

## Why it matters

Self-neglect can include neglect of personal care, health and/or the home environment and can involve hoarding; it can lead to serious harm, safeguarding concerns and sometimes death.

People frequently experience shame, fear of losing control, and distress about others seeing their home; rapid 'clear-outs' or enforcement without engagement can be re-traumatising and often fails to achieve sustained change.

In Redbridge, there is a multi-agency Self-Neglect & Hoarding Protocol to support coordinated responses, risk management and escalation



## Trauma, self-neglect and hoarding: what might be going on?

Self-neglect/hoarding can be linked to:

bereavement, loss, relationship breakdown, or major life transitions

past or current abuse/violence, exploitation, neglect, institutional experiences

mental ill-health, neurodiversity, dementia, brain injury, executive functioning difficulties

isolation, poverty, substance use, physical ill-health or chronic pain

fear of services, prior negative experiences, or worries about eviction/losing pets or possessions

## What "trauma-informed practice" means

Trauma-informed practice means we:

- Realise trauma can affect individuals, families and communities and can shape behaviour and engagement.
- Recognise signs of trauma (for example, hypervigilance, distrust, avoidance, anger, shame, substance use, difficulties organising tasks).
- Respond by building safety and trust, offering choice, working collaboratively and empowering the person.
- Resist re-traumatisation (avoid actions/ communication that recreate feelings of powerlessness or threat).

## Redbridge SAB 7 Minute briefing Trauma Informed Practice Support, information & advice

## Six principles are the core elements of Trauma-Informed Practice:

**Safety:** Prioritise physical, psychological and emotional safety for the person and staff.

**Trustworthiness:** Be transparent: explain worries, options, thresholds, and what happens next.

**Choice:** Maximise choice and shared decision-making; pace work at what is tolerable.

**Collaboration:** Work "with" not "to"; coordinate across agencies with clear roles.

**Empowerment:** Build skills and confidence (small steps, strengths, celebrating progress).

**Cultural consideration:** Be curious and respectful about identity, culture, disability, trauma, and stigma.

[GOV Working Definition of TIP](#)

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## What good practice looks like:

### DO

- Lead with relationship:** first contacts are often about rapport and understanding, not "fixing the home".
- Use respectful, non-judgemental language** (e.g., "belongings/ possessions" not "rubbish").
- Ask permission** before moving/touching items; explain what you are worried about and why.
- Work at the adult's pace** with small, achievable goals ('harm-reduction'): access to exits, cooker, bathroom, bed.
- Be professionally curious:** explore the person's history, meaning of possessions, and what makes change possible.
- Check mental capacity** for the specific decision(s) and consider executive capacity (ability to carry out decisions).
- Coordinate multi-agency support** early (health, housing, fire, VCS) and agree a named lead and plan.

### DON'T

- Don't rush to enforcement** or clearance without a plan for engagement, consent (where possible), and aftercare—this can increase risk and trauma.
- Don't treat self-neglect/hoarding as a "lifestyle choice"** without exploring capacity, coercion, exploitation and the impact on others.
- Don't work alone:** avoid single-agency drift; use structured multi-agency risk management when risk is high or escalating.
- Staff wellbeing (vicarious trauma):** High-risk self-neglect/hoarding work can be emotionally taxing so use supervision/reflective space to debrief

## A simple 5-step approach for frontline staff

### Step 1: Prepare & safety-plan -

Plan the visit (lone working, PPE if needed, exits, pets, fire risk, infestations). Think: what might feel threatening to the person? How will we reduce shame and increase control?

### Step 2: Engage (first conversations) -

Start with "What matters to you?" and "What would make things a bit safer/easier?". Be clear about concerns (e.g., fire exits blocked, health risks) but stay collaborative and compassionate.

### Step 3: Assess risk and capacity -

Assess immediate risks to the adult/others (fire, trip hazards, infection, malnutrition, utilities, structural issues). Use RSAB tools where available (e.g., clutter image rating scale) and record evidence, not opinions. Consider mental capacity for key decisions and whether the person can implement decisions (executive capacity).

### Step 4: Agree a plan (harm-reduction + strengths) -

Agree small goals: clear a path to exit; safe use of cooker; access to bathroom; medication storage; refuse removal schedule. Identify who does what and by when; include contingency if engagement reduces. Offer practical and therapeutic support options (GP/CMHT, OT, housing, VCS, advocates, bereavement support).

### Step 5: Review, escalate, and sustain -

Review progress regularly; relapse prevention is normal—expect slow change. If risk is high or increasing, convene a multi-agency meeting and use the RSAB escalation/resolution process if needed.