



Hoarding and Severe Domestic Squalor

A Guideline for Western Australia

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Foot in the Door Guidelines: Stepping Towards a Solution to Resolve Incidents of Severe Domestic Squalor in South Australia.

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Introduction

Local government authorities and service providers have dealt with situations of hoarding and squalor for many years. There is increasing recognition that this public health issue is having a severe impact on the individuals involved, their families and any children or dependents, including animals, in their home. It can also impact neighbours and the surrounding community and requires significant resources from local government and other service providers. For this reason, some Australian states have developed recommendations regarding the most appropriate response to situations of hoarding and squalor in their jurisdiction. This has driven the development of a Western Australian toolkit to aid local government authorities in their response to situations of hoarding and squalor.

The Purpose of this Document

This guideline was primarily written to support Environmental Health Officers of local government in their response to individuals living in conditions of hoarding and squalor. However, as interagency collaboration is essential, it has also been developed to assist the various agencies who work with these individuals to better understand their role in supporting the individual.

It aims to:

- Provide information about hoarding and severe domestic squalor for Environmental Health Officers to increase their understanding of what is a complex problem for many individuals.
- Identify the current best principles of intervention, service provision and inter-agency coordination recommended by South Australian and Victorian Government, and other organisations nationally.
- Provides recent examples of interventions involving Western Australian local government, health professionals and non-government organisations to demonstrate the various current approaches to situations of hoarding and squalor.
- Raise awareness of the various agencies who may be of assistance to local government when managing cases of hoarding and squalor and
- Improve the benefits of a coordinated effort through cross agency responses.

Compulsive Hoarding

Nearly everyone keeps some things that they don't need or use. Keeping items in case they become useful in the future is fairly common.

For compulsive hoarders however, this behaviour is far more extreme.

People who compulsively hoard keep things for the same reasons as anyone else:

- For sentimental value and emotional attachment,
- For utility value and future usefulness, and
- For aesthetic value

Compulsive hoarders acquire more items than non-hoarders and although the items may be similar, people who hoard often collect identical and multiple types of the same item. Initially the individual's possessions may be organised but as the volume of items increases disorganisation generally follows.

For people who hoard, getting rid of extra possessions is extremely difficult and emotionally exhausting. Organising their possessions is also difficult and resisting the impulse to acquire new things is almost impossible.

Defining Compulsive Hoarding

There is no explicit definition of compulsive hoarding however the widely accepted international definition of compulsive hoarding is made up of three primary characteristics:

- The acquisition of and failure to discard a large number of possessions that appear to be useless or of limited value.
- Living spaces are cluttered to the point that they can't be used for the activities for which they were designed.
- Significant distress or impairment in functioning, caused by the hoarding.

(Frost & Gross 1993)

Characteristics of Compulsive Hoarding

A hoarder will begin by collecting items that are important to them and which potentially may be used in the future. This can then extend to seemingly useless items. To an objective outsider the need to collect such items will be clearly exaggerated by the hoarder. Having an understanding of the underlying cognitive processes which drive compulsive hoarding behaviour is critical in attempting to resolve such cases. These include compulsive acquisition, inability to discard possessions, poor organisational skills and avoidance behaviours (Cherian & Frost 2007)

Compulsive Acquisition

Individuals gather new items which they may not have identified as needing for a specific use but feel it is worth getting 'just in case' it is useful in the future. Acquisition is often associated

with a positive mood and can be used to compensate for the negative moods they may be experiencing. Acquisition can occur through purchasing, 'freebies' or stealing from a combination of commercial and non-commercial sites such as garage sales, newspapers, rubbish tips or on the internet. The continuous acquisition of items can lead to debt and depletion of personal savings (Tolin et al 2007). If the individual does not acquire the item they feel strongly about, they may feel grief and distress at the lost opportunity.

Inability to Discard Possessions

Possessions are associated with a feeling of safety and comfort and may be perceived as an extension of the person themselves. If someone was to move or discard their possessions the person may feel they have lost part of their identity. When discarding possessions they are likely to experience severe anxiety and distress because the items are perceived to have greater value than their true worth or have not yet been utilised to their full potential.

Poor Organisational Skills

Individuals find organisation of their possessions difficult and items often end up in haphazard piles leading to severe clutter. This clutter typically prevents the normal use of spaces for activities of daily living such as cooking, bathing and sleeping in a bed. Some individuals also prefer items to be stored in a place where they are visible so they don't forget where they are.

Avoidance Behaviours

The inability to make decisions about their possessions, such as where to store them or if they should be thrown out, often results in no decisions being made at all. This avoidance behaviour is viewed more favourably by the individual than potentially making the wrong decision about the items. Individuals who hoard are often perfectionists and fear the negative consequences of wrong decisions such as discarding an item which has not been used.

The majority of compulsive hoarders are not willing seekers of help. Their situation is often brought to the attention of local government or public health authorities after calls from concerned family, friends or neighbours or complaints about the condition of their property or their behaviour. Individuals are secretive, embarrassed and may be ashamed of their predicament. Avoiding visitors and distancing themselves from friends or family mean many individuals live many years in relative social isolation.

Animal Hoarding

The hoarding of animals is a specific type of hoarding, generally accompanied by the hoarding of other items, where individuals accumulate a large number of animals for which they are unable to provide adequate care. It is a complex behaviour resulting from psychological and behavioural deficits that may impede on a person's ability to care for themselves and their animals.

Characteristics of Animal Hoarding

- Failure to provide minimal standards of sanitations, space, nutrition and veterinary care for the animals,
- Inability to recognise the effects of this failure on the welfare of the animals, human members of the household and the environment,
- Obsessive attempts to accumulate or maintain a collection of animals in the face of progressively deteriorating conditions, and
- Denial or minimisation of problems and living conditions for people and animals.

(Patronek, Loar, Nathanson 2006)

Whilst animal hoarding may begin as an act of compassion, eventually the needs of the animals are neglected and compulsive care giving, despite being inadequate, is pursued to fulfil the unmet needs of the person.

Animal hoarders lack insight into the actual welfare of the animals, therefore they are often kept in overcrowded conditions, suffering from starvation, disease, behavioural problems and eventual death (Vaca-Guzman, Arluke 2005). Failure to properly dispose of animal excrement and the smells arising from these conditions is usually what brings animal hoarders to the attention of others (Macfarlane 2010).

A person who hoards animals can be any gender, age and from any socio-economic background.

Intervention in animal hoarding cases is almost always complex. There is no one universal solution. Each person comes with a different history, a different set of circumstances and resources, unique medical and psychological diagnoses that may all affect what kind of intervention might work best and very few people trained to assist.

Animal hoarding has almost a 100 per cent recidivist rate, meaning the person keeps offending. Some would say treatment of a person who hoards animals requires a lot of therapy, commitment and preparedness of the person to want to make a change to that behaviour. Simply taking away hoarded animals from the location can cause tremendous fear, apprehension, loneliness and grief for the person concerned. They may see the animals as a replacement for their family and be extremely distressed by threats to their desire to care for their animals. With enhanced knowledge and understanding of animal hoarding, human service professionals would be better prepared to respond, evoke greater rapport and cooperation and engage in the interdisciplinary efforts that are essential for optimal resolution.

Severe Domestic Squalor

Squalor describes an unsanitary living environment that has arisen from extreme and/or prolonged neglect and poses substantial health and safety risks to people or animals residing in the affected premises, as well as in the community.

Characteristics of Severe Domestic Squalor

Severe domestic squalor is a term used primarily in Australia and refers to households that are extremely cluttered, in a unsanitary or terrible condition, and where the accumulation of items such as personal possessions, rubbish, excrement and decomposing food creates an environment that jeopardises the health and wellbeing of the occupants. In addition, daily living activities such as cooking, bathing and sleeping are difficult or impossible.

Extreme cases of severe domestic squalor can also impact on neighbours, through the property being a fire hazard, emitting a foul odour or harbouring vermin.

Whether someone lives in 'squalor' can be a subjective judgement that is influenced by the attitudes, previous exposure to unclean environments and living condition of the person making the assessment. To enable objective labelling of dwellings there have been attempts to define:

- Poor living conditions – an appropriate and sensitive term for most unpleasant domestic situations
- Severe domestic squalor – which suggests more extreme conditions

Neither definition refers to the individual's financial means, employment status or their standing in the community (Snowdon 2005). Individuals living in situations of severe domestic squalor (with or without compulsive hoarding) can experience multiple negative consequences. These include:

- Risks to their safety due to falls, trips and slips
- Increased risk of fire due to accumulated refuse being a fire hazard and impeding the exit of the occupant and entry of emergency personnel in the case of a fire
- Being unable to receive certain services such as Home and Community Care because the squalor poses too great a risk for service providers to allow their staff inside (occupational health and safety regulations)
- Isolation from family, friends and the wider community due to their living conditions
- Insecure tenancy and higher risk of eviction and homelessness
- Complaints from neighbours, legal issues and council work orders.

Factors Contributing to Severe Domestic Squalor

Severe domestic squalor can occur in a range of household types and age groups, in both younger and older people, singles and couples.

There are multiple triggers, vulnerabilities and circumstances that can lead to a situation of severe domestic squalor such as:

- Obsessive compulsions and indecisiveness
- Apathy and impaired executive function resulting from brain disease or mental disorder can be attributed to the accumulation of rubbish and useless items
- Lack of impulse control

- Frontal lobe dysfunction (Snowdon 2009).
- Domestic violence, economic and cultural poverty, diverse cultural values and beliefs, war or other trauma
- Dementia or alcohol-related brain damage or mental health issues such as schizophrenia and depression present in 50-75% of people living in severe domestic squalor
- Drug addiction or loss of cognitive function

Studies have shown moderate to high rates of medical problems for people who live in severe domestic squalor conditions. In particular issues related to mobility, continence, sensory impairment (especially visual) and nutritional issues such as diabetes and obesity are co-morbid conditions.

Current research

Compulsive Hoarding

There have been no major epidemiological studies on the prevalence of compulsive hoarding in its own right. This is because compulsive hoarding was previously viewed as a symptom of Obsessive Compulsive Disorder (OCD), an anxiety disorder characterized by uneasiness, apprehension and repetitive behaviours or a combination of obsessions and compulsions aimed at reducing the anxiety. It is also difficult to estimate how many people are affected because people who have a hoarding problem tend to live alone and don't invite others into their home.

American literature reports OCD has a lifetime prevalence between one and three percent of the population and approximately 25-30% of people with OCD are clinical compulsive hoarders (Saxena, Maidment 2007).

A Victorian study indicated that 10-20% of all OCD patients have compulsive hoarding as their primary diagnosis and a further 40% have compulsive hoarding as a secondary symptom (Moore & Jeffreys 2008). Co morbidity in individuals with hoarding type OCD is extremely common with 92% having one or more additional psychiatric diagnosis.

The most common co morbidities in hoarding type OCD are:

- Major depression
- Bipolar disorder
- Substance abuse
- Panic disorder
- Generalised anxiety disorder
- Social phobia

Severe Domestic Squalor

Anecdotal evidence from agencies involved in working groups indicates that the incidence of hoarding and squalor is quite wide spread and is prevalent across all types of housing and socio economic status. People may be living in their own home, public housing or private rental properties. Individuals may be employed or living on income support.

A survey sent to the environmental health department at local governments throughout WA in August 2013 collected information about the number of cases currently estimated in each locality. There were responses from 41 of the 140 local governments.

- 46.3% reported 0-5 cases
- 14.8% reported 6-10 cases
- 7.4% reported 11-15 cases
- 0% reported 16-20 cases
- 3.7% reported 21+ cases
- 27.8% reported unknown number of case

The prevalence of SDS in Central Sydney is estimated to be 1.5 per 1000 in people aged 65+ (Snowdon 2009).

The prevalence rate of hoarding/SDS in South Australia was collected in a 2009 local government survey (Government of South Australia).

	2004	2005	2006	2007	2008
Total number of hoarding/SDS complaints	126	145	389	548	642
Of the number of complaints, the number found to be justified/substantiated	66	75	96	97	117
Total number of cases that were reoccurring cases previously investigated	18	22	26	28	41

The survey found that the total number of hoarding/SDS complaints rose significantly between 2004 and 2008 as did the number of justified complaints. In 2008, 41 of the 117 cases were reoccurring cases, indicating that approximately 35% of cases were not resolved successfully.

Underlying Issues Associated with Severe Domestic Squalor

Mental Health, Physical Health and Disability

National and international research suggests that more than two thirds of people living in SDS have an active mental illness (Halliday, Banerjee, Philpot, Macdonald 2000). The most commonly identified mental illnesses are dementia, substance abuse, schizophrenia and to a lesser extent developmental disorders and depression. A form of physical disability is not uncommon in people living in SDS including mobility, continence and sensory impairment (Northern Sydney SDS Working Party 2005).

A literature review of 1100 cases of SDS found that over half of the cases were elderly individuals and the most common diagnosis reached was dementia (Snowdon, Shah, Halliday 2007).

A cross-sectional study in London, of people living in squalor and who received cleaning services, used standardized instruments to investigate the relationship between squalor and mental and physical disability (Halliday, Banjeree, Philpot, MacDonald 2000). 51% of the 81 person sample group were under 65 years of age. The study found:

- 70% had an ICD-10 mental disorder
 - Schizophrenia
 - Dementia
 - Organic mental disorder
 - Anxiety-related disorder
 - Mood disorder
 - Developmental disability
- Alcohol and/or drug abuse often present with other mental disorder and without.

- 26% had a physical disability which contributed to their squalor.

Snowdon and Halliday found that of clients aged 65+ living in severe or moderate squalor in Central Sydney 2000-2008:

- 40% suffered dementia
- 20% had alcohol related brain damage and/or alcohol abuse
- 13% suffered from schizophrenia
- As well as obsessive compulsive disorder, depression, frailty and medical illness

Drug and Alcohol Misuse

Snowden et al. (2007) found that alcohol abuse was present in 27% of SDS case reports. A further 10% of clients use other substances. In these cases the person's behavior may be due to other problems such as drug addiction or loss of cognitive function that impacts on their ability to make judgments.

Housing Insecurity and Risk of Eviction

McDermott and Gleeson's Australian study (2009) on SDS reported that 54% of clients were living in public housing, 39% were in privately owned homes and 7% were living in private rental accommodation. People living in squalor are also more likely to experience housing insecurity and this was true for 41% of clients in their study.

Snowdon and Halliday found that of clients aged 65+ living in severe or moderate squalor in Central Sydney 2000-2008:

- 43% lived in Department of Housing properties
- 43% were owner occupiers (or owned by a close relative)
- Remainder in private rental, NGO-run accommodation

A Clinical Perspective – International Classification

Research in the mental health field is being undertaken internationally to more accurately define hoarding behaviour.

Diagnostic and Statistical Manual of Mental Disorders

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM) is used by health professionals to varying degrees internationally and although not used by health professionals in Australia, it is often referred to by policy makers when making funding decisions and is widely cited as a reason for clinical interventions.

Previously, compulsive hoarding was one of the eight symptoms of obsessive compulsive disorder (OCD) and obsessive compulsive personality disorder (OCPD). There is significant evidence that compulsive hoarding would be more accurately classified as a disorder rather than a symptom of OCD and OCPD (Pertusa et al. 2008). The latest edition of the DSM-5, released in May 2013, states:

Hoarding Disorder Diagnostic Criteria

- A. Persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions.
- B. This difficulty is due to strong urges to save items and/or distress associated with discarding.
- C. The symptoms result in the accumulation of a large number of possessions that fill up and clutter active living areas of the home or workplace to the extent that their intended use is no longer possible. If all living areas become decluttered, it is only because of the interventions of third parties (e.g., family members, cleaners, authorities).
- D. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
- E. The hoarding symptoms are not due to a general medical condition (e.g., brain injury, cerebrovascular disease).
- F. The hoarding symptoms are not restricted to the symptoms of another mental disorder (e.g., hoarding due to obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another Psychotic Disorder, cognitive deficits in Dementia, restricted interests in Autism Spectrum Disorder).

International Classification of Diseases

International Classification of Diseases (ICD-10) is an international standard diagnostic classification for all general epidemiological purposes as well as health management and clinical use.

Hoarding is not explicitly covered in ICD-10.

Catholic Community Services Severe Domestic Squalor Pilot Project – Sydney, NSW

Funded by the NSW Department of Ageing, Disability and Home Care the SDS project provided assessments for people living in squalor, who if accepted for further intervention, received individual case management and coordinated service delivery from a range of service providers to assist them.

Between 1 August 2008 and 31 July 2009, 218 individuals were referred to the program, of which 55% were male, 45% were female, the average age was 62 years old and 58% were under the age of 65. Individuals were referred by 12 sources including The Housing Department NSW, Home and Community Care Services, community mental health services and community health services. 208 individuals were assessed for program eligibility and 110 individuals were accepted into the program. Upon entry individuals were experiencing on average, five negative consequences of living in severe domestic squalor, such as safety and fire risks, were unable to receive services, were isolated and had insecure tenancy (threat of eviction).

When in the program, clients received comprehensive assessment, service coordination, advocacy, referral and case management. The services provided for each client were

coordinated by a single case worker who could deliver individualised, flexible and sustainable care specific to the client's situation.

The project interventions focused on three key areas;

- Reducing the consequences associated with squalor,
- Addressing any underlying impairments and
- Improving the client's living conditions.

(McDermott & Gleeson 2009).

Key Purposes of Case Management

- To achieve an optimal outcome for the client from planned and coordinated support service intervention
- To maximise client involvement in decision making
- To empower the client to take maximum control of their situation and be as independent as possible
- To provide quality support in line with the agreed plan of care
- To ensure all stakeholders work in collaborative and coordinated way to address client support issues.

Case Management Process

Engagement	A trusting and working relationship is established and agreement to engage with a case management process agreed.
Holistic Assessment	A comprehensive picture of the client, their situation, needs, strengths, abilities and resources is developed.
Planning	A goal orientated plan of action to address client needs and support gaps is negotiated with the client and co workers.
Implementation	A range of formal and informal support services are put in place to meet case planning goals.
Monitoring	The case plan is monitored and adjusted to meet changing needs.
Closure	The effectiveness of the case plan in meeting agreed goals is evaluated, documentation completed, client feedback sought and the client/case manager relationship ended.

(Cripps, Roberson 2009).

Outcomes for Clients and Service Providers

Upon exit from the program a sample of 57 clients who participated in the program for an average of six months, was used to determine if the program had achieved its goals. Quantitative client data collected at entry and exit of the program was supplemented by qualitative data from interviews with stakeholders and clients.

The assessment found:

- A significant decrease in the number of consequences experienced from living in squalor from an average of five to less than one.
- A significant decrease in the experience of safety, health and fire risks from living in squalor and the associated ineligibility for services due to OHS risks.
- Reduced isolation from wider the community and increased social involvement.
- Rreduced risk of eviction from current home.
- Increased involvement from other agencies to appropriately address underlying issues experienced by people living in squalor particularly community services and aged care services.
- Increased access to kitchen and sleeping areas and decrease in global measure or squalor in home.

Recommendations for future intervention and service delivery based on the SDS Project evaluation

These recommendations were based on the results from the project evaluation. Feedback was sought from case workers, health practitioners and clients on what they found to be the projects strengths and limitations. They are most relevant to support service providers however can be applied to local government Environmental Health Officers to provide guidance on the development of future hoarding and squalor intervention practices

Service Model

- Case management – ideally this would be provided by a central organisation that has knowledge, expertise and resources to appropriately address the squalor.
- Service coordination – involving relevant agencies to ensure that underlying issues are addressed and avoid duplication of services.
- Flexible and individualised support – workers must be given time and resources to build trust and foster relationships with people living in squalor, accounting for individual circumstances when developing strategy of service provision.
- Ongoing support – support that is not limited by time.
- Holistic assessment, support and sustainability – promoting sustainable outcomes using services that address underlying issues and the consequences associating with squalid living conditions.
- Staff supervision – provision of support structures for staff.
- Sharing expertise and advice – use of formal and informal approaches to build community capacity response to squalor.

Service Principles

- Respect for client and non-judgemental attitudes
- Develop trust and rapport
- Move slowly and don't expect changes to living conditions to happen immediately
- Quick fix (one-off clean-ups) are usually not sustainable and can jeopardise trust between client and service providers
- Provide consistent ongoing support
- Communicate regularly with client and other service providers

(McDermott, Gleeson 2009).

The SDS project has been adopted by four teams in the Sydney region who are co-located with other aged and community care programs run by Catholic Community Services. They continue to use the strategies of the pilot project and are funded by NSW Aging Disability and Home Care.

Severe Domestic Squalor Guidelines

Severe Domestic Squalor has been recognised internationally as a complex issue with a wide range of factors to consider when planning an intervention. Over the past ten years several authorities have developed guidelines and action plans specific to squalor (and hoarding) including the Ottawa community in Canada, the Middlesex-London Health Unit in London, the Mental Health Association of San Francisco, the Department of Aging Disability and Home Care New South Wales and in Public and the Environmental Health Council in South Australia.

Each of these guidelines highlighted the importance of creating interagency partnerships and coordination between service providers. It is widely acknowledged that hoarding and severe domestic squalor require a multidisciplinary response to achieve successful outcomes.

The key recommendations from each of these guidelines are below:

Key Recommendations	Reference
Develop a hoarding task force and case management approach.	<ul style="list-style-type: none"> ➤ Merkel 2007 ➤ The NSW Department of Aging Disability and Home Care 2007
Develop an agreed interagency protocol/service agreement.	<ul style="list-style-type: none"> ➤ Middlesex-London Health Unit 2000 ➤ Dinning 2006 ➤ The NSW Department of Aging Disability and Home Care 2007 ➤ The NSW Department of Aging Disability and Home Care 2004 ➤ Mental Health Association of San Francisco 2009
Develop educational materials for those involved in compulsive hoarding (including both clients and health professionals).	<ul style="list-style-type: none"> ➤ Merkel 2007 ➤ Middlesex-London Health Unit 2000 ➤ Dinning 2006 ➤ The NSW Department of Aging Disability and Home Care 2004
Focus efforts on early detection and resolution.	<ul style="list-style-type: none"> ➤ Middlesex-London Health Unit 2000
Provide ongoing support to the individual (relapse prevention).	<ul style="list-style-type: none"> ➤ Middlesex-London Health Unit 2000 ➤ The NSW Department of Aging Disability and Home Care 2007
Develop a localised inventory of hoarding related stakeholders and outline their roles.	<ul style="list-style-type: none"> ➤ Dinning 2006 ➤ Middlesex-London Health Unit 2000 ➤ Mental Health Association of San Francisco 2009
Develop a standardised assessment tool and management checklist.	<ul style="list-style-type: none"> ➤ The NSW Department of Aging Disability and Home Care 2004
Increase access to treatment.	<ul style="list-style-type: none"> ➤ Mental Health Association of San

	Francisco 2009
Establish a single entry point for referrals.	➤ Mental Health Association of San Francisco 2009

Responding to Hoarding and Squalor

The following information is designed to guide service providers in their response to cases of hoarding and squalor.

Principles Underpinning the Service Response

Environmental Health Officers may not necessarily be focusing on the needs of the person, but on the public and environmental health impact of their living conditions. Regardless of the intention of the service, the following principles should be considered when planning a response to situations of hoarding and squalor. Agencies need to work together to ensure that range of services involved address these principles.

- Competence – Individuals living in situations of hoarding and squalor are considered competent to make informed decisions unless there is evidence to the contrary.
- Self-determination – With the appropriate information and support that recognises diversity, individuals should be encouraged to make their own decisions.
- Appropriate protection – Where a person is not competent to make their own decisions due to mental incapacity or being a younger person or child, it may be necessary to appoint a guardian or administrator. Even when a person or child is unable to make all decisions themselves, their views should be taken into account as far as possible. The welfare of any affected animals must also be appropriately protected.
- Promote personal and social wellbeing – The promotion of a person's, child's or animal's safety and wellbeing is essential and equally important.
- Recognition of relationships – All responses to hoarding and squalor cases should be respectful and inclusive of existing relationships that are considered important to the person living in those conditions.
- Collaborative responses – Effective prevention and response requires a collaborative approach that recognises the complexity of the issue, and the roles, skills and experience of appropriate services, including those responding from regulatory and support frameworks.
- Community engagement – The most effective response is achieved when agencies and services work collaboratively and in partnership with the community.

(Victorian Department of Health 2013).

Intra-Agency Collaboration

Local Government have a range of services which can work together to manage cases of hoarding and squalor. Whilst collaborating with external agencies will enable the most comprehensive response, local government services also have the ability to assist people living in hoarding and squalor conditions. It is for the Local Government itself to discuss and implement procedures that enable coordination between departments.

A response to cases of hoarding and squalor is shared amongst service providers and no one agency is solely responsible for the outcome. A common understanding between all services about how they can best work together, combine expertise and deliver a coordinated effort is necessary to deliver an integrated service and achieve sustainable outcomes for people living with hoarding and squalor.

This approach has been recommended by: SA Guidelines 'A Foot in the Door', NSW Catholic Community Services Severe Domestic Squalor Pilot Project (McDermott & Gleeson 2009), VIC Department of Health Discussion Paper (2013) and Practical Resource for Service Providers (2013) and international literature.

Which Services Respond?

A multidisciplinary intervention involving services from various sectors is recommended for people with complex needs such as someone with hoarding behaviours or who is living in a squalid environment. They may have multiple or chronic issues which need to be addressed.

For example the person may:

- Be difficult to engage, have been stigmatised by worker perceptions or have limited trust in the system, service providers and other people
- Have behaviour management or poor self-management issues
- Not have accessed reliable and accurate assessments (and have a possible undiagnosed condition)
- Have an acquired brain injury, physical health issues, mental health issues, suicide/self-harm issues, an intellectual disability, use alcohol or other drugs or be exposed to violence
- Experience or be at risk of homelessness
- Have dependents including people who are elderly, frail, disabled, children or animals
- Have neglected the state of buildings and surrounding property.

Each service provider should have a means by which a client can be linked to other services as required to meet their complete range of needs, including those of animals, in a timely manner.

Currently there are different types of existing services who respond largely independently to cases of hoarding and squalor. Establishing an agreed yet flexible way of providing those services together will benefit the person with hoarding and squalor and the service providers.

The Benefits of Service Coordination

For the person with hoarding and squalor:

- Provision of up-to-date information about services available in the local area and who best to contact in specific circumstances
- Each service provider can act as an access point to all types of services – allowing clear and consistent referral pathways
- Improved response times to requests for information and referral
- Information transferred confidentially between relevant service providers as required- no need to repeat their information
- Improved and timely identification of needs
- Consistent service standards from each provider

1. Initial Referral

Local government often receive the first referrals or requests for assistance in cases of people living in hoarding and squalor conditions. This may result in the local government employees becoming the 'key worker' or coordinator of such cases. Local government can provide assistance to the client and also refer the person to other appropriate health and community services such as mental health, aged care, drug and alcohol, NGO or HACC.

Local government may also be contacted by neighbours, friends or relatives who have concerns or complaints regarding someone living in hoarding or squalor conditions.

Other agencies, including Regional Assessment Services, Aged Care Assessment Teams, Home and Community Care Workers, Allied Health Workers, Tenancy Support Workers and Department of Housing Officers, may also be notified of or discover hoarding and squalor issues in their clients and contact local government,.

Useful information to collect at initial referral (if possible);

- Length of time person has been living in unclean conditions
- Type of housing person lives in (privately owned, rented or public housing)
- Family, carer, friend or neighbour visiting regularly?
- Occurrence of neighbour disputes
- Utilities in home and community services
- Person's character, habits and medical/psychiatric history
- Others living in house or animals
- Language or communication barriers

If the referral indicates that the property may be posing risks to public health, the Environmental Health Officer may undertake an inspection. Prior to this occurring, and only if possible, it is beneficial to contact the person's family, friends or next of kin, GP or other agencies who may be assisting the person. This can help identify who has a relationship of trust with the person living in hoarding and squalor conditions, who may be the most appropriate person to broach the subject. It may also reveal that other agencies have already taken steps to manage the hoarding and squalor situation prior to local government involvement.

Referral and Disclosure of Personal Information

Referral is the transmission of personal or health information relating to an individual from one agency to another. This is done for the purpose of further assessment, care or treatment. Referral between agencies is vital to interagency collaboration and providing a holistic service to people living in situations of hoarding and squalor.

All agency personnel need to handle a clients personal and health information in accordance with the requirements imposed by the relevant privacy legislation. Workers are also encouraged to become familiar with their agencies privacy and confidentiality policy and procedures.

Privacy laws require that if an organisation is going to collect personal or health information, the client must be informed of the intended use of the information. The client must also consent in writing to the collection, proposed use and future disclosure of the information.

It is recommended that common agreements should be reached between services regarding the disclosure of information, to ensure that the sharing of a client's personal and health information between services occurs in accordance with privacy laws.

2. The Home Visit

The purpose of the initial home visit is to;

- determine if hoarding is present;
- assess whether the person is living in squalor and to rate the extent of the squalor;
- assess the nature and severity of any associated health and lifestyle issues; and

- ask a preliminary identification of strategies required to address the issues identified.

The agency that received the initial referral should conduct the first home visit. However, in some cases it may be more appropriate for another staff member or agency to either undertake the visit or accompany the person conducting the visit. Such instances could be where certain risks have been identified, such as child neglect, poor animal welfare or a fire hazard, or if the client has developed rapport with a particular agency or staff member. Environmental Health Officers should follow their usual procedure in arranging an inspection to the person's home.

When undertaking the home visit, it is important to be mindful that the nature of the initial contact made with the client is extremely important; it can have a significant bearing on the client's acceptance of help. Therefore, it is important that workers approach the client with sensitivity and respect. Generally, the client is more likely to be successfully engaged if an interest is shown in them and their particular reason for needing help. If the person agrees to accept help, the likelihood of achieving significant change and improving conditions for the individual and others is considerably greater.

Options that could be considered include:

- If the person is too fearful to open the door, try leaving a note in the mailbox or under the door, asking them to make contact. Keeping privacy concerns in mind, discrete enquiries with neighbours might be of assistance.
- If the person requests an interpreter or has inadequate language skills, a professional interpreter should be used. Refer to your organisation's procedures regarding the engagement and use of interpreters. Cultural and linguistic factors can impact on the success of engagement with the person.
- Ask the person how he/she feels that they could benefit from help, and identify the perceived needs.
- Be persistent, sensitive to the person's needs and careful not to overwhelm them. Even if their initial reaction is negative and they reject any intervention, it is still important to continue to try to establish a relationship.
- Avoid imposing your own values and judgement. Many people living in squalor often do not even perceive that their home is dirty.
- Take time. An immediate focus on a need for cleaning can cause distress, and sabotage chances of achieving a successful alliance.

3. The Assessment

It is important to carefully distinguish hoarding disorder from non-pathological collecting, as well as from the general medical conditions that may result in the accumulation of possessions. Each case of hoarding and severe domestic squalor can differ significantly in nature and severity and it is unlikely that any two cases will be treated the same. The associated risks to the individual, neighbours and the community also vary depending on the degree of hoarding and severe domestic squalor on the property. For this reason several assessment scales have been designed to allow service providers to objectively assess the severity of the situation,

inform the appropriate intervention strategies and also provide a common language and understanding of each case across agencies. These include:

- The Environmental Cleanliness and Clutter Scale (Halliday, Snowdon 2006)
- Clutter Image Rating Scale (Steketee & Frost 2007)
- The Severe Domestic Squalor Assessment Scale (Government of South Australia)
- Hoarding Rating Scale (Tolin et al 2008)

Use of these assessment tools requires no or minimal specific training and can provide useful information about the severity of hoarded materials, hoarding behaviour and squalor. They can also be shared with other agencies that may be involved in the case and can be useful when coordinating a response between multiple services. A modified assessment tool has been developed to use in Western Australia and can be found in Appendix 1. The use of this tool is recommended to all local governments as it provides a clear picture of the condition of the property and the associated risks, so everyone has the same understanding of the situation and it reduces the need for multiple assessments of the property to be undertaken. It also avoids any insensitive language that may otherwise have been used to describe the condition of an individual's home. The assessment should ideally be conducted directly with the sufferer and in the person's home. If the individual of interest is not available or refuses to be interviewed, this interview may be administered to a reliable informant.

Other Assessment Tools

Clutter Image Rating Scale

This novel assessment tool was developed to overcome the over- and under-reporting of the severity of clutter by the person themselves or service providers during assessment. It contains a series of nine images displaying rooms with increasing levels of clutter from clutter-free to severely cluttered. It can be completed by the person, service provider or both simultaneously, by selecting the image that most closely resembles the level of clutter in a room of their home. There are images of a living room, kitchen and bathroom however they could be applied to many areas of the home.

A benefit of the Clutter Image Rating Scale is that it eliminates the need for language to describe the level of clutter in the home and also can objectively record changes in clutter over time if completed throughout the duration of the intervention. Generally, clutter that reaches image four and above is having an impact on their life and it is recommended they seek assistance for their hoarding behaviour.

The Clutter Image Rating Scale has been used in a variety of recent studies and has been found to correlate highly with the Hoarding Rating Scale (found below), particularly the item assessing clutter.

This tool only measures clutter, and should be supplemented with tools that measure other aspects of hoarding (Tolin et al. 2010).

A copy of the Clutter Image Rating Scale available at Appendix 2.

The Severe Domestic Squalor Assessment Scale

A modified version of the Environmental Cleanliness and Clutter Scale, called The Severe Domestic Squalor Assessment Scale (SDSAS), has been developed in South Australia to reflect their delivery of services and highlight when intervention is required. The SDSAS also accounts for the accumulation of items outside as well as inside the home, as most properties have a yard. The same rating scale as the ECCS is used.

A copy of the Severe Domestic Squalor Assessment Scale can be found in 'A Foot in the Door' SA Guidelines or at ;

http://www.sa.gov.au/upload/franchise/Housing,%20property%20and%20land/Housing%20SA/CH/Domestic_squalor_guidelines_community_housing.pdf

The Hoarding Rating Scale

This is a brief semi-structured interview that assesses the features of compulsive hoarding such as clutter, difficulty discarding, acquisition, distress and impairment. It can quickly determine the presence and severity of compulsive hoarding through the interview questions. It is not necessary that Environmental Health Officers conduct this assessment however it may be useful for informing the referral of an individual to mental health services. Most commonly mental health practitioners or other service providers will assess the severity of an individual's hoarding behaviour.

The Hoarding Rating Scale is appropriate for assessing symptoms of compulsive hoarding in clinical and non-clinical environments between a worker and the person concerned.

The five questions include three about clutter, difficulty discarding and excessive acquisition while the other two focus on distress and interference caused by the hoarding behaviour. Initial studies suggest that a score of 14 or higher indicates a probable hoarding problem.

A copy of the Hoarding Rating Scale available at Appendix 3.

Mental Capacity and Competence

'Mental capacity' is most commonly assessed clinically by medical professionals such as psychiatrists. This may include assessment of cognitive skills, including, awareness, knowledge, judgement and reasoning, as well as their ability to execute decision making and actions.

The capacity to live independently requires the person to be able to understand the decision at hand, perform activities of daily living in their home and to appreciate their limitations or care needs.

A person living in situations of hoarding and squalor who refuses assessment of their mental capacity may or may not be aware of the potential consequences of their decisions and the associated risks. As long as they can demonstrate understanding of the choices and their consequences, they are generally considered to have mental capacity sufficient to make this decision. If workers are uncertain about the decision-making capacity of the person, they are recommended to seek advice from the Public Advocate, General Practitioner or Psychiatrist.

If it is determined that the person is lacking the mental capacity to make decisions about their circumstances, they may need to be made on their behalf. If this is the case consideration

should be given to the person's autonomy and values, while also protecting the person from further harm and minimising harm to others. A guardian may be appointed as a substitute decision-maker.

'Competence' is a legal term that is usually presumed unless a court has determined otherwise. Evidence is presented by medical officers, family members and individuals and based on this a judgement about whether the person is competent to make certain decisions is made.

Being incompetent and lacking mental capacity are not all-inclusive terms. A person can demonstrate lacking capacity in one domain however this does not mean that the person is not capable of rational decisions across other domains and vice versa.

4. Planning an Intervention for Squalor where Compulsive Hoarding is Present

When a living environment containing hoarded items and squalor causes distress, impairment or is unsafe to the person or the immediate neighbourhood, an intervention is required. Environmental Health Officers may only be necessary in the instance that the items are posing a risk to public health. However if the presence of significant hoarding is not posing a risk to public health but may be impacting negatively on the person, it is encouraged that the relevant service providers are contacted.

The following information is primarily for interventions in compulsive hoarding cases including those resulting in severe domestic squalor. Although it may not be utilised by Environmental Health Officers, understanding the intervention strategies in cases of compulsive hoarding enables the shared understanding between various service providers about the multidisciplinary response required by hoarding and squalor cases.

The Shared Action Plan Checklist contained within 'A Practical Resource for Service Providers' can be used to assist agencies work together in planning, delivering and reviewing the services provided to people living in situations of hoarding and squalor. It relies heavily on the collaboration between service providers to deliver a single response. Completing the Shared Action Plan Checklist may also give local government and others a greater understanding of what is required for effective inter-agency collaboration.

A copy of the Shared Action Plan Checklist is available at Appendix 4.

The Quick Fix is Ineffective

International and national stakeholders from various sectors agree that the quick fix, a one off enforced physical clean-up, is an ineffective response to compulsive hoarding cases and it is discouraged because:

- It can cause extreme anxiety, trauma, depression and even suicide as the person has not willingly consented to the clean-up
- The home will revert to its original state, filled with collected items
- It does not address the underlying psychological disorder, only removes the symptoms of hoarding behaviours

(Mogan 2010).

Trying to remove the physical evidence of compulsive hoarding behaviours or another underlying mental or physical condition does not bring about change. Health (including mental health) and community services need to work with the person to achieve gradual and sustainable change.

The sometimes severe adverse reaction to clean-ups has caused them to be banned in some US states and counties.

(VIC Department of Health 2013).

Psychological or Medical Treatments

Unfortunately compulsive hoarding, either alone or in the presence of OCD, does not generally respond well to conventional medical treatments. Approximately only one third of individuals medicated for hoarding behaviour show adequate improvement. There may be no 'cure' for hoarding, however clinical assistance can support individuals transitioning from hoarding behaviours to more sustainable and healthy behaviours. The treatment of hoarding is complex because compulsive hoarders:

- Have highly personalised reasons for hoarding
- Have ambivalent and avoidant personality styles
- Are uncertain about themselves leading to object-driven compensation
- Need treatment to accommodate interfering variables such as rigidity, control and reluctance for treatment
- Fear making decisions and have ingrained beliefs about their possessions

Treatment of hoarding requires:

- Assessment by a mental health professional such as a psychologist or psychiatrist to determine broad and specific treatment goals
- Liaison with health and welfare agencies because hoarding requires collaboration
- The understanding that therapy/counselling are not a quick fix, there is a focus on harm minimisation and achieving goals

A Cognitive Behavioural Therapy (CBT) protocol for hoarding has shown promise. CBT aims to help the person understand that they over-value their possessions to the extent that they form their sense of identity and safety.

An effective treatment strategy will challenge the beliefs and thoughts of a hoarder, for example:

- Someone will find this item useful.
- I never throw anything away.
- I must keep all things that remind me of this person.
- I know exactly where everything is.
- How helpful to me is this clutter and mess?
- These things are my life, I don't know why!
- Throwing things away is rejecting them.
- Keeping a thing is to accept it into my life.

The CBT protocol for hoarding delivers treatment in a group format and focuses on compulsive acquisition, difficulty in discarding clutter and disorganisation. Identification of the thoughts and

emotions that sustain these hoarding behaviours allows the group as a whole to question their validity.

Barriers to Intervention Strategies

Many barriers to the effectiveness of intervention strategies stem from the hoarding individual themselves. Individuals often hide their hoarding behaviours in fear of embarrassment and therefore do not seek the assistance of health professionals until years after hoarding began. There is also limited awareness amongst the general public and perhaps hoarders themselves about compulsive hoarding as an illness itself or symptom of OCD. The lack of insight into the severity and impact of their hoarding behaviours essentially prohibits the success of any form of treatment. When people do not have insight into their illness they are more likely to drop out of treatment programs, stop taking medication or never even seek support at all.

The lack of training specific to compulsive hoarding by health professionals means individuals often receive the wrong diagnosis and do not receive the treatment most appropriate to them. There is also difficulty in finding local health professionals as well as the cost of treatment, which both act as barriers to individuals who have decided to seek assistance or family or friends who are concerned about their behaviours.

Arranging Cleaning Services

Although not an effective sustainable solution to hoarding and squalor, clearing and cleaning of a property may be necessary and can be required under the *Health Act 1911*. For example if the occupant is at risk of eviction if the condition of their property does not improve or if their living conditions are posing immediate threat to their health and well-being (also consider temporary accommodation in these circumstances). Conversely, during the course of the intervention, the individual may accept the assistance of specialist services to remove items and/or refuse and clean-up.

The process of arranging cleaning services for individuals can be found at Appendix 5 (engaged clients) and Appendix 6 (disengaged clients).

An agreement in writing between the client and cleaning service can identify which items can and cannot be removed during cleaning and prevent subsequent accusations from the client that items were moved without their permission or stolen.

A flow chart regarding the planning for cleaning for co-operative and unco-operative clients can be found in Appendix 5 and 6 respectively and a copy of a Cleaning Services Agreement can be found at Appendix 7.

The Compliance Role of the Environmental Health Officer

It is sometimes the case that despite the best efforts of Environmental Health Officers and other support services, that individuals living in situations of hoarding and domestic squalor are not responsive to the intervention strategies and their property remains in a state that causes a nuisance or danger to public health. There are also situations where the individual is competent and capable of making the decision to improve the standard of their property and carry out the works to do so, however choose not to. In these cases it may be necessary for Environmental Health Officers to use a legislative approach.

The *Health Act 1911* empowers local government to develop local laws regarding how situations of hoarding and domestic squalor causing a nuisance or danger to public health can be dealt with by Environmental Health Officers. A simplified version of the section of the Health Act pertaining to situations of hoarding and squalor can be found in Appendix 8.

Information about Service Providers

Government Agencies

North Metropolitan Health Service (08) 9346 3333 www.nmahs.health.wa.gov.au

South Metropolitan Health Service (08) 9318 7500
www.southmetropolitan.health.wa.gov.au

WA Country Health Service www.wacountry.health.wa.gov.au

Home and Community Care (HACC)

HACC is a cost-shared program between the Commonwealth and State/Territory Governments. It provides funding for services that support people who live at home and whose capacity of independent living is at risk of premature or inappropriate admission to long term residential care.

A person may be eligible for HACC if they:

- are older and frail and having difficulty with everyday tasks
- have a disability
- are the carer of a frail older person or someone with a disability

HACC Regional Assessment Services (RAS) will assess a person's eligibility for HACC support and identify their needs and goals. Following the assessment the RAS assessor will refer the client for appropriate support within or outside the HACC program.

The HACC Program seeks a contribution from clients toward the cost of the support services provided that is fair and affordable. The contribution is based on the level of support that a person receives. People receiving a number of support services from HACC service providers are protected from paying excessive fees by an applied limit called a 'Fees Cap'. The HACC Fees Cap is increased annually effective 1 July. No person will be denied a service because they cannot afford to pay.

Services which are provided under the program include:

- Counselling, support, information and advocacy
- Domestic assistance
- Social support
- Nursing care
- Personal care
- Allied health care
- Respite care
- Centre based day care
- Food services
- Home maintenance
- Home modification
- Transport

For more information, visit the WA Department of Health
www.health.wa.gov.au/hacc/home/index.cfm

Commonwealth Respite and Carelink Centres

Information centres for older people, people with disabilities and those who provide care and services

Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere in Australia

For more information 1800 052 222

Department of Environment Regulation

The Atrium, Level 4
168 St Georges Terrace.
Perth WA 6000

Tel: (08) 6467 5000

Fax : (08) 6467 5562

Email address: info@der.wa.gov.au

Website: www.der.wa.gov.au

Regional offices contact details

Albany - 120 Albany Highway, Albany WA 6330

Phone: 08 9842 4567

Fax: 08 9841 7105

Email: southcoast@der.wa.gov.au

Booragoon 181-205 Davy Street, Booragoon

Phone: 08 9333 7510

E: grswanbooragoon@der.wa.gov.au

Broome - 111 Herbert Street, Broome WA 6725

Phone: 08 9195 5538

Fax: 08 9193 5027

Bunbury - Cnr of Dodson Road and South West Highway, Bunbury

Phone: 08 9725 4300

Email: grswanbunbury@der.wa.gov.au

Geraldton - Level 1, 201 Foreshore Drive, Geraldton WA 6531

Phone: 08 9964 0901

Email: midwest@der.wa.gov.au

Kalgoorlie - 32 Brookman Street, WA 6433

Phone: 08 9080 5555

Fax: 08 9021 7831

Email: goldfields@der.wa.gov.au

Karratha - Lot 3 Mardie/Anderson Roads, Karratha WA 6714

Phone: 08 9182 2000

Fax: 08 9144 2000

Email: northwest@der.wa.gov.au

Kununurra - Lot 248 Ivanhoe Road, Kununurra WA 6743
Phone: 08 9168 4200
Fax: 09 9168 2179

Mental Health Services

- Specialist mental health services are in place in the public sector and also in the private sector.
- Mental Health Services (MHS) provide mental health services across the age spectrum, including crisis response, assessment, inpatient and community treatment, rehabilitation and support to people experiencing mental health problems and disorders, and their families and carers.
- In a number of MHSs, there are designated Specialist Mental Health Services for Older People that have a specialist capacity to assess, treat and manage a complex range of mental health disorders in older people.
- People who live in severe domestic squalor are often referred to Specialist Mental Health Services for Older People or Adult Mental Health Services, in order to assess whether a mental health problem may have precipitated or led to the unclean living situation. Some people may be transferred to an inpatient unit under the Mental Health Act as mentally ill or mentally disordered, permitting a brief period of hospitalisation for assessment and ongoing management.

For more information contact WA Department of Health on (08) 9222 4222,
www.health.wa.gov.au

Aged Care Assessment Teams (ACATs)

- Aged Care Assessment Teams (ACATs) comprehensively assess the needs of frail older people and assist them and their carers to access available care services appropriate to their needs.
- ACATs provide information to suitable care options, and can help arrange access or referral to appropriate residential or community care services such as Home and Community Care (HACC). ACAT assessment and approval is required before people can access residential aged care, Community Aged Care Packages (CACPs) or Extended Care at Home (EACH) Packages.

ACATs provide a range of assessments including:

- The duration and severity of domestic squalor
- Whether the person has dementia or other health issues
- How the person is managing financially
- Whether the person is at risk of abuse

Other ACAT services include:

- Negotiating with family/friends and offering appropriate support
- Organising cleaning

For further information contact Local Aged Care Assessment Teams through the local Area Health Service.

Office of the Public Advocate

Guardians appointed by the State Administrative Tribunal. *The Guardianship and Administration Act 1990* provides for the appointment of guardians to safeguard the best interests of adults with decision-making disabilities. These disabilities may be as a result of:

- Intellectual disability
- Mental illness
- Acquired brain injury
- Dementia

Guardianship may be considered an option where there is:

- A need for somebody with legal authority to make decisions in the best interests of a person with a decision-making disability
- Unresolved conflict between family members and/or primary care providers about the person's best interests
- Concern that the person may be at risk of neglect, exploitation or abuse.

For more information contact 1300 858 455 or (08) 9278 7300 or visit

<http://www.publicadvocate.wa.gov.au>

Department for Child Protection and Family Support

Crisis Care Line : (08) 9223 1111

Country free call: 1800 199 008

Metropolitan Offices

Armadale	(08) 9497 6555	Cannington	(08) 9351 0888
Fremantle	(08) 9431 8800	Joondalup	(08) 9301 3600
Midland	(08) 9274 9411	Mirrabeeka	(08) 9344 9666
Perth	(08) 9214 2444	Rockingham	(08) 9527 0100

Regional Offices

Albany	(08) 9841 0777	Broome	(08) 9193 8400
Bunbury	(08) 9722 5000	Busselton	(08) 9752 5600
Carnarvon	(08) 9941 7222	Collie	(08) 9734 1699
Derby	(08) 9193 3700	Esperance	(08) 9083 2566
Fitzroy Crossing	(08) 9163 9800		
Geraldton	(08) 9965 9500	Halls Creek	(08) 9168 6114
Kalgoorlie	(08) 9022 0700	Karratha	(08) 9185 0200
Katanning	(08) 9821 9000	Kununurra	(08) 9168 0333
Laverton	(08) 9088 2900	Leonora	(08) 9037 2300
Mandurah	(08) 9583 6688	Manjimup	(08) 9771 6000
Meekatharra	(08) 9981 1104	Merredin	(08) 9041 6900
Moora	(08) 9653 0100	Mullewa	(08) 9961 1004
Narrogin	(08) 9881 0123	Newman	(08) 9175 4600
Norseman	(08) 9039 1129	Northam	(08) 9621 0400
Onslow	(08) 9184 3900	Roebourne	(08) 9182 0500

South Hedland (08) 9160 2400 Tom Price (08) 9188 0100
Wyndham (08) 9161 3500

Department of Housing

The Department of Housing seeks to improve people's access to secure, appropriate and affordable housing. The services they offer include:

- Homeless advisory service 1800 065 418

The purpose of the Homeless Advisory Service is to provide information to primary and secondary homeless people that will assist them to seek their own accommodation. Every effort is made by the Homeless Advisory Service to assist homeless people to link with crisis accommodation services.

- Public housing
- Community housing
- Private rental assistance

Albany (08) 9845 7144
Armadale (08) 9391 1600
Broome (08) 9158 3600
Bunbury (08) 9792 2111
Busselton (08) 9781 1300
Cannington (08) 935h0 3244
Carnarvon (08) 9941 6500
Derby (08) 9158 4000
Esperance (08) 9072 3000
Fremantle (08) 9432 5300
Geraldton (08) 9923 4444
Halls Creek (08) 9168 9300
Joondalup (08) 9404 3300
Kalgoorlie (08) 9093 5288

Karratha (08) 9189 1700
Kununurra (08) 9166 5100 or 1800 646 960
Kwinana (08) 9411 9500
Mandurah (08) 9586 6100
Manjimup (08) 9771 7800
Meekatharra (08) 9956 5000
Merredin (08) 9081 3800
Midland (08) 9250 9191
Mirrabooka (08) 9345 9655
Narrogin (08) 9881 2802
Northam (08) 9690 1900
South Headland (08) 9160 2800
Victoria Park (08) 9350 3700

For more information and to contact your local Department of Housing branch visit www.dhw.wa.gov.au

WA Health

- WA Health provides acute care facilities (public hospitals), community health services and public health programs
- Directly operates some residential and community care services, and provides longer-term hospital care through public sector mental health and aged care services
- Area Health Services (AHSs) provide a range of population-based aged care, mental health, drug and alcohol rehabilitation services, in addition to general health services

- WA Health shares responsibility with the Australian Government of Health and Ageing (DoHA) for the operation of ACATs under the Aged Care Assessment Program
- WA Health also administers the health component of the HACC Program, under which it provides community nursing, allied health and some day care services

For more information contact the WA Department of Health (08) 9222 4222,
www.health.wa.gov.au

Legal Aid – Social Inclusion Programme

The Social Inclusion Program at Legal Aid WA helps people to resolve civil law problems which are impacting on their daily lives. The focus of the program is to assist people who are on a low income, vulnerable and at risk of social exclusion. The Social Inclusion Program is available to all Western Australians.

Legal Aid can also assist with appropriate referrals to relevant support agencies, financial counselling services, Ombudsmen, dispute resolution services or other specialist services. The service is free and confidential.

Telephone InfoLine: 1300 650 579

Open Monday to Friday 8.30 am to 4.30 pm (Australian Western Standard Time) except public holidays

Perth Office: 55 St Georges Terrace ,Perth, WA 6000
Telephone: (08) 9261 6222
Facsimile: (08) 9325 5430
Postal Address: PO Box L916, Perth WA 6842

Non-Government Agencies

Anglicare Housing Advocacy Support Service (HASS)

- Supported Housing Assistance Program (SHAP) – Assists people over 50 to acquire and remain in secure housing or helps make a successful transition from supported accommodation to independent living. Assists with applications, finding accommodation, writing letters, removals. HASS also administers Community Aged Care Packages and can help arrange a variety of services to support independent living.
- Fremantle/Kwinana (08) 6310 0500
- Mandurah/Pinjarra (08) 9581 0502
- Stabilising Homes Mandurah (08) 9581 0583
- Stabilising Tenancies Rockingham (08) 9528 0701
- Family Housing (08) 9263 2081

Support and Advocacy Service for People in Private Rental Accommodation (SAS)

Accept referrals from real estate agents or landlords or other relevant agencies.

- Armadale (08) 9497 6555
- Cannington (08) 9351 8800
- Joondalup (08) 9301 3600
- Midland (08) 9274 9411
- Perth (08) 9214 2444
- Rockingham (08) 9527 0100

UnitingCare West Private Tenancy Support Service

Uniting Care West work with people at risk of being homeless due to private rental issues and provide practical assistance to those in metropolitan Perth experiencing a temporary housing crisis. Their aim is to assist and support individuals or families at the earliest opportunity before debts or tenancy issues become unmanageable. They assist tenants and property managers to achieve positive outcomes.

For more information contact (08) 9220 1288

St Bartholomew's House

St Bartholomew's House helps people who are homeless or at risk of homelessness achieve positive life outcomes. They have a Homeless & Transitional Support Service which offers secure accommodation and support services for single men aged 18 years and above experiencing homelessness. They can provide crisis accommodation for up to 7 days, depending on the support needs of the resident. Residents are provided with a private bedroom, shared bathroom facilities, laundry facilities, designated smoking areas and three meals a day. Residents who are eligible and choose to be part of the Transitional Accommodation program, will be provided with a private room with en-suite and TV, communal laundry facilities and self catering facilities in the communal kitchen located on each floor. All residents on the transitional program will be provided with, and expected to participate in, one on one case management on

a weekly basis to provide advice, advocacy, emotional support and develop an individualised case management plan to aid residents in moving on and into a more independent life.

Self-referrals and walk-ins are accepted but any prospective residents are encouraged to call first and complete a telephone interview. This provides the service with the opportunity to advise if there are any current vacancies and if they require any documentation from health practitioners. A referral form must be completed for service users with a mental health diagnosis, returning from Hospital or with a specific high care need and are only accepted during office hours, not on weekends or public holidays. There is a waiting list for applicants with high support needs.

St Bart's Mental Health Support Services coordinate accommodation for people living with a mental illness. Community Supported Residential Units (CSRUs) are medium to long term accommodation for people living with a mental illness who need 2-4 hours support per day in order to live independently in the community.

All residents of the CSRU's must -

- Be referred by the local mental health service
- Be aged between 18 – 65 on entry
- Be living with a mental illness
- Have support needs of between 2 – 4 hours per day
- Have the desire to live in the CSRU
- Have provided informed consent
- Have significant links to the area
- Be homeless or at risk of homelessness (may be living with elderly parents/family and be at risk of losing their tenancy)

Address: 7 Lime Street, EAST PERTH WA 6004

Telephone: 08 9323 5100

Facsimile: 08 9325 3699

Email: reception@stbarts.org.au

Australian Red Cross

The Australian Red Cross has a number of programs to support people to maintain their housing, avoid homelessness and link people with housing providers as well as employment, health, finance and social integration services.

110 Goderich Street, East Perth WA 6004

Phone: 08 9225 8888

Freecall: 1800 810 710

Fax: 08 9325 5112

WestAus Crisis Centre – Peel Region Only

WestAus Crisis & Welfare Services has been in operation since 1994 and provides assistance to people who are behind with their rent payments, facing eviction and having difficulties with their property manager. Their qualified support workers work in partnership with clients to:

- Get their tenancy back on track.
- Increase knowledge and skills in areas that will assist in maintaining tenancy in the long term.
- Assist clients to develop links to other community resources and services.
- Advocate on their client's behalf with other agencies and creditors.
- Assist with mediation and conflict resolution in relation to private rental.
- Provide regular home visits to maintain the long term success of their rental.

Telephone: (08) 9582 9920 Or (08) 9582 7757

Website: <http://westauscrisis.org.au/index.php>

Tenancy WA Inc.

Tenancy WA Inc. is an independent, not-for-profit, specialist community legal centre who provide free, quality legal services to residential tenants across Western Australia. They work with and on behalf of tenants; community members and services; and governments to improve the capability of residential tenants to maintain successful tenancies and resolve their own tenancy issues. Their mission is to provide free quality legal services including information, advice, casework, representation, referrals, community legal education, training, law and policy reform advocacy.

Advice line:

9:00am-4:00pm Monday to Friday (except public holidays)

- 9221 0088 (Metropolitan)
- 1800 621 888 (Country callers – Free call)

Contact details: 2/18 Plain Street
East Perth WA 6004

admin@tenancywa.org.au

<http://www.tenancywa.org.au/>

Perth Home Care Services

Perth Home Care Services (PHCS) are a non-denominational, community benefit organisation that specialises in delivering person-centred solutions to support people to live at home with dignity. PHCS is based in Perth, with offices in Osborne Park and Jandakot. PHCS operates under the name 'Regional Home Care Services' (RHCS) outside of the Perth metropolitan area, with offices in Toodyay and Geraldton, providing support to people in regional areas, such as the Wheatbelt and the Midwest. They also support people in Broome and Carnarvon.

For a subsidised fee, PHCS help clients get up, showered and ready for the day, help you with shopping, household chores and errands, help prepare meals and provide a break for regular carers.

Crisis Respite: (08) 9204 7801

Head Office: 30 Hasler Road (level 2), Osborne Park WA 6017

Postal Address: PO Box 1597, Osborne Park DC 6916

(08) 9204 7800 admin@phcs.org.au

Jandakot: Unit 1, 234 Berrigan Drive Jandakot WA 6164

(08) 9412 3400

Mandurah: 1/98 Pinjarra Road Mandurah WA 6210

(08) 9582 4800

Geraldton: Level 1 Lotteries House, 114 Sanford Street, Geraldton WA 6530

(08) 9920 7600

Wheatbelt: 98 Stirling Terrace Toodyay WA 6566

(08) 9574 9800

Animal Hoarding

Royal Society for the Prevention of Cruelty to Animals (WA) (RSPCAWA)

The mission of RSPCAWA is to improve the welfare of animals through leadership, collaboration with stakeholders and the provision of quality services. They have the power to investigate animal cruelty, protect all animals from abuse, neglect, and abandonment under the State's *Animal Welfare Act 2002*.

Phone: 9209 9300

Fax: 9248 3144

Email: rspca@rspcawa.asn.au

Web: www.rspcawa.asn.au

Report Cruelty: 1300 CRUELTY (1300 278 3589)

Examples of Current Practice

Whilst these examples are not meant to indicate best practice, they are displays of the current capacity of local government and other agencies to respond to cases of hoarding and squalor.

Examples of Inter Agency Collaboration

The City of Melville, Department of Housing, Fremantle OAMHS

Cases of hoarding and squalor in the elderly population may be reported to local government by non-government organisations (NGOs) such as who provide services in the home. The City of Melville has a good working relationship with Fremantle Older Adult Mental Health Services (OAMHS). Often there is referral to Fremantle OAMHS who can assess the individual and if necessary deliver the appropriate support services. If required, a direction to undertake works, under the Local Government Act 1995, will be issued, in which a caveat is placed on the property for costs to be recouped following the sale of property. Environmental Health Officers may also request up to \$600 from the local government to assist the individual with the financial hardship of rubbish removal and skip bin hire.

In general, cases of hoarding and squalor may be reported to local government by ranger services or community monitoring services. If it can be established that the premises are causing a nuisance according to the Local Government Act 1995 (rodents or mosquito harbourage, odour etc), Environmental Health Officers can issue a direction to undertake compliance action. The City encourages anyone who is concerned about an individual who may be living in squalid conditions to report the property to the Department of Housing Nuisance hotline or contact the local government to can discuss the situation directly with the Department of Housing Officers.

There are also regular network meetings involving various agencies in Melville, which means concerns raised can be worked on collaboratively with input from different perspectives.

City of Stirling – Regional Assessment Service

Regional Assessment Service (RAS) visits clients in their own home to assess client needs and to refer for HACC/ non HACC services if required. The Regional Assessment Service often identifies hoarding and squalor when completing an assessment.

RAS has identified the difficulty of finding clients HACC services, due to high OSH risk to the Support Workers, and the need for specialised workers in this area. Clients often do not have the ability to pay for a one off clean up which also presents another problem. Local government are able to provide a one off clean up as they can recoup the monies at the time of sale of the property, however RAS acknowledges that one-off clean ups do not offer sustainable outcomes to either the client or local government.

If a client is under 65, referral has been made to the mental health teams for assessment as if there is a mental health condition, as it may facilitate referral to a specialised service provider to best meet the client's needs. Perth Home Care and Southern Cross have mental health funding, but the client must be attached to a mental health clinic to access their services. Tendercare also provide services for clients with a mental health condition without the requirement of attendance to a clinic.

Referral to ACAT can occur if the client is over 65 years and referral to St Bartholomew's has also been helpful. Other services such as Personal Helpers and Mentor Services (PHAMS) have also provided support to clients in the form of motivation and mentoring.

The Shire of Boyup Brook, Red Cross

An elderly woman residing on a rural property had been reported to the local government regarding environmental health complaints. The local government decided that issuing orders for work to be carried out would only lead to non-compliance and eventual eviction of the woman. The Red Cross became involved to assist the woman get her affairs in order and address her health issues, some of which were associated with the potable water supply on the property. The Red Cross had been given authority to act on the woman's behalf and was able to provide her with copies of water sampling results from the property and discuss matters since she had minimal understanding of the issues raised and was struggling with various health complaints. Involvement of The Red Cross helped prevent the issue of work orders, which local government also did not view as a good option. With assistance the woman has organised to upgrade the electrical supply, clean the water tanks and improve the condition of the property. The situation was relatively complex as there were legal monetary issues and court directives surrounding the environmental health concerns. A good outcome has been achieved thus far.

City of Kwinana, Department of Child Protection, Department of Housing, Carer Options, Anglicare

There have been numerous hoarding and squalor cases in the City, all with a long history of non-compliance. In the majority of cases, the most effective strategies employed by the City are the implementations of EHO's authority under the Local Government Act 1995, Health Act 1911 and Health Local Laws.

A property owned by the Department of Housing was brought to the attention of the City's Environmental Health Officers by the Department of Housing. The local government had been contacted years earlier regarding the same tenant, and issued a Section 135 Health Act Notice, which was alleviated after the tenant had cleaned up. The tenant had a physical medical condition, was verbally abusive and kept 11 cats on the property. Three of her children were in the Care of the (then) state Department for Child Protection.

An inspection revealed the accumulation of rubbish and disused materials on the premises and an insanitary condition within the house resulting from the tenant failing to undertake routine cleaning and maintenance. All inspections were conducted by an EHO and accompanied by a Department of Housing representative.

Throughout this time, the City of Kwinana EHOs participated in several *Strong Families** meetings with the tenant along with various Government and non-Government agencies in a coordinated approach, conducted by an independent facilitator. The tenant received assistance from Carers Options and Anglicare to work through the cleaning schedule. The Department of Child Protection provided skip bins for clean ups and local government attempted to coordinate clean up schedule and provided extensions on time limits to coincide with verge collection pick-ups.

Over a period of three years various inspections and Section 184 Health Act Notices were issued. Some progress was made in making the property compliant however eventually a Section 135

Health Act Notice was issued and the tenants vacated the house leaving the rubbish and materials behind.

**Strong Families* is an inter agency initiative administered by the Department of Child Protection. When a number of agencies provide support to a family, it is very important that the agencies work together in a coordinated way, and that the family is involved in the decisions around what assistance is needed. Strong Families brings family members and agency workers together to share relevant information, identify goals and develop plans to help meet the family's needs.

Local Government Policy and Intra Agency Collaboration

City of Cockburn – Uninhabitable Premises Position Statement

In 2009 the City prosecuted a resident for non-compliance with clean-up orders under the Local Government Act 1995 and the court imposed a fine of approximately \$8000. This was not the preferred outcome for the City, as the materials causing concern were not removed, or for the tenant because he was fined a large sum of money. The City then developed a more compassionate approach to hoarding and squalor cases, which is contained in the Uninhabitable Premises Position Statement. This can be found in Appendix 9.

An External Agency Perspective

Complex Needs Care Team (CoNeCT) Joondalup, Homeswest, HACC, GP

A 63 year old woman, with ongoing medical conditions, was discharged from hospital for management in the community, despite strong allied health concerns about her ability to manage. When CoNeCT staff visited the Homeswest property it was found the woman was living in squalor and was hoarding cats that had free reign of the house. The house was in total disrepair and could not be locked. The woman was confused and had cognitive deficits impacting on her compliance with medication and daily living, which called her capacity into question. She had previously been receiving Home and Community Care Services (HACC) from the local government in her home, however they withdraw due to the occupational health and safety (OSH) risks caused to staff by the condition of her property.

CoNeCT arranged for the woman's GP to review her situation and assist her to become medically stable and compliant and negotiated with the HACC provider to recommence services, until an ACAT assessment could be completed. Liaison with various external agencies allowed for significant progress to be made. The local government, with assistance from the local church, removed rubbish and cleaned the property; Cat Haven removed excess cats and Homeswest addressed the disrepair and lack of security of the property.

The woman was subsequently readmitted to hospital. During this time CoNeCT negotiated with Homeswest to renovate the property including replacing the kitchen and bathroom, floor coverings and paint. The local church assisted to clean the yard. The hospital paid for an industrial clean including removing belongings unable to be washed and replacing them with second hand clothes, white goods and furniture.

After discharge, the woman was able to receive HACC services and live independently.

Development of Uninhabitable Premises Position Statement

Coordination within Local Government - City of Cockburn, Case on which Position Statement (PSPD21) Uninhabitable Premises was developed.

11 August 2010

A property was referred to Health Services by Community Services and the Aged Care Assessment Team from Fremantle Hospital. At the time, the property owner and their two adult children were living in the house.

12 August 2010

An Environmental Health Officer (EHO) and a representative from the City's Community Services team visited the house. They identified cat faeces, a strong odour of urine, mould and general refuse (rubbish) and the kitchen, bathroom and laundry were also in a state of disrepair.

The property owner and children all suffered from various illness and were identified as vulnerable. Discussions about the findings from the home inspection were held between the City's Health Service, Disability Access and Inclusion Officer (DAIO) and Financial Counselling Officer. It was established that the work that was required to the property would not be done by the owner due to their ill health.

16 September 2010

Health Act 1911 Section 135 (Dwelling unfit for habitation) and 139 (owner may be required to clean or repair house) notices were served on the property. The property owner's wife, who was not living at the house, was located and also served the same notices as she was listed on property title.

The City's Health Service organised a quote for the works to be carried out, this was estimated to be \$13,000. It was agreed that the owner would not be capable of doing the required works, so the DAIO organised for emergency relief funding to be used to find the three people living in the house accommodation for two weeks whilst the works in the Section 139 notice were completed.

Normally 28 days is required from the day the notice is served before the City can begin any works and place any costs involved as a charge on the property title. Money charged on the property title is recouped by the City when the house is sold. To remove this requirement and have works start as soon as possible, a Statutory Declaration was completed and signed by both property owners. Both owners agreed to the estimated cost of the work and the intent that the costs be placed as a charge on the property title.

The DAIO and EHO worked with the property owner before any contractors started. They organised what belongings and other materials would be kept or removed. The DAIO and EHO also visited the house regularly whilst the contractors were working to monitor progress and ensure nothing that was not agreed upon was thrown out.

The DAIO and EHO also carried out minor cleaning, sorting and repairs where they could to help.

Some additional works that were not in the original quote were needed, such as the repointing of tile ridges and replacing valley flashing. These were not undertaken unless they had approval from the property owners.

Mid October 2010

The property owner and dependents returned home.

7 December 2010

A notice of Intention to Register Charge against Land and Premises was served. The final costs of the works was \$13,610.55.

The City's DAIO, Financial Counselling Service and Community Services continued to provide contact, counselling and services to the property owner and dependents to help them sustain the improved house conditions as best as possible.

Rockingham-Peel Aged Care Assessment Team

Cases of squalor and/or hoarding are usually referred to Aged Care Assessment Team (ACAT) via GP's or government funded service providers, however ACAT accept referrals from any source. Issues of hoarding and squalor are often linked with cognitive impairment and/or psychiatric illness. The primary concern of ACAT is to ensure that a formal diagnosis is available and that reversible conditions are identified and treated if possible. ACAT may liaise with Older Adult Mental Health Service (OAMHS) colleagues regarding these types of cases.

In a few extreme cases of squalor, ACAT sourced a private cleaning contractor to assist with cleaning property, prior to the client being accepted for ongoing support by a government-funded provider such as HACC in order that the property met the OHS requirements. The cost has been borne by the client or their family in these cases.

Case Study

Provided by Anglicare WA's Supported Housing Assistance Program (SHAP)

Bill (name changed), who is in his sixties, is a single male with long term mental health issues, residing in a third floor high density Department of Housing (DOH) bed-sit. Access to the property was via a flight of external, concrete stairs. The only door to the property was situated at the top of the stairs.

He was referred to Anglicare for chronic hoarding. His tenancy was at risk.

Accessing the interior of the property was difficult as almost all of the available space was taken up by clutter. Entering through the door required Bill to pull his lounge chair out of the hallway, forcing it in to the kitchen in order that the door could be opened. Workers were often left standing at the top of the stairs in heavy rain or burning sunshine, waiting for him to open the door.

Bill's mental health condition had been diagnosed many years previously, and although vigilant with his medication, was resistant to requests from medical staff to change his prescription. Bill's mother (who had been his sole carer) had passed away a year previously. Bill had been left the contents of her home which he had managed to squeeze into the bed-sit, in addition to his collection of shopping brochures, empty boxes, and food and lolly wrappers.

His mother had been pivotal in his ability to function and he was "stuck" in the ways she had instilled. Bill's hygiene was almost none existent, as the shower recess had been used as

storage space. He washed in the vanity sink, whilst wearing his clothes. When asked about this, he defended the behaviour by advising the worker that there was a water shortage and he was “doing his bit”.

Using usual SHAP strategies; involving a case worker working with client to develop and implement a case plan addressing the identified and agreed issues within a case management framework, assisting the client to engage in social networks and community and providing practical support where required, the situation was improved by a small degree, however it was clear that more stringent intervention strategies were needed. Specialised cleaners were engaged for specific tasks, which Bill paid for, however the improvements were soon lost by the volume of continued hoarding.

SHAP recognised Bill was socially isolated and suggested programmes he could join and attend. Fremantle Mature Aged Mental Health (FMAMH) became involved as did the Public Trustee (PT). By this time an interim order was in place for health and housing.

Regular joint visits from PT, FMAMH, DOH, and SHAP failed to improve the situation.

A multi agency meeting was called to discuss options and strategies. Individual agencies have limited mandates and it soon became apparent that a united approach was the only way forward. It was decided to seek involuntary admission of Bill to hospital for a specified number of weeks.

During his time in hospital Bill was to:

- Be assessed and his medication changed and administered accordingly,
- Have his hygiene issues addressed and be encouraged to buy new clothes,
- Have his property cleared of rubbish, his mother’s possessions and have items moved into storage, which Bill was to pay for, and
- Have his unit thoroughly cleaned, treated for infestation, receive new floor coverings, and painted throughout.

Bill’s treating Doctor was clear with him, prior to his return to the property, that should internal, property conditions deteriorate to a similar level in the future, the process would be repeated and he would bear the costs involved.

Upon release, fortnightly cleaners, visits from the community nurse and hospital appointments were arranged and suggestions of several areas of social interaction were made. Follow up interviews revealed improved standards at the bed-sit, hoarding and clutter had been resolved, (excess possessions stored in self storage facility) and Bill’s ability to manage the tenancy had improved to the satisfaction of the DOH.

Case Study - Derek

Provided by City of Cockburn

Derek (name changed) is a 35 year old male who until recently held a full time job working in a noxious industry. He has poor personal hygiene and his body is usually covered in dirt. He lives in an upstairs unit which he owns in a block of 10 flats.

Entry to Derek's unit requires negotiating collected furniture, electrical equipment, newspapers and magazines, discarded food wrappers and thousands of plastic bags. The kitchen has no serviceable space in which to cook or clean. The bathroom is unusable and completely cluttered. There is no hot water. All of the floor space is covered with rubbish, discarded food containers and plastic bags. Derek also has a large shed full of collected items.

Derek has mentioned that he is aware he has a problem and recognises that he may have Obsessive Compulsive Disorder. Derek is extremely concerned about the environment and recycling and does not wish to discard anything. Despite numerous attempts to encourage Derek to make the residence habitable he has not been able to do so.

He had been referred to the City of Cockburn previously for uninhabitable premises and to the RSPCA for animal hoarding and neglect. The City has previously had to provide cleaners to clean up the premises and bill Derek for the costs. The City's environmental health services has provided skip bins and extra recycling bins to assist and clear timetables for work to be done with no success.

Discussions with Derek by Human Services staff indicate that he would like assistance but there is no program that the City can refer Derek to. Derek has had previous contact with adult mental health services but does not reply to their letters and they won't intervene unless he is escorted by the police. The police are reluctant to intervene in this case.

Derek has no social relationships that the City is aware of except for an aunt who has effectively given up trying. Derek currently lives a socially isolated life in an environment of severe domestic squalor. The City of Cockburn is reluctant to make Derek homeless and impose significant costs on him to carry out a clean up when the problem is likely to occur again without ongoing support.

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Appendices

Appendix 1 WA Hoarding and Squalor Assessment Tool

Demographic details						
Name of person	Surname		Other names			
Date of birth <i>and/or</i> approximate age of person						
Gender	Male		Female			
Marital status	Single	Married/ de facto	Widowed	Divorced	Separated	Not sure?
Address						
Does he/she live alone?	Yes		No			
If not, who with?						
Number and type of pets						
Home ownership	Owner	Tenant – private	Tenant – DOH	Other – non-owner (e.g. lodger)		
Accommodation type	House	Unit	Bedsit	Other (specify)		
How long has he/she been living like this?	Less than 1 year	1–3 years	4–10 years	Over 10 years		
Known medical illnesses and/or disabilities:						
Known mental disorders now or in the past:						
Name of Assessor: Date:						

Part A – Assessment for Hoarding Disorder

1) Do you experience difficulty discarding or parting with possessions?

- Yes → Go to question 2
- No → Hoarding Disorder is not present, go to Part B

2) Do you intentionally keep these items? Are they important or useful for you?

Do you generally feel distressed or upset when discarding possessions?

- Yes to both questions → Go to question 3
- No → Hoarding Disorder is not present, go to Part B

3) Do you have a large number of possessions which congest or clutter your home?

- Yes → Go to question 4
- No → Hoarding Disorder is not present, go to Part B

4) Do the difficulties discarding clutter cause you distress?

Do the difficulties or the clutter interfere with your family life, friendship or ability to perform well at work or home?

- Yes to one or both questions → Go to question 5
- No → Hoarding Disorder is not present, go to Part B

5) Do you have any general medical conditions or a history of head injury?

- Yes → Go to next question
- No → Hoarding Disorder is present. Go to Part B

Did you have difficulties with discarding/clutter before you became ill/ suffered a head injury?

- Yes → Hoarding Disorder is present. Go to Part B
- No → Hoarding Disorder is not present, go to Part B

Part B – Squalor Assessment

1. Accessibility

How easy is it to enter and move around the dwelling?

0	1	2	3
Easy	Somewhat Impaired	Moderately Impaired	Severely Impaired
0 – 29%	30 – 59%	60 – 89%	90 – 100%
% of floor space inaccessible for use or walking across			

2. Accumulation of Refuse or Garbage

In general, is there evidence of excessive accumulation of garbage or refuse e.g. food refuse, packaging, discarded containers or other unwanted material?

0	1	2	3
None	A Little	Moderate	A Lot
	Bins overflowing, up to 10 emptied containers scattered around.	Garbage and refuse littered throughout the dwelling.	Garbage and waste piled knee high, clearly no recent attempt to remove garbage.

3. Accumulation of Items of Little Obvious Value

In general, is there evidence of accumulation of items that most people would consider useless or should be thrown away?

0	1	2	3
None	A Little	Moderate	A Lot
	Items are organised and do not impede movement or prevent access to appliances.	Items cover furniture in most areas and have accumulated throughout the dwelling.	Items are piles waist high in most areas. Cleaning would be difficult or impossible, appliances are inaccessible.

4. Cleanliness of Floors and Carpets

0	1	2	3
Acceptably Clean in All Rooms	Mildly Dirty	Very Dirty	Filthy
	Floors and carpets look like they haven't been cleaned for days. Some scattered rubbish.	Floors and carpets very dirty and look like they haven't been cleaned for some time.	With rubbish or dirt throughout.

5. Cleanliness of Walls, Furniture Surfaces and Window Sills

0	1	2	3
Acceptably Clean in All Rooms	Mildly Dirty Dusty or dirty surfaces. Dust or dirt is easily removed by finger or damp cloth.	Very Dirty Grime or dirt on walls. Cobwebs and other signs of neglect. Greasy, messy, wet and/or grubby furniture	Filthy Walls and surfaces are so dirty that an average person would not wish to touch them.

6. Bathroom and Toilet

0	1	2	3
Acceptably Clean in All Rooms	Mildly Dirty Dusty or dirty surfaces. Dust or dirt is easily removed by finger or damp cloth.	Very Dirty Grime or dirt on walls. Cobwebs and other signs of neglect. Greasy, messy, wet and/or grubby furniture	Filthy Walls and surfaces are so dirty that an average person would not wish to touch them.

7. Kitchen and Food

0	1	2	3
Clean & Hygienic	Mildly Dirty & Unhygienic Dirty cook-top and work surfaces. Refuse mainly in the bin.	Moderately Dirty & Unhygienic Oven, surfaces and floor are dirty. Bins overflowing. Some rotten or mouldy food. Fridge unclean.	Very Dirty & Unhygienic Oven, surfaces and cupboards filthy. Large amount of refuse and garbage over surfaces and floor. Putrid food.

8. Odour

0	1	2	3
None	Unpleasant e.g. urine smell present, unaired room.	Moderate Bad but can remain in the room.	Unbearable Assessor has to leave the room very soon due to odour.

9. Vermin

0	1	2	3
None	Few e.g. cockroaches.	Moderate Visible evidence of vermin in moderate numbers e.g. droppings and chewed papers.	Infestation Alive and/or dead in large numbers.

10. Sleeping Area			
0	1	2	3
Clean and Tidy	Mildly Unclean Untidy, bed unmade, sheets unwashed for weeks.	Moderate Bed sheets unclean and stained. Clothes and/or rubbish over floor areas.	Unbearable Sleep surface unclean or damaged. Either no sheets or extremely dirty bed linen.

Total Score: _____

Do you think that this person is living in Squalor?			
No	Yes with mild clutter	Yes with moderate clutter	Yes with severe clutter

Additional Comments:

Part C – Living Conditions Assessment

1. Is there running water in the dwelling?
2. Is the electricity and/or gas connected and working?
3. Are there animals present? Are they being appropriately fed and cared for?
4. Is the dwelling structurally unsafe?
5. Are there vulnerable people living on the property? Are they being adequately cared for?
6. Is there an increased fire risk associated with the property?
7. Are there OH&S risks associated with the property?

Where the response to any of the above questions is 'yes', please note the details below.

Appendix 2 Clutter Image Rating Scale (CIRS)

(Frost & Steketee 2005).

The purpose of this tool is to gauge the impact of hoarding on the person with the hoarding behaviour.

Clutter Image Rating Scale: Part 1 of 3 – Kitchen

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating Scale: Part 2 of 3 – Bedroom

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating Scale: Part 3 of 3 – Living room

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



1



2



3



4



5



6



7



8



9

Appendix 3 Hoarding Rating Scale (HRS-I)

(Tolin et al 2007).

Please use the following scale when answering items below:

0	No problem
2	Mild problem, occasionally (less than weekly) acquires items not needed, or acquires a few unneeded items
4	Moderate, regularly (once or twice weekly) acquires items not needed, or acquires some unneeded items
6	Severe, frequently (several times per week) acquires items not needed, or acquires many unneeded items
8	Extreme, very often (daily) acquires items not needed, or acquires large numbers of unneeded items

Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?

0	1	2	3	4	5	6	7	8
Not at all difficult		Mild		Moderate		Severe		Extremely difficult

To what extent do you have difficulty discarding (or recycling, selling, giving away) ordinary things that other people would get rid of?

0	1	2	3	4	5	6	7	8
Not at all difficult		Mild		Moderate		Severe		Extremely difficult

To what extent do you currently have a problem with collecting free things or buying more things than you need or can use or can afford?

0	1	2	3	4	5	6	7	8
Not at all difficult		Mild		Moderate		Severe		Extremely difficult

To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?

0	1	2	3	4	5	6	7	8
Not at all difficult		Mild		Moderate		Severe		Extremely difficult

To what extent do you experience impairment in your life (daily routine, job/school, social activities, family activities, financial difficulties) because of clutter, difficulty discarding, or problems with buying or acquiring things?

0	1	2	3	4	5	6	7	8
Not at all difficult		Mild		Moderate		Severe		Extremely difficult

Interpretation of HRS total scores (Tolin et al 2010).

Mean for nonclinical samples: HRS total 3.34, standard deviation = 4.97.

Mean for people with hoarding problems: HRS total 24.22, standard deviation = 5.67.

Analysis of sensitivity and specificity suggest an HRS total clinical cut off score of 14.

Criteria for clinically significant hoarding (Tolin et al 2008).

A score of 4 or greater on questions 1 and 2, and a score of 4 or greater on either Question 4 or Question 5.

Appendix 4 Shared Action Plan Checklist

(Victorian Department of Health 2013).

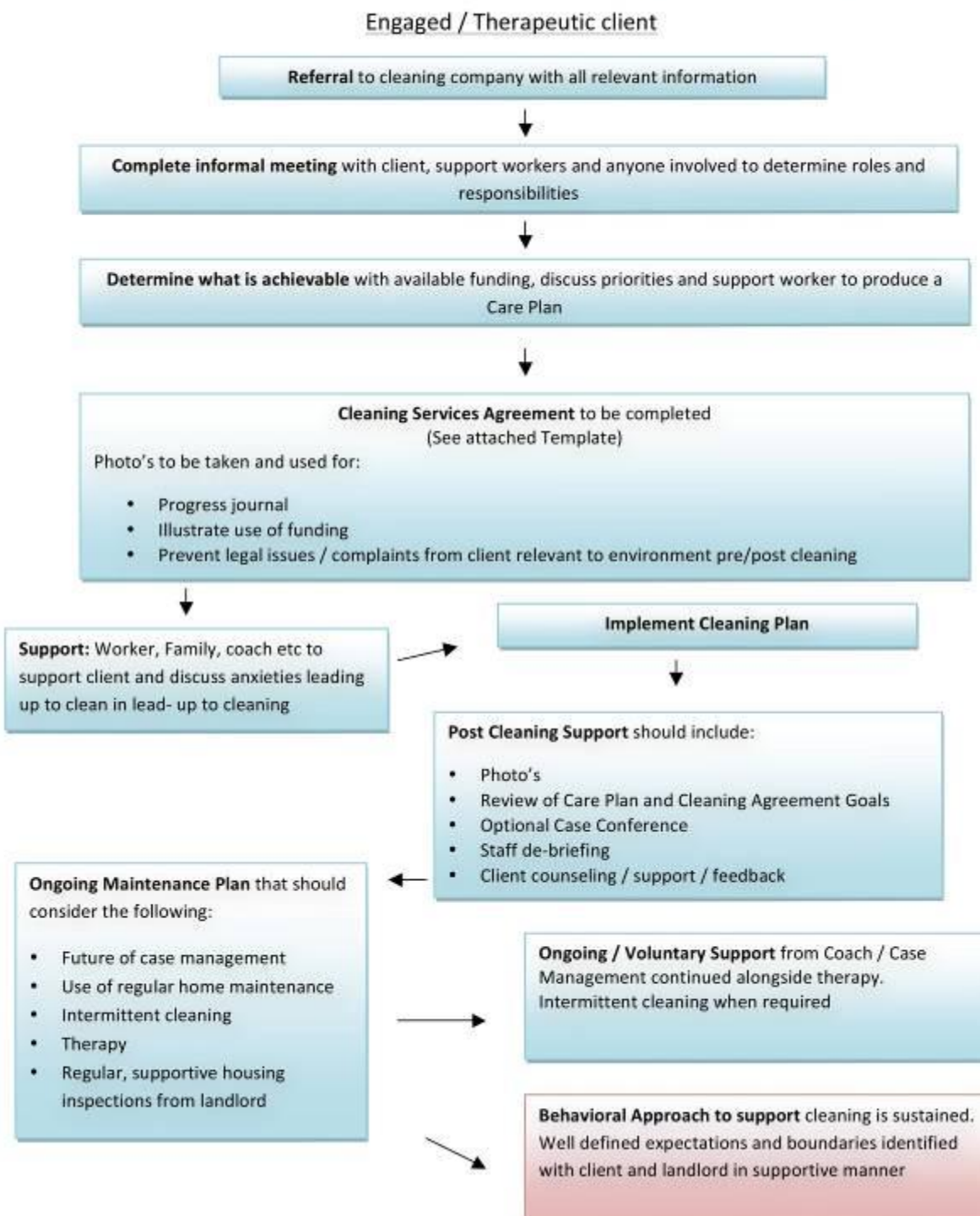
This checklist aims to assist agencies to work together, plan, deliver and review services provided to people with complex needs.

	Key elements or principles	Achieved (yes or no)	Actions
1	Is there provision to identify the service coordination of initial needs if required?		
2	Are there multiple needs/multiple services/other agencies?		
3	Is there difficulty coordinating appointments or managing health needs?		
4	Is there an agreed way of explaining the benefits of coordinating services to the person (including people with CALD background)?		
5	Is there a system between services to decide how information is shared, when and with whom?		
6	Has the consent process been fully explained to the person?		
7	Is there an agreed process to nominate an agreed worker?		
8	Is this type of work clearly defined and included in a worker's position description?		
9	Are needs and risks identified holistically, including, where appropriate, those of carers, children and animals?		
10	Does the assessment cover all elements – clinical, social, psychological, welfare and lifestyle?		
11	Are equipment requirements or other needs identified?		
12	Is the action plan designed with and for the person and shared with carers, if appropriate, and with the person's consent?		
13	Does the action plan address how the person might live with the condition (practically, socially as well as medically)?		
14	Are all existing service/action plans taken into account when developing a community plan?		
15	Are the issues prioritised according to the person's current situation?		
16	Does the action plan document self-management support strategies, where appropriate?		

	Key elements or principles	Achieved (yes or no)	Actions
17	Are the action plan goals written in the person's own words?		
18	Do proposed actions take into account all available information?		
19	Are the actions realistic and achievable?		
20	Does each action of the action plan clearly state who is responsible?		
21	Have referrals for other services been discussed, and consent given by the person?		
22	Do all professionals undertaking action planning have access to up-to-date evidence and information, including a service directory?		
23	Are there processes and support tools in place to ensure regular reviews of proposed actions?		
24	Are changes documented?		
25	Does the review process include a means of indicating improvement?		
26	Are there processes in place for regular collaborative meetings?		
27	Have agreed pathways of service delivery been established and documented across and within agencies?		
28	Are end-of-life plans included as part of the action planning process, where appropriate?		
29	Do the professionals from different organisations, individuals and carers work as a single response team?		
30	Do all participants in the action plan have access to a copy, either print or electronic form, including the person?		
31	Are there systems in place to ensure communication and feedback between one another?		
32	Are there processes in place to ensure reassessment if there is a change in the person's health or service status?		
33	Is there a well documented process for re-entry into any service system?		
34	Is the action planning process led/endorsed from strategic levels throughout the organisation/s?		

Appendix 5 Planning for the Provision of Cleaning for Engaged Client (Lodden-Mallee Region Hoarding Working Group 2012).

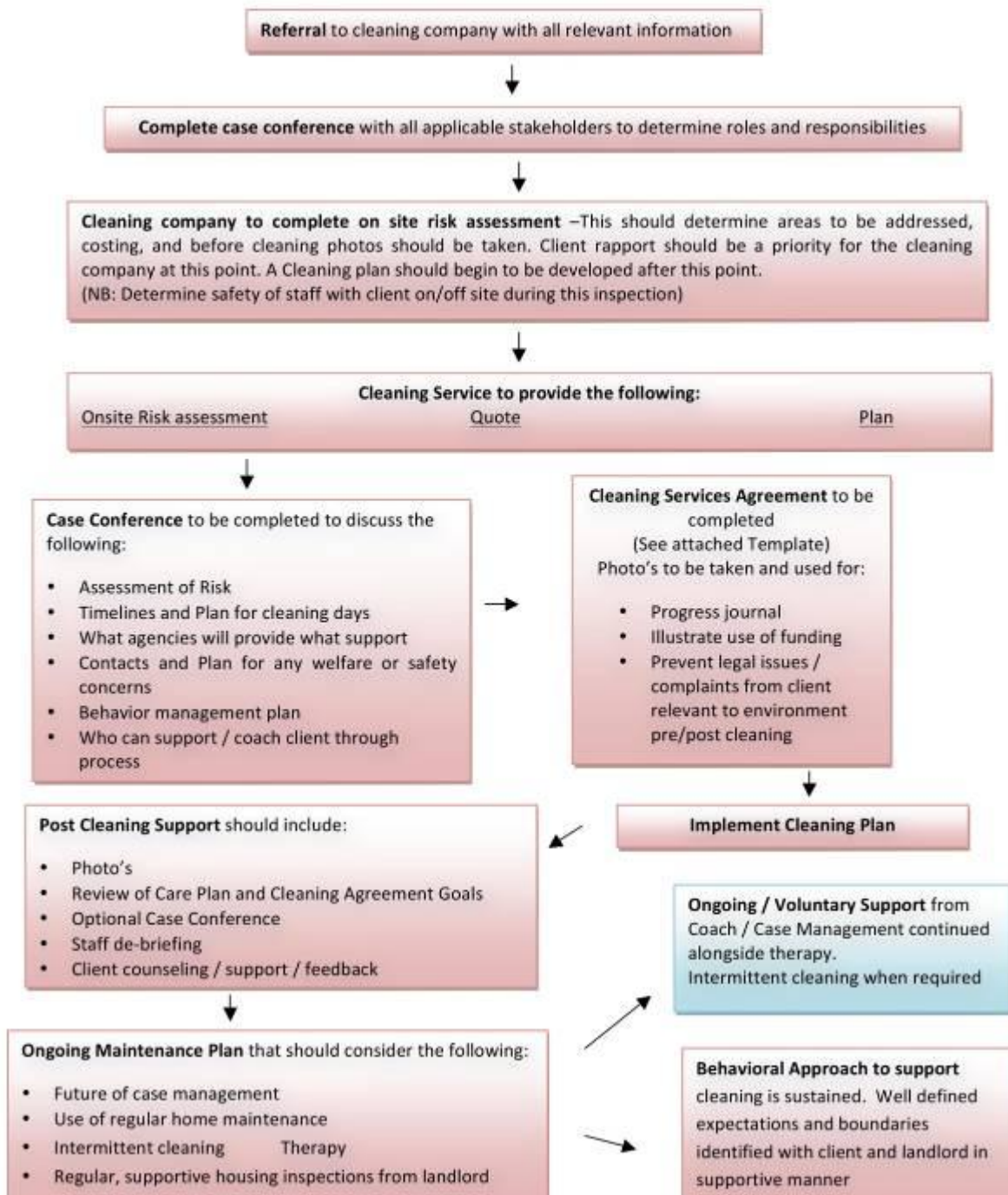
Flow Chart for Accessing Cleaning



Appendix 6 Planning for the Provision of Cleaning for Disengaged Client (Lodden-Mallee Region Hoarding Working Group 2012).

Flow Chart for Accessing Cleaning

Non Engaged / highly complex client (Behavioral Approach)



Appendix 7 Cleaning Services Agreement

(Lodden-Mallee Region Hoarding Working Group 2012).

This is an agreement between:

Name of service:
Name of cleaning business:
Client name:

Client telephone:
Client address:
Date of cleaning visit: Time:
Rooms to be cleaned:
Articles/items to be removed:
Articles/items not to be removed:

Signed (cleaning business): Date:
--

<p>I, _____ (insert name), agree to the cleanup of my property and removal of unwanted items as stated at the top of this form. I acknowledge that it is my responsibility to clearly identify the items that I do not wish to be removed and the areas I do not want to be cleaned. It is also my responsibility to be present during the cleanup to ensure that it is undertaken according to the stated action plan. I understand that where I have accessed a cleaning service referred to me, that the referral service (e.g. people, clinical, animal, housing, local municipal council) is not liable for any damages or removal of non-authorised items that may occur during the process of the cleanup.</p>
Signed (client): Date:

Referral service: Worker's name:
Program: Date:

Appendix 8 Health Act Interpretation for Hoarding and Domestic Squalor

This section outlines the powers of a local government, as described in Part 5, Division 1 of the Health Act 1911.

In advanced cases of hoarding or domestic squalor, the local government has two options:

- i. Proceed under sections 135 then 137 then 140 (if applicable), or
- ii. Proceed under section 139 then 140 (if applicable).

Option (i)

The local government resolves to declare a house (or part thereof) unfit for human habitation (Section 135). This notice can specify that the house or any part of the house cannot be occupied by any person after a specified time. Once such a notice has been issued, it is an offence for any person to occupy the house or part of the house that has been declared unfit.

Once the house has been declared unfit for human habitation due to conditions of hoarding and domestic squalor, the local government can (under a Section 137 notice) direct the owner of the house to carry out works or take down and remove the house within the time frame specified in that notice. It is possible that the notice may only direct the owner to take down and remove the house and not allow them to undertake other works.

A person who takes down a house, building or other structure, whether or not this is because of a notice from local government, they must clean the land to the local governments' satisfaction and remove all rubbish to a place specified by the local government.

Option (ii)

If the local government is of the opinion that the house is in need of repair or in a state of uncleanness (without declaring it unfit for human habitation), the local government may issue a notice (under Section 139) directing the owner to clean and/or repair the house within a time specified in the notice.

If the owner is not compliant with the notice the local government can then do the works specified and recover the costs from the owner (Section 140). The procedure is specified in the *Registration, Enforcement and Discharge of Local Authority Charges on Land Regulations*. The local government can sell or dispose of materials from the building, the money can be used to recoup the costs of doing the works and if there is a surplus, must be paid to the owner.

If the local government is taking down and removing a house that has been declared unfit due to hoarding and domestic squalor, any authority that supplies the house with electricity, gas or water should be requested to make sure that equipment, fixtures and fittings in or around the house supplying electricity, gas or water are removed and will not interfere the taking down and removal of the house.

Any person who is affected by any notice is able to apply to the State Administrative Tribunal for a review of that notice.

Under Section 145, a medical officer of health can order that a house or part of house, furniture and items be cleansed to the satisfaction of an environmental health officer. The occupier must comply with this order. If the owner or occupier is not compliant with the order and the medical officer agrees it is necessary, the local government can carry out the order and recover the costs from the owner or occupier. This does not replace the person from the penalty of not carrying out the work themselves and they have still made themselves liable by their default.

Registration of Charges Against Land in Pursuant of Health Act 1911 (Original advice provided by McLeods for City of Cockburn).

Step by Step:

- 1) Section 371 of the Health Act 1911 (Act) provides that, where a local government carries out work under the Act, the cost of that work is recoverable from the owner of the land the subject of the work, and will constitute a charge on that land, until paid.
- 2) Section 372 of the Act provides that the abovementioned charge must be registered and administered in accordance with the *Registration, Enforcement and Discharge of Local Authority Charges on Land, Regulations* (Regulations).

A local government cannot serve the Notice of Intention to Register Charge against Land and Premises before the works are completed and the costs have been paid by the local government. However the local government must always advise the owners that they intend to place the cost of the works as a charge on the land. The right of the owner to dispute the charge and the process to follow should also be advised.

Note; if the officer is not serving the documents in person, the documents must be served by registered mail, not regular post. Regulation 1(4) of the *Registration, Enforcement and Discharge of Local Authority Charges on Land Regulations* provides that the Notice of Intention to Register a Charge must be served by registered post to the actual address of the owner if that address is known or, where that address is not known (such as in this instance), to the address shown on the Certificate of Title.

Accordingly, the Notice of Intention to Register a Charge should be served by registered post to the address shown on the Certificate of Title, which should be the same as shown on the Notice itself.

It does not matter that the Notice may be returned to the local government. For the purposes of having the charge registered, it is important that the procedures in the Regulations are followed. Provided those procedures are followed, Landgate will register the charge.

- 3) Regulation 1 requires a local government to serve a Notice of Intention to Register Charge against Land and Premises, in accordance with Form A, on the owner of the land. The Notice provides that the local government will apply to register the charge after the expiration of three days from service. The right of the owner to dispute the charge and the process to follow should also be advised. Service can be affected by prepaid registered letter, process server or in person to ensure that service is properly affected. The process server should be able to provide an affidavit, confirming that service was affected.

- 4) The owner, once served, can serve a Notice of Dispute, in accordance with Form B, on the local government within three days. If such a Notice of Dispute is received, the local government must refer the dispute to the Magistrates Court within 10 days. The Court will then list the matter for hearing in the next 7 days. A representative of the local government needs to attend that hearing, or the matter will be determined in its absence. If the notice under which the

work was carried out is found to be invalid, or the work has been carried out otherwise than in accordance with the Act, then the local government (presumably) would be unable to register the charge, and the costs would not be recoverable. The unsuccessful party to the dispute will also be liable for court costs.

5) If the owner does not serve a Notice of Dispute within three days, the local government can proceed to register completed Forms C and D at Landgate, along with;

- a statutory declaration by an authorised officer of the local government ;
- a copy of the completed Form A Notice; and
- payment of the Landgate registration fee.

The charge will then be registered against the land.

6) The charge will remain on the land until the debt is satisfied, and will prevent the land from being able to be transferred until that time. The charge is removed by the registration of completed Forms H and I at Landgate, with payment of the Landgate registration fee.

7) If the charge is registered, then the local government should be able to recover its costs from the owner even if the owner does not have the ability to pay the costs, as the land should not be capable of disposal until the local government executes a completed Form H, confirming that the costs have been paid.

Appendix 9 Uninhabitable Premises Position Statement

(Prepared by City of Cockburn)

BACKGROUND:

At times, properties within the City have been identified as uninhabitable under the provisions of the Health Act due to the lack of adequate cleaning or due to the accumulation of matter. This matter may be offensive and or be of such a high volume to hinder free movement around a home or property and potentially harbour vermin. Some of the residents of these uninhabitable premises have been identified as being frail aged and/or having a functional disability. These people have not had the capacity to arrange clean up of their premises to the required standard.

The Health Act provides the City with the power to either prosecute the owner or occupier and/or to do the works and claim the money back at a later date. Where the occupants are vulnerable there is a need to take a more compassionate approach rather than the legal option. Nevertheless, the City wherever possible should ensure the cost of a cleanup be recouped especially when the costs can be placed as a charge against the property and reclaimed when the property is sold.

This process should only be triggered where the property is owned and occupied by the same person or family. Properties that are tenanted either privately or via the Department of Housing must be cleared/repaired at the owner's expense.

Various forms of legislation relating to disability services have made it essential for public authorities to clarify how they are addressing these issues.

PURPOSE:

To specify when the City will determine that an owner is vulnerable and therefore the City will undertake the cleaning and/or removal of material so that a dwelling and related surrounds are fit for human habitation.

POSITION:

- (1) On referral of a complaint about a premises and where the Environmental Health Officer identifies that the occupant may have a disability or be frail aged, the City's Disability Access and Inclusion Officer (DAIO) will undertake an initial assessment. If the result of this assessment is that the resident is unable to bring the premises up to a suitable standard without support, then the DAIO will refer to appropriate agencies including the City of Cockburn's Family Support services, Financial Counseling services, and Home and Community Care services.
- (2) The Environmental Health Officer will obtain an estimate of the costs, E.g. quote for cleaners to clean a house or property. Each case will be assessed by the Manager of Environmental Health and based upon a two tiered approach.

- (3) Tier 1 – If the cost of the cleanup is predicted to be minor (less than \$2,500) then the funds be taken out of the Community Services emergency fund at the discretion of the Manager Community Services.
- (4) Tier 2 – If the predicted costs are greater than \$2500 then Health Act Notices will be served and the costs will be placed as a charge on the property title.
- (5) The Public health notice will require that the cost of the cleanup be re-paid over a period of time or the cost placed on the property requiring funds for the cleanup cost to be returned to the City at the point of sale of the property. If necessary, and if viable, Financial Counselling Service will be arranged to develop a re-payment plan suited to the individual's needs.
- (6) If the resident requires ongoing support the Disability Access and Inclusion Officer will refer the resident for an assessment for Home and Community Care Support services
- (7) Each premise shall be inspected annually by an Environmental Health officer to ensure that the premises are maintained in an acceptable condition.
- (8) The maximum cost per individual premises shall not exceed \$15,000 without the approval of the Chief Executive Officer.

Definitions:

1. Equity

Fair distribution of resources and opportunities according to need and access to decision-making processes.

2. Disability Access and Inclusion Plan (DAIP)

The Disability Services Act 1993 (amended 2004) requires that all public authorities develop and implement a DAIP. The City of Cockburn's DAIP, available at <http://www.cockburn.wa.gov.au>, outlines how the City will work to enable persons with disabilities to have equal access to its facilities and services.

3. Uninhabitable

Uninhabitable is used for properties where there is an accumulation of matter and or filth to such a degree that it makes the premises unliveable and a potential health risk to the occupants and possibly occupants of neighbouring properties. This does not include issues to do with unsafe structures which are catered for through the Building Code of Australia and other legislation.

This document can be made available in alternative formats on request for a person with a disability.

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