED which states that infirmity is the inability to do something.

Prevalence and demographics

Data on self-neglect and hoarding in the UK context seems to be limited and does not appear to be recorded separately from the broader category of neglect. However a study by the National Association of Professional Geriatric Care Managers in the USA found that, *'76 percent of the care managers surveyed reported that elderly self-neglect is the most common non-financial form of elder abuse/neglect that they encounter in their practices'* (Boothroyd, 2014)

Mataix-Cols (online) states that hoarding affects between 2 and 5 per cent of the population which in UK terms would be more than 1.2 million people. This is supported by a London based study (Nordsletten et al, 2013) that found *a 'lower-bound prevalence of approximately 1.5%'* (p.451) and that it impacts regardless of gender and is *'associated with substantial adversity'* (p.451)

The literature reviewed indicates that only a small proportion of people experiencing hoarding will come to the attention of services and are likely to be experiencing other physical or mental health issues. This is supported by the conclusions of the research undertaken by Birmingham City Council (2016). Another study suggests that hoarding may be a feature in one quarter to a third of those diagnosed with Obsessive Compulsive Disorder (OCD) (Frost et al 1996), indicating that hoarding is not solely related to OCD. Indeed hoarding is likely to be more prevalent than OCD (Holmes, 2015).

An Australian study (McDermott and Gleeson, 2009) analysed the data of a hoarding and squalor project over a twelve month period. The project received 218 referrals and provided a service to 157 people. The analysis found that:

- 55% of referrals were regarding males and 45% females
- The average age was 62 with over half being under 65
- Referrals were received from a wide range of agencies
- Overall half were in public housing but 39% were owner occupiers and 7% in private rentals
- 41% did not have secure accommodation due to their living conditions
- Nearly one fifth of people refused a service with 13% requiring immediate placement or hospital care

Those accepted for services were more likely to experience health, safety and fire risks and have an issue with hoarding. Other issues noted were being unable to receive services, being refused services, isolation and insecure tenancy.

Findings indicated that specific work around hoarding and squalor with those over 65 with, *'age related problems or cognitive impairments, as well as poorer physical and mental health'* (McDermott and Gleeson, 2009 p.5) is less likely to be effective within their current accommodation as these issues can prevent the development of sustainable solutions. In these instances other interventions were arranged.

In an American study of over 4000 older people (Dong et al, 2012), the prevalence of self-neglect (including hoarding) and its manifestations varied notably. However, the highest rates of prevalence were amongst those with low income (less than USD 15000) where self-neglect was recorded as a factor amongst nearly 22% of males and just over 15% of females.

In Scotland recognition of the issue appears to be growing amongst Adult Protection Committees. This is supported by the fact that 57% of the 2014 – 2016 biennial reports available on the Scottish Government website make reference to self-neglect. At this stage

numbers appeared to be small though increasing in some areas, however one APC noted a significant increase.

Assessment

To develop the service user's insight and motivation the practitioner may need to spend several sessions building a relationship before attempting to engage in formal assessment. This will be a feature throughout the work to enable the service user to own the decisions they make (Steele & Frost 2006). Having reached the point of assessment, below are some factors to consider when assessing someone in relation to self-neglect or hoarding.

Firstly, with regard to hoarding it may be useful to ascertain whether the service user is hoarding or collecting. A straightforward comparison of these categories is available in Holmes (2015) covering issues around emotional attachment, size of the hoard and discarding etc.

In instances of other forms of self-neglect, it may be useful to clarify the form the neglect is taking e.g. adequate sustenance and hydration, adequate clothing and heating, neglect of the living environment or apparent untreated medical needs. It is of course possible that the service user may be experiencing a wide range of self-neglect issues including hoarding.

It may be useful to focus the assessment around social, environmental and structural influences in the person's life (McDermott, 2012) providing a holistic view (McDermott and Gleeson 2009). In this way the practitioner may be able to locate underlying issues at both a personal and societal level which are impacting upon the person.

Addressing issues simultaneously has been noted to provide better outcomes (Kress et al 2016). This is based upon work by Hall et al (2013) who suggest that there are three categories of hoarding. These being non-comorbid hoarding, hoarding with depression and hoarding with depression and inattention. They suggest it may be more straight forward to meet the needs of people experiencing hoarding without other issues or diagnoses. Therefore it is important as part of the assessment to understand whether there are any comorbid issues which are not being treated, as treating them may increase the chance of successful work around the hoarding issue. By this logic it would seem sensible to apply a similar approach to self-neglect. This emphasises what appears to be a key theme in the literature, that is the need to involve all appropriate agencies and relevant others, in a multi-agency approach.

The Self-Neglect Severity Scale (Eastern Pennsylvania Geriatrics Society and Dyer et al 2006). Noted in the references these provide links to a free article which provides background details and the draft assessment tool. The issues noted include identifying and specifying the factors relating to personal appearance and hygiene and/or living conditions e.g. hoarding, public safety/health issues such as fire, flood and infestation and untreated physical or mental health issues etc. It may be useful from an Adult Support and Protection perspective to consider these issues in terms of the person's ability to safeguard their own wellbeing, property and rights (ASPA 2007). This may assist with any decisions regarding the basis upon which interventions are carried out. This does not mean that work should only be carried out where the person is known or believed to be an adult at risk of harm but considering the legislative supports available may assist in taking some of the work forward.

The Hoarding Rating Scale-Interview (Tolin et al 2010) considers:

- The impact on the usability of household rooms
- Issues regarding the gathering of new things and discarding others

- Issues causing emotional distress, either through attachment to the items gathered or due to relationship issues caused by the self-neglect or hoarding
- The impact upon daily routine and finances
- The longevity of the issues

The HOMES® Multi-disciplinary Hoarding Risk Assessment covers issues around the following themes:

- Life events e.g. trauma, which may be causing the self-neglect or hoarding
- Insight into the seriousness of the issue
- Health and safety issues or structural issues with the property
- Diagnosed or undiagnosed mental health issues
- The ability to react appropriately in an emergency situation

The Clutter – Hoarding Scales (life-pod) offer a photograph based comparison tool to rate the severity of the issue and offers headings to aid assessment. These include the structure and accessibility of the home, animals, functionality of rooms, health and safety and environmental health.

The cognitive behavioural model suggests considering three factors; information processing, beliefs regarding hoarding and emotional reactions (Orr et al, 2017).

Finally the assessment will need to identify any other issues such as depression, grief or loss that will require parallel interventions (Steketee & Frost 2006).

Intervention

A common theme in the literature is the need for a multi-agency/intra – and inter professional response which also accesses and deploys available supportive systems e.g. family, friends, Home Care Services, Fire and Rescue Service, Self-help groups etc. It may be beneficial to consider Self Directed Support in this regard to design a support package that targets specific needs within the context of self-neglect and hoarding.

In addition to this the literature clearly suggests that effective interventions of this nature will require a long term approach. This will involve discussions and decisions within and between the relevant agencies as well as clear communication with the service user as to the commitment that is required by all parties.

Where a clean-up is being considered, all parties should reflect upon the impact this may have including possible detrimental effects to long term effective work with the service user. It is essential to understand the emotional attachment to the items that are gathered or the psycho social rationale for the gathering of such items and how their removal could cause further distress and damage relationships with professionals. Clearly there may be health and safety issues which drive such decisions but professionals need to understand the impact from the service user's perspective. One service user described the removal of things from her home as feeling like, *'…somebody stripping you naked and standing you outside in the cold on your own'* (Birmingham Adult Safeguarding Board, 2016). A description such as this clearly articulates the trauma that clean-ups can cause.

In his presentation of the work by Braye et al (2014) on self-neglect, Preston Shoot (2014) stated that service users identified the following as being necessary in an effective intervention:

- Respectful, timely engagement
- Identify and understand motivational (what motivates the service user to change) as well as legislative options
- Encourage a person-centred approach which is not intrusive, directive or pushy
- Demonstrate compassion, reliability and understanding
- Base intervention on developing a trusting relationship
- Be with the person when clearing/cleaning is taking place, promoting choice where possible
- Support the service user in a way they see as relevant (perhaps addressing any immediate concerns they have)
- Consider practical assistance e.g. equipment, benefits advice, advocacy, re-housing or access to therapeutic interventions
- Links with others, seemingly referring to social and support opportunities

They note the need to acknowledge at practice and management levels that this work takes time (e.g. the need to slowly build relationships). Presenting these findings (Preston-Shoot, 2014) stated the research also noted that carrying out work around self-neglect can feel lonely, helpless, frustrating and risky for practitioners. Based upon this Preston Shoot (2014) highlighted that practitioners required:

- Places and spaces to discuss ethical conundrums, such as capacity and consent, respect for autonomy and duty of care
- Time to build relationships and explore the background and context of the service user's self-neglect
- Collaborative and multi-agency approaches
- The need to be persistent, patient, resilient, respectful, curious and honest
- Not to set high expectations
- Work out when to be hands off (encouragement and direction) and hands on (providing practical assistance)
- Take small steps and value/celebrate small achievements
- Recognise what is being given up and what can take its place and the level of intervention the service user can manage
- Take a risk containment as opposed to risk removal approach
- Work alongside the service user and be the bridge to maintain contact with others (family and services) to assist in managing anxieties of family, community and other agencies

Steketee & Frost (2006) produced a practitioner manual which provides in –depth guidance on working with someone around the issue of hoarding. The below is a sample of some of the areas they cover but by no means encapsulates all the areas of practice, tools and techniques the manual states are required. However those noted resonate with the points raised in the other literature referenced in this paper:

- Work on creating a living space by focussing upon the intended purpose for each room
- Avoid clean ups (where possible) and develop the service users insight into the impact of the issue upon their lives/environment
- Assist the service user to develop a system to categorise hoarded items in relation to keeping or disposing of them.
- Identify the satisfaction derived from hoarding and what this can be replaced with
- Work with them on their emotional attachment and beliefs about hoarded items

- Reinforce the categories developed to avoid re-emergence and acknowledge and manage anxiety about loss of possessions and control
- Problem solve the issues that the hoarding creates e.g. family arguments, health etc.
- Develop a method for identifying risk of relapse
- Ask the service user to record their goals to re-enforce the work done, keeping them central to it
- Offer advice but do not make the decisions on categorising and removal
- Do not touch or remove anything without express permission of the person whilst they are present
- Consider objects first as paper records can be complicated to categorise
- Ask the service user to think out loud to understand their thinking and offer advice
- Try to encourage them to consider an item only once to reduce hesitancy
- Be flexible and innovative e.g. making a case for funding of storage space
- Deciding how to dispose of items is important as is remembering the importance of the items to the service user
- Undertake regular home visits to encourage and maintain successes.

The above are largely supported by an Australian project study (McDermott and Gleeson 2009) which found that to effectively address the issues services need to provide: case management and coordination; and flexible individualised ongoing and sustainable support. This same study also states that the principles upon which interventions should be based are those of respect through a non-judgmental approach, building trust and rapport and taking the time to build this whilst avoiding quick fixes which can damage the relationships that have been built. In addition consistent and ongoing support coupled with regular and honest communication with the service user and other agencies is required.

Finally in some areas self-help groups have been established but these do not appear to be widespread in Scotland.

Capacity

This is an area that requires more in depth analysis than can be provided in this paper but below are some brief comments to promote discussion and some reference points with regard to possible tools when considering someone's mental capacity.

> In common law, we all, as adults, have a right to make our own decisions. Others must assume that we have capacity to act and make decisions unless there is evidence otherwise. No one should be regarded as lacking capacity just because they make unwise, unusual decisions, or because they have a particular diagnosis, illness or condition. (Scottish Government, 2010 p. 4)

The issue of capacity, or a lack of capacity around certain tasks or functions appears to be heavily linked to the research around self-neglect and hoarding. As noted above, legally capacity is assumed but self-neglect and hoarding may indicate the need for capacity to be assessed, especially where there are concerns around the legal right to intervene. This is a complex area and care is required to ensure that someone has the capacity to consent to any intervention. It may therefore be worth considering the definition of capacity in some depth when assessing someone, perhaps paying particular attention to the person's ability to act under the Adults with Incapacity (Scotland) Act 2000, Section 1 (6) (a). This could assist in considering someone's ability to carry out plans they articulate during an assessment or their

ability to act in an emergency, perhaps where clutter leads to fire. In turn this may assist practitioners to consider any impact these factors may have upon someone's capacity to understand the need for support.

It has been suggested that assessing the service user's ability to make informed choices should be in the context of their stated wishes and feelings balanced with an assessment of their ability to act, beyond statements made within assessments (Aanand et al 2006). More simply it may be useful to consider these issues in terms of decisional and executive capacity, noting that evidence of decisional capacity may not correlate with executive capacity. However we should always attempt to understand the reasons why someone may be lacking executive capacity and support them to translate decisional capacity into executive (Collopy, 1988). In other words we need to consider the person's ability to articulate a decision versus their ability to enact it. As an example, when considering a person's capacity to self-care, it may be useful to clearly contrast their stated wishes or self-reported capabilities with the actual actions they take to address their needs or situation. This may assist in understanding whether the person's actions or inactions are related to issues of mental capacity, physical capacity or other issues.

Debates around someone's capacity are often connected to discussions around the person's lifestyle choices. This clearly connects to the person's autonomy and human rights which must be carefully considered. However in coming to a conclusion that it is indeed an issue of lifestyle choice, it may be useful to consider and record the evidence gathered to support this. It may be helpful to consider what Collopy (1988) describes as the polarities of autonomy. These relate to decisional vs executive capacity as above but also include; clearly mapping the areas the person has delegated and ensuring this has not been done under duress; recognising partial capacity, assessing decisions in the context of the person's values and historical decision making, understanding the person's ability to make short term vs long term decisions and enhancing choices.

In practice, Series (2013) suggests the need to assess capacity before any proxy decisions are taken and that the assessment focusses upon *'clearly defined decisions'* where the person is supported to make decisions and that those involved are clear regarding what is a capacity issue and what is an unwise decision (p2) . This could perhaps include developing an understanding of why the person is not acting, which in turn is leading to their current living situation.

Although from the court's perspective a medical view is often required with regard to capacity, many front line staff will likely have the skill set to at least provide an informal view which may be relied upon by others when conducting a formal assessment. Noting that some of the below are referencing different legal jurisdictions, they may be useful in considering your view of a service user's capacity, though it remains important to apply Scottish legislation and its principles:

- Think Capacity Think Consent (NHS Education for Scotland, 2012)
- Communication and Assessing Capacity A guide for social work and health care staff (Scottish Government, 2008)
- Toolkit for Primary Care: Capacity Assessment (Scott, 2008)
- Decision Specific Screening Tool (Edinburgh City Council and NHS Lothian, 2015)
- Consent to Treatment A guide for mental health practitioners (Mental Welfare Commission, 2010)

Finally the British Psychological Association have produced a set of standards to guide the approach taken to assessing capacity covering pre-assessment, assessment, enhancing capacity, testing outcomes and recommendations (British Psychological Association, 2010). This document appears to be written in the context of the Mental Capacity Act (England and Wales) but the standards seem applicable within the Scottish context.

Ethical Dilemmas

The balance practitioners are attempting to achieve is that between what can be the contradictory ethics of autonomy, benefit (in terms of benefiting the person's wellbeing), doing no harm and providing equal access to services and supports. Other factors can be the tensions between procedure, professional autonomy and professional registration (McDermott, 2011).

In considering how these elements compete within professional decision making it may be useful to consider that respecting autonomy does not necessarily mean not engaging the service user and may include balancing the needs of the person with the needs of the community, for example where there is a potential fire or health risk. Such dilemmas may be addressed through assessment and building a trusting relationship with the service user in a medium to long term intervention. This then provides the opportunity to work respectfully with the person to understand and resolve the risks and issues their situation raises (McDermott, 2011). The suggestion is that key to resolving these dilemmas is having the time and space to reflect on all the issues and challenges to ensure that solutions reflect a balance between the person's wishes and their needs according to assessment which can only be achieved over time through relationship based work (McDermott, 2011). Clearly there will be situations where the level of risk does not allow for a medium to long term approach. In such instances it may be worth considering how this work can be taken forward once the immediate risks have been addressed to reduce the possibility of them arising in the future.

One finding from a study of practitioner intervention may offer the beginnings of a different paradigm to consider where issues of capacity and autonomy are not felt to be clarifying the decision. That is, '*how* to intervene rather than *whether* to intervene (McDermott 2010), for example working with someone with the stated outcome of building a trusting relationship as the vehicle to address ethical dilemmas whereby the relationship develops and the service user is more amenable to direct work or support due to the trust developed (McDermott, 2011). Care of course will be required in this regard to ensure the relationship is open and honest, built on trust as opposed to applying pressure.

Additionally, care needs to be taken that the values upon which decisions are based recognise the difference between what has been described as squalor and what may be a different perception of socially acceptable standards of self-care and cleanliness. This brings us back to the issue of assessment and risk. In some instances further assessment may address some of the issues but in others risk may be the deciding factor as to whether intervention is pursued. Some local authorities have developed threshold tools and one such tool is referenced here which covers the issue of self-neglect, providing examples of when issues may be significant or critical (North Tyneside). It is noteworthy however that this tool is clear that professional judgment based upon the knowledge of the person and their situation is key.

Multi-agency working and other resources

The Scottish Fire and Rescue Service (SFRS) recognise hoarding as a serious issue and have recently published guidance for their staff which includes an assessment tool. It is possible that joint working with SFRS may more effectively engage service users. On this basis it is worthwhile developing links with your local SFRS representatives in order to raise awareness locally of how to refer to one another. Making this connection may also assist in exploring how your agency can work jointly with SFRS and a service user experiencing hoarding or self-neglect where a fire safety issue is apparent.

In addition to this practitioners could also consider the legislative supports that may be available through joint work with colleagues from Environmental Health, Housing and Public Health, depending upon the circumstances.

Further Information and Guidance

Where considering the development of local practice guidance or seeking further information please refer to the reference list. Some of the material listed is described below.

Compulsive Hoarding and Acquiring: Therapist Guide (Steketee and Frost, 2006). This is an extensive manual for practitioners and the authors themselves are often referenced by others. A précis of some of the areas covered is offered above but for those entering into detailed work with a service user this guide appears to provide a full and systematic approach. This guide is published alongside a separate but related workbook for service users.

The North Tyneside Self Neglect Guidance (2016) offers a comprehensive guide within the English safeguarding context. This freely available document includes generic and specific advice for practitioners and reference to a threshold tool (version 4). It promotes the use of an approach which considers; mental capacity, the need for a creative approach, persistence, multi-agency working and thorough recording of risk assessment including risks to others. This guidance also covers ceasing involvement and managing *'critical level of harm'*. It also incorporates reference to a Risk Enablement Panel similar to those noted in the recent NAPC paper on Multi-agency Risk Management (2018).

A Foot in the Door (Government of South Australia) provides a useful outline to assist in developing background material and the steps required to support those experiencing issues related to self-neglect and hoarding. This guide is based upon a definition of severe domestic squalor and care is required in ascertaining whether this outlines the way in which you would wish to define and manage issues locally. It should also be compared to the other materials referenced in this briefing and any existing local practice or procedures. This guide supports professional judgement as to the urgency of need as well as considering the level of risk to the individual and their community. It also provides a useful structure and some detail in relation to definition, assessment and case management. Beyond this and of particular interest to those developing a local model are appendices outlining what is termed the investigation process and an assessment scale. It also usefully defines different types of hoarding. This is a freely available document and is listed with a hyperlink in the reference section.

A Psychological Perspective on Hoarding DCP Good Practice Guidelines (Holmes, 2015), British Psychological Society. This guide provides useful background and notes the impact of trauma as a possible trigger for hoarding. Interestingly it notes types of hoarding which now include hoarding of electronic data, perhaps leading to more equipment in the household or more expenditure on cloud storage. Practitioners may be keen to view the assessment model

provided which looks at motivation to change followed by assessing the hoarding behaviours. This guide recommends involving clinical psychologists both in direct work and also in the development of practice models and guides.

Working with people who hoard (Orr et al., 2017). This briefing offers a succinct overview of hoarding behaviours, their assessment and interventions. It focusses practitioners upon the service user's information processing, beliefs and emotions to understand why they hoard. It also briefly covers service users' perspectives, risk assessment and interventions beyond social care. It is written in the English context so care is needed when referencing the legislation section.

The Life-Pod App. This app is described by Life-pod as being designed to help people reduce compulsive buying. They state it is easy-to-use and assists in; setting goals, developing strategies, recording purchases and making journal entries.

This paper has drawn a lot on the work conducted in Australia and this body of work may also be helpful. The McDermott and Gleeson (2009) study found that the service model should be based around: case management, coordination, flexibility, holistic assessment, staff supervision and sharing expertise. This work further describes a set of principles required to support the work. These included; respect, non-judgemental approaches, building trust and rapport, slow pace of work, consistent support, and transparency with all parties (McDermott and Gleeson, 2009). In addition the Junction Australia and Hoarding and Squalor websites may also be helpful.

In Summary

This paper provides an overview of some of the research and other tools developed in the field of self-neglect and hoarding. It demonstrates a clear resonance on key issues which need to be addressed and provides reference to resources which could be accessed to develop Adult Support and Protection practice.

To be effective in working with people experiencing self-neglect and hoarding, staff will require the scope to build relationships over time so as to understand the whole person; to better assess risk and capacity and to create flexible interventions using multi-agency resources (Braye et al 2015). Having reached the point of assessment this should commence with the service user's motivation to change before moving onto a detailed assessment of their situation (Holmes, 2015).

Successful interventions for hoarding using a CBT approach take approximately one year (Kress et al 2016) and this may be a guide for interventions regardless of the model used or whether the issue is one of hoarding or self-neglect. This is partly due to the need to develop strong and trusting relationships with the service user (Orr et al 2017) which is not short term in nature. This in turn may require a focus upon staff training, skill maintenance and confidence. Organisations may therefore wish to consider specific models e.g. CBT, Motivational Interviewing etc. Staff will also require opportunities for supervision and sharing expertise as well as clear procedures which locate self-neglect and hoarding within adult protection policies where appropriate. Where possible, engaging clinical psychologists locally to ascertain any scope for group supervision with those undertaking this work may be a useful model.

To address these issues assessment and care management arrangements need to be flexible and holistic within a multi - agency approach. They also need to include a clear assessment of

mental capacity in terms of the service users' ability to both articulate and demonstrate their decisions. The service user needs to be engaged respectfully, demonstrated by a non-judgmental approach with a goal of building trust and rapport through a consistent and transparent approach.

Where the issues of hoarding and self-neglect are noted as a priority by Adult Protection Committees, this briefing provides an overview of the issues and potential resources which could be used as the basis to develop interagency strategies and training as well as being a direct resource for individual practitioners.

Given the interest across Scotland at this time it may be worthwhile considering an inter-disciplinary/multi-agency national group to consider these materials and draft a guidance document in the Scottish context for others to consider. Such a group could also consider self-help models and perhaps encourage the development of such groups locally. On this basis this document will be shared with Adult Protection Committees for their consideration.

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