

# Hoarding and squalor

## A practical resource for service providers

June 2013



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Internal cross-references in this resource are hyperlinked. If you are using the PDF version of this document and you follow a cross-reference hyperlink, use the keyboard shortcut Control + left-arrow to return to the cross-reference page.

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## Feedback

We welcome your comments with regard to this publication. Please email ideas or information to:  
[aged.care@health.vic.gov.au](mailto:aged.care@health.vic.gov.au).

# Executive summary

Historically, hoarding and squalor situations are not new, but the way services respond is continually evolving. Cases are highly complex, and it is clear that there are no easy or simple answers, and no two cases are the same. Importantly, neither living condition (hoarding or squalor) is defined by financial means, age, gender, sexual orientation, culture, employment status nor the person's standing in the community.<sup>1</sup>

Hoarding is recognised as a diagnosable (and treatable) behavioural mental health condition.

Squalor describes a living environment.

To develop this publication we drew on the expertise of a representative stakeholder group (refer to [Appendix 1 Hoarding and squalor project stakeholder group](#)), together with international, national and local knowledge on the subject of hoarding behaviour and squalor.

This practical resource offers a basis to guide service delivery and practice. Its purpose is to build service system capacity by assisting services to work in a collaborative manner, encouraging the coordination of sector response.

We do not suggest or intend here to divert specific funded or regulated purposes to specialised hoarding or squalor programs. Rather, this resource is intended to help strengthen the capacity of those services to work together when responding to the complexity of hoarding behaviour or squalid conditions.

The practical service response to these situations is firmly based on principles that support the person with the presenting concern, as well as any dependents (such as children, people who are frail, have a disability or animals), so that they are well cared for and treated with the respect they deserve as living beings (refer to [Table 1 Principles underpinning service response to hoarding and squalor situations](#)).

The aim of a service response, particularly one that relates to complex life situations, is to enable and empower the person to act on their own behalf, to exercise their rights and be confident of the services and resources available to assist them.

While hoarding behaviour and the causes of squalor have clinical histories dating back decades, they are today recognised as public health issues for people who live in these situations with significant comorbidity and morbidity as well as having impaired neuropsychological functioning.

This practical resource does not attempt to define any aspect of diagnosis or clinical intervention, because that skill and responsibility lies in the professional areas of psychology, psychiatry, psychogeriatrics and geriatrics, as well as the broader ambit of mental health. The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders ((DSM-5) edition was published in May 2013.<sup>2</sup> Hoarding has been included as a discrete disorder in its own right within the chapter about obsessive-compulsive and related disorders.<sup>3</sup> (refer to [Appendix 2 DSM-5 changed the diagnostic criteria of hoarding](#)).

Connecting and building rapport (a relationship) with the person first is central to assessing the severity of hoarding behaviour in a home or on a property.

Building service system capacity to respond to people living in these situations is seen as the best way to support them to address the challenges that surround them. These broad service systems are made up of multiple and varied sectors seeking to strengthen their understanding of such circumstances and to

1 Snowdon J. 2005.

2 Refer to the American Psychiatric Association, <http://www.dsm5.org/Pages/Default.aspx> *Diagnostic and Statistical Manual of Mental Disorders*.

3 World Psychiatry Association, refer to [http://www.spu.org.uy/wp/WP\\_June\\_2013.pdf](http://www.spu.org.uy/wp/WP_June_2013.pdf).

build their ability to effectively respond. Providing assistance and joint service response to such cases is extremely difficult work.

In reality, many programs, businesses and services have eligibility and engagement limitations, service provision time allocations, reporting requirements and funding targets.

The intention of this resource is to encourage the gradual building of skills and knowledge within and between services and sectors – all the while knowing that this takes time. The steps forward will be small ones; the effort required will be taxing and persistent. The outcomes cannot be anticipated and may well at times seem unsuccessful.

We all have the responsibility to actively do something to assist people living in these circumstances, and to encourage improved and sustainable health and wellbeing outcomes, so that the person and their dependents can live in a safer and less risky environment. Service providers should not ignore them, but engage and support them.

In some regards, dealing respectfully with persons affected by squalor and hoarding to effectively address the challenges and risks that they face is a matter of human rights, as set out in the UN Convention on Human Rights of Persons with Disabilities and the Victorian Charter of Human Rights and Responsibilities. Situations also need to be acknowledged where we can do little to help, and recognise that we do not have a 'moral' right to pressure people to do what we think is 'normal' or 'acceptable'. In these situations we need to support one another in how we deal with our feelings, perhaps including helplessness or offence (for example, wondering how a person can live like that) over the long term.

Different sectors (including private and government-funded services, such as housing, animal, regulatory, environmental health, health services, social work, aged care and mental health) have planned or are planning to adapt this material and apply it to their own practices in a variety of ways. Examples include:

- considering the integration of reference to this practical resource into program guidelines (for central government office program areas)
- exploring the possibility of utilising some of the tools to assist with objective assessment, referral and joint action planning
- referring to and discussing this practical resource, its implications and use at international, national, divisional and local sector events, including raising awareness by contributing to industry peak body events
- utilising specific practical response information (for example, flowcharts) in team meetings and case discussions, in service response opportunities or local forums and service induction programs to raise awareness and enhance multiple sector responses
- using the case studies, questions and answers and principles; for example, in small group discussions within teams or mixed sector local workshops, applying them to local situations, discussing how a previous service response could have been improved or planned differently and what might improve capacity to respond
- brainstorming with managers, supervisors and staff about what they would like to learn regarding hoarding and squalor cases, planning an appropriate opportunity to discuss, raising awareness of both conditions and service response opportunities and educating and learning without pressure
- looking for opportunities in the quality systems of existing organisations, services or programs to include policy reference or quality measures regarding how best to respond to situations involving hoarding behaviour and squalor situations (this reference may be included in a component of an existing quality measure; for example, responding to complex circumstances or cases)
- exploring and building more defined protocols with other sectors in a local area; while other organisations might look to include a trigger at the point of receiving the initial information that prompts them to ask questions about whether the referral involves hoarding or squalor.

To understand the conditions affecting these situations, and possible difficulties that arise when addressing them, takes time, patience and collaborative work with other sectors, including occasionally seeking specialist support. The business of getting service coordination right is vitally important for successful agency partnerships and for the possibility of sustained improvement for the person concerned.

This document contains several very useful quick reference tools and prompts, such as the tools section, questions and answers, the service summary table and case studies.

The positions adopted are intended to be consistent, or at least resonate with interstate and international experience, in order to assist further work by other jurisdictions on the subject of hoarding and squalor.

A hoarding and squalor key messages statement (x4 A4 pages) is available in:

- hard copy (that is, printed), which can be obtained by contacting the Department of Health-appointed distribution centre, Warehousing Fulfilment Distribution Solutions (WFDS) – phone: (03) 9793 8111 or email: [orders@wfds.com.au](mailto:orders@wfds.com.au) by providing details of the quantity required and address for delivery.

This publication, the hoarding and squalor practical resource and the hoarding and squalor key messages statement are both available in:

- soft copy (web based) – refer to [www.health.vic.gov.au/agedcare/publications/hoarding.htm](http://www.health.vic.gov.au/agedcare/publications/hoarding.htm)



# 1 Introduction

People living with hoarding behaviour or in a squalid living environment need to be acknowledged and supported to enable them to manage their behaviour so they might live safely with minimal risk to themselves and the community.

People who hoard or live in squalor work in a broad range of careers or job roles – or they could experience or be at risk of homelessness.

People who hoard or live in squalor are of all ages, all socio-economic and cultural backgrounds and can be of any gender or sexual orientation. They are not only those who are of an older age, although hoarding and squalor conditions might be more evident at that stage of their life due to the impact of time and life circumstances.<sup>4</sup> Hoarding prevalence rates have been estimated at two to five per cent in adults.<sup>5</sup>

Hoarding behaviour and squalid living conditions define quite different circumstances, but under certain conditions may co-exist. Hoarding describes behaviour by a person that is evidenced by, for instance, vast collections of different items and articles that have been kept and not discarded; whereas squalor describes a living environment. When a person hoards organic matter or animals, a squalid environment will eventuate.

Often, hoarding behaviour and the poor health status of a person living in a squalid environment co-occurs with other behaviours and mental health conditions. Substance abuse, including alcohol, nicotine, prescription and illegal drugs is often present.

A predominate focus on the severity of clutter in home, or the degree and type of squalor, in isolation from engagement with the person, will not bring about sustained behavioural change. The person needs to be central to action planning and decision making, which includes moving at the person's pace.

## 1.1 What doesn't work?

A person who compulsively hoards has within their personality traits an ingrained reluctance to part with items that they've come to see as extensions of themselves. Each and every item is important to them – often seemingly of an exaggerated value.

Too often, one-off clean-ups have been orchestrated by well-meaning public and private services, families or friends, thinking that 'getting rid of the mess' will resolve the concern. It is now known locally (and confirmed internationally) that this approach is not effective, and in fact causes great distress and pain for the person concerned – particularly if they were not involved or considered in the effort.

The health and welfare needs of the person and any dependent others (such as children, frail adults or animals) must be the focus of an initial response. It is important to develop action plans to meet the needs of each person or dependant. This process may occur concurrently or consecutively.

Hoarding and squalor are symptoms exhibited by the person and should not be seen as the problem to be managed in isolation from its cause – hoarding disorder is a mental health condition.

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<sup>4</sup> See *Discussion paper – hoarding and squalor 2012*.

<sup>5</sup> Pertusa et al. 2010.

## 1.2 Clinical treatment

Agreeing to clinical treatment may be quite difficult for the person who hoards. There may be no 'cure' for hoarding, but there are ways to clinically assist the person and help them transition effectively to more healthy behaviours.

Equally, a person living in a squalid environment may show some resistance to treatment, but for different diagnostic reasons. Working with people living in a squalid environment not related to hoarding behaviour requires different approaches, which lead to different outcomes.

## 1.3 What's the concern?

Hoarding behaviour and squalid living environments can pose several associated problems and concerns in a person's life, which may involve laws, policies and daily living requirements in areas as diverse as sanitation, safety, fire risk, mental health, physical health, animal protection, building safety and others.

In Victoria a broad range of sectors and related services have been responding to hoarding and squalor situations, often in isolation from one another. Varying degrees of experience and expertise have evolved from practice, with several initiatives undertaken to improve skills and cooperation. For example, 'practice champions', local networks and forums have been held in Gippsland, Geelong, Loddon Mallee, North West, Eastern and Southern Metropolitan Melbourne.

Sectors such as animal welfare, environmental health, municipal by-laws and a broad range of community and clinical services have all been grappling with how best to respond. No matter what geographic area or what sector, service providers have been seeking guidance on what to do and how to do it in the best possible way.

*The Victorian Public Health and Wellbeing Plan 2011–2015* aims to improve the health and wellbeing of all Victorians by engaging communities in prevention, and by strengthening systems for health protection, health promotion and preventive healthcare across all sectors and levels of government. The aim is to achieve lasting improvements in the health of all Victorians, with particular emphasis on the needs of those who are worse off and who experience poorer health than others in our community. The plan highlights that improving health really is everybody's business:

- individuals, families and communities
- the health sector, non-government organisations, researchers, private and voluntary sectors
- all levels and sectors of government.

## 1.4 The purpose of this resource

This resource provides direction, context and practical tools to help strengthen the capacity of funded or regulated services to work together when responding to these situations. It does not attempt to present any aspect of diagnosis or clinical intervention, because that skill and responsibility lies in the professional areas of psychology, psychiatry, psychogeriatrics and geriatrics, as well as under the broader ambit of mental health.

This resource emphasises that people have the right to make their own choices about how they live, and that the role of agencies is to assist the person to help themselves by providing advice and other supports. However, where a person's choices adversely impact on human dependents or animals, or the broader community, government agencies may be required to take action to improve the welfare of those dependents.

The challenge is for public and private providers, regulatory, health and community sector providers (as well as emergency services) to work together, drawing on one another's expertise and specialities and develop a common understanding of how, who and in what sequence services might best be able to support and address the needs of people and animals living in such conditions.



By building this capacity, a more cohesive, person centred and animal aware approach should result; one that is sustainable and provides good outcomes for those concerned. This resource presents a common response framework by:

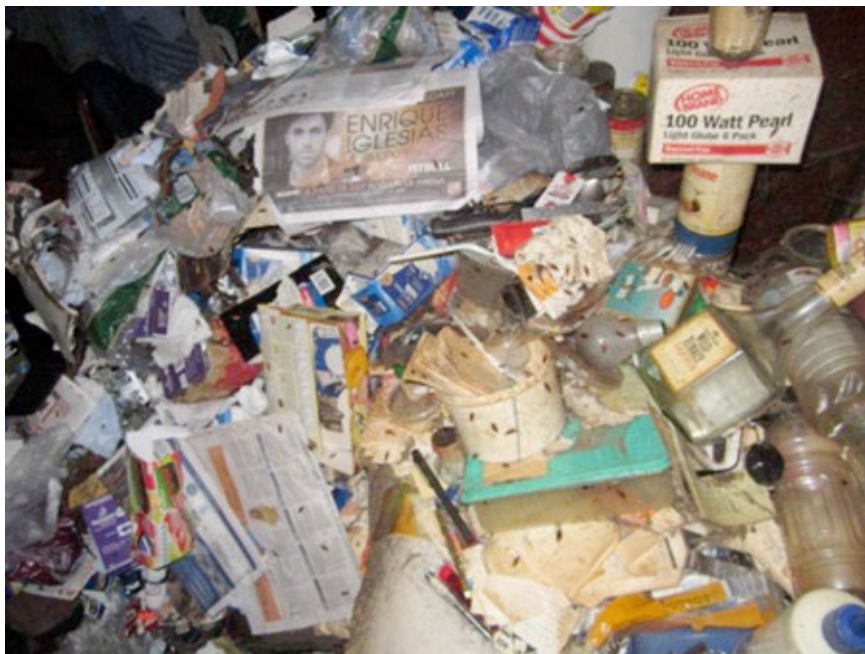
- discussing the difference between hoarding *behaviour* and a squalid *environment*, where they intersect and why
- placing the person, human dependents and animals first in a planned response, ensuring they are safe and risk is minimised
- presenting direction on how to work collaboratively
- confirming a common language, systems and tools that can be utilised by services
- presenting information about service types, what they do and how to contact them.

Central to this framework is the key requirement that services and agencies coordinate their responses, particularly when multiple services are involved. This requires a high level of communication and feedback between service providers, so that assessment, support and care is coordinated but not duplicated.

These cases are tough and extremely complex. Typically, several areas of a person's life are affected, including at times how their animals are cared for. Effective intervention requires professionals working together in the same direction and at the same speed, meeting the relevant legal and ethical requirements, while also ensuring that the current and future health and safety of the person, the animals and family are addressed. Regulatory requirements will still need to be met, but this resource explores how those requirements can be approached in different ways with service partners.

We trust that this material will resonate with readers from both private and government-funded services, enabling them to move forward confidently with each other, and address these complex cases in ways they had been previously unable to.

**Figure 1 An example of infestation in a person's home**



## 2 Defining hoarding and squalor situations

Not all cases involving hoarding or squalor require a service response. There may be situations where a degree of hoarding is evident, or a squalid environment is obvious to some extent, but the person or persons living there and their neighbours are managing to live compatibly with the presenting situation, and neither the health nor safety of the person or their dependents (that is, children, frail adults or animals) is at risk.

The people living on the premises may well have other service needs (such as case management, advocacy, or other supports) to manage their housing, financial, medical or daily living requirements (for example, personal care, carer support, disability or mental health support, or animal welfare requirements), but may not require any services to specifically address a concern about a hoarding or squalor situation.

### 2.1 Principles to guide all service responses

The following common set of principles to underpin a system-wide approach provides a stable common base for a consistent service response to hoarding and squalor situations across the broad range of sectors involved.

Not all services involved in responding to such situations do so with a focus on the needs of the person. Rather, they may have a regulatory role, where environmental health or the welfare of animals is the foremost consideration, or it may be a local response to a house fire or local municipal laws that drives the response.

No matter what the intention of the service, the principles discussed in this section should be taken into account when planning a response. Organisations and agencies need to work in partnership to ensure that the right mix of services is involved to adequately address these principles.

The following principles endeavour to scope the work of all services, including those where the person traditionally is not the primary focus (for example, fire response, animal welfare, local laws and public health).

**Table 1 Principles underpinning service response to hoarding and squalor situations**

| Principle  | Description   |
|--|---|
| Competence   | All persons are considered competent to make informed decisions unless there is evidence to the contrary.   |
| Self-determination                                 | With appropriate information and support that recognises diversity, <sup>a</sup> 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 a child, it may be necessary to appoint a guardian or administrator.<br><br>Even when a person or child is unable to make all decisions themselves, their views should be taken into account as far as possible.<br><br>The welfare of any affected animals must also be appropriately protected. |
| Promote personal and social wellbeing <sup>b</sup> | 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.  |

<sup>a</sup> Diversity:

- A service response needs to recognise and appreciate individual difference and create an environment where the contributions of people with different backgrounds, experiences and perspectives are valued and accommodated.
- The Victorian population is highly diverse across various dimensions, such as disability, gender, Indigenous status, faith, ethnicity, language, age and sexual/gender identity. Diversity can also relate to levels of education, a field of endeavour, skills, socio-economic background, personality profile, geographic location, marital status and whether or not the person has carer responsibilities.

These diversity factors require two complementary service response approaches:

- one that supports and promotes diversity, including accessible and appropriate service delivery
- and
- one that reduces discrimination, marginalisation and disadvantage.

<sup>b</sup> The promotion of personal and social wellbeing:

The term 'best interest' as statement of principle is currently broadly challenged,<sup>6</sup> on the basis that it is outdated both in terms of meaning, function and intent, for example:

- it is often criticised for inviting the supportive decision maker (for another person) to do what they think would be best, thereby imposing their own values on the person they are supporting
- it has been argued that 'best interests' has come to constitute somewhat of a euphemism for overriding another person's free will
- the term is also strongly associated with decision making for children, which inappropriately translates to a paternalistic attitude to adults with impaired decision-making capacity.

If the term continues to be used it might impede the evolution of the practice of acting in a manner that respects the rights, will and preferences of people to the maximum possible extent.

In the context of this resource, one of the overarching principles is to 'promote the personal and social wellbeing' of the person, so this phrase is used as an alternative to the term 'best interests'.

<sup>6</sup> Refer to: Chapters 17.112; 17.120; 17.122 in the Victorian Law Reform Commission's: *Guardianship Final Report 2012*.

## 2.2 Definitions

Developing a definitive description of either hoarding or squalor is challenging, because the words are often used interchangeably and in varying contexts. Also, often the person's needs and health status are not that well understood.

For the purpose of this practical resource, the following definitions of hoarding and squalor have been decided upon by the Hoarding and squalor project – stakeholder group (refer to [Appendix 1 Hoarding and squalor project stakeholder group](#)), to guide the practical service response of multiple types of service providers and programs.

### 2.2.1 Hoarding

#### Definition of hoarding

Hoarding behaviour is the persistent accumulation of, and lack of ability to relinquish, large numbers of objects or living animals, resulting in extreme clutter in or around premises. This behaviour compromises the intended use of premises and threatens the health and safety of people concerned, animals and neighbours.

This definition takes into account the importance of not making a judgment about the value of the items stored by people who hoard. Often the perception by others is that hoarded items lack value. Actually, the objects, items or living animals are of immense value to those that hoard them.

Hoarding is behaviour that may manifest either as a symptom (most commonly in OCD) or as a possible syndrome that develops with age.<sup>7</sup>

The definition aims to encompass any hoarding condition that may come to the attention of service providers. It aligns with current clinical diagnostic thinking, but its purpose is to define a practical situation encompassing the following aspects:

- it reflects the fact that some people who hoard actively acquire things or animals from external sources, while others might passively accumulate over years without relinquishment (for example, with regard to animals, a person could just allow their animals that are not desexed to keep breeding without acquiring more)
- the word 'relinquish' captures the fact that objects or animals are valued by the person and not easily given away or surrendered
- objects (for example, piles of newspapers) may be neatly piled up along corridors and not necessarily fill or clutter living areas, which may remain available for their intended use
- some objects and animals may be hoarded outside the home in other buildings or spaces, in non-living areas
- every situation is different, and the impact of a person's hoarding behaviour can be anywhere on a continuum of severity from low to high. Assessment for health, safety and risk is important, depending on the degree to which a person's or animal's living conditions and wellbeing are compromised
- for a first response agency that is assessing risk, whether a person's hoarding is compulsive or not is not so relevant at that stage – an underlying cause would be up to mental health professional to determine.

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<sup>7</sup> Sansone & Sansone 2010.

## What causes hoarding?

Hoarding may be hereditary. Up to 85% of people with hoarding behaviour can identify another family member who displays this behaviour. Hoarding can begin after brain damage, such as strokes, surgery, injuries, or infections. Family experiences and psychological factors may also play a role in the development of hoarding and emotional stress may heighten symptoms.

Hoarding is a complex disorder that is believed to be associated with four underlying characteristics.<sup>8</sup>

- First there are certain core vulnerabilities including emotional dysregulation in the form of depression or anxiety along with family histories of hoarding and generally high levels of perfectionism.
- Second, people who hoard appear to have difficulties processing information, in particular in attention, memory, categorization, and decision-making. The areas of the brain that control these functions roughly correspond to the brain regions that have been shown to activate differently in people who hoard.
- Third, people who hoard form intense emotional attachments to a wider variety of objects than do people who don't hoard. These attachments take the form of attaching human-like qualities to inanimate objects, feeling grief at the prospect of getting rid of objects, and deriving a sense of safety from being surrounded by possessions.
- Fourth, people who hoard often hold beliefs about the necessity of not wasting objects or losing opportunities that are represented by objects. Additional beliefs about the necessity of saving things to facilitate memory and appreciation of the aesthetic beauty of objects contribute to the problem.

People who hoard have a variety of reasons for doing so:

- to avoid wasting things that might have value
- they have a fear of losing important information
- the emotional meaning of objects
- they appreciate the aesthetic appeal of objects, especially their shape, colour, and texture.

Three behaviours characterise hoarding:

- acquiring too many possessions
- difficulty discarding or getting rid of them when they are no longer useful or needed
- difficulty organising possessions.

When these behaviours lead to enough clutter and disorganisation to affect someone's health or safety, or they lead to significant distress, then hoarding becomes a 'disorder'.<sup>9</sup>

People who hoard may have personality traits that include avoidance, anxiety, indecisiveness, perfectionism and poor socialisation skills. The person is often resistant to change, procrastinates or agonises over decisions, leaving items that may previously have been of value to decay or deteriorate to the point where the items are perceived by others to be worthless.

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<sup>8</sup> Tolin, et al.

<sup>9</sup> International OCD Foundation, *Diagnosing Hoarding*.

**Table 2 List of the most frequently hoarded items<sup>10</sup>**

| Description               | Rank | Endorsing (%) |
|---------------------------|------|---------------|
| Clothes                   | 1    | 89            |
| Greeting cards/letters    | 2    | 79            |
| Bills, statements         | 2    | 79            |
| Books                     | 3    | 77            |
| Magazines                 | 4    | 68            |
| Knick-knacks              | 5    | 66            |
| Mementoes/souvenirs       | 5    | 66            |
| Records/tapes             | 6    | 64            |
| Pictures                  | 7    | 62            |
| Sentimental objects       | 8    | 60            |
| Recipes                   | 8    | 60            |
| Wrapping paper, materials | 9    | 58            |
| Papers, pens, gifts       | 9    | 58            |
| Stationery, old things    | 10   | 56            |

Other items include:

- **hobby/craft material:** art materials, bells, bones, bottles of wine, craft projects, playing cards, postage stamps, rocks, sheet music, shells, timber and loose wool
- **information:** advertisements, assignments, business cards, classic novels, old diaries, email, exercise routines, footy records, holiday pamphlets, information, maps, medications (out of date) notices, sayings / musings from self / others, school books, university notes
- **personal:** coats, dental floss, hair conditioner, jumpers, moisturisers and bubble baths from hotels, perfume bottles, phone messages, photographs, shampoo bottles, shoes, shower caps, skin scabs, toothbrushes, toothpaste
- **sentimental:** baby clothes, blankets from grandma, child art, children's books, children's school work, collars from deceased dogs or cats, dead plants, knitting from grandma, letters, little gifts, love letters, own notes on rock or folk music events, pay slips, theatre or opera programs, toys, broken items that are 'loved' but not mended
- **useful things:** broken things that could have other uses, building materials, dried food stuffs (out of date), envelopes, fittings, glad wrap washed and recycled, industrial waste, kerbside cast-offs with mechanical or Steptoe potential, metal/tin, nuts and bolts, bits and pieces of paper of all sorts, plastic bags, plastic containers, product samples, recyclables, tin, wire, wood.

### Animal hoarding

People who hoard animals are encompassed in the broader definition of hoarding (refer to Section [2.2.1 Hoarding](#)). The following information has been included to enhance understanding about people who hoard animals and why they do so.

<sup>10</sup> Mogan 2008.

**Definition of animal hoarding**

The accumulation of large numbers of animals that overwhelms the person's ability to provide a minimum standard of nutrition, sanitation and veterinary care.

**Issues**

Animal hoarding is a specific type of hoarding which involves poorly understood, maladaptive, destructive behaviour of which the aetiology and pathology are only beginning to emerge.<sup>11</sup>

There is no standard definition of animal hoarding.<sup>12</sup> Only basing the definition of animal hoarding on the number of animals in a household may not be useful. The inability to care for the animals' welfare is invariably part of any existing definition.

People with animal hoarding behaviour should never be confused with legitimate and worthwhile animal rescue efforts. Legitimate shelter, rescue service or sanctuary puts the needs of the animals first, recognises when capacity to provide care is exceeded, and takes the required steps (that is: stopping intake, increasing adoption, increasing staff or resources) in order to provide proper care.

The lack of mental capacity to recognise and understand the effects of the person's own behaviour on the welfare of the animals sets animal hoarders apart from people who are mentally fit and are just cruel or neglectful of a large number of animals.

The hoarding of animals is a complex behaviour that results from a variety of psychological and behavioural deficits that may limit a person's ability to care for themselves or others.

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

If the person is aware of developing a problem and they are unable to correct it, this may result in the continuing deterioration of conditions for the animals. Eventually, the needs of the animals become lost to the person's need for control (refer to Section [3.5.1 Risk management](#)).

**Why people hoard animals**

At the beginning stages of hoarding animals people exhibit some ability to care for their animals or may look like they are on a seemingly benevolent mission to save them. The resulting compulsive care-giving is pursued to fulfil unmet *human* needs, while the real needs of the animals are ignored or disregarded.

The Victorian Animal Hoarding Advisory Group advises that animal hoarding is characterised by:

- the person having more than the typical number of companion animals, livestock or wild animals
- failure by the person to provide even minimal standards of nutrition, sanitation, shelter, space and veterinary care, with this neglect often resulting in illness and death from starvation, spread of infectious disease, untreated injury or medical condition and the inability of animals to express normal behaviours
- denial by the person of their inability to provide this minimum care and the impact of that circumstance on the animals, the household and human occupants of the dwelling
- the person's persistence, despite this failure, in accumulating animals.

<sup>11</sup> Patronek & Nathanson 2009 Clinical Psychology Review 29:274–281.

<sup>12</sup> Patronek 1999.



Animal hoarders often fall into one of the following three categories, but can sometimes exhibit characteristics across categories:<sup>13</sup>

- **The overwhelmed caregiver** initially provides adequate care for the animals and believes that while a problem has slowly developed, it's not as serious as others think it is. The overwhelmed caregiver may be socially isolated, but is willing to accept intervention.
- **The rescue hoarder** develops a compulsion based on a strong desire to rescue animals from possibly deadly situations, actively acquiring animals, believing no one else is capable of caring for them. They often work with a network of enablers, gaining proximity to the animals and finding it difficult to refuse to take in any new animals.
- **The exploiter hoarder** takes in animals to serve their own needs and is indifferent to any harm caused to the animals. Typically denying a problem exists, this type of hoarder rejects authority figures or any outside help and has a strong need to be in control while expressing very little remorse or guilt. They may continue to acquire animals over time.

Sometimes animal hoarders act as individuals and at other times they present as an animal rescue service. They may have an overwhelming sense of responsibility for the animals, believing they have an innate ability to communicate and empathise with them.<sup>14</sup>

### International classification scale

#### *Clinical diagnostic criteria*

Workers from most health services and community service agencies are not asked to 'diagnose' the symptoms of a person; this is the responsibility of mental health professionals.

There is some benefit in knowing that work is occurring internationally in the mental health field to more accurately define hoarding behaviour. Recent evidence points to hoarding as being a genetic, neurobiological and behavioural condition.<sup>15, 16</sup> Refer to [Appendix 2 DSM-5 changed the diagnostic criteria of hoarding](#) with regard to the proposed diagnostic criteria for inclusion in DSM5.

### 2.2.2 Squalor

#### Definition of 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 others in the community.

The term *domestic squalor* is specific to the Australian experience<sup>17</sup> and is used to describe living conditions, not people. Prolonged or extreme hoarding may lead to squalor.

The definition above encompasses the following thinking:

- the term 'squalor' is preferred over the term 'environmental neglect', because the general meaning of 'squalor' is more universally recognised, which strengthens an ability to achieve a common understanding between services in relation to the state of the living environment
- people living in these conditions may believe they are actively helping the environment by recycling or by rescuing animals

<sup>13</sup> Patronek G, Loar L, Nathanson J, 2006.

<sup>14</sup> Frost 2000.

<sup>15</sup> Saxena 2007; Pertusa et al. 2008a.

<sup>16</sup> Mogan et al. 2012.

<sup>17</sup> Halliday et al. 2000.



- emotional and negative terms such as 'filthy' and 'disgusting' do not assist an appropriate service response; words such as 'unsanitary', 'unhygienic', 'hazardous' and 'unclean' are more objective
- the Victorian Department of Health Office of the Chief Psychiatrist suggests that terms such as 'disgusting' are particularly problematic and contribute to stigma.

### What causes squalor?

Whether someone lives in 'squalor' is subjective and often influenced by the attitude, exposure to the unclean environment and personal living conditions of the person making the assessment. There have been attempts to define:

- *Poor living conditions* which is an appropriate and sensitive term for most unpleasant domestic situations covering a range of health conditions and domestic circumstances, and
- *Severe domestic squalor* which suggests more extreme conditions.

Both conditions overlap in different ways with other concepts such as senile squalor,<sup>18</sup> OCD,<sup>19</sup> Diogenes syndrome<sup>20</sup> and social withdrawal.<sup>21</sup>

Basically there is no one diagnosis and no easy answers – which highlights the necessity of seeking clinical assessment and treatment.

## 2.3 When hoarding and squalor intersect

Domestic squalor can be accompanied by hoarding and the accumulation of consumer items, packaging and animals.<sup>22</sup> However, care needs to be taken not to label every case of hoarding or excessive collecting as a case of severe domestic squalor. This would not be helpful and could be regarded as insulting to the 'collector' concerned.

Some people might neglect (for example, seem not to care about) their own cleanliness, their dependants' or their home's, and don't dispose of rubbish. This may be due to a broad range of health conditions, including some types of disability, dementia, schizophrenia, drug addiction or alcoholism. Also, some people may not have developed or learned adequate living skills to support themselves on a daily basis.

In the above cases and those determined as constituting hoarding, clutter may become so excessive that it inhibits effective cleaning, collects dust and supports the likelihood of rodent infestation and prohibits the intended use of the space (that is, what it was designed for), often leading to the improvisation of unsafe and unhygienic practices.

Additionally, where animals of any type are hoarded and not kept clean or cared for, or where organic matter is accumulated and not cleaned, a squalid environment develops.

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<sup>18</sup> Shah 1991.

<sup>19</sup> Winsberg et al. 1999.

<sup>20</sup> McDermott et al. 2009.

<sup>21</sup> Sheehan et al. 1998.

<sup>22</sup> Stepney 1994.

## 2.4 Ritualistic collecting

Some people collect ritualistically, rather than compulsively or on impulse. Ritualistic collection and unmotivated accumulation of objects and rubbish should not be referred to as hoarding.<sup>23</sup>

Maier<sup>24</sup> suggests there are three types of hoarding:

- egosyntonic collecting that is 'addictive' and gives the hoarder pleasure, so they collect more; impulse control is the problem
- egodystonic, where the person feels compelled to hoard for fear something bad will happen if they don't; the hoarder does not feel pleasure, similar to an obsessive compulsive disorder
- stereotypic hoarding, which involves collecting without emotion.

'Collecting' is the systematic acquisition of specific types of objects (for example, stamps, coins, posters, DVDs, crockery, porcelain, movies, clothing), which are kept and maintained in designated places. Unlike hoarding, the items are frequently valued by other collectors and often exchanged to enlarge or enhance the value of a collection.

Hoarding can be differentiated from collecting behaviour, where collectors are proud of their collection, and enjoy, maintain and display them. The collector's items are organised and functional, with further items added when budget permits; the home is generally not cluttered, but might become so in an 'organised way'.

A hoarder tends to be more ashamed of their behaviour, and their items are not organised in the same way as for a collector, particularly at advanced hoarding stages. Excessive or inappropriate collecting (and especially a failure to discard) may lead to similar safety and risk issues that occur with hoarding.

## 2.5 Early intervention is encouraged

The age of onset of hoarding behaviour may be in childhood (as young as 10 years of age) or early adolescence, with mild symptoms at age 17, moderate in the mid-20s and extreme by the mid-30s. The impact of hoarding behaviour becomes more burdensome with age: it is three times more frequent at 55 and older, than between 34 and 44 years. A person generally does not often seek help or assistance until middle age.<sup>25</sup>

Regardless of the age of onset, there is usually a significant time lag of many years between the onset of symptoms and when a person first seeks treatment or support.

Compulsive hoarding tends to be a chronic disorder. Left untreated, it usually worsens gradually over time.

It is important for service providers to identify and offer assistance to a person experiencing hoarding or living in squalor as early as possible in that person's life course. No matter what the person's age, they may have a severe lack of insight into their hoarding behaviour, with family members indicating the person might be in denial or delusional.

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<sup>23</sup> Maier 2004.

<sup>24</sup> Maier 2004.

<sup>25</sup> Tolin et al. 2010.

**Figure 2** An example of a room where there is a hoarding issue



## 3 Building service system response capacity

This section presents some key considerations and directions that aim to enhance agency and sector understanding of what is required to effectively plan and deliver services when responding to hoarding and squalor situations.

Building the capacity of service systems to respond to such circumstances is significantly enhanced by strengthening a common understanding between all services about how they might best work together, coordinating effort and expertise so that the person (and any dependents) can experience a service that is integrated, easy to access and navigate, and is more likely to produce a sustainable outcome.

### 3.1 Which services respond?

A service response to hoarding or squalor situation is shared and coordinated, no one service type or provider has sole responsibility (refer to Section [5 Collaborating with other services](#)).

A person with complex needs such as someone with hoarding behaviour or who is living in a squalid environment, may be defined as someone with multiple and chronic issues who requires multidisciplinary interventions and a cross-sector approach to achieve optimal stability and better outcomes, including connecting with their community.<sup>26</sup>

Amongst a range of factors the person may:

- display at-risk or high-risk behaviours
- be difficult to engage
- have behaviour management issues
- have poor self-management capabilities
- not have accessed reliable and accurate assessments (and therefore have a possible undiagnosed condition)
- be in transition and may have no sense of belonging or connection to community or family
- have been stigmatised by worker perceptions
- have needs and goals that may be in dispute or disagreement
- have limited trust of the system, service providers, all types of institutions or other people
- experience or be at risk of homelessness
- have an acquired brain injury (ABI) physical health issues, neurological issues, mental health issues, suicidal/self-harm issues, an intellectual disability, use alcohol or other drugs or be exposed to family violence
- frequently use emergency services (for example, ambulance, hospital or police).

Not only will there be concern for the person living on the property, but also for any dependents (people who are frail, disabled, children or animals), the state of buildings and the surrounding property.

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<sup>26</sup> EMR 2009.

## 3.2 Service coordination

Situations such as those described above are extremely complex, with no easy answers or quick remedy available. Service response is best sustained and managed when the joint planning, management and skill of a variety of services all work together – not always at the same time, but certainly all knowing what needs to be done, by whom and when.

Consequently, a common means of working together needs to be established between services that describe:

- knowing how and with whom to share resources, knowledge and expertise with at a local, divisional and specialist level
- a common language
- an understanding of what needs to be done, when and by which service.

This means that each service provider or type of service should have in place the means by which a person can be linked to other services, enabling a coordinated response to meet the full range of needs, including those of animals, in a timely manner.

Many different types of existing services do currently respond to hoarding and squalor situations, at times independent of one another, so it makes sense to establish an agreed flexible and creative way of providing services together. Both public and private services are in a position to better organise themselves and respond to the people living in these situations, putting the person and dependents first.

This is not an easy task to aspire to – let alone achieve, particularly in situations involving hoarding and squalor. Therefore, many different sectors can become involved, each with their own culture, their own unique purpose and using language commonly understood by their immediate collegiate group.

People living in circumstances of hoarding and squalor too often fall between the cracks of support, services and treatment. Their lives often *do not* change for the better; they continue on by themselves, often in virtual, if not real, isolation. However, when a person's health and wellbeing suffers and deteriorates, and their quality of life is affected, over time, service provider support can make a difference, achieving small changes. People living in these circumstances can, with appropriate support from others, make life changing decisions.

### 3.2.1 The benefits of service coordination

Service coordination offers multiple benefits to the person and service providers.

**Benefits for the person include:**

- provision of up-to-date information about local service availability and support options for them or their representative to contact the most appropriate service
- no wrong door – every contact a person has with a service provider whether animal, health (including environmental and clinical), housing, aged, community and regulatory services should be the right point of access to all types of services
- clear entry points, plus transparent and consistent referral pathways and processes that are easy to navigate
- improved and timely identification of needs through an initial needs identification process
- improved response times to requests for information and referral
- confidential transfer of information for referral purposes in a way that does not require the person to repeat their information
- improved access to assessment and coordinated action planning
- increased knowledge of the local service system and access to resources that support service coordination, such as the Human Services Directory (HSD)<sup>27</sup>

27 Refer to the Human Services Directory at: <http://humanservicesdirectory.vic.gov.au/Home.aspx>

- consistent service standards from each service provider.

**Benefits for service providers include:**

- improved ability of service providers to deliver a coordinated response to people accessing multiple services
- practices, processes, protocols and systems that set out clear guidelines and expectations around key areas of work and interagency practice, including continuous quality improvement strategies aligned with core accreditation standards
- documented practice standards for initial contact, initial needs identification and action planning
- improved consistency and quality of information about the person and information sharing through the use of common templates (refer to Section 8 [Tools to assist](#)).
- more efficient use of resources through improved information and feedback from referrals, fewer inappropriate referrals and less duplication of services
- streamlined services through the provision of a consistent, agreed, standardised way for practitioners within and across organisations to identify the needs of the person, identify appropriate services, make referrals, provide feedback, communicate and coordinate services which lead to improved operational efficiency.

### 3.2.2 Types of complex circumstances

**People living in complex circumstances and who are identified as having high levels of need may refer to:**

- families with children with disabilities, where several different organisations are providing support
- people with disabilities with a diverse range of needs arising from physical and behavioural causes
- people with disabilities requiring the development of appropriate responses for personal and/or respite care
- people with complex medical issues, which may pose critical issues for assessment and action planning
- older people with chronic illness and unstable health conditions requiring coordinated management across acute, subacute, community and community health and home care sectors
- older people with dementia or other cognitive impairment
- people (including older people) who are extremely socially isolated and withdrawn
- circumstances involving difficult OHS issues for community and home care sector workers
- people with mental health conditions, whose functional limitations may fluctuate substantially over time
- people with psychiatric disabilities where inter-organisation agreements may be required to access specialist assessment expertise
- people with family and carer needs that require additional service support.

**Inter-organisation relationships, agreements and protocols may relate to:**

- knowing how to access specialist expertise for secondary consultations, advice or assessment
- the extent and type of information provided on referral
- joint assessment
- case or situation conferencing or discussion
- action planning and ongoing support
- use of specialist assessment tools
- how to involve family members and primary carers in the assessment and review process as well as other organisations providing services
- how information relevant to the case, from health practitioners, other services (including regulatory officers, specialists and direct support workers) is shared.



## 3.3 Key coordination stages to consider

### 3.3.1 Initial contact and needs identification

#### Brief definition

Initial contact and needs identification occurs when a person has a first contact with a service, and usually includes providing that person with accurate and comprehensive information about what services and support are available to them. Identification of initial needs is a broad, shallow screening process to uncover underlying and presenting issues. As well as focusing on the presenting, obvious or most pressing issues, the service provider or officer engages in a broad conversation (if possible) about the person's health and wellbeing to identify if other areas of need exist. This might include consideration of opportunities for health promotion, illness prevention, early intervention, self-management capabilities, restorative options and regulatory requirements. The welfare or support needs of others such as animals, family members or neighbours should also be taken into account at this stage.

Initial needs identification is not a diagnostic process, but a determination of the person's or animal's safety and risk, the person's willingness to accept assistance, and their eligibility and priority for services.

The service provider or officer must use judgment and discretion to decide the extent and intensity of the process, to ensure the person has enough information to understand options but is not overwhelmed. The gathering and analysis of information at this stage reduces risk and informs the urgency and type of assessments required.

**Table 3 Determining the most appropriate initial response service**

| Referral source  | Service   |
|--|---|
| The person makes the referral themselves   | Determine the most appropriate response service or joint visit, based on the person's identified need (for example, whether they are facing eviction).<br>Determine if there is any immediate risk to the person/others or animals (refer to <a href="#">Section 3.5.1 Risk management</a> ).   |
| A third party (neighbour/family/church and so on) makes the referral with the person's knowledge/consent (they may provide a range of information)   | Determine the most appropriate response based on identified need.<br>Determine whether there is any immediate risk to the person/third party or animals (refer to <a href="#">Section 3.5.1 Risk management</a> ).  |
| A third party (for example, a neighbour) makes the referral without the person's knowledge, but is doing it out of concern for the person or their dependents (for example, children, animals) | Child Protection or ChildFirst or a local municipal council EHO is required to investigate the complaint; but they may refer on; or there may be a joint visit with the service that is best placed to establish a relationship (refer to <a href="#">Section 3.5.1 Risk management</a> and <a href="#">Section 3.6.6 When disclosure is permitted</a> ).   |
| Another service (for example, GP, hospital) who knows the person makes the referral with the person's knowledge and consent (the service can provide information)                              | Depending on the initial assessment of the referring service, other services also respond; further program-specific assessments would also be required (refer to <a href="#">Section 3.6.5 Obtaining consent</a> ).   |
| Another service makes referral without the person's knowledge or consent.  | Seek facts as to whether the person has been asked about referral, and if they haven't, why.<br><br>If they have been asked and did not give consent, determine why and on what grounds the referring service is now acting.<br><br>Are there mental health or capacity issues for the person concerned? Has a clinical service been involved? If not, consider involving one (refer to <a href="#">Table 5 Core services that respond to hoarding and squalor situations</a> , nos 8–16).<br><br>Has an emergency service been involved? If so, for what reason? |

When an initial referral is made by third party and not the person themselves, it is worth considering if your service is the most appropriate to undertake the initial contact.

If it appears from the information provided at referral that it may take some time and effort to establish a relationship with the person (for example, the neighbour says the person is reclusive), and your service is not able to address that, then identifying the most appropriate service to undertake the initial needs assessment is important.

#### 3.3.2 Assessment

##### Brief definition

Assessment involves a decision-making methodology that collects, weighs and interprets relevant information about the person. Assessment is not an end in itself, but merely part of the process of delivering service, support and treatment. It is an investigative, often incremental, process using professional and interpersonal skills to uncover relevant issues to develop an action plan. There are three types of assessment each with its own purpose:

- **service-specific assessment:** where the person has a relatively straightforward, obvious and distinct need
- **specialist assessment:** where the presenting issues require specialist service response
- **comprehensive assessment:** where the person has multiple or complex needs or the situation is unclear and a comprehensive approach is indicated.

Some service providers receive funding to undertake program assessments relevant to their service type or particular discipline. All programs have some form of assessment requirements, usually expressed through program guidelines.

In hoarding and squalor cases, the need for clinical assessment plays an increasingly vital role (refer to Section 3 Building service system response capacity and Figure 3 Hoarding and squalor service response flowchart (Part A) and Figure 4 Hoarding and squalor service response flowchart (Part B) and Section 5.1 A list of service types and Table 5 Core services that respond to hoarding and squalor situations, nos. 8–16.

#### 3.3.3 Action planning

##### Brief definition

Action planning is a process of deliberation that incorporates a range of activities, such as service coordination, case management, referral, feedback, review, assessment, monitoring and exiting. Action planning involves an assessment and determination of competing needs, assisting the person to come to decisions that are appropriate to their needs, wishes, values and circumstances.

Coordinated action planning between services is particularly important for people with chronic and complex needs. A common action plan assists with managing day-to-day crises and maintaining a future-focused perspective over a period of time to reach the person's identified longer-term goals.

##### Action plans:

- identify processes to avoid duplication between agencies/services regarding assessment and other service coordination elements
- develop a system for communicating or sharing information between agencies/services (noting relevant privacy requirements)
- develop an agreed set of tools and systems to support a coordinated response
- identify overall service response through one plan, with representative inputs from all teams, services and sectors.



The Better Health Channel fact sheet on mental health action plans<sup>28</sup> indicates that action planning can have the following benefits:

- assists in setting and achieving goals
- encourages the person to be involved in their care
- manages long-term care in a clear, concise way
- provides an essential checklist to ensure continuity of care
- prompts the person to take more responsibility for their care needs
- encourages a team approach to the person-centred plan
- focuses on improving and maintaining health, rather than waiting for illness onset
- increases awareness of the person and the carer regarding which services are needed and why.

### 3.4 Hoarding and squalor service response flowcharts

The circumstances surrounding hoarding and squalor are tough and extremely complex. Effective intervention requires professionals working together in the same direction and at the same pace, meeting legal and ethical requirements while ensuring the current and future health and safety of the person, their dependents and animals is addressed.

Service responses to these situations are still very much at a pioneering stage. It is every service's challenge and responsibility to get involved and to talk about it and respond to it – not to ignore it. Progress will be made by taking small steps, as apart from leaps and bounds.

A strength for services working in collaboration is that expertise and skill about how to best work with a person living with hoarding and squalor can be shared and learned together.

For services to coordinate actions with one another, several key decision making points have been identified for consideration, and are presented in the following flowcharts, while moving through the following three stages:

- initial contact and identification of needs
- assessment
- joint action planning.

Two flowcharts have been developed that indicate the means by which a broad mix of service providers might work together to suitably address the circumstances of a person living with hoarding behaviour or in squalor.

On the following pages [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#) provide some guidance with regard to steps to take and other services to collaborate with.

- [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) indicates an initial starting point when first contact is made and the identification of need begins. A checklist has been added at that initial stage (refer to [Section 8.6 Contact other local services after receiving an initial referral](#)) to assist with thinking through which other agencies to approach as service response partners.
- [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#) provides direction on how to work with people who resist assessment or service support.

The flowcharts are blueprint guides only and are not intended to be followed rigidly.

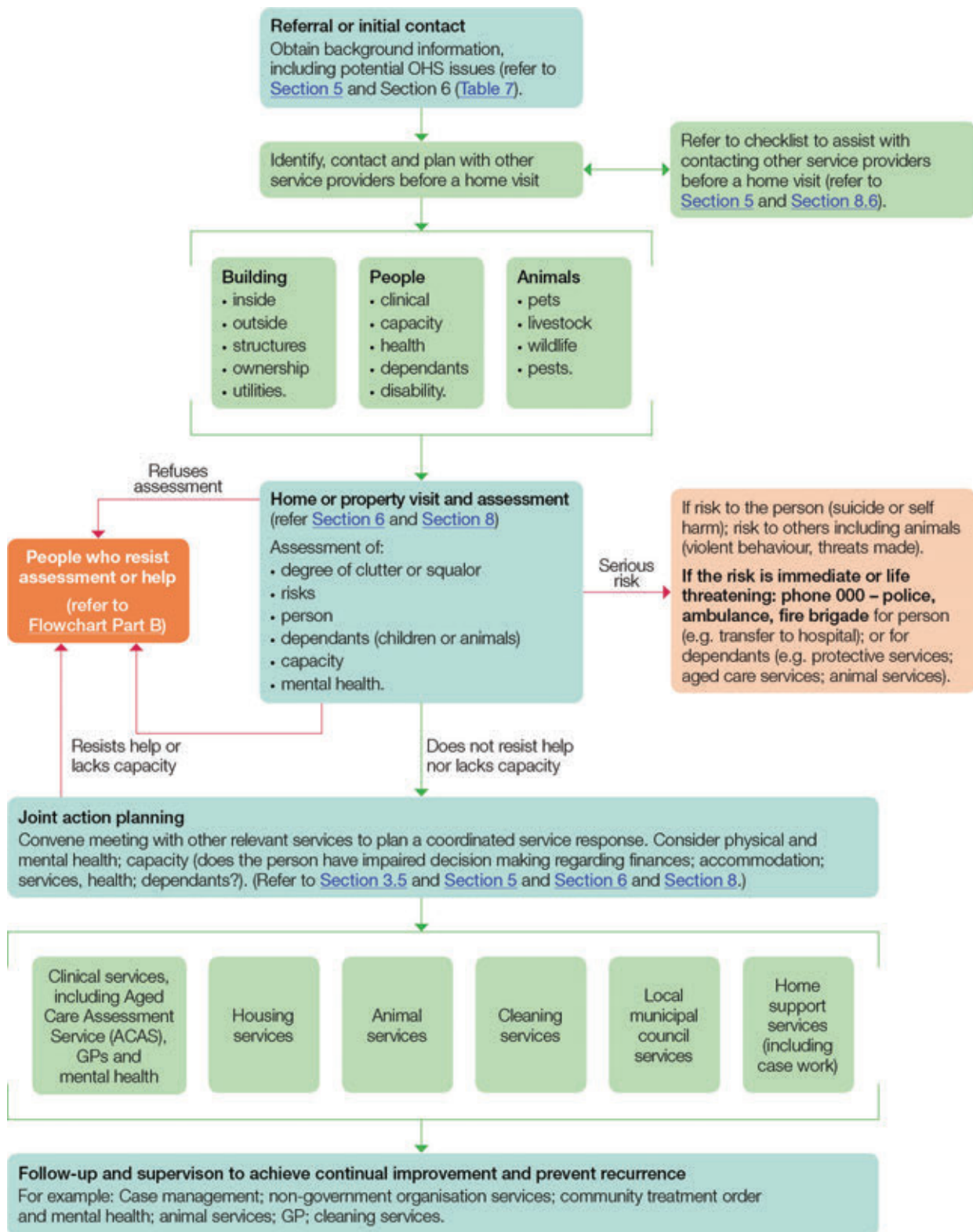
The flowcharts suggest the importance of an informed and well-planned intervention involving several service types (which ones and when depends on the situation) as opposed to only law enforcement or only a building response or only responding to health needs.

28 Refer [http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental\\_health\\_care\\_plans](http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Mental_health_care_plans)

Assessment of risk to the person, others or animals must always be undertaken. An actual scenario may not necessarily follow the sequence found in the flowcharts, but may well represent an immediate risk at any stage. This highlights the urgency of some realistic situations that could be encountered.

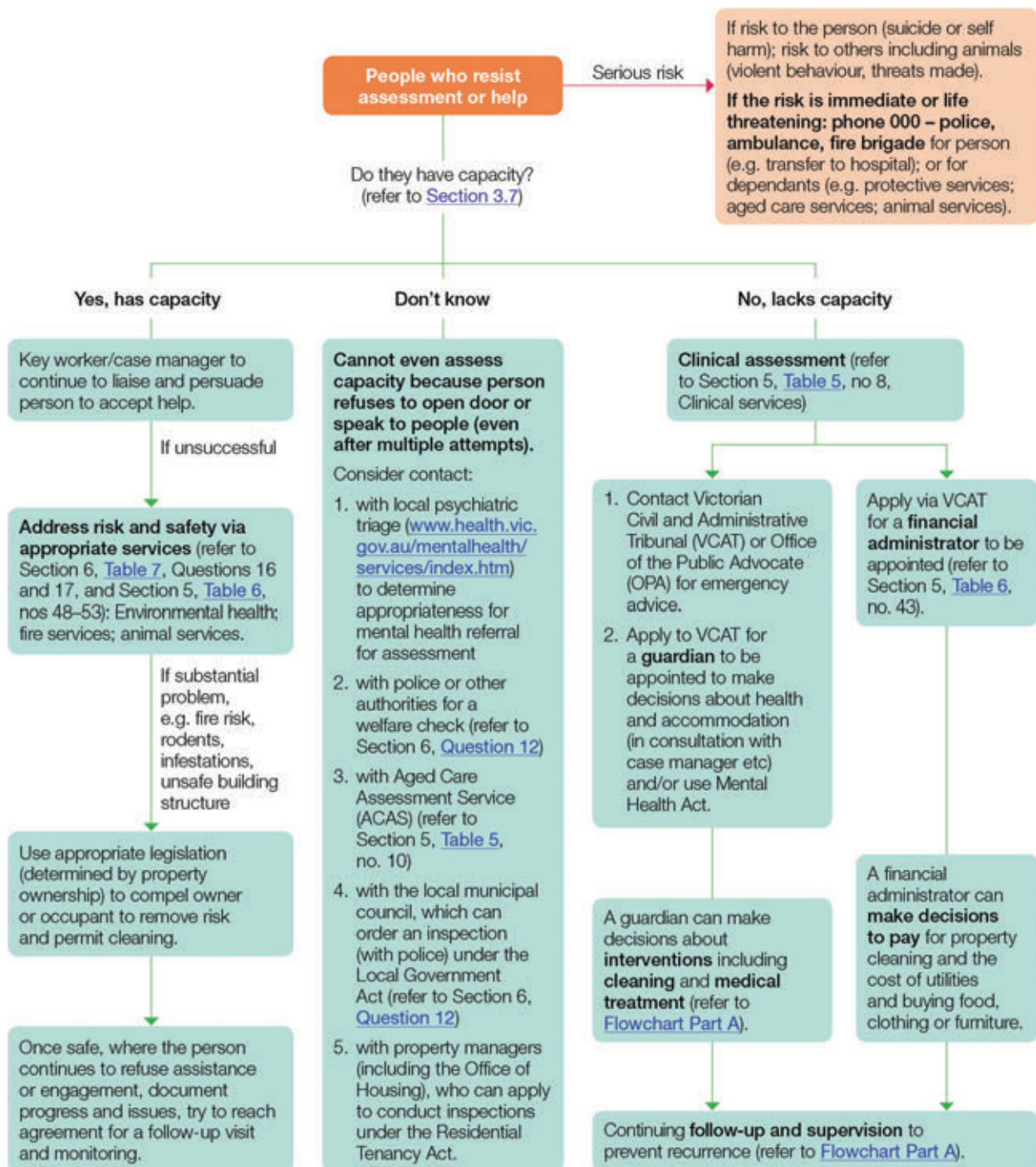
Sectors or local service provider networks may decide to create their own flowcharts incorporating these blueprints or aspects of them, in order to incorporate further information, but they may still be built on the pathways and decision points indicated (refer to [Section 8.10 Sample sector and local area flow chart response to hoarding](#) and [Section 8.11 Planning for the provision of cleaning \(flow charts and cleaning agreement\)](#)).

Figure 3 Hoarding and squalor service response flowchart (Part A)



Adapted with permission from Snowden and Halliday 2009.

**Figure 4 Hoarding and squalor service response flowchart (Part B)**



Adapted with permission from Snowden and Halliday 2009.

## 3.5 Common service coordination tasks

Where multiple agencies are involved in supporting a person (and possibly that person's carer), service providers should clarify service coordination and monitoring roles. This may involve:

- deciding which agency undertakes the service coordination role on a case-by-case basis, and the expectations of that role
- determining when the service coordination role might change to another service, which might depend on the service response required
- how and when other service providers supporting that person inform the service coordinator of changes in their service provision role
- how agencies will inform the service coordinator of concerns regarding the person's situation, and requesting an action plan review meeting, if needed
- relevant local service providers participating in meetings convened by the service coordinator.

A service coordination meeting might also involve people who form an informal support network (such as family, friends or neighbours) for the person concerned, so that both formal and informal support networks are coordinated.

Prior planning and agreement by agencies as to how they might work together will strongly contribute to 'ownership' of the agreed process, bringing with it a stronger commitment.

Delivering coordinated services to people encompasses common tasks that can be applied at any stage. Complex situations such as those involving hoarding and squalor require additional considerations.

### 3.5.1 Risk management

Hoarding and squalor environments pose risks for fire, physical falls, collapse of buildings, poor sanitation and other health risks that potentially affect people and animals (refer to [Question 17 How does my service assess for urgency, the person's safety and the level of risk?](#)).

In our society, nobody can impose a standard of living onto other people, but there needs to be maintenance of common standards with regard to safety and environmental health, to ensure that no harm is caused and living conditions are safe and healthy for the community as whole.

People living in hoarding or squalid conditions, for the people and animals living with them or near them and for the surrounding environment, susceptibility to poor health and illness is heightened with greater exposure to a range and types of risk. Examples are below.

#### Vulnerable people

People who hoard or live in squalor and are older, disabled or who have a mental health condition are at greater risk due to a broad range of health conditions and related consequences, including reduced mobility. They may or may not live alone or have supportive neighbours, but they certainly face challenges that could be life-threatening and not conducive to a healthy lifestyle, for instance:

- trying to walk inside a cluttered home or outside in a cluttered or squalid yard is a challenge for anyone young or old, but manoeuvring around accumulated possessions threatens safety (for example, hazardous material poorly stacked/stored; excessive dust and disintegrating debris and blocked pathways), all contribute to the risk of falling or tripping and doesn't permit routine daily activities (that is, having a functioning kitchen, a place to eat meals, access to shower or bath)
- easily losing keys, money and important papers (such as bills, wills, mobile phones)
- misplacing medications or keeping old expired medicines that are no longer safe to use, refusing to discard the drug, believing it would be wasteful
- risking illness or even death if old medicines are taken along with currently prescribed or over-the-counter medications (certain drugs should never be combined)



- issues related to having non-functioning utilities (telephone, gas, water, electricity) which might have been disconnected due to safety concerns by the utility company, or because the person has been unwilling or unable to pay for services, the cost of reconnection or repair function failure
- reduced vision and hearing might increase the risk of falls, serious injury or death, due to reduced ability to hear or see the safety mechanisms in place (for example, smoke alarms) or to clearly see how masses of objects or animals were inhibiting movement and access thereby heightening risk
- delayed access by emergency personnel in an emergency, which may hinder rescue and evacuation
- wherever a person with hoarding behaviour lives and children are under their care in that home, the following concerns should be considered and acted on by service providers for the ongoing safety and care of the children:
  - are there impediments to their development and care (for example, space to play, somewhere to do homework, have friends visit or somewhere clean to eat, bathe and sleep)
  - are they living with risk, if so to what level?
  - are they expected to 'look out' for the adult carer
  - should anything impede the activity of the adult, is the child able to call 000 for assistance?
- for those who live in squalor, it is more a matter of making tracks through accumulated, mixed and matted papers, rotting food, garbage and human and animal waste, which may be nauseating.
- building stronger cooperation between sectors and services might better address a number of these risks through an enhanced understanding of each sector's purpose. The hoarding and squalor principles (refer [Table 1 Principles underpinning service response to hoarding and squalor situations](#)) have endeavoured to capture this intention.

#### **The impact of animal neglect**

Animal hoarding inevitably results in considerable animal suffering from neglect. The impact of keeping a large number of animals in a living environment without the ability to provide adequate care and husbandry often creates squalid conditions, which creates a range of risks to animals and people in that environment, for example:

- if a primary focus responds to the needs of a person, there is a risk that the welfare of affected animals may not be addressed as required. Compromising animal welfare may occur inadvertently when responding primarily to the needs of a person. While recognising the very important role that animals play in many people's mental wellbeing, animal welfare needs to be sensitively upheld at all times, no matter what is occurring for the person.
- the living environment may contain an accumulation of faeces, urine, fur, fleas and rotting food. In extreme cases there may also be decaying animal carcasses.
- there is likely to be deterioration of fixtures and fittings, with the potential for some structural decay. Depending on the level of damage and squalor, this may result in the home being condemned as unfit for human habitation.
- a person's health is affected when they inhale high levels of ammonia or particles of animal droppings that have dried and turned to dust. This can cause lung and respiratory problems.
- a person's health can also be affected by bacterial infections and the transmission of zoonoses such as ringworm, internal parasites and toxoplasmosis.
- the cleaning demands that accrue from having a large number of animals often outweigh a person's capacity, regardless of their physical or mental health status.

#### **Fire and the risk to fire fighters**

Victoria's fire services – the Metropolitan Fire and Emergency Services Board (MFB) and Country Fire Authority (CFA) – are responsible for emergency responses in all hazards as well as the safety of the community. MFB data collection confirms an increase in the identification of incidents in residential households involving hoarding.

Research<sup>29</sup> conducted by MFB has identified that hoarding-related incidents in the Metropolitan district:

- are larger fire events, requiring more fire fighting resources
- result in a significantly increased level of structural damage to a home
- accounted for 24 per cent of all preventable residential fire fatalities between 1999 and 2009
- occurred at a rate of one in every ten days between 2011 and 2012.

Hoarding increases the risk of fire, because:

- the accumulation of items results in an abnormally high fuel load and greater opportunity for ignition
- blocked exits and narrow pathways result in blocked egress for occupants and access for responding fire fighters
- unsafe or non-functioning utilities result in unorthodox and high fire risk practices related to cooking, heating, lighting and electrical use.

After a fire incident in a hoarding household, the high fire risk remains and is sometimes increased. This occurs when damage to infrastructure such as utilities (gas, electricity and water) or fixed appliances increases the likelihood of the person using unsafe or unconventional methods to prepare a hot meal, stay warm or have lighting in their home.

#### *Risk reduction advice*

When working with people affected by hoarding, the MFB and CFA recommends risk reduction in the first instance, which includes:

- installing smoke alarms and promoting testing at least monthly
- unblocking all exits
- widening internal pathways
- identifying if utilities such as gas and electricity are connected and safe
- identifying areas used for cooking and establishing a one metre clearance around all fixed cooking and portable appliances and meal preparation areas
- establishing a one metre clearance around all fixed and portable heating sources
- disconnecting any electrical appliances not required for use
- identifying all electrical extension and appliance cords and removing any accumulated items on them
- identifying the use of naked flame (candles and so on) and their removal
- identifying all electrical power boards and ensuring they are used safely, for example:
  - having one power board per power point
  - having no double adaptors plugged into power boards
  - unplugging any power boards plugged into other power boards
  - removing any accumulated items on power boards.

#### *MFB hoarding notification*

MFB has developed a hoarding notification system, which involves placing a discreet electronic alert on a property address (with the permission of the resident) where there is evidence of hoarding. In the event of a fire or other emergency at that address, responding fire fighters are advised that there is hoarding or high fuel load at the property. The aim of this notification is to increase preparedness and safety for fire fighters.

This notification system is not currently available in CFA areas of regional responsibility.

<sup>29</sup> Aufiero, M, Carlone, T, Hawkins, W, Murdy, S. Analysis of Preventable Fire Fatalities of Older People and People with Disabilities: Risk Reduction Advice for the Community Care Sector. An Interactive Qualifying Project Report submitted to the Faculty of Worcester Polytechnic Institute in partial fulfilment of the requirements for the Degree of Bachelor of Science (May 2011).

To receive more information about the hoarding notification system email [hoardingnotification@mfb.vic.gov.au](mailto:hoardingnotification@mfb.vic.gov.au) for an electronic information pack, including a map of the Metropolitan district for which the MFB has regional responsibility.

#### *Inspections*

In some circumstances the MFB and the CFA can perform an inspection of a hoarding property, which can only occur with the consent and presence of the affected person and the agency or service representative who has requested the inspection. The purpose of an inspection is to identify the level of hoarding and provide risk reduction advice specific to an individual's home.

#### **The role of Victoria Police**

Police are often called to premises that may fall within the definitions of 'hoarding' and 'squalor' for a range of reasons, including allegations of domestic violence.

The protection of life and property is a fundamental function of policing. Where appropriate, police may relay information and work collaboratively with other agencies who may be better equipped to deal with such issues.

Where deemed necessary, police may apprehend a person who appears to be mentally ill, if they have reasonable grounds for believing that the person has either:

- recently attempted suicide or attempted serious bodily harm to themselves or another person
- is likely by neglect or act to attempt suicide or effect serious bodily harm to themselves or another person (*Mental Health Act 1986*, Section 10 and 10.1).

'Reasonable grounds' are based on a person's behaviour and appearance, and any other relevant information available. Police may enter premises and use such force as may be reasonably necessary, with such assistance as required, to apprehend under Section 10 or 10.1 of the *Mental Health Act. 1986*.

#### **The role of local municipal council environmental health and local laws**

At times, a response to immediate risk may need to occur at the point of referral or initial contact (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#)). This risk response may still involve consultation with and assistance from different services, but local municipal council environmental health officers, in administering the nuisance provisions of the *Public Health and Wellbeing Act 2008* are bound by a statutory duty of care. Failure to respond or address a problem once it is known can result in significant liability at law.

### **3.5.2 Allocating a service coordinator**

Allocating a service coordinator will usually depend on whether there is an existing trusted service relationship already in place with the person concerned. Several human service organisations may be prepared to coordinate a complex situation, for example: psychiatric disability and rehabilitation support services (PDRS); Social Housing Advocacy and Support (SHASP); Support for High Risk Tenancy (SfHRT) program; community aged and disability services (HACC, ACAS or Home Care Packages) public housing; local community health; district nursing; mental health services provided in the community or a GP. It is the role of each team to identify the lead key worker, who will then be part of an interagency coordinated response.

Cases involving hoarding and squalor are tough and extremely complex.

Effective intervention requires professionals working together in the same direction at the same pace.

The service coordinator has overall responsibility for ensuring that the interagency service team develops an action plan which is implemented and reviewed. Sometimes a broad range of providers may already be delivering services to that person or their carer. In these circumstances the service response to



hoarding or squalor would be incorporated into the existing action plan and agreement reached between existing providers as to which provider would undertake the service coordination role.

A general principle to trigger a coordination role would be at the point of identification and assessment (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#) as with any other complex case, the staff member:

- notifies their supervisor
- assesses or arranges for assessment of the situation (including involving the person living on the property)
- draws together a comprehensive history of the person, clarifying what their needs and support requirements are, before contacting other services
- proceeds according to agency or service policy and procedures
- involves other appropriate services, depending on the circumstances of each case, as it unfolds.

In some situations the case may be managed within the one type of service, using their established internal policies and procedures; or in the case of one organisation having multiple service types, an intra-service referral might occur (for example, within a local municipal council).

A supervisor, in consultation with relevant others, may decide there is no need to involve other services; however, complex cases such as these generally require a multidisciplinary service response, which does require the timely and appropriate coordination of services and assessment.

### **Case management and service coordination<sup>30</sup>**

Case management usually involves the coordination of community services for people who have a particular diagnosis or disability, by allocating a professional from the relevant service to be responsible for the assessment of need, development and implementation of action plans. The case management role is characterised by having the specialist sector expertise most relevant to the person's need.

Service coordination may form part of the case manager's role if the person with complex needs requires services from a diverse range of sectors and there is a need to plan, clarify responsibilities and communicate regularly with all members of the service team.

Dedicated service coordination supports case management when the complexity of the person and the number of services involved means that a creative and flexible, cross-sector approach is required. Service coordinators usually work in close collaboration with the case manager and complement that role; alternatively, they work actively to identify a case manager when there is not one already allocated. The service coordinator can ensure that long-term planning and coordinated care progresses while the case manager concentrates on the day-to-day needs of the person. Specialised service coordinator roles include dedicated positions such as HARP workers, emergency department (ED) service coordinators, MACNI care coordinators, social workers, HACC workers and mental health care coordinators.

### **3.5.3 Referral**

Referral is the transmission of personal or health information relating to an individual from one agency to another, with the individual's consent for the purpose of further assessment, care or treatment. Referral between services and sectors is integral to working with many people, particularly those with complex needs or chronic disease.

When considering hoarding or squalor referral pathways, the specific needs of the person in relation to their culture and health needs must always be considered (refer to [Section 2.1 Principles to guide all service response](#)) after obtaining their consent for referral action.

The type of hoarding or squalor, together with the individual factors of each case, will influence the type of referral made; for example, GP, neurologist, psycho-geriatrician, geriatrician or neuropsychologist for capacity testing, seeking advice from OPA or VCAT, liaising with other local service providers, such as

<sup>30</sup> Department of Human Services Eastern Metropolitan Region (EMR) 2009.

RSPCA, DEPI animal inspectors, local municipal council animal management officers, ACAS, Home Care Packages for older people; HACC or subacute services to plan appropriate support as well as social workers based in hospitals (refer to Section 5 [Collaborating with other services](#) for further information).

## 3.6 Protection of the person's information

Privacy and confidentiality are separate and distinct concepts. Both are key issues to be considered in all elements of service coordination and referral.

### 3.6.1 Confidentiality

Confidentiality:

- is a concept that is related to, but different from, privacy
- is an obligation of confidence, which is generally owed by the recipient of information to the provider of the information
- is about controlling the disclosure of information
- often deals with information other than personal information
- applies to information that is confidential to one of the parties for any reason, regardless of whether or not that information is protected by privacy law.

### 3.6.2 Privacy

Generally, 'privacy' means many different things to different people. Central to all ideas of privacy is keeping one's own actions, conversations, information and movements free from public knowledge and attention. However, what privacy means as a general concept is often different from what privacy means under law.

Privacy law regulates the collection, use, storage and disclosure of 'personal information'. 'Personal information' is defined in the *Information Privacy Act 2000 (Victoria)* as being information from which a person's identity can be reasonably ascertained. The concept is explained further in resources developed by the Office of the Victorian Privacy Commissioner (OVPC).<sup>31</sup>

Personal information that relates to the health of an individual, or that is collected in the course of a person receiving health service, is defined under Victorian law as 'health information'. The collection, use, storage and disclosure of health information is governed by the *Health Records Act 2001 (Victoria)*. Information about the requirements of that Act is available in material published by the Health Services Commissioner<sup>32</sup>.

### 3.6.3 Use and disclosure of personal information

#### Department of Health and Department of Human Services Privacy Policy

These two departments are committed to protecting the privacy of personal information they and their funded service partners handle.

The services and functions that the departments and their partners provide relate primarily to the areas of health, community support and the protection of public health and safety. Due to the nature of the services provided it is recognised that much of the information collected is particularly sensitive.

Both departments are bound by the Victorian privacy laws, the Information Privacy Act (Victoria) and the Health Records Act (Victoria), as well as other laws that impose specific obligations in regard to handling information.<sup>33</sup>

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<sup>31</sup> Refer to the Privacy Laws at: <https://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/pages/privacy-laws>

<sup>32</sup> Refer to Health Service Commissioner website <http://www.health.vic.gov.au/hsc/resources/faq.htm>

<sup>33</sup> Department of Human Services, Corporate Integrity Information and Resolutions Unit. For further information refer to: <http://www.dhs.vic.gov.au/pdpd/ciiru>

### 3.6.4 Which privacy laws should I comply with?

Different privacy laws apply to different types of organisations and programs.

All organisations or agencies, and their respective workers, need to ensure that they handle all personal information and health information in accordance with the requirements imposed by applicable privacy legislation. Depending on the nature of the organisation and the number and type of services it provides, these requirements may be imposed by the following legislations in the following table.

**Table 4 Privacy requirements may be imposed by the following legislations**

| Legislation             | Requirements  |
|-------------------------|---|
| Information Privacy Act | <p>The <i>Information Privacy Act 2000 (Victoria)</i> and its associated Information Privacy Principles (IPPs)<sup>34</sup> cover state government agencies and local municipal councils and are concerned with setting minimum standards in relation to the collection and handling of personal information (refer to: <a href="http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/information-privacy-act">http://www.privacy.vic.gov.au/privacy/web2.nsf/pages/information-privacy-act</a>).</p> <p>The IPPs are the practical core of the Information Privacy Act, incorporating safeguards for a range of personal information handling activities, such as collection, storage, access, transmission, use, disclosure and disposal. With limited exemptions, all Victorian government agencies, statutory bodies and local municipal councils must comply with the ten IPPs:</p> <ul style="list-style-type: none"> <li>IPP 1: Collection</li> <li>IPP 2: Use and Disclosure</li> <li>IPP 3: Data Quality</li> <li>IPP 4: Data Security</li> <li>IPP 5: Openness</li> <li>IPP 6: Access and Correction</li> <li>IPP 7: Unique Identifiers</li> <li>IPP 8: Anonymity</li> <li>IPP 9: Transborder Data Flows</li> <li>IPP 10: Sensitive Information.</li> </ul> <p>To further understand and implement the IPPs refer to the guidelines: <a href="https://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/files/guidelines-to-the-information-privacy-principles">https://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/files/guidelines-to-the-information-privacy-principles</a>.</p> |
| Health Records Act      | <p>The <i>Health Records Act 2001 (Victoria)</i> covers the handling of health information by state government agencies, local municipal councils and the private sector by creating a framework to protect the privacy of individuals' health information and by regulating the collection and handling of that information (refer to <a href="http://www.health.vic.gov.au/healthrecords/">http://www.health.vic.gov.au/healthrecords/</a>).</p> <p>The Act:</p> <ul style="list-style-type: none"> <li>• gives individuals a legally enforceable right of access to health information about them that is contained in records held in Victoria by the private sector and</li> <li>• establishes Health Privacy Principles (HPPs) that will apply to health information collected and handled in Victoria by the Victorian public sector and the private sector. HPPs are designed to protect privacy and promote the person's autonomy, while also ensuring safe and effective service delivery and the continued improvement of health services.</li> </ul>  |
| Privacy Act             | <p>The <i>Privacy Act 1988 (Commonwealth)</i> applies to the Commonwealth public sector and some parts of the private sector (refer to the Commonwealth Office of the Australian Information Commissioner's website at: <a href="http://www.oaic.gov.au/">http://www.oaic.gov.au/</a>).</p>   |

The Office of the Australian Information Commissioner (OAIC)<sup>35</sup> have published (April 2013) a Guide to information security: 'reasonable steps' to protect personal information.<sup>36</sup> This guide is intended to help agencies and private sector businesses comply with the information security requirements under the Privacy Act.

<sup>34</sup> Refer to the Privacy Laws at: <https://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/pages/privacy-laws>

<sup>35</sup> Refer [Office of the Australian Information Commissioner \(OAIC\)](http://www.oaic.gov.au/)

<sup>36</sup> Refer: [http://www.oaic.gov.au/images/documents/privacy/privacy-guides/information-security-guide-2013\\_WEB.pdf](http://www.oaic.gov.au/images/documents/privacy/privacy-guides/information-security-guide-2013_WEB.pdf)

## Privacy principles interact and co-exist with other legislation

Existing provisions in other statutes governing the confidentiality, use and disclosure of personal information or health information and access to certain kinds of information continue to apply, alongside IPPs and HPPs.

Specific statutory provisions override the general standards in both the Health Records Act 2001 (Victoria) and the Information Privacy Act (Victoria) to the extent of any inconsistency. Where organisations also receive funding for services from the Commonwealth Government, the Commonwealth requirement must be adhered to in the first instance. Where the Victorian requirement is more onerous than the Commonwealth requirement (that is, more restrictive of how the information can be dealt with) the higher standard is applied.

### 3.6.5 Obtaining consent

In general, information gathered or collected about a person who has capacity should only be shared with someone else, including another agency or service, with the consent of that person. For assessment considerations regarding testing for capacity refer to [Section 3.6 Protection of the person's information](#) and [Section 3.7 Mental capacity and competence](#) and [Section 3.8 Guardianship and Administration orders](#) and [Section 3.9 Duty of care](#) and [Question 22 Where do I refer for assessments of competence or capacity for adults?](#)

## Information privacy policies

Workers of organisations or agencies that provide services are encouraged to become familiar with their organisation's privacy and confidentiality policy and procedures.

Individual agency policies and procedures should set out formal processes for the collection, storage, use and disclosure of personal information and health information. In particular, policies should establish processes for obtaining and documenting consents in relation to collection, handling, disclosure and sharing of health information and personal information (refer to [Appendix 3 Information Privacy Principles](#)).

Under the Victorian privacy legislation, an individual from whom an organisation collects personal information or health information may make a request to the organisation for information about the organisation's privacy policy and procedures. The person may also request a statement of what personal information or health information about the person the organisation holds. If a person finds that personal information or health information about them held by an organisation is not accurate, they have the right to have that information corrected. An organisation providing services relating to hoarding and squalor (and thus involving the collection and use of health information and personal information) should have policies and procedures that allow them to comply with their statutory obligations in relation to these matters.

## Privacy collection statements

Privacy law requires that an organisation collecting personal information or health information must inform the individual from whom the information is being collected of the intended use of the information.

Organisations should have a document that is provided to a person prior to engagement that describes the intention of the organisation for the collection, use and disclosure of personal or health information relating to the person (a 'privacy collection statement'). The privacy collection statement should set out:

- the purpose for which the information is being collected
- why and how the organisation collects it
- how the agency uses the information
- the legislative context that governs the collection, storage, handling, use and disclosure of the information.

Providing accurate and complete information in the privacy collection statement will ensure that any consent given by the person for use and disclosure of information relating to them is appropriate and sufficient for the organisation's purposes.

### Shared consent forms

When collecting personal information or health information from a person, an organisation should obtain consent from the person for the collection of the information, and for the proposed use and disclosure of that information (refer to [Figure 18 Consent to share information](#)).

The consent should be recorded in writing. The privacy collection statement referred to above should be provided to the person when the organisation seeks consent. The privacy collection statement and the written consent should be stored together on the organisation's files, so that it is clearly recorded what the person has consented to (refer to [Figure 18 Consent to share information](#)).

Consent should be obtained prior to the provision of services by the service provider. Verbal consent might be a suitable and at times a necessary first step in some circumstances, and if consent is obtained in this way it should be recorded in the person's file. Ideally, any verbal consent should subsequently be confirmed in writing.

Consent is one of several conditions to be met for health information or personal information to be transferred interstate or overseas (refer to IPP 9: Transborder data flows).<sup>37</sup>

Where a matter is referred from one agency to another, it is the responsibility of the referring agency to ensure that:

- the person concerned has consented to the disclosure of their personal information and health information to the recipient agency  
or
- the disclosure of that information to the recipient agency by the referring agency is otherwise permitted under privacy law.

### 3.6.6 When disclosure is permitted

The person and their carer should be informed of their legal rights relating to privacy and confidentiality, as well as the limitations on these rights. Exceptions to restrictions on disclosure of personal information and health information include:

- where the use or disclosure is for a purpose that is directly related to the primary purpose for which the information was collected, and the person concerned would reasonably expect the information to be used or disclosed for that secondary purpose<sup>38</sup>
- where the law (other than privacy law) allows or requires the disclosure of the information
- where the disclosure is necessary to lessen or prevent serious and imminent threat to the life, health, safety or welfare of an individual. Generally, for this exception to apply, there must be a clear and imminent threat to an identifiable person of serious bodily injury or death (refer to [Appendix 3 Information Privacy Principles](#), 2.1 (d)).

Information may also be used or disclosed for secondary purpose and without consent, for these additional reasons:

- the disclosure is necessary to lessen or prevent a serious threat to public health, public safety or public welfare
- the disclosure is for the purposes of investigating or reporting suspected unlawful activity

<sup>37</sup> Refer to the IPP guidelines, at: <https://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/files/guidelines-to-the-information-privacy-principles>

<sup>38</sup> Refer to the Health Records Act information sheet 'Use and Disclosure of Health Information' at: [www.health.vic.gov.au/hsc/infosheets/disclosure.pdf](http://www.health.vic.gov.au/hsc/infosheets/disclosure.pdf)

- the disclosure is reasonably necessary for the activities of law enforcement agency, or the information has been requested by ASIO
- the disclosure necessary for research or statistical analysis in the public interest, and certain criteria are satisfied.

If you are unsure in any given situation, as to whether information can be disclosed or not, or whether there might be any legal ramifications, consider consulting:

- **Office of the Health Services Commissioner** – for health information: phone: 8601 5222; email: [hra@dhs.vic.gov.au](mailto:hra@dhs.vic.gov.au); website: [www.health.vic.gov.au/hsc](http://www.health.vic.gov.au/hsc).
- **Office of the Privacy Commissioner (Victoria)** – for personal information that is not health information: within Australia, phone: 1300 666 444; email: [enquiries@privacy.vic.gov.au](mailto:enquiries@privacy.vic.gov.au); website: <http://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/pages/home>.

#### 3.6.7 Sharing personal information or health information between organisations

Common agreement should be reached between services regarding the disclosure of information, to ensure that sharing of information between services occurs in line with privacy law and practice. Sometimes, the exchange of such information between agencies is authorised by law (refer to [Appendix 3 Information Privacy Principles](#), 2.1 (f)). If you know when you collect information that you may need to share it with other organisations, you should include that disclosure in the privacy consent that is obtained from the person when you collect the information.

Organisations often fear that disclosing information might leave them open to an action for defamation or breach of confidentiality. Each organisation needs to refer to their policy and procedures to clarify how the laws of privacy, defamation and confidentiality affect the organisation and align with good work practice in the organisation's dealings. It is unlikely that an action for defamation would succeed if a statement of opinion is made in good faith by a worker in the course of their duty and is disclosed only to those involved in the service response.

Further considerations may include:

- what the legislative, legal and ethical restrictions on disclosure of the relevant information are (for example, Section 141 of the *Health Services Act 1988* and Section 135A of the *National Health Act 1953* may prohibit health and community workers from sharing information about the person without their permission unless an exception applies)
- under what circumstances an organisation will allow another organisation access to its records
- on what conditions an organisation will provide a written report to another organisation, and what will be included in it
- whether an organisation releases information needed in a legal tribunal, or whether disclosure will only be made in response to a subpoena
- if the worker really needs all the personal information they propose to collect (noting that it is a principle of privacy laws that information should only be collected to the extent necessary for the relevant purpose)
- whether people who provide information over the telephone or the internet or in person are given clear notice about how the information will be used and disclosed.

A helpful general guide to the privacy laws that affect Victorians is *Private Lives, Your Guide to Privacy Law in Victoria (second edition 2008)*<sup>39</sup> produced by the Victoria Law Foundation. The booklet is not intended to be substitute for legal advice.

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39 Victoria Law Foundation 2008, at [http://www.privacy.vic.gov.au/privacy/web2.nsf/files/private-lives-your-guide-to-privacy-law-in-victoria-booklet/\\$file/booklet\\_07\\_09.pdf](http://www.privacy.vic.gov.au/privacy/web2.nsf/files/private-lives-your-guide-to-privacy-law-in-victoria-booklet/$file/booklet_07_09.pdf).



## Sharing information with interstate or Commonwealth agencies

If a Victorian service provider or organisation is sharing information with an agency that is interstate or is a Commonwealth agency, it is important to consider that the other agency will be subject to privacy laws from its own jurisdiction. The privacy laws from that jurisdiction may also apply to the Victorian service provider, and/or may affect the ways in which that Victorian organisation can use information obtained from the interstate or Commonwealth agency. Furthermore, if personal information or health information is being transferred out of Victoria, or obtained from outside Victoria, Information Privacy Principles and Health Privacy Principles will apply.

## Feedback between services

Feedback is essential for good communication between services. Feedback can include acknowledgment that referral has been received and the subsequent action that will be taken. Feedback between services, including clinical services (including general practices) is essential to communicate the outcomes of program and clinical assessment (including treatment plans) and action planning. However, where feedback includes personal information or health information, care should be taken that the disclosure of such information during the feedback process does not contravene privacy requirements.

## 3.6.8 Recording personal information and health information for your organisation's internal purposes

### Recording personal information on your organisation's file

Privacy requirements indicate that all personal information collected on any person, or their carer should be handled in the strictest confidence, including the recording of information on the person's files (refer to [Appendix 3 Information Privacy Principles](#), IPP 1 Collection and IPP 2 Use and Disclosure).

File confidentiality must be preserved, particularly if notes are recorded for other members of the family and are stored in the same file. Ideally, notes for each individual should be stored in separate files.

### The importance of clear and accurate documentation

Service coordination tools and accurate file notes should be used to document clear and relevant details of each hoarding or squalid situation (refer to [Section 8.6 Contact other local services after receiving an initial referral](#) and [Section 8.7 Shared action plan checklist](#) and [Section 8.9 Templates to assist with service coordination tasks](#)). Without good documentation it is difficult to assess what is occurring, show progress or detail service provider response – especially for situations that proceed to the Victorian Civil and Administrative Tribunal (VCAT) and the Office of the Public Advocate (OPA) (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), nos 43 and 44). Organisations should ensure that their privacy processes and procedures facilitate comprehensive record keeping in compliance with privacy laws.

## 3.7 Mental capacity and competence

Competence and capacity are terms often used interchangeably, although they are not exactly the same.

### 3.7.1 Mental capacity

'Mental capacity' is generally determined by clinical assessment (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16 and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#)). Determinations of capacity may include assessment of cognitive skills (awareness, knowledge, judgment and reasoning) as well as a person's ability to execute necessary tasks (actual ability to carry out a decision or action).

In the case of ability to live independently, the person must be able to understand the decision at hand, to perform daily living skills and tasks in their home environment, and to appreciate their limitations or special care needs.

In order to make valid decisions in relation to their medical treatment, a person must be able to:

- recognise there is decision to be made
- understand the information relevant to the decision to be made
- understand the options for treatment
- understand the possible consequences of each option (that is, risks, burdens, and benefits)
- rationally process the information to arrive at a decision consistent with their values.

### 3.7.2 Competence

'Competence' is a legal term and is often presumed unless a court has determined otherwise.

A testing of competence generally occurs within a legal environment, where evidence is presented by medical officers, family members and individuals, and on the basis of this information a decision is made about whether or not the person is competent to make decisions regarding certain matters.

Neither incompetence nor mental incapacity is global or all-inclusive. A lack of competence or inability to make reasoned and informed decisions about major medical treatments does not mean the person cannot decide if they need pain medication or less invasive assistance. Furthermore, if the person demonstrates capacity in one domain (that is, independent living) this does not mean that the person is automatically capable of rational decisions across other domains, including financial or medical matters.

## 3.8 Guardianship and Administration orders

Should there be any concern about the need for protection of person aged 18 years or over who, as result of disability, is unable to make reasonable decisions about their personal circumstances, or their financial and legal affairs, an application can be made to the Victorian Civil and Administrative Tribunal (VCAT) for a Guardianship Order or an Administration Order (refer to [Section 6 Questions and answers](#) and [Table 7 List of questions and answers](#), Question 14 and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 43). In this context 'disability' means:

- intellectual impairment
- mental disorder
- brain injury
- physical disability
- dementia.



Where a person has a disability and lacks capacity to make certain decisions about their lifestyle, or legal or financial matters it may be appropriate to apply for one of the following:

- a **Guardianship Order** appoints the persons named in the order to act on behalf of the individual in relation to decisions concerning: the individual's medical and clinical needs; accommodation (where someone lives); managing and representing the person with regard to access to services and case management/action plans
- an **Administration Order** appoints the persons named in the order to act on behalf of the individual in relation to decisions or transactions concerning the individual's financial and legal affairs (including property).

With regard to cases involving hoarding and squalor, both applications are often needed, because the guardian cannot make decisions with regard to property and finances, and administrators will require a guardian prior to acting on property decisions.

### 3.9 Duty of care

A duty of care is the obligation to take reasonable care that one's act or omission does not cause foreseeable loss or damage to another person.

Various factors determine when duty is owed, and to whom the duty is owed. Generally, a service organisation providing services to a person owes duty of care to that person in relation to the provision of those services.

Duty of care applies not only to the physical actions of a worker, but also to advice the worker gives or fails to give. Workers should take care not to give advice beyond their level of competence or beyond what a person in their position would generally be expected to provide.

Under the *Wrongs Act 1958* (Victoria) a worker is not negligent in failing to take precautions against risk of harm unless:

- the risk was foreseeable (that is, it is a risk of which the person knew or ought to have known)
- the risk was not insignificant (this includes risks that are not far-fetched or fanciful)<sup>40</sup>
- in the circumstances, a reasonable person in the worker's position would have taken those precautions.<sup>41</sup>

In light of the above, it is prudent for workers and organisations to:

- conduct regular risk assessments of cases  
and
- maintain ongoing engagement with a person (that is a client), to the extent possible under the circumstances, always taking into account the person's expressed preferences regarding engagement with services.

It is not always appropriate to refrain from acting on information that indicates a risk arising from hoarding behaviours or squalid living environments simply because the person concerned (or their carer or family member) has requested that no action be taken. Doing so may lead an organisation to take an action that is a breach of duty of care, or lead to the organisation taking no action, in circumstances where that omission constitutes a breach of duty of care. However, there will often be legal requirements that must be satisfied before certain actions can be taken without the consent of the person concerned (for example, sharing of information relating to the person, refer to [Section 3.6.6 When disclosure is permitted](#) and [Section 6 Questions and answers](#), Question 24; administration of medical treatment or an authority to access private premises, refer to [Section 3.5.1 Risk management](#) and [Section 6 Questions and answers](#), Question 12).

<sup>40</sup> Wrongs Act 1958 (Victoria) Section 48(3).

<sup>41</sup> Wrongs Act 1958 (Victoria) Section 48(1).

If an organisation has any concerns about the duty of care that is owed in a particular case, legal advice should be sought.

### 3.10 Considering human rights

The Victorian Charter of Human Rights and Responsibilities requires that all public authorities must act compatibly with the human rights outlined in the Charter, and must give proper consideration to those human rights when making any decision.

The rights protected in the Charter include:

- freedom of movement
- privacy and reputation, which includes the right not to have one's home arbitrarily or unlawfully interfered with
- property rights, being the right not to be deprived of one's property other than in accordance with law
- equality before the law, which includes freedom from discrimination.

The term 'public authority' is defined relatively broadly, and includes:

- government departments and agencies
- local municipal councils
- an entity established under statute that has functions of public nature
- an entity performing a public function for or on behalf of the government.

If a service provider or organisation is uncertain as to whether it is a public authority for the purposes of the Charter, legal advice should be sought.

The Charter does provide that limitations can be placed on a person's human rights under certain circumstances, but the limitation on the right must be 'reasonable... and demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.

Generally, where actions and decisions undertaken during the provision of services are consistent with existing laws, they will be permissible under the Charter. For example, laws regarding privacy, capacity, mental health, animal protection and public and environmental health allow for authorities to take actions under circumstances that could otherwise be considered to be incompatible with a person's human rights. The circumstances where such actions are possible, and the requirements that must be satisfied before action can be taken, are discussed in [Section 3.6.6 When disclosure is permitted](#) and [Section 3.9 Duty of care](#) and [Question 12 What services can respond, and how, to a person who hoards or lives in squalor and owns their own home?](#) and [Question 17 How does my service assess for urgency, the person's safety and the level of risk?](#)

However, a legal challenge to a decision or action taken by a service provider or organisation may include arguments that the organisation failed to comply with the Charter. It is therefore prudent for service providers, organisations and businesses to ensure that its policies, procedures and practices take account of the human rights outlined in the Charter.

**Figure 5 An example of a squalid environment and self-neglect**



This building (which was a milk bar) has now been demolished. A man aged in his 60s lived here. He was later diagnosed with Korsakoff's syndrome. The picture shows a squalid environment and self-neglect.

## 4 Agencies supporting an appropriate response

Intervening in hoarding and squalor cases is a complex process that requires significant knowledge, understanding and expertise. How to respond effectively is, in many ways, still at a stage of infancy – we all have much to learn.

There are no easy answers to hoarding or squalor cases, but service response expertise is growing and providers are working together to achieve good results for people living in these circumstances. There is a steady and increasing amount of knowledge developing across a broad mix of services from both public and private agencies and businesses willing to share, work together or provide secondary consultation with other providers.

### 4.1 What is expected of agencies or organisations?

Services are provided by agencies or organisations, so one of the first steps an agency can take is to accept some responsibility to respond to such cases by ensuring appropriate policies and procedures are in place for all staff to follow.

Exposure to this knowledge relating to working with people who hoard or live in squalor is not always available for staff through current professional training qualifications such as medical, nursing, social work, personal care, mental health, or via regulatory roles such as environmental health, animal husbandry or local laws. Nor is it regularly available through professional development or post-qualification training. Education and support opportunities for staff are becoming much more readily available refer [Section 9 Resources and contacts](#) and [Appendix 1 Hoarding and squalor project stakeholder group](#).

In many situations people with hoarding behaviour or who live in a squalid environment will not be receptive to receiving services into the home. They do not generally encourage nor invite anyone to enter their home or come onto the property, due to possible embarrassment, the condition of the property, as well as an overwhelming sense of the living environment being out of control. Where animals are concerned there are additional perspectives to consider, as mentioned in [Section 2.2.1 Hoarding](#) and [Question 3 What do I do if companion animals or horses are involved?](#) and [Question 4 What do I do if livestock are involved?](#) and [Question 5 What do I do if native wildlife or exotic animals are involved?](#)

These circumstances apply equally to people with hoarding behaviour or living in a squalid environment who are employed and who leave the property to go to work, arranging their social life and commitments away from their home environment.

### 4.2 Agency policy and procedures that address hoarding and squalor situations

Ensuring that management, supervisors and workers are competent and confident is part of planning to participate in coordinated responses to complex situations, such as in these cases involving people, animals, buildings and at times, family members and neighbours.

Agencies and organisations need to ensure all staff, including those in management and supervisory roles:

- become familiar with their agency or organisation's policy that addresses hoarding and squalor cases (this could be encompassed in a broader quality or program guideline, for example, a response to complex cases)
- become familiar with this practical resource and the related *Discussion paper – hoarding and squalor 2012*

- arrange for opportunities to discuss practice response and related issues (refer to [Section 3 Building service system response capacity](#))
- identify and build steps to create and improve relationships and systems with appropriate local services to better respond to these cases (refer to [Section 5 Collaborating with other services](#)).

### 4.2.1 Expectations of staff

Service providers may suspect something is not quite right by noticing the condition of a property, having received phone calls of concern from neighbours or noticing several risk factors upon visiting the person with regard to the person and their behaviour in the community.

The points below would apply in different ways to different workers, depending on the service they work for and the role they are employed in (for example, program or clinical assessment, environmental health, animal services or people services).

The worker *is* expected to:

- follow their agency's policies and procedures (for example, local municipal council HACC services' staff already have procedures to follow if there are emergencies as part of their everyday practice)
- if the risk is urgent, immediate or life-threatening, phone 000 police, ambulance, fire brigade
- let their supervisor know of any suspected, disclosed, witnessed or alleged cases of hoarding or squalor in the first instance
- discuss possible options with the person
- clinically assess (if working in a professionally recognised clinical role) or plan for a clinical assessment of the person
- assess the person's living situation, including their health and wellbeing
- assess the health and wellbeing of any dependents (human and animal) living with the person
- refer to appropriate authorities should there be a suspicion of criminal concerns
- refer to other suitable support agencies or for a clinical assessment
- keep a detailed, confidential record of what happened and what is discussed.

The worker is *not* expected to solve issues or concerns with regard to the person's or their dependents' circumstances, in isolation from other services (specialist or generalist services relating to animal welfare, building, health, mental health, environment, legal, safety or law enforcement)

The supervisor *is* expected to:

- follow their agency's policies and procedures
- contact police, fire services, or ambulance via triple zero (000) if the matter is urgent
- ensure consultation occurs with specialist services (refer to [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#)) if unsure about what action is required
- refer or support the care manager or support worker to refer any concern about the health or welfare of a person or animal to the appropriate authority, agency or service where further action or intervention is required, to ensure the person or animal's safety and wellbeing (refer to [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#)) – where possible, the supervisor should seek the consent of the person to a referral
- ensure discussion occurs about possible options with the person and any family members, if appropriate, and provide or organise support as required
- ensure detailed and secure confidential records are being kept of what happens in accordance with agency record-keeping policies and procedures
- inform their manager of concerns or issues regarding the situation

- gather, substantiate and document clear and relevant evidence using existing service coordination tools (refer to Section [3.6 Protection of the person's information](#))
- involve other agencies in assessment and action planning, as appropriate.

### 4.3 Ways for agencies to support staff

Sustainable outcomes embrace the following good practice considerations:

- **identify issues early** – this may mean, at times, prior to receiving a complaint (that is, local municipal council regulatory services, animal welfare services, mental health services, property concerns)
- **raise awareness by educating workers** in all service types (refer to [Table 5 Core services that respond to hoarding and squalor situations](#)) about what hoarding or squalor is and isn't; identify internal and external strategies to respond; build and strengthen working relationships with other sectors and community organisations relevant to the situation outside of the normal range of service types
- **consider the inclusion of triggers or indicators to identify hoarding or squalor cases** on the organisation's quality system to ensure response and management is occurring and document who monitors case progression
- **understand roles and responsibilities**; that is, who is responsible for what and work together, contributing to an overall response for the people and animals involved
- **actively pursue a more flexible service response** which is more considered, empathetic, understanding and flexible, in synch with a regulatory one which is process driven and often rigid.

Service response to these situations requires individual and collective staff capacity to:

- build healthy professional relationships with other sectors, as well as the people they provide service to
- be flexible
- be patient, with a robust ability to understand, without judgment
- be prepared and able to learn
- use varying response and engagement techniques
- maintain a sense of good humour.

Seek secondary consultation from specialist services such as SfHRT, MACNI, and mental health if the team is not sure which services are most appropriate (refer to [Table 5 Core services that respond to hoarding and squalor situations](#)).

#### 4.3.1 Specific hoarding and squalor education and training opportunities

A supported, informed and knowledgeable workforce is a healthy and motivated one. All organisations should provide time and resources to ensure management and staff are well supported to address complex situations.

Education and training can be provided through a broad range of experience:

- in service training on aspects of hoarding and squalor, which needs to be ongoing (even if once a year)
- using prerecorded training materials (that is, DVDs, record of forum or case or network discussion) as one tool in a suite of educational tools required
- engaging clinical and practice specialists to speak at local education forums or seminars
- providing opportunities, with appropriate guidance, for staff to discuss their experiences and speak about how they might be able to develop or adapt previous approaches to achieve a more sustained outcome
- inviting service and clinical practitioners from other sectors who have developed some expertise in this area to share their experiences, so that skills and approaches can be shared, learned and built on



- similarly, initiate opportunities for local service discussion from different sectors to decide how to plan a small learning program over a couple of years using whatever methods work for that group of services (perhaps combining this with existing network or meeting opportunities)
- utilise components of this hoarding and squalor practical resource as a basis for local team meeting discussion.

Subject matter to consider might include:

- understanding the health status of the condition
- the interrelatedness between hoarding and squalor (including animal hoarding)
- how to best work with people living in these conditions (for example, how to build and maintain trust and engagement; how to recognise and work with the person to reduce harm; how to identify any changes in attitude that might need to be made to more effectively work with people who hoard or live in squalor)
- identification of actions (either individual or organisational) that might produce counterproductive outcomes for the person concerned (for example, it is important to work as a team to share the role and decrease worker burnout)
- how to work in partnership with other services to sustain positive change for the person concerned
- how to look after yourself (including management of emotions) over a prolonged period of engagement with a person, their family and the neighbourhood
- how to be exposed to or learn about best practice results
- access to quality supervision and debriefing opportunities.

The book *Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding*<sup>42</sup> is a particularly useful resource and can also be read by people who hoard, their families and friends. Scales and surveys from the book have been useful in helping to normalise behaviours and avoid shaming.

## 4.4 Supporting those involved in the direct response

Choosing and supporting workers to undertake the range of tasks involved in responding to such cases is integral to successful and sustainable outcome.

### 4.4.1 This type of work may not suit all staff

Workers who provide services directly to members of the public (either in the community or in a service environment), and their supervisors, should be supported by their employing organisation through regular supervision as well as through other opportunities to provide feedback about their work, including a capacity to discuss concerns about home and property visits as well as the staff member's general support needs.

*A worker should not be placed in a position of compromise*, which might occur if the worker feels caught between a discussion with a member of the community and expectations of their role as a direct service worker (refer to Section 3.9 Duty of care).

Responding to hoarding and squalor situations can be extremely demanding in a range of ways, including the ability to work cooperatively with different staff from several different organisations – possibly over a longer period of time than in less complex cases. The following aspects should be considered.

- the provision of regular acknowledgement of successful outcomes achieved by individuals is important, based on the sustained effort, commitment and skill of the workers concerned – particularly if there have been additional obstacles to manage to achieve results
- workers from different services types are generally suited to particular types of work, based on character and personality traits, because, apart from technical skill or knowledge, obtaining the right match to the role is very important for both the organisation and the workers

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<sup>42</sup> Tolin et al. 2007.

- the capacity of staff to maintain a respectful sense of good humour while working in this complex area can assist with staff moral. If a balanced perspective starts to wane over time, or at a particular point in the service response, it may be necessary to ease the person off the case and replace with another team member. Supporting the health of staff in relation to the impact of working with people living complex lives is important no matter what the needs of the staff member might be, keeping in mind that staff express health needs in a variety of different ways.
- staff who might wish to be involved in such cases, but find they are unable to contribute (for example, due to reactions such as repulsion or feeling sick) should still have their contribution valued and confirmed, rather than being placed in a situation where they may feel a form of failure or inadequacy
- staff involved in these cases – particularly over a period of time – debriefing and review opportunities should be offered that focus on them and what they need, as distinct from how they are working with the person and the person's needs
- while a complete clean-up of the property may not be productive, there are occasions when a degree of decluttering is essential to create adequate entry and egress, reduce fire risks and reduce occupational health and safety concerns for agencies or businesses who provide services to the person. During such a clean-up, two staff from a human service team, as well as an animal welfare team, when appropriate, should be on site, in addition to the cleaners, to troubleshoot unexpected events and provide support and assistance to the person if required.
- the human service team should perform a follow-up visit to the property and then chair a debriefing session for frontline staff which might include a formal handover to other service providers, who might then assess for the provision of daily living services, community service or animal welfare concerns.

### 4.4.2 Post initial intervention

The types of post initial intervention services that a person might need once engagement is holding and initial activities have been completed include:

- **Supporting the person:** personal support needed for issues associated with grief and loss, neighbours, legal and financial matters and changes of circumstance immediately following any intervention. Consider referral to clinical treatment services if agreed to and if possible, ones that are easy to access (refer to [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#)).
- **Service provision:** service suitability, eligibility and availability. All service providers need an understanding of how to work with people who are living with a hoarding condition or have a squalor history. No matter what the person's circumstance, their health condition and history needs to be understood to ensure a stabilised and sustained living environment with minimal risk – whether that should involve housing, health, animals, other people living in the house or maintaining a capacity to seek or continue employment.

### 4.4.3 Cross-sector work<sup>43</sup>

The identification of service coordination champions across sectors and within organisations will contribute to cross-sector success. The role of a champion might include the coordination of regular presentations utilising interagency experts' dissemination of up-to-date information on each service, including service coordination practice as a part of organisational orientation or induction programs and providing information regarding access points for a range of services to new staff.

Collaborative approaches to cross-sector working, capacity building and workforce development will continue to strengthen the delivery of service coordination, including:

- planning and running cross-sector training and networking opportunities
- utilising online communication and resource sites

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<sup>43</sup> EMR 2009.



- undertaking joint recruitment approaches
- resourcing cross-sector resource development to support practice
- enabling collaborative research projects.

Clarity of the respective roles and responsibilities by both management and staff is necessary to ensure the services involved deliver the right intervention, at the right time and in the right place.

Risk assessment and risk management plans are an essential part of working with people with complex needs and should be incorporated into day-to-day practice and communicated to all members of the service team.

#### 4.4.4 Practice

The utilisation of secondary consultation and access to specialist hoarding and squalor support services assists in the development of an action plan and subsequent service interventions that respond to the identified needs of the person.

It is important for management and staff to be aware of statutory and regulatory requirements that inform service provision and guide practice, in order to deliver optimal service response. This is especially important in relation to issues regarding confidentiality and capacity for informed consent (refer to Section [3.6 Protection of the person's information](#)).

It might be useful to encourage workers to visit local services in other sectors, build relationships and become familiar with what is available and how your service might work with these other services on hoarding and squalor cases.

Networking is important, as is understanding the purpose, language and culture of other services. Where required, seek clarification from the service concerned, develop relationships.

### 4.5 Occupational health and safety considerations

First, all relevant organisational policies and procedures apply, including occupational health and safety considerations. However, should there be occupational health and safety concerns, these should not be used as a reason for not responding to hoarding and squalor situations. Additional planning and resourcing involving consultation with other services – both public and private – could be beneficial to find a means to move forward in a different way than might usually have been considered.

These cases often challenge the way service response is considered and planned for, particularly when such environments are difficult to navigate and work in. It is important to provide staff with the necessary tools and equipment to undertake this work to ensure their cleanliness, health and safety.

#### 4.5.1 Risks for workers

The following possibilities should be considered:

- when managers or supervisors are planning for workers to access a dwelling, consider whether the environment is impacted upon by hoarding (which would restrict movement) or squalor (which provides greater ability to walk around, but may present organic concerns) or both hoarding and squalor which would combine both considerations when planning worker protection and support.
- before entering a squalid environment, workers would benefit by wearing protective clothing (for example, gumboots or heavy waterproof shoes, overalls or older clothing and disposable gloves if needed. Workers may need to take clean newspapers for multiple uses (for example, to cover chairs if workers want to sit down, for table tops, to wrap things in and so on). Keep in mind that stepping in or over organic matter is likely to occur, and that the risk of slips and falls is heightened.
- some workers will wear head protection of some kind (for example, hats to protect themselves from fleas, if animals are involved) or different types of face masks to allow the worker to breathe more easily in dwellings with high ammonia levels (due, for example, to high levels of animal urine or faeces).

- in the case of a hoarding household or property, be aware of stacked items (no matter how high), and don't lean on them for support. Make sure workers are instructed to always walk on the ground, and not on scattered material. Workers also need to be aware of their own safety with regard to electricity, gas and water.
- the fire risk inside a hoarding household is significant, and it is recommended that smoke alarms are arranged to be installed inside the home prior to the introduction of workers, including those involved in large-scale removal.

### 4.5.2 Receiving a referral

When receiving a referral for a hoarding or squalor situation it may be helpful to consider the following, and if necessary, obtain further information from the referring agency on these questions:

- What are the reasons for the referral?
- Who has made the referral and why now?
- What are the immediate risks identified at referral?
- What are the immediate needs identified at referral?
- Is the property accessible? (For example factors affecting accessibility may include clutter, overgrowth, unsocialised animals or abusive behaviour.)
- Is the property structurally safe?
- Can the property be made secure?
- Is there running water and functioning sewerage?
- Is electricity and/or gas connected?
- Is there odour?
- Is there evidence of infestation or pests?
- Is there evidence of rotting food, faeces or urine?
- Are there any risks to the inhabitants or neighbours?
- Is there an accumulation of large amount of possessions?
- What is the nature of the accumulated items?
- Does the clutter impede exits and egress?
- Does the clutter prevent the use of living spaces as they were designed?
- Are there resultant unsafe improvisations for heating and cooking?

Proceed according to the service response flowcharts (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#)).

## 5 Collaborating with other services

Integral to developing a shared understanding of how to work with other services is the need to identify those services and know what they can offer and be aware of their roles and responsibilities. The following information has been developed for all health services, community agencies, animal welfare agencies, regulatory, housing, cleaning and emergency services to build knowledge about how, who and when to connect with other services outside of familiar sector practice at local, regional, divisional and specialist level.

The structure of sectors, programs and businesses varies, depending on where any one organisation locates its service outlets. This section provides information about a broad range of services that, in one way or another, responds to hoarding or squalor situations.

**Section 5.1 A list of service types** presents two tables:

- [Table 5 Core services that respond to hoarding and squalor situations](#), describes services that can respond to hoarding and squalor cases due to their core expertise
- [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#) lists several, more specialist, services that are likely to become involved, depending on the circumstances of the case.

The two tables provide slightly different service information. In the first column, consecutive numbering runs through both tables to assist with identification of the service type in [Section 5.2 Service descriptions](#). Each table provides a page reference to find out more detail about each service.

**Section 5.2 Service descriptions** presents service descriptions, which unfold the meaning of the tables in [Section 5.1 A list of service types](#). Similar headings per service section (for example: housing services, clinical services, people services and animal services) have been used in both sections, with the aim of providing some means of understanding unfamiliar sectors. Each service description provides some means of how to connect with that service type in a local area.

### 5.1 A list of service types

It is understood that each service needs to remain true to its purpose, but also needs to link in with other services to know how best and when they might contribute to a case involving hoarding and squalor.

Each service would benefit from developing practices or means of working cooperatively with other services – planning how best to support one another in response, what roles to take, when and how (refer to [Section 3.5 Common service coordination tasks](#) and [Section 4 Agencies supporting an appropriate response](#)).

Building these partnership arrangements would assist the person involved in each case by ensuring they are not overwhelmed with multiple visits, too many services all at once and possibly each with a range of different expectations. Such circumstances would not be easily managed by anyone, let alone by a person with a diminished capacity to trust, a heightened sense of caution and a lifestyle well-rehearsed to keep people away.

**Table 5 Core services that respond to hoarding and squalor situations**

| Organisation   Service type   Service                 |  | Refer to page      | Regulatory function | Clinical assessment | Program assessment | Initial contact, information gathering, action planning |
|---|--|--------------------|---------------------|---------------------|--------------------|---|
| <b>Housing services</b>                               |  |                    |                     |                     |                    |   |
| <b>Department of Human Services Community Housing</b> |  |                    |                     |                     |                    |   |
| <i>Housing Support programs</i>                       |  |                    |                     |                     |                    |   |
| 1   | Support for High Risk Tenancies Program (SfHRT)  | <a href="#">49</a> | –                   | –                   | ✓                  | ✓   |
| 2   | Social Housing Advocacy and Support Program (SHASP)  | <a href="#">50</a> | –                   | –                   | ✓                  | ✓   |
| 3   | Indigenous Tenancies at Risk (ITAR) Program  | <a href="#">51</a> | –                   | –                   | ✓                  | ✓   |
| <i>Homelessness response program</i>                  |  |                    |                     |                     |                    |   |
| 4   | Crisis accommodation providers   | <a href="#">51</a> | –                   | –                   | –                  | ✓   |
| <b>Department of Health Ageing and Aged Care</b>      |  |                    |                     |                     |                    |   |
| <i>Low-cost accommodation and support programs</i>    |  |                    |                     |                     |                    |   |
| 5   | Community Connection Program   | <a href="#">52</a> | –                   | –                   | ✓                  | ✓   |
| 6   | Housing Support for the Aged   | <a href="#">52</a> | –                   | –                   | ✓                  | ✓   |
| 7   | Older Persons High Rise Support Program  | <a href="#">53</a> | –                   | –                   | ✓                  | ✓   |
| <b>Clinical services</b>                              |  |                    |                     |                     |                    |   |
| 8   | Clinical specialists: <ul style="list-style-type: none"> <li>• consultant physicians in geriatric medicine or geriatricians</li> <li>• aged psychiatrists</li> <li>• general physicians</li> <li>• neurologists</li> <li>• neuropsychiatrists</li> </ul> | <a href="#">54</a> | –                   | ✓                   | –                  | ✓   |
| 9   | General practitioners (GP) – local/regional  | <a href="#">55</a> | –                   | ✓                   | ✓                  | ✓   |
| 10  | Aged Care Assessment Service (ACAS) Victoria   | <a href="#">56</a> | –                   | ✓                   | ✓                  | ✓   |
| 11  | Aged Persons Mental Health Services (APMHS)  | <a href="#">57</a> | –                   | ✓                   | ✓                  | ✓   |
| 12  | Adult mental health services   | <a href="#">58</a> | –                   | ✓                   | ✓                  | ✓   |
| 13  | Child and adolescent mental health services  | <a href="#">59</a> | –                   | ✓                   | ✓                  | ✓   |
| 14  | Alcohol and drugs treatment services   | <a href="#">60</a> | –                   | ✓                   | ✓                  | ✓   |
| 15  | Psychologists (private)  | <a href="#">60</a> | –                   | ✓                   | ✓                  | ✓   |
| 16  | Psychiatrists (private)  | <a href="#">61</a> | –                   | ✓                   | ✓                  | ✓   |
| <b>People services</b>                                |  |                    |                     |                     |                    |   |
| 17  | Home and Community Care (HACC)   | <a href="#">61</a> | –                   | –                   | ✓                  | ✓   |
| 18  | Psychiatric disability and rehabilitation support services (PDRS): community managed mental health   | <a href="#">62</a> | –                   | –                   | ✓                  | ✓   |

| Organisation   Service type   Service   |  | Refer to page      | Regulatory function | Clinical assessment | Program assessment | Initial contact, information gathering, action planning |
|---|--|--------------------|---------------------|---------------------|--------------------|---|
| <b>Animal services</b>                  |  |                    |                     |                     |                    |   |
| 19                                      | RSPCA Victoria Inspectorate  | <a href="#">63</a> | ✓                   | ✓                   | –                  | ✓   |
| 20                                      | RSPCA Victoria   | <a href="#">63</a> | –                   | ✓                   | –                  | ✓   |
| 21                                      | Department of Environment and Primary Industries (DEPI) – re native wildlife or exotic species | <a href="#">64</a> | ✓                   | –                   | –                  | ✓   |
| 22                                      | Department of Environment and Primary Industries (DEPI) – re livestock                         | <a href="#">65</a> | ✓                   | –                   | –                  | ✓   |
| <b>Local municipal council services</b> |  |                    |                     |                     |                    |   |
| 23                                      | Municipal local laws   | <a href="#">66</a> | ✓                   | –                   | –                  | ✓   |
| 24                                      | Animal management  | <a href="#">67</a> | ✓                   | –                   | –                  | ✓   |
| 25                                      | Environmental health   | <a href="#">68</a> | ✓                   | –                   | –                  | ✓   |
|   | HACC (refer to number 17 in this table)  |                    |                     |                     |                    |   |
| 26                                      | Town planning (planning enforcement/investigative)   | <a href="#">69</a> | ✓                   | –                   | –                  | ✓   |
| 27                                      | Building department  | <a href="#">69</a> | ✓                   | –                   | –                  | ✓   |
| 28                                      | Municipal fire prevention  | <a href="#">70</a> | ✓                   | –                   | –                  | ✓   |

**Table 6 Other services that become involved in response to hoarding and squalor situations (specialist)**

| Service type            |  | For service details refer page |
|-------------------------|--|--------------------------------|
| <b>Housing services</b> |  |                                |
| 29                      | Department of Human Services – Shared supported accommodation for people with a disability                                   | <a href="#">71</a>             |
| 30                      | Real estate agents   | <a href="#">72</a>             |
| 31                      | State Trustees – estate management   | <a href="#">72</a>             |
| 32                      | Housing for the Aged Action Group Inc. (HAAG)  | <a href="#">73</a>             |
| <b>People services</b>  |  |                                |
| 33                      | Department of Human Services – Child protection services   | <a href="#">73</a>             |
| 34                      | Child FIRST/family services  | <a href="#">74</a>             |
| 35                      | Department of Human Services; Department of Health and Department of Justice – Multiple and Complex Needs Initiative (MACNI) | <a href="#">77</a>             |
| 36                      | Department of Health and Ageing; Home Support Program and Home Care Packages (Commonwealth)                                  | <a href="#">78</a>             |
| 37                      | Community health services  | <a href="#">80</a>             |
| 38                      | Disability services  | <a href="#">81</a>             |
| 39                      | Personal Helpers and Mentors (PHaMs) Program (Commonwealth)  | <a href="#">81</a>             |
| 40                      | Department of Human Services Family violence services  | <a href="#">82</a>             |
| <b>Animal services</b>  |  |                                |
| 41                      | Commercial pest control operators  | <a href="#">83</a>             |
| 42                      | Local veterinarian services  | <a href="#">83</a>             |
| <b>Legal services</b>   |  |                                |
| 43                      | Victorian Civil and Administrative Tribunal (VCAT) – guardianship and administration orders                                  | <a href="#">84</a>             |
| 44                      | Office of the Public Advocate (OPA) – guardianship   | <a href="#">85</a>             |
| 45                      | Environment Protection Authority Victoria – advice about contaminated items  | <a href="#">86</a>             |
| 46                      | Legal practitioners (private) – estate management, financial management  | <a href="#">86</a>             |
| 47                      | Victorian Legal Aid – community legal aid services   | <a href="#">87</a>             |
| <b>Risk and safety</b>  |  |                                |
| 48                      | Melbourne Metropolitan Fire and Emergency Services Board (MFB)   | <a href="#">87</a>             |
| 49                      | Victorian Country Fire Authority (CFA)   | <a href="#">88</a>             |
| 50                      | Victoria Police – local police services  | <a href="#">88</a>             |
| 51                      | Ambulance Victoria (AV)  | <a href="#">89</a>             |
| 52                      | Commercial cleaning and organising businesses  | <a href="#">89</a>             |
| 53                      | Energy Safe Victoria (ESV) – electricity, gas and pipeline safety  | <a href="#">90</a>             |
| 54                      | Public and private utility services – electricity, gas, oil, water and sewerage  | <a href="#">91</a>             |

## 5.2 Service descriptions

This section provides detailed descriptions of the services listed in [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#). The service types are not listed in any priority order, but consecutive numbering has been applied to assist with the location of service descriptions.

In addition, to assist with finding these and other services in a local area, refer to the Human Services Directory (HSD) at <http://humanservicesdirectory.vic.gov.au/Home.aspx>, which provides practitioners and service providers with access to accurate and up-to-date information about health, social and disability services in Victoria.

This information may be used both to inform the general public and for providers of services to communicate with other practitioners, including referring people to other services.

### 5.2.1 Core services

#### Housing services

##### *Department of Human Services – Community Housing*

| 1 Support for High Risk Tenancies Program (SfHRT) |   |
|---|---|
| Service description                               | <p>The Support for High Risk Tenancies Program (SfHRT) provides secondary and tertiary consultation, professional development and priority projects across program areas of the Department of Human Services and other funded community organisations.</p> <p>SfHRT aims to strengthen the human service system's response to people with complex care needs through the integration and coordination of services to:</p> <ul style="list-style-type: none"> <li>• create sustainable tenancies with high and complex needs</li> <li>• develop greater understanding of the needs and service response options for the person, to address service system barriers and gaps</li> <li>• identify service development opportunities within the Department of Human Services, funded organisations and interdepartmentally action these to increase area capacity</li> <li>• focus specifically on high-risk tenancies.</li> </ul> <p>The Divisional coordinator works across government departments and funded organisations to explore and negotiate solutions to presenting issues in order to sustain tenancies and improve service responses to people with complex needs. Brokerage is attached to this program.</p> <p>SfHRT builds capacity and skill enhancement in workers to provide person-centred best practice for people with the most complex needs by providing:</p> <ul style="list-style-type: none"> <li>• secondary consultations: staff work collaboratively with key service providers to facilitate the development of workers' skills, knowledge and confidence in managing people with complex needs</li> <li>• innovative training and education, focusing on broad service coordination.</li> </ul> |
| Role in relation to hoarding and squalor          | <p>SfHRT works with a broad range of service providers on hoarding and squalor cases, particularly those whose tenancies are at risk and households with high and complex needs.</p> <p>SfHRT provides secondary consultation and assistance to key workers and case managers in providing a coordinated approach to service delivery</p> <p>SfHRT provides assistance to identify and link people with appropriate service delivery options</p> <p>SfHRT provides training seminars on hoarding, covering issues such as managing risk and developing management plans to decrease the impact of hoarding on people and the service system.</p> <p>SfHRT can initiate referral to MACNI if required (refer to <a href="#">Table 6 Other services that become involved in response to hoarding and squalor situations (specialist)</a>).</p>  |

|                       |  |
|-----------------------|--|
| Clinical assessment   | No   |
| Regulatory function   | No   |
| Triggers for referral | <p>Consultation with SfHRT should occur primarily for people who are characterised by some of the following:</p> <ul style="list-style-type: none"> <li>• those who are not responding to multiple intervention attempts</li> <li>• those who are having extraordinary difficulty accessing required interventions</li> <li>• those who have exhausted many of the common interventions for their presenting behaviours or circumstances</li> <li>• those for whom the service system has experienced ongoing difficulty with engagement, including assertive outreach</li> <li>• those who have evidence of enduring and repetitive poor outcomes</li> <li>• those who are experiencing multiple and repetitive crises</li> <li>• those for whom there is multiplicity of views among program/service providers regarding the most appropriate service response( and no clear agreement on way to proceed</li> <li>• those who are not eligible for Multiple and Complex Needs Initiative (MACNI).</li> </ul>   |
| Referral requirements | <p>Contact your local Divisional Coordinator for details of referral processes as this may vary between divisions, in accordance with the following:</p> <ul style="list-style-type: none"> <li>• potential referrals to the coordination process should be initially identified by the case manager, program and services advisor or senior housing officer and raised with their appropriate team leader/manager</li> <li>• if determined at this first point of case review that all service options have reasonably been explored, the potential referral should be raised with the responsible program/service manager for consideration</li> <li>• subject to endorsement by the manager responsible, secondary consultation* occurs to discuss the case</li> <li>• the local coordinator should provide assistance and advice in the completion of any required referral forms. Contact your local coordinator for further information.</li> </ul> <p>* The secondary consultation role of the coordinator forms a key element of the coordination process, which ensures alternative options to address the person's need are fully explored. Consultations are recorded and submitted every six months to the Department of Human Services central office. If you do not have consent the coordinator may still offer a non identifying secondary consultation.</p> |
| How to contact        | <p>Contact your local Department of Human Services office and ask to be transferred to the Client Outcomes and Service Improvement Branch, Complex Clients unit. To locate the local Department of Human Services office appropriate to your service go to: <a href="http://www.dhs.vic.gov.au/about-the-department/contact-us/locations">http://www.dhs.vic.gov.au/about-the-department/contact-us/locations</a>.</p>   |

## 2 Social Housing Advocacy and Support Program (SHASP)

|  |   |
|--|---|
| Service description                      | <p>The Social Housing Advocacy and Support Program (SHASP):</p> <ul style="list-style-type: none"> <li>• provides tailored case management and support to public housing tenants to maintain their housing and prevent homelessness</li> <li>• provides new tenants with tailored support to help them establish their tenancy</li> <li>• supports existing tenants to maintain their tenancy in situations where this is breaking down or at risk of breaking down</li> <li>• connects tenants to a range of non-government services in their local community, where they can get independent help and support.</li> </ul> |
| Role in relation to hoarding and squalor | <p>Provides case management support to clients to deal with hoarding issues and work with other service providers to assist in stabilising the tenancy</p>  |
| Clinical assessment                      | No  |
| Regulatory function                      | No  |



|                       |  |
|-----------------------|--|
| Triggers for referral | A person's housing is at imminent risk due to notice to vacate, rent arrears or environmental and health and safety concerns.  |
| Referral requirements | The person must be residing in public housing and referred through the local housing office, self referral or other sources.   |
| How to contact        | Contact your local Department of Human Services office and ask to be transferred to the housing unit that manages the Social Housing Advocacy and Support Program. To locate the local Department of Human Services office appropriate to your service go to:<br><a href="http://www.dhs.vic.gov.au/about-the-department/contact-us#content-heading-4">http://www.dhs.vic.gov.au/about-the-department/contact-us#content-heading-4</a> |

### 3 Indigenous Tenancies at Risk (ITAR) Program

|  |   |
|--|---|
| Service description                      | The Indigenous Tenancies at Risk (ITAR) Program provides services to people with an indigenous background residing in public or social housing experiencing issues with their tenancy.  |
| Role in relation to hoarding and squalor | Provides case management for a range of concerns including support to deal with hoarding and squalor related issues and to work with other service providers to assist in stabilising the tenancy.  |
| Clinical assessment                      | No  |
| Regulatory function                      | No  |
| Triggers for referral                    | Rental arrears, notification by OoH housing service officers, antisocial behaviour, hoarding and concern about the condition of the property.   |
| Referral requirements                    | The person must be residing in public or social housing; or connected with housing service officers, or other indigenous or mainstream homelessness service providers.  |
| How to contact                           | Contact your local Department of Human Services office and ask to be transferred to the housing unit that manages the Indigenous Tenancies at Risk program. To locate the local Department of Human Services office appropriate to your service go to:<br><a href="http://www.dhs.vic.gov.au/about-the-department/contact-us#content-heading-4">http://www.dhs.vic.gov.au/about-the-department/contact-us#content-heading-4</a> |

## Department of Human Services – Homelessness response program

### 4 Crisis accommodation providers

|  |  |
|--|--|
| Service description                      | Crisis accommodation providers present specialist homelessness assistance to people who experience or are at risk of homelessness.   |
| Role in relation to hoarding and squalor | May be a first point of contact for initial assessment, planning and referral for housing assistance and housing-related support needs.  |
| Clinical assessment                      | No   |
| Regulatory function                      | No   |
| Triggers for referral                    | Contact with SfHRT, SHASP or ITAR programs is generally in place prior to connecting with homeless entry points such as crisis accommodation providers.<br><br>The person's housing is at imminent risk due to notice to vacate, rent arrears or environmental health and safety concerns.<br><br>The person presents as immediately homeless. |
| Referral requirements                    | Self or worker referral to homelessness entry point service.   |
| How to contact                           | To speak directly with a housing and support worker 24 hours, 7 days a week – phone: 1800 825 955.   |

**Department of Health – Ageing and Aged Care****Low-cost accommodation and support programs**

| <b>5 Community Connection Program</b>    |   |
|--|---|
| Service description                      | <p>The Community Connection Program targets older people with multiple or complex needs who are homeless or living in insecure or low-cost accommodation and aims to:</p> <ul style="list-style-type: none"> <li>• use proactive and reactive interventions to identify, assess and work with people who are homeless or are living in low-cost accommodation to facilitate their ongoing access to appropriate mainstream and specialist services</li> <li>• systematically cultivate an effective and sustainable partnership with the local service system, to assist them to develop service structures that are more responsive to the needs of the target group</li> <li>• utilise effective and durable strategies and long-term solutions to establish and maintain the target group's ongoing access to appropriate services</li> <li>• improve the capacity of the target group to manage their own health and welfare needs and make decisions regarding their use of services</li> <li>• broker or purchase packages of care for people in the target group with complex or multiple needs to reduce their need for higher levels of assistance in the future.</li> </ul> |
| Role in relation to hoarding and squalor | Apply the aims of the program (above) to older people with hoarding behaviour or living in a squalid environment.   |
| Clinical assessment                      | No  |
| Regulatory function                      | No  |
| Triggers for referral                    | A person who experiences or is at risk of homelessness who has multiple or complex needs  |
| Referral requirements                    | As above  |
| How to contact                           | <a href="http://www.health.vic.gov.au/agedcare/services/lowcost/connection.htm">http://www.health.vic.gov.au/agedcare/services/lowcost/connection.htm</a>   |

| <b>6 Housing Support for the Aged</b>    |   |
|--|---|
| Service description                      | <p>Housing Support for the Aged supports people aged 50 and over with complex needs and a history of homelessness to maintain long-term public housing and improve their health and wellbeing. The aim of the program is to improve the health and wellbeing of older people with unmet support and care needs who are entering or living in public housing by:</p> <ul style="list-style-type: none"> <li>• assisting clients to maintain stable housing and independence through monitoring and providing and/or purchasing care and support</li> <li>• ensuring clients obtain access to additional health, welfare and community care services by providing linking and case management assistance</li> <li>• enhancing the social contact of isolated clients by providing social support or linking them into social and recreational activities. Brokerage is attached.</li> </ul> |
| Role in relation to hoarding and squalor | Assist the target group of this program who are living with hoarding behaviour or who are living in a squalid environment.  |
| Clinical assessment                      | No  |
| Regulatory function                      | No  |
| Triggers for referral                    | A tenant aged 50 years or over at risk of losing their tenancy or in need of support to maintain their tenancy  |
| Referral requirements                    | As above  |
| How to contact                           | <a href="http://www.health.vic.gov.au/agedcare/services/lowcost/housing.htm">http://www.health.vic.gov.au/agedcare/services/lowcost/housing.htm</a>   |

| 7 Older Persons High Rise Support Program |   |
|---|---|
| Service description                       | <p>Older Persons High Rise Support Program provides monitoring and support to tenants of eleven older persons high-rise public housing estates in the inner suburbs of Melbourne. The purpose of the program is to improve the health and wellbeing of older tenants living in direct tenure housing at the selected older persons high rise estates and has the following objectives:</p> <ul style="list-style-type: none"> <li>• to ensure isolated and vulnerable tenants have access to support and services</li> <li>• to contribute to older public tenants' sense of safety, independence and security</li> <li>• to enhance the social and community involvement of older public tenants.</li> </ul> |
| Role in relation to hoarding and squalor  | To apply the purpose of the program to older tenants living with hoarding behaviour or who are living in a squalid environment.   |
| Clinical assessment                       | No  |
| Regulatory function                       | No  |
| Triggers for referral                     | Public housing tenants residing in high rise estates that are at risk of losing their tenancy or need support to maintain their tenancy   |
| Referral requirements                     | As above, and tenants of designated public housing estates (refer to the website below)   |
| How to contact                            | <a href="http://www.health.vic.gov.au/agedcare/services/lowcost/highrise.htm">http://www.health.vic.gov.au/agedcare/services/lowcost/highrise.htm</a>   |

## Clinical services

| 8 Clinical specialists                   |  |
|--|--|
| Service description                      | <p>Several medical specialists are involved in providing diagnosis for varying purposes. These include general physicians, physicians in geriatric medicine, neurologists, psychiatrists of both older aged people and those that meet the needs of those less than 65 years of age, as well as neuropsychiatrists.</p> <p>The diagnosis is more commonly made in an outpatient clinic or private medical rooms.</p> <p>The assessment process has general elements, including thorough medical history and physical examination, preliminary cognitive assessment and exclusion of contributing factors such as depression, delirium or drugs. Blood test screening and radio-imaging are required. Informant history is also undertaken.</p> <p>A brief description of the specialities is provided below, adapted from the Royal Australian College of Physicians and Psychiatrists.</p> <p>Age is relative to the medical area of specialty; refer below.</p>  |
| Role in relation to hoarding and squalor | <p>Medical specialists are not usually an initial point of contact or referral; however, once having undertaken diagnosis they do maintain an ongoing role in medical management of the person. Their main roles are:</p> <ul style="list-style-type: none"> <li>• <i>Consultant physicians in geriatric medicine or geriatricians</i> have expertise in the diagnosis and management of complex and/or multifactorial medical disorders impacting on the cognition and functional status of older people. Geriatricians adopt a diagnostic approach in order to identify reversible pathologies impacting on a person's function, psychological and social wellbeing.</li> <li>• <i>Aged psychiatrists</i> focus on the assessment, treatment and prevention of mental disorders in older people. This involves an understanding of the complex interactions that occur between the ageing process, medical factors and the social, psychological, spiritual and cultural issues of later life.</li> <li>• <i>General psychiatrists</i> that focus on the assessment, treatment and prevention of people (between 16 and 64 years of age) with serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder.</li> <li>• A <i>general physician</i> adopts a holistic approach to the person and provides high general specialist services across a spectrum of health and illness, which is not limited by the boundaries of medical subspecialties.</li> <li>• A <i>neurologist</i> focuses on the diagnosis and management of diseases affecting the central, peripheral and autonomic nervous systems. Many of the conditions neurologist manage are chronic and disabling so, in addition, a neurologist may need to treat psychological complications, liaise with other medical and allied health professionals or be involved in rehabilitation.</li> <li>• <i>Neuropsychiatrists</i> are specialists within mental health service and offer neuropsychiatric assessment and advice to mental health, neurological and other medical services. Patients include those with early onset dementia, rarer neurodegenerative conditions and chronic psychotic disorders. Neuropsychiatrists are generally based within a tertiary hospital setting and work in a multidisciplinary team.</li> </ul> <p>There are many common features that link the specialists mentioned above; they often work in an interdisciplinary manner, bringing their own strengths to a consultation. The availability of specialists, particularly in remote and rural areas, impacts on the type of clinician seen, although tele-health is an increasingly used method of facilitating diagnosis by specialists where appropriate.</p> |
| Clinical assessment                      | Yes  |
| Regulatory function                      | No   |
| Triggers for referral                    | <p>Concerns about overall health condition or capacity to undertake daily living tasks and functioning</p> <p>Seeking diagnosis.</p>   |

|                       |  |
|-----------------------|--|
| Referral requirements | <p>Referral by GP is required in most instances for the person to obtain a Medicare rebate; however, other specialists may also refer.</p> <p>Other workers or family can also contact triage without a GP referral.</p>   |
| How to contact        | <p>Psychiatric triage (information, assessment and referral) 24 hours day, 7 days a week.</p> <p>For catchment-specific triage phone numbers, go to:<br/> <a href="http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm">http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm</a></p> <p>Adult Mental Health Services (for people aged 16–64 years of age):<br/> <a href="http://www.health.vic.gov.au/mentalhealth/services/adult/">http://www.health.vic.gov.au/mentalhealth/services/adult/</a></p> |

## 9 General practitioners (GP) – local or regional

|  |   |
|--|---|
| Service description                      | <p>General practice is the first point of call for most people of all ages with illness and disability, focusing mainly on clinical patient management with an increasing involvement in structured chronic disease management, comprehensive health assessments and action planning, as well as clinical care.</p> <p>Practice nurses play a pivotal role in general practice, providing direct clinical care, management of disease screening activities, practice organisation and administration, facilitating access to services and service coordination.</p> <p>Each general practice is organised differently. There are a range of activities where a practice nurse is involved directly with a person; some practices have nurse-led chronic disease clinics.</p> <p>When working with or communicating with general practice it is important to understand how it is organised, who the key contact is for a particular person or if clinical information needs to be sent or received.</p>   |
| Role in relation to hoarding and squalor | <p>The relationship that a person and their family/carer builds with the GP or nurse practitioner over time, means the practitioners are likely to have a unique insight into a person's life, so any changes in health status might be more readily noticed. The practice nurse works closely with the GP to assess and provide support.</p> <p>Capacity to identify if a person displays hoarding behaviour or lives in a squalid environment may be difficult to determine if the person is only seen in a clinical setting.</p> <p>If the GP suspects any significant health or lifestyle concern they will usually take a comprehensive history and possibly test to exclude other causes. This should also include discussion with the family/carer. The GP manages any medical condition, including a review of medications, management of chronic and acute illness and the ongoing needs of the person.</p> <p>The GP may refer for further assessment and diagnosis working in collaboration with other specialist assessors (refer to Section 5.2.1 Core services, <a href="#">Clinical Services</a>, nos 8–16) such as physicians, neurologists and private geriatricians.</p> <p>The GP needs to be kept up to date with changes to a person's condition, referrals and services that a person receives so that clinical information can be provided as necessary.</p> <p>The practice nurse can assist with action planning, health assessments and support for the person and their carer.</p> |
| Clinical assessment                      | Yes   |
| Regulatory function                      | No  |
| Triggers for referral                    | The GP should be notified about any change in a person's condition or health needs and any subsequent health referrals that service makes for the person.   |
| Referral requirements                    | A letter or SCTT referral to the general practice explaining the reason for referral should contain the relevant known clinical information and general health concerns including daily functional capacity.  |

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| How to contact | <p>General Practice Victoria website:<br/> <a href="http://gpv.staging.blissmedia.com.au/content.asp?cid=33,80&amp;type=rural&amp;=Rural%20Divisions">http://gpv.staging.blissmedia.com.au/content.asp?cid=33,80&amp;type=rural&amp;=Rural%20Divisions</a></p> <p>The Department of Human Services Human Services Directory, at:<br/> <a href="https://humanservicesdirectory.vic.gov.au/Search.aspx">https://humanservicesdirectory.vic.gov.au/Search.aspx</a></p> |
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## 10 Aged Care Assessment Service (ACAS) Victoria

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| Service description                      | <p>The Aged Care Assessment Program is jointly funded by the Commonwealth and State governments. In Victoria the program is called the Aged Care Assessment Service (ACAS). The role of ACAS is to comprehensively assess the needs of frail, older people and assist them to access the most appropriate types of care and support.</p> <p>Anyone can make a referral to ACAS provided they have the consent of the person or their carer. The target group is frail, older people 65 years and over and Aboriginal people aged 50 years and over.</p> <p>An ACAS assessment is required for entry to Commonwealth funded residential aged care services, the Transition Care Program and Home Care packages.</p> <p>ACAS also directs frail, older people who have complex social and medical problems onto appropriate services, including restorative care options. The legislative basis for the ACAS is the <i>Aged Care Act 1997</i> and associated Aged Care Principles.</p> |
| Role in relation to hoarding and squalor | <p>Early concerns will be identified during the assessment process.</p> <p>ACAS provides assessments and referrals for services for both the older person and their carer, as well as initial screening for problems with memory, thinking and planning.</p> <p>ACAS has protocols or guidelines with other agencies including Disability Services, the Office of the Public Advocate, HACC Assessment Services and Aboriginal Services.</p> <p>ACAS would refer to other specialist clinicians or geriatricians for post-diagnosis support, depending on the health concern. They also provide short-term service coordination as required.</p> <p>ACAS does not provide ongoing management or support.</p>   |
| Clinical assessment                      | Yes  |
| Regulatory function                      | No   |
| Triggers for referral                    | <p>A person's care and support needs are significant.</p> <p>An assessment is required for restorative care options or a Commonwealth-funded service.</p> <p>Carers are encouraged to be at the assessment; referrals can be made to support the carer as required.</p>  |
| Referral requirements                    | <p>SCTT referrals can be made via electronic referral, phone or fax. If unsure whether the referral is appropriate, ring the ACAS intake worker to discuss, and advise if the situation is urgent, because referrals are prioritised according to need.</p> <p>Always include consent, demographic data, date of birth and a detailed description of reasons why an ACAS assessment is required (for example, hoarding behaviour, living in squalor, carer concerns, risks at home).</p>   |
| How to contact                           | <p>To find the ACAS relevant to your geographic area go to:<br/> <a href="http://www.agedcareaustralia.gov.au/internet/AgedCare/Publishing.nsf/content/acat+finder">http://www.agedcareaustralia.gov.au/internet/AgedCare/Publishing.nsf/content/acat+finder</a> or <a href="http://www.health.vic.gov.au/agedcare/services/assess.htm">www.health.vic.gov.au/agedcare/services/assess.htm</a>.</p> <p>Or for contact enquiries – phone: 9096 7389 or email: <a href="mailto:aged.care@health.vic.gov.au">aged.care@health.vic.gov.au</a>.</p>   |

| 11 Aged Persons Mental Health Services (APMHS) |   |
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| Service description                            | <p>Public sector APMHS includes acute aged persons' inpatient services, community case management and aged persons' mental health residential care services. Older people and their carers receive case management and support, including community-based assessment and rehabilitation.</p> <p>APMHS are primarily for people with long-standing mental illness who are over 65 or who have developed functional illnesses such as depression and psychosis in later life. APMHS are also for people with psychiatric or severe behavioural difficulties associated with organic disorders.</p>  |
| Role in relation to hoarding and squalor       | <p>APMHS multidisciplinary teams provide specialist expertise in medical assessment and treatment, psychological, behavioural, social and functional assessments and a corresponding range of therapeutic interventions.</p> <p>Initial assessment and diagnosis may occur in the APMH inpatient setting as part of the admission findings. Recognition would best occur when undertaking home visit.</p> <p>Community referrals from APMH may be made to several sources for further assessment, diagnosis or carer support (for example, ACAS).</p> <p>APMHS aged persons' assessment and treatment teams (APATS) provides case management and education for consumers and carers, as well as consultation to other service providers. Some APATS have capacity to treat acutely unwell people in the community.</p> <p>APMH nursing homes and hostels provide a range of specialist bed-based services to people who cannot be managed in mainstream aged care residential services due to their level of persistent cognitive, emotional or behavioural disturbance. They may remain in these units for extended periods, but opportunities are sought to achieve discharge to a less restrictive environment, such as a generic nursing home.</p> <p>Acute inpatient services provide short-term inpatient management and treatment during an acute phase of mental illness until sufficient recovery allows the person to be treated effectively in the community. These services are located with other residential aged care services or general hospitals. In some rural services, aged acute inpatient beds are co-located with an adult inpatient unit.</p> <p>Early recognition might occur, when a home visit might be required.</p> <p>Initial assessment and diagnosis may occur in the APMH inpatient setting as part of the admission findings. Community referrals from APMH may be made to CDAMS for further assessment, diagnosis or carer support.</p> |
| Regulatory function                            | No  |
| Triggers for referral                          | <p>Individual services will have different referral requirements.</p> <p>Typical referral triggers are often related to behaviours of concern.</p> <p>A GP referral with history may be requested.</p>  |
| Referral requirements                          | <p>Anyone can make a referral or enquiry by accessing the services website and psychiatric triage numbers.</p> <p>Consistent with Department of Health service standards and chief psychiatrist guidelines.</p>   |
| How to contact                                 | <p>Psychiatric triage (information, assessment and referral) 24 hours day, 7 days a week.</p> <p>For catchment-specific triage phone numbers, go to:<br/> <a href="http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm">http://www.health.vic.gov.au/mentalhealth/services/aged/index.htm</a> </p>  |



| 12 Adult mental health services          |   |
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| Service description                      | <p>Adult specialist mental health services are aimed primarily at people with a serious mental illness or mental disorder who have associated significant levels of disturbance and psychosocial disability due to their illness or disorder.</p> <p>All specialist mental health services are required to provide a range of components so that people have access to similar service responses and functions wherever they live. These include inpatient, community bed-based and community treatment options.</p>  |
| Role in relation to hoarding and squalor | <p><b>Mobile support and treatment services (MSTS):</b> provide intensive long-term support to people with prolonged and severe mental illness and associated high-level disability.</p> <p><b>Continuing care services:</b> the largest component of adult community based services. These services provide non-urgent assessments, treatment, case management, support and continuing care services to people with a mental illness in the community.</p> <p><b>Primary mental health and early intervention teams (PMHEI):</b> support and enhance the capacity of primary care providers, especially general practitioners and community health services, to recognise and respond to mental disorders more effectively. They provide consultation, liaison, education and training services to primary care providers for both low and high prevalence disorders.</p> <p><b>Community care units:</b> provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a home-like environment where people can learn or relearn everyday skills necessary for successful community living.</p> <p><b>Acute inpatient services:</b> provide voluntary and involuntary short-term inpatient management and treatment during an acute phase of mental illness, until the person has recovered enough to be treated effectively and safely in the community.</p> <p><b>Secure extended care inpatient services:</b> provide medium- to long-term inpatient treatment and rehabilitation for consumers who have unrelenting and severe symptoms of mental illness, together with associated significant disturbance, which inhibit their capacity to live in the community.</p> <p><b>Prevention and recovery care services (PARC):</b> a new supported residential service for people experiencing a significant mental health problem, but who do not need or no longer require hospital admission. In the continuum of care, they sit between adult acute psychiatric inpatient units and a client's usual place of residence.</p> |
| Clinical assessment                      | Yes   |
| Regulatory function                      | No  |
| Triggers for referral                    | Individual services will have different referral requirements. Typical referral triggers are often related to behaviours of concern. A GP referral with history may be requested.   |
| Referral requirements                    | Anyone can make referral or enquiry by accessing the services website and psychiatric triage numbers.   |
| How to contact                           | <p>Psychiatric triage (information, assessment and referral) 24 hours day 7 days a week. For catchment-specific triage phone numbers go to:</p> <p><a href="http://www.health.vic.gov.au/mentalhealth/services/adult/index.htm">http://www.health.vic.gov.au/mentalhealth/services/adult/index.htm</a></p>  |

| 13 Child and adolescent mental health services |   |
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| Service description                            | <p>Specialist child and adolescent mental health services provide a range of community and inpatient treatment services for children and adolescents up to the age of 18 with a serious emotional disturbance.</p> <p>This includes young people with a diagnosable psychiatric disorder whose condition is considered seriously detrimental to their growth or development and/or where there are substantial difficulties in the person's social or family environment.</p> <p>Young people aged 16–18 years may receive service from either child and adolescent mental health services or adult area mental health services, depending on their needs.</p>  |
| Role in relation to hoarding and squalor       | <p><b>Intensive mobile youth outreach services (IMYOS):</b> provides intensive outreach mental health case management and support to adolescents who display substantial and prolonged psychological disturbance, and have complex needs that may include challenging, at-risk and suicidal behaviours. These services work with young people who have been difficult to engage using less intensive treatment approaches.</p> <p><b>Continuing care, clinical teams:</b> provide a range of services starting with initial intake to provide advice, information and screening. They undertake assessment and treatment of children and adolescents experiencing significant psychological distress and/or mental illness and their families. Services include crisis assessment, case management, multimodal treatments, individual, family and group therapy and parent or carer support. They also provide consultancy services to other community agencies and service providers. Child and adolescent mental health services work extensively with other service sectors, including schools, general practitioners, paediatricians, youth and family services, child protection and welfare agencies.</p> <p><b>Acute inpatient services:</b> provide short-term assessment and/or inpatient treatment for children and adolescents who have a severe emotional disturbance and who cannot be assessed satisfactorily or treated safely and effectively within the community.</p> <p><b>Child and adolescent mental health services' adolescent day programs:</b> offer an integrated therapeutic and educational program for young people with behavioural difficulties, emotional problems such as severe depression and/or anxiety, emerging personality difficulties or a severe mental illness such as early psychosis.</p> <p><b>Conduct disorder programs:</b> conduct disorder is the most severe type of disruptive behaviour in children and young people, with such behaviours as extreme aggression, truancy, lying, stealing, lack of empathy or running away. Programs offering multilevel early intervention and prevention designed to reduce the prevalence and impact of conduct disorder are currently being piloted in Victoria, and are not currently available in all catchment areas.</p> <p>* Services may refer a child or young person who is experiencing hoarding or who has lived long term in a hoarded or squalid environment.</p> |
| Clinical assessment                            | Yes   |
| Regulatory function                            | No  |
| Triggers for referral                          | Individual services will have different referral requirements. Typical referral triggers are often related to behaviours of concern. A GP referral, including a medical history, may be requested.  |
| Referral requirements                          | Anyone can make referral or enquiry by accessing the services website and psychiatric triage numbers.   |
| How to contact                                 | <p>Psychiatric triage (information, assessment and referral) 24 hours day 7 days a week. For catchment-specific triage phone numbers go to:</p> <p><a href="http://www.health.vic.gov.au/mentalhealth/services/child/index.htm">http://www.health.vic.gov.au/mentalhealth/services/child/index.htm</a></p>  |

| 14 Alcohol and drugs treatment services  |  |
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| Service description                      | Alcohol and drugs treatment services are predominantly funded by the Department of Health, but the Commonwealth Government also funds several treatment programs.<br>Adult treatment services are available to adults aged 18 years and above, and at least one agency currently runs a program specifically for older people.   |
| Role in relation to hoarding and squalor | Clinical assessment services: screening, information provision and assessment services are available in regard to the problematic use of alcohol and drugs. Where necessary, referral to a treatment service for clinical assessment can be made where an individual treatment plan is developed in consultation with the client.<br>Treatment services: the range of alcohol and drug treatment services include counselling, withdrawal, residential rehabilitation and case coordination. |
| Clinical assessment                      | Yes  |
| Regulatory function                      | No   |
| Triggers for referral                    | Concern about a person's health in relation to alcohol and drug use.   |
| Referral requirements                    | Anyone can make an enquiry by contacting DirectLine for information, screening and where appropriate, be provided with the referral details of an alcohol and drug treatment service.  |
| How to contact                           | DirectLine 1800 888 236 (information, screening and referral) 24 hours a day 7 days a week.  |

| 15 Psychologists (private)               |  |
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| Service description                      | Psychologists (private); The Australian Psychological Society (APS) is the largest professional association for psychologists in Australia, representing over 20,000 members. Their website has a facility to search for a psychologist in your local area, including over 2,300 private psychologists across Australia. |
| Role in relation to hoarding and squalor | APS is able to provide information about how to access private psychologists and their services.<br>The degree of expertise may vary between psychologists with regard to diagnosis and support for hoarding and squalor cases.  |
| Clinical assessment                      | Yes  |
| Regulatory function                      | No   |
| Triggers for referral                    | Concern about a person's mental health.  |
| Referral requirements                    | As above, anyone can seek the services of a psychologist.  |
| How to contact                           | Phone: (03) 8662 3300<br>Toll free: 1800 333 497<br>Email: <a href="mailto:contactus@psychology.org.au">contactus@psychology.org.au</a><br><a href="http://www.psychology.org.au/">http://www.psychology.org.au/</a> .   |

| 16 Psychiatrists (private)               |  |
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| Service description                      | <p>Psychiatrists (private); Royal Australian and New Zealand College of Psychiatrists (RANZCP) is the principal organisation providing accreditation and representation for the medical specialty of psychiatry in Australia and New Zealand.</p> <p>RANZCP is responsible for training, examining and awarding the Fellowship of the College qualification to medical practitioners. There are currently 3,500 Fellows of the College who account for approximately 85 per cent of all practising psychiatrists in Australia, and over 50 per cent of psychiatrists in New Zealand. RANZCP:</p> <ul style="list-style-type: none"> <li>• conducts training and examinations for qualification as a consultant psychiatrist</li> <li>• administers the continuing professional development program (CPD) for practising psychiatrists</li> <li>• holds an annual scientific congress and various sectional conferences throughout the year</li> <li>• publishes journals, statements and other policy documents</li> <li>• represents psychiatrists with government, allied professionals and community groups.</li> </ul> |
| Role in relation to hoarding and squalor | <p>RANZCP is able to provide information about how to access private psychiatrists and their services.</p> <p>The degree of expertise may vary between psychiatrists with regard to diagnosis and support for hoarding and squalor cases.</p>  |
| Clinical assessment                      | Yes  |
| Regulatory function                      | No   |
| Triggers for referral                    | Concern about a person's mental health; need for a clinical psychiatric assessment or medication review.   |
| Referral requirements                    | As above, anyone can seek the services of a psychiatrist.  |
| How to contact                           | <p>Phone: (03) 9640 0646 or toll free: 1800 337 448 (for Australian residents).</p> <p><a href="http://www.ranzcp.org/Resources/find-a-psychiatrist.aspx">http://www.ranzcp.org/Resources/find-a-psychiatrist.aspx</a></p>   |

## People services (non-clinical)

| 17 Home and Community Care (HACC) |  |
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| Service description               | <p>In Victoria the HACC program is jointly funded by the Commonwealth and Victorian governments.</p> <p>HACC Living at Home assessments are provided by HACC assessment services and incorporate a holistic assessment, action planning and service-specific assessment for the person and their carer and service coordination as required.</p> <p>The HACC program is designed to support older people, people with a disability and their carers whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care.</p> <p>Those who are referred have a need for basic maintenance and support services to enable them to live independently at home.</p> <p>All people in the target group are eligible for a Living at Home assessment. Eligibility does not depend on age or income. However, not all those eligible are able to receive an immediate service. HACC providers use priority of access guidelines to manage demand for services.</p> |

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| Role in relation to hoarding and squalor | <p>The HACC assessors' role is to:</p> <ul style="list-style-type: none"> <li>• identify signs or concerns of general nature</li> <li>• understand how these issues affect the everyday life of the person and their carer</li> <li>• discuss options for further information, support education and diagnosis</li> <li>• provide referrals as agreed</li> <li>• determine eligibility for HACC services such as home care, person care, home maintenance, meals on wheels and social support.</li> </ul> <p>HACC assessors refer to relevant specialist services as required – predominately ACAS – as well as to a wide range of providers to support older people and their carers.</p> |
| Clinical assessment                      | No   |
| Regulatory function                      | No   |
| Triggers for referral                    | <p>Triggers for referral include:</p> <ul style="list-style-type: none"> <li>• the person is unable to cope independently with everyday activities such as housework, showering and dressing</li> <li>• the person has poor nutrition</li> <li>• the person is becoming socially isolated due to their inability to drive, use public transport or other reasons</li> <li>• carer stress (if the person has carer).</li> </ul>   |
| Referral requirements                    | Referrals should include a description of the person's areas of need, including the carer's need for support. SCTT core templates and optional templates as required (refer to Section 8.9 Templates to assist with service coordination tasks).   |
| How to contact                           | To contact the local HACC assessment service in your area go to:<br><a href="http://www.health.vic.gov.au/hacc/downloads/pdf/assess_list_2012.pdf">http://www.health.vic.gov.au/hacc/downloads/pdf/assess_list_2012.pdf</a>  |

## 18 Psychiatric disability rehabilitation and support (PDRS) services

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| Service description                      | <p>Psychiatric disability rehabilitation and support (PDRS) services (community managed mental health) play a vital role in supporting people and their carers throughout the recovery process, and form part of the broader Victorian specialist mental health service sector.</p> <p>PDRS services are predominantly funded by the Department of Health to provide services to the adult population (aged 16–64). However, there are several limited programs offered to the aged population (aged 65 years and over) in some areas. Local PDRS services have defined catchment areas, typically in line with the local area mental health services.</p> |
| Role in relation to hoarding and squalor | <p>PDRS services are commonly referred to as non-clinical services. Strong and effective working relationships between clinical and PDRS services are essential to providing quality treatment and care.</p> <p>PDRS services develop and maintain links with other service providers at local, state and national levels to ensure specialised coordinated support and rehabilitation, and to promote community integration for people with psychiatric disabilities.</p> <p>PDRS has formal processes to promote interagency collaboration.</p>  |
| Clinical assessment                      | No   |
| Regulatory function                      | No   |
| Triggers for referral                    | Individual services will have different referral requirements. Typical referral triggers may be related to behaviours of concern or an individual's difficulty managing daily living independently in the community.   |

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| Referral requirements | A formal diagnosis is not a prerequisite, but a functional assessment is made of the person's ability to manage their daily lives and to live independently in the community. The person needs to live in the catchment area of particular PDRS funded program. SCTT can be used for referral, but it is not essential (refer to Section 8.9 <a href="#">Templates to assist with service coordination tasks</a> ). |
| How to contact        | Department of Health website:<br><a href="http://www.health.vic.gov.au/mentalhealth/services/disability/index.htm">http://www.health.vic.gov.au/mentalhealth/services/disability/index.htm</a>  |

## Animal services

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| <b>19 RSPCA Victoria Inspectorate</b>    |  |
| <b>20 RSPCA Victoria</b>                 |  |
| Service description                      | <p>19 RSPCA Victoria Inspectorate provides regulatory services under the <i>Prevention of Cruelty to Animals Act 1986</i> and parts of the <i>Domestic Animals Act 1994</i> in relation to hoarded animals or animals living in squalor; that is, domestic and non-domestic animals (other than livestock species).</p> <p>20 RSPCA Victoria also provides a range of animal care-related support services such as desexing, vaccination, grooming, advice, education, treatment and rehoming.</p>   |
| Role in relation to hoarding and squalor | <p><b>Referral/initial contact and assessment</b></p> <p>RSPCA Victoria gives advice on animal cruelty or welfare issues, and responds to enquiries from the public or other bodies. RSPCA will receive reports of cruelty or concerns about welfare issues, including those concerning animal hoarders or object hoarders with animals whose welfare is at risk.</p> <p>RSPCA Victoria will make any necessary further enquiries to investigate complaints of cruelty or other welfare issues and, depending on the circumstances, may visit a property to inspect animals in their current environment. They will assess the needs of the animals involved and support the person contacting them, collaborating with any other agencies already involved or otherwise required.</p> <p><b>Joint action planning</b></p> <p>RSPCA Victoria will work collaboratively with the DEPI, Zoos Victoria and other specialists to assess:</p> <ul style="list-style-type: none"> <li>• the needs of animals involved in hoarding and/or squalor situations</li> <li>• the environment affecting any animals</li> <li>• the financial and physical capacity to provide appropriate care or treatment in the situation</li> <li>• the willingness of animal owners/carers to cooperate with animal welfare initiatives such as desexing, vaccinating and reducing numbers</li> <li>• the need for regulatory intervention.</li> </ul> <p><b>Follow up</b></p> <p>RSPCA Victoria will endeavour to collaborate with any relevant individuals or bodies involved in a case in order to secure the best welfare outcomes for the animals affected.</p> |
| Clinical assessment                      | <p>Yes</p> <p>RSPCA's veterinarians can undertake clinical assessments of these animals.</p>   |
| Regulatory function                      | <p>Yes</p> <p>RSPCA Victoria provides regulatory services in the form of the inspectorate, which is empowered to enforce the Prevention of Cruelty to Animals Act 1986 (POCTAA) and parts of the Domestic Animals Act (DAA) to investigate poor animal welfare and cruelty.</p> <p>Part of this regulatory service may include removing animals from a property/person for treatment, negotiating the surrender of animals, seizing animals under POCTAA and rehoming where possible.</p>  |

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| Triggers for referral | <p><b>Characteristics of an animal hoarder:</b></p> <ul style="list-style-type: none"> <li>• has more than the typical number of companion animals, horses, native wildlife or exotic animals</li> <li>• failure by the owner to provide even minimal standards of nutrition, sanitation, shelter, space and veterinary care, with this neglect often resulting in illness and death from starvation, spread of infectious disease, untreated injury or medical condition, and the inability of animals to express normal behaviours</li> <li>• denial by the owner of their inability to provide this minimum care and the impact of that failure on the animals, the household and human occupants of the dwelling</li> <li>• the owner's persistence, despite this failure, in accumulating animals.</li> </ul> <p><b>Characteristics of an object hoarder with animals:</b></p> <ul style="list-style-type: none"> <li>• the person is not an animal hoarder, but there are concerns for the welfare of any companion animals, horses, native wildlife or exotic animals being kept at the property.</li> </ul> |
| Referral requirements | <p>Anyone can contact the RSPCA with animal welfare or cruelty concerns.</p> <p>Report by phone or website (details below) with as much information as possible, including names, ages and addresses of people involved; number, type and condition of animals involved; details of the affected animals' environment; physical or financial capacity of the owner/carer to continue to care for the animals; any case worker/guardian/agent or other agencies involved; what support or service is being requested or anticipated to be needed.</p>  |
| How to contact        | <p>RSPCA Victoria – phone: 9224 2222 or report cruelty via the website: <a href="http://www.rspcavic.org/services/inspectorate/report-cruelty">http://www.rspcavic.org/services/inspectorate/report-cruelty</a></p>   |

## 21 Department of Environment and Primary Industries (DEPI) – wildlife and exotic animals

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| Service description                      | Department of Environment and Primary Industries (DEPI) – re wildlife and exotic animals. Many native wildlife species can only be kept if the person has the appropriate permit or authority under the <i>Wildlife Act 1975</i> . Most exotic species can only be imported and kept with the appropriate authorisation. |
| Role in relation to hoarding and squalor | DEPI responds to situations involving animal hoarders or object hoarders with animals that are or include native wildlife or exotic species.   |
| Clinical assessment                      | No   |
| Regulatory function                      | Yes  |
| Triggers for referral                    | For advice/assistance on whether the person is illegally keeping native wildlife or exotic species in terms of either the type of species kept or the numbers kept.  |
| Referral requirements                    | Anyone can contact DEPI with these animal authorisation concerns.  |
| How to contact                           | DEPI – phone: 136 186.   |



| 22 Department of Environment and Primary Industries (DEPI) – livestock |  |
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| Service description  | <p>Department of Environment and Primary Industries (DEPI) – re livestock.</p> <p>DEPI's veterinary officers and animal health officers can provide advice on and investigate livestock welfare and cruelty. The officers can work with owners to develop plans for the appropriate housing and husbandry of livestock animals, or sale of animals, to ensure the welfare of animals and owners is maintained. If euthanasia of livestock is necessary, these officers are authorised for that purpose.</p>  |
| Role in relation to hoarding and squalor                               | DEPI responds to animal hoarders or object hoarders with livestock whose welfare is at risk.   |
| Clinical assessment  | DEPI's veterinary officers can undertake a clinical assessment of livestock animals.   |
| Regulatory function  | Appointed as inspectors under the Prevention of Cruelty to Animals Act 1986 to investigate poor animal welfare and animal cruelty.   |
| Triggers for referral  | <p><b>Description of an animal hoarder</b></p> <p>Unlike companion animals and native and exotic wildlife, it is not so easy to determine what a 'typical number' of livestock animals is, because there is an enormous range in the numbers of livestock animals kept on farms.</p> <p>However, if the owner has livestock animals (cattle, sheep, pigs, goats, chickens, and so on) in a non-farm situation, make an assessment of the following as to whether the following problems exist. And, if on farm, the following problems exist, this is justifiable cause to suspect livestock hoarding.</p> <ul style="list-style-type: none"> <li>• Failure by the owner to provide even minimal standards of nutrition, sanitation, shelter, space and veterinary care, with this neglect often resulting in illness and death from starvation, spread of infectious disease, untreated injury or medical condition, and the inability of animals to express normal behaviours.</li> <li>• Denial by the owner of their inability to provide this minimum care and the impact of that inability on the animals, the household and human occupants of the dwelling.</li> <li>• The owner's persistence, despite this inability, in accumulating animals.</li> <li>• An object hoarder with animals: if the person is not an animal hoarder, but there are concerns for the welfare of any livestock animals being kept at the property.</li> </ul> |
| Referral requirements  | Anyone can contact DEPI with these animal welfare or cruelty concerns.   |
| How to contact   | DEPI – phone: 136 186.   |

## Local municipal council services

The capacity of these areas in a local municipal council is vital, because they often provide leverage to engage a person living with hoarding behaviour or in a squalid environment, which is only effective in the long term if partnering occurs with complementary services – either in other local municipal council departments or external agencies.

| 23 Municipal Local Laws                  |   |
|--|---|
| Service description                      | <p>The <i>Local Government Act 1989</i> gives local municipal councils in Victoria the power to create local laws within their own municipalities. Local laws are designed to protect and enhance the health and safety of residents and visitors and the amenity of the municipality. Generally, compliance and enforcement of local laws is undertaken by authorised officers who can issue infringements for non-compliance in accordance with the provisions of the specific local law.</p> <p>Local laws vary between local municipal councils and are based on local needs and priorities. They are usually available on local municipal council websites.</p> <p>Municipal local laws officers apply local laws to all residents and visitors to the municipality.</p> <p>Many local municipal councils also undertake non-regulatory functions to promote community safety, such as education and awareness programs.</p> |
| Role in relation to hoarding and squalor | <p>If there are local laws in place that apply to hoarding behaviour and squalor situations, they will mainly relate to the safety and amenity of the area; they:</p> <ul style="list-style-type: none"> <li>• generally have no jurisdiction inside the home</li> <li>• focus on street frontage of the property</li> <li>• commonly use orders that relate to unsightly property, fire risk, dangerous property.</li> </ul> <p>Local municipal councils' compliance powers may be a useful tool in assisting individuals to agree to improve the safety of their situation, particularly if the external and visible part of their property is involved.</p>  |
| Clinical assessment                      | No  |
| Regulatory function                      | Municipal local laws  |
| Triggers for referral                    | <p>Responding to neighbourhood complaints about the amenity or safety of property, such as accumulated rubbish, perceived health hazards or fire risk.</p> <p>Other agencies may request advice/assistance from local municipal council.</p>  |
| Referral requirements                    | As above.   |
| How to contact                           | Check for relevant local laws on the local municipal council website, or contact the local municipal council and ask for local laws.  |

| 24 Animal Management                     |   |
|--|---|
| Service description                      | <p>The RSPCA has primary responsibility for animal cruelty and neglect investigations.</p> <p>Local municipal councils play a role in promoting animal welfare with animal owners through registering domestic animals under the Domestic Animals Act, and in taking action when planning, or local laws relating to animal numbers are not complied with.</p>  |
| Role in relation to hoarding and squalor | <p>The Victorian planning provisions set limits, according to zones, on the number of animals that can be kept at a property.</p> <p>Local municipal councils may also establish local laws to further limit the number of animals that can be kept on private residences in certain areas. The Domestic Animals Act requires all cats and dogs to be registered with a local municipal council. Registration is mostly paper-based and does not involve a great deal of personal contact between local municipal council officers and owners of animals.</p> <p>Animal management officers and the Prevention of Cruelty to Animals Act (POCTA) general inspectors undertake these roles.</p> <p>Local municipal council officers who are authorised officers under Section 72 of the Domestic Animals Act can apply to the Minister to be a general inspector under the Prevention of Cruelty to Animals Act (POCTA). The primary purpose of general inspectors is to encourage considerate treatment of animals and to prevent cruelty to animals.</p> <p>It is up to the local municipal council to elect (or not) whether they will seek to have general inspectors. Currently most local municipal councils have not sought to employ general inspectors.</p> |
| Clinical assessment                      | No  |
| Regulatory function                      | Domestic Animals Act, local laws, Prevention of Cruelty to Animals Act  |
| Triggers for referral                    | Complaints from the public, reports of roaming animals  |
| Referral requirements                    | As above  |
| How to contact                           | At your local municipal council ask first for the animal management officer. You may be directed to a local laws officer, depending on the local municipal council structure.   |

| 25 Environmental Health                  |  |
|--|--|
| Service description                      | <p>Local municipal council environmental health officers (EHO) undertake public health activities, including responding to public health hazards, assessing public health risks and taking appropriate action.</p> <p>Local municipal EHOs respond to the general public and determine when the situation is likely to result in a nuisance as defined under the Public Health and Wellbeing Act 2008 (PHWA). EHOs have the power to investigate nuisances under the (PHWA) (see: <a href="http://www.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s58.html">http://www.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s58.html</a>).</p>  |
| Role in relation to hoarding and squalor | <p>Local municipal councils may be alerted to cases of hoarding and squalor when they investigate nuisances under the PHWA or respond to complaints from the public. If the local municipal council determines there is a risk to public health, they can require rectification of the problem under the PHWA, or seek warrant from the Magistrates Court to gain entry to a private property.</p> <p>Investigating squalor and hoarding is not their role, unless there is a risk to public health that is causing a nuisance. Examples where this might occur include infestation of vermin, using the rear yard as a toilet or rotting stored garbage resulting in odours and health issues.</p> <p>Local municipal councils' environmental health units also work in collaboration with other local municipal council services and other community-based health and community agencies.</p> <p>The scale of the local municipal council response will depend on the hazards and sanitation risks identified. Actions can include:</p> <ul style="list-style-type: none"> <li>• educate and advise regarding the appropriate management guidelines</li> <li>• issue health warnings (for example, fire risks, quality of air)</li> <li>• directing remedial action (for example, cleaning and sanitising, compliance with management guidelines, pest control, demolition or repair, action taken to address access for a period of time or recommending an evacuation).</li> </ul> |
| Clinical assessment                      | No   |
| Regulatory function                      | Public Health and Wellbeing Act 2008   |
| Triggers for referral                    | Community concern, odour, noise, visual pollution, public health and safety concerns reported by resident/agency   |
| Referral requirements                    | As above   |
| How to contact                           | Ask for the environmental health unit at the local municipal council.  |

### HACC Services

| HACC Services   |
|---|
| Refer to <a href="#">17 Home and Community Care (HACC)</a> in this section. |

| 26 Town Planning (planning enforcement/investigative) |  |
|---|--|
| Service description                                   | Town planning (planning enforcement/investigative). Local municipal council can investigate breaches of its planning scheme and planning permits by owners or occupiers of land. |
| Role in relation to hoarding and squalor              | Minimal role   |
| Clinical assessment                                   | No   |
| Regulatory function                                   | Rarely applicable <i>Planning and Environment Act 1987</i> and Victorian planning provisions   |
| Triggers for referral                                 | Community concerns regarding compliance with planning scheme or planning permit  |
| Referral requirements                                 | As above   |
| How to contact  | Ask for the planning and building compliance section at the local municipal council.   |

| 27 Building department                   |  |
|--|--|
| Service description                      | <p>Building department (structural or building surveyor)</p> <p>Local municipal council building inspectors investigate dangerous buildings and buildings that don't comply with or are constructed without the required planning permits.</p> <p>Local municipal council building departments are involved if a building is structurally unsound. Buildings or structures can become dangerous because of poor maintenance, fire or storms.</p> <p>The building owner is responsible for looking after the building, renovations or the costs involved in making a building safe should it become dangerous, for the life of the building. This includes checking and looking after its essential safety measures, such as smoke alarms, child barriers to pools and spas, and termite management</p> <p>Local municipal council can issue notices and orders to owners of buildings, and may take owners of a dangerous or dangerously constructed buildings to court. Emergency works and fines may apply to dangerous buildings.</p> |
| Role in relation to hoarding and squalor | <p>By law, safety measures in a building must exist and must always work. They must be checked and looked after regularly. Safety measures make sure the people in the building, people in the next buildings and people on the street can be safe in a fire or other emergency.</p> <p>Local municipal councils do not have powers in the building legislation about the manner in which property is maintained by owners.</p> <p>Situations where buildings may be considered structurally unsound include:</p> <ul style="list-style-type: none"> <li>• loose or falling building materials</li> <li>• walls or fences that are in danger of collapse and unstable chimneys.</li> </ul> <p>When the electrical supply is clearly unsafe, local municipal council or the MFB or CFA can then refer the matter to Energy Safe Victoria and request an inspector.</p>  |
| Clinical assessment                      | No   |
| Regulatory function                      | Section 126 of the Planning and Environment Act 1987   |
| Triggers for referral                    | <p>Property appears structurally unsound or dangerous.</p> <p>When there are clearly illegal structures attached to the main dwelling</p>  |
| Referral requirements                    | As above   |
| How to contact                           | Ask for the building enforcement unit at the local municipal council.  |

| 28 Municipal fire prevention             |  |
|--|--|
| Service description                      | <p>Municipal fire prevention is a statutory responsibility of all municipalities. Every local municipal council must appoint a fire prevention officer to give effect to certain fire prevention provisions in the <i>Country Fire Authority Act 1958</i> (the CFA Act) and the <i>Metropolitan Fire Brigades Act 1958</i> (the MFB Act), including the serving of fire prevention notices.</p> <p>Section 41 of the CFA Act and Section 87 of the MFB Act provide for the serving of fire prevention notices on the owner or occupier of (other than public authority) in respect of anything:</p> <ul style="list-style-type: none"> <li>(a) on land, other than building or in building</li> <li>(b) on the adjacent half width of any private street that abuts that land – other than a prescribed thing or class of things) that by its nature, composition, condition or location constitutes or may constitute danger to life or property from the threat of fire.</li> </ul> <p>In the case of the CFA, the CFA Act provides the head of power. CFA provides policy, planning leadership, standards for training and best practice in municipal fire prevention in the country area of Victoria as defined by the Act. CFA also carries the audit responsibility for municipal fire prevention plans. There is no requirement for local municipal councils in the metropolitan fire district to develop a municipal fire prevention plan.</p>   |
| Role in relation to hoarding and squalor | <p>Local municipal councils have powers to impose orders for a clean-up if there is a fire risk to property.</p> <p>Municipal fire prevention officers issue permits to burn and fire prevention notices in their municipality in the country area of Victoria. Each local municipal council's fire prevention officers conduct inspections of private properties prior to the fire danger period to assess them for fire hazards.</p> <p>Properties deemed to be high fire risk (for example, long uncut grass) to either them or their immediate neighbours are issued with a fire prevention notice, instructing the landholder to carry out certain works to reduce the risk. Landholders are given a period of time to comply before a second round of inspections are conducted.</p> <p>Local municipal council will enter land and carry out fire hazard reduction works when landholders do not comply with their fire prevention notice and bill the cost of the works back to the owner</p> <p>Need to identify:</p> <ul style="list-style-type: none"> <li>• what local laws or regulation could be typically applied by MFB officers</li> <li>• what type of notice might be issued (hazard abatement, unsightly property and so on).</li> </ul> <p>In what context this can be applied (only external to the home and in some LGAs this is further restricted to the front yard only) (refer to <a href="#">Question 12 What services can respond, and how, to a person who hoards or lives in squalor and owns their own home?</a>).</p> |
| Clinical assessment                      | No   |
| Regulatory function                      | Yes  |
| Triggers for referral                    | Imminent fire season (in the country areas of the Victoria); for example, complaints re fire hazard, long grass  |
| Referral requirements                    | As above   |
| How to contact                           | Ask for the municipal fire prevention officer at the local municipal council.  |

## 5.2.2 Other services

### Housing services

| 29 Department of Human Services – Shared supported accommodation for people with a disability |  |
|---|--|
| Service description   | <p>The Department of Human Services Shared supported accommodation service is a generalist program for people with a disability who have high support needs. People with a lower level of need are provided with supports outside of the accommodation model.</p> <p>The accommodation model includes congregate care and group homes, the latter providing support for four to six people.</p> <p>Residents often go to work or daytime activities during business hours, and when home in the mornings and evenings are generally supported by one or two disability support staff in areas such as:</p> <ul style="list-style-type: none"> <li>• household management (for example, cleaning and shopping)</li> <li>• general self-care (for example, eating, dressing, preparing food)</li> <li>• personal hygiene (for example, bathing, toileting as required)</li> <li>• participating in the local community (for example, going to a sporting match, movies or hobby class).</li> </ul> <p>The environment is kept home-like. If a resident needs a specific health or other support that support staff are not trained or able to provide, services should be accessed by a relevant community-based provider as for other members of the community.</p> |
| Role in relation to hoarding and squalor  | <p>Disability support staff are expected to support the resident to visit their general practitioner as required, this would include any concerns with regard to hoarding behaviour or a squalid living environment.</p> <p>Where possible and practical, disability support staff will modify support and the home environment to meet the individual resident's needs.</p>   |
| Triggers for referral   | <p>If a person has support needs related to a disability that cannot be met by family, friends or other services in the community, referral can be made for ongoing disability support from Disability Services.</p> <p>People can register their need for ongoing disability support on the Disability Support Register if they meet the criteria as determined under the <i>Disability Act 2006</i> (see the Disability Access Policy: <a href="http://www.dhs.vic.gov.au/for-individuals/disability/start-here/access-to-disability-supports">http://www.dhs.vic.gov.au/for-individuals/disability/start-here/access-to-disability-supports</a>).</p>   |
| Referral requirements   | <p>The Disability Support Register (DSR) is a database of all the people with confirmed need for funding to purchase supports that meet their disability needs (through an Individual Support Package) or for supported accommodation. The DSR is used to allocate these supports in a fair and efficient manner when funding or vacancies become available. For further information refer to: <a href="http://www.dhs.vic.gov.au/for-individuals/disability/start-here/disability-support-register">www.dhs.vic.gov.au/for-individuals/disability/start-here/disability-support-register</a>.</p> <p>Several requirements must be met before an application can be submitted to register on the DSR.</p>  |
| How to contact  | <p>If you need assistance contact Disability Intake and Response on 1800 783 783 or a disability service provider in your local area.</p> <p>More information about supported accommodation can be found at: <a href="http://www.dhs.vic.gov.au/for-individuals/disability/accommodation">http://www.dhs.vic.gov.au/for-individuals/disability/accommodation</a></p>   |



| 30 Real estate agents                    |  |
|--|--|
| Service description                      | Real estate agents assist any person of adult age to buy, sell, rent or lease housing stock such as houses, apartments, flats, and townhouses.   |
| Role in relation to hoarding and squalor | <p>Certain consequences of hoarding behaviour or living in a squalid environment can impact on rental or leasing contracts in both public and private markets.</p> <p>Circumstances such as falling behind in rental payments; managing utility connections; complaints from neighbours; maintenance of the property; not responding to requests to declutter; and possible eviction notices might be cause for a private real estate agent to become involved in hoarding and squalor situations.</p> |
| Triggers for referral                    | The circumstances require the involvement of the private real estate agent as the property manager (refer to Section 3.4 Hoarding and squalor service response flowcharts and Figure 3 Hoarding and squalor service response flowchart (Part A) and Figure 4 Hoarding and squalor service response flowchart (Part B)).  |
| Referral requirements                    | Anyone can contact a private real estate agent.  |
| How to contact                           | <p>The Real Estate Institute of Victoria (REIV) – phone: 9205 6666.</p> <p><a href="http://www.realestate.com.au/find-agent">http://www.realestate.com.au/find-agent</a></p>   |

| 31 State Trustees – estate management    |  |
|--|--|
| Service description                      | State Trustees is a state-owned company that provides a range of services including financial support for people who cannot manage their own affairs because of their disability. State Trustees acts as an administrator for people with disabilities when appointed by VCAT (refer to Table 6 Other services that become involved in response to hoarding and squalor situations (specialist), no 43).   |
| Role in relation to hoarding and squalor | <p>Where the management of an estate might be required, including rental property.</p> <p>Assistance with wills, with establishing enduring powers of attorney (financial, medical treatment) or enduring power of guardianship.</p> <p>State Trustees sells a large amount of properties per year at public auction through a panel of preferred real estate agents in both metropolitan and country areas. The types of properties sold on behalf of their clients include:</p> <ul style="list-style-type: none"> <li>• deceased estates</li> <li>• people whose affairs are being managed under an enduring power of attorney</li> <li>• people whose affairs are being managed under a VCAT order.</li> </ul> |
| Triggers for referral                    | When a person requires financial management assistance   |
| Referral requirements                    | <p>VCAT order</p> <p>Personal contact</p>  |
| How to contact                           | <p>Phone: 9667 6466 (outside Melbourne 1300 138 672).</p> <p><a href="http://www.statetrustees.com.au">www.statetrustees.com.au</a></p>  |

| 32 Housing for the Aged Action Group Inc. (HAAG) |   |
|--|---|
| Service description                              | Housing for the Aged Action Group Inc. (HAAG) offers free, confidential and quality advice to older people in private rental who experience or are at risk of homelessness who need information and support about accommodation issues or have a housing problem.   |
| Role in relation to hoarding and squalor         | <p>HAAG offers four main services, all of which might apply to an older person living in a hoarding or squalor situation:</p> <ul style="list-style-type: none"> <li>• housing options</li> <li>• private renters assistance</li> <li>• outreach care and housing</li> <li>• retirement housing advice and support</li> </ul> <p>The Home at Last service provides a Victoria-wide central contact point for older people who experience or are at risk of homelessness. The service aims to assist older people who live in insecure, unsafe or inappropriate housing by providing them with information and advice and linking them in to appropriate, specialist support services and housing providers.</p> |
| Triggers for referral                            | An older person who is living in a private rental situation who may experience or is at risk of homelessness.   |
| Referral requirements                            | As above  |
| How to contact                                   | <p>Phone: 1300 765 178 or 9654 7389.</p> <p>Email: <a href="mailto:haag@oldertenants.org.au">haag@oldertenants.org.au</a></p>   |

## People services

| 33 Department of Human Services – Child Protection Services |   |
|---|---|
| Service description   | <p>The Department of Human Services Child Protection Program is specifically targeted at those children and young people at risk of harm or where families are unable or unwilling to protect them.</p> <p>The main functions of the Child Protection Program is to:</p> <ul style="list-style-type: none"> <li>• investigate matters where it is alleged that child is at risk of harm</li> <li>• refer children and families to services that assist in providing the ongoing safety and wellbeing of children</li> <li>• take matters before the Children's Court if the child's safety cannot be ensured within the family</li> <li>• supervise children on legal orders granted by the Children's Court</li> <li>• provide and fund accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need.</li> </ul> |
| Role in relation to hoarding and squalor                    | <p>Sometimes a report may be about the impact on a child of a parent or grandparent's hoarding behaviour or their squalid living conditions, or these issues may be identified during the course of Child Protection involvement.</p> <p>Where living conditions pose a significant risk of harm to children, the department will make substantial efforts to assist the family to address the situation. This may include engaging other services, such as family services, local municipal council and mental health, and practical support, such as arranging and funding industrial cleaners or rubbish removal.</p> <p>Children may be placed out of the home if necessary to ensure their safety and development. This can occur either by agreement with their parents or by a court order, depending on the circumstances.</p>  |
| Triggers for referral                                       | Some professionals (such as doctors, nurses, police and school teachers) are legally obliged to report suspected child abuse. In addition, any person who believes on reasonable grounds that a child needs protection can make a report to the Victorian Child Protection Service.   |

|                       |   |
|-----------------------|---|
| Referral requirements | Anyone can contact, ring or email. It is the Child Protection worker's job to assess and, where necessary, further investigate if a child or young person is at risk of harm.   |
| How to contact        | For Child Protection contacts in each Department of Human Services region refer to: <a href="http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/child-protection-contacts">http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/child-protection-contacts</a><br>Child Protection after hours service (including weekends) – phone: 131 278 or <a href="mailto:queries.childprotection@dhs.vic.gov.au">queries.childprotection@dhs.vic.gov.au</a> . |

### 34 Child FIRST (Family Information, Referral and Support Teams)

|  |   |
|--|---|
| Service description                      | <p>Child FIRST is funded by the Department of Human Services to support vulnerable children and families. Teams are established in designated local catchments across Victoria to provide a community-based referral point into Family Services.</p> <p>Child FIRST practitioners are experienced in assessing the needs of families.</p> <p>Community-Based Child Protection will facilitate collaboration between these community-based intake services and Child Protection, providing advice to Child FIRST and Family Services about the engagement of families with complex needs and the identification of significant risk indicators, to ensure timely Child Protection involvement if a child is at risk of significant harm.</p>   |
| Role in relation to hoarding and squalor | <p>A referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need to protect and promote their healthy development.</p> <p>Where a Child FIRST team forms a view that a child or young person is in need of protection they must report the matter to Child Protection.</p>  |
| Triggers for referral                    | <p>Families requiring the support of Family Services have complex needs which can adversely impact on a child's development, if appropriate supports and interventions are not provided in timely manner.</p> <p>Significant concerns about the child's wellbeing and development are highlighted by how often issues are occurring, how serious the issues are and, most importantly, how the issues are affecting the child's development.</p>  |
| Referral requirements                    | <p>Community service organisations can refer to Child FIRST, which will inform them of the outcome of a referral, often inviting the service provider to be included in the assessment, planning and action to support the child and family.</p> <p>In most cases, better outcomes for the child, young person and family are achieved when a referral is made with their consent and participation.</p>  |
| How to contact                           | <p>There are 24 Child FIRST sites established in catchments across the state. Refer to the table below to find the appropriate local Child FIRST service referral number. In some areas referrals about Aboriginal children and families can be made directly to an Aboriginal organisation, as indicated with an asterisk in the table.</p> <p><a href="http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/family-and-parenting-support/family-services/child-first-child-and-family-information,-referral-and-support-teams">http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/family-and-parenting-support/family-services/child-first-child-and-family-information,-referral-and-support-teams</a></p> <p>See supplementary table below.</p> |

**Contact details for Child FIRST, by DHS division and area (as at May 2013)**

Supplement to the above service description for item 34

| DHS Division | DHS Area                | DHS Area LGAs  | Child FIRST Catchment          | Child FIRST LGAs  | Child FIRST referral number |
|--------------|-------------------------|--|--------------------------------|---|-----------------------------|
| North        | Loddon                  | Loddon, Campaspe, Greater Bendigo, Macedon Ranges, Mt Alexander, Central Goldfields      | North Central                  | Loddon, Campaspe, Greater Bendigo, Macedon Ranges, Mt Alexander, Central Goldfields | 1800 260 338                |
|              | Mallee                  | Mildura, Swan Hill, Buloke, Gannawarra   | Mallee                         | Mildura, Swan Hill, Buloke, Gannawarra  | 1300 665 218                |
|              | Hume Moreland           | Hume, Moreland   | Hume Moreland                  | Hume, Moreland  | 1300 786 433                |
|              | North Eastern Melbourne | Nillumbik, Banyule, Yarra, Darebin, Whittlesea   | North East Metro               | Nillumbik, Banyule, Yarra, Darebin, Whittlesea                                      | (03) 9450 0955              |
| East         | Outer Eastern Melbourne | Yarra Ranges, Knox, Maroondah  | Outer East                     | Yarra Ranges, Knox, Maroondah   | 1300 369 146                |
|              | Inner Eastern Melbourne | Manningham, Whitehorse, Monash, Boroondara   | Inner East                     | Manningham, Whitehorse, Monash, Boroondara  | 1300 762 125                |
|              | Goulburn                | Greater Shepparton, Strathbogie, Moira, Mitchell, Murrindindi                            | Goulburn Valley                | Greater Shepparton, Strathbogie, Moira  | 1300 854 944                |
|              |                         |  | Lower Hume                     | Mitchell, Murrindindi   | 1800 663 107                |
|              | Ovens Murray            | Wodonga, Indigo, Towong, Wangaratta, Benalla, Mansfield, Alpine                          | Upper Hume                     | Wodonga, Indigo, Towong   | 1800 705 211                |
|              |                         |  | Central Hume                   | Wangaratta, Benalla, Mansfield, Alpine  | 1800 705 211                |
| South        | Outer Gippsland         | East Gippsland Wellington  | East Gippsland                 | East Gippsland  | (03) 5152 0052              |
|              |                         |  | Wellington                     | Wellington  | (03) 5144 7777              |
|              | Inner Gippsland         | Latrobe, Baw Baw, South Gippsland, Bass Coast  | Latrobe Baw Baw                | Latrobe Baw Baw   | 1800 339 100                |
|              |                         |  | South Coast                    | South Gippsland, Bass Coast   | (03) 5662 5150              |
|              | Southern Melbourne*     | Greater Dandenong, Casey, Cardinia*  | South East*                    | Greater Dandenong, Casey, Cardinia*   | (03) 9705 3939              |
|              |                         |  |                                | Aboriginal children and families (Casey, Cardinia and Greater Dandenong)*           | (03) 9794 5973              |
|              | Bayside Peninsula       | Frankston, Mornington Peninsula, Kingston, Bayside, Glen Eira, Stonnington, Port Phillip | Frankston Mornington Peninsula | Frankston Mornington Peninsula  | 1300 721 383                |
|              |                         |  | Inner Middle                   | Kingston, Bayside, Glen Eira, Stonnington, Port Phillip                             | 1300 367 441                |

| DHS Division | DHS Area          | DHS Area LGAs   | Child FIRST Catchment   | Child FIRST LGAs   | Child FIRST referral number |
|--------------|-------------------|---|-------------------------|--|-----------------------------|
| West         | Barwon            | Geelong, Surfcoast, Queenscliff, Colac-Otway  | Barwon                  | Geelong, Surfcoast, Queenscliff                                    | 1300 551 948                |
|              |                   |   | Colac-Otway Corangamite | Colac-Otway, Corangamite   | (03) 5232 5500              |
|              | Western District  | Corangamite, Warrnambool, Moyne, Glenelg, Southern Grampians Northern Grampians, Horsham, West Wimmera, Yarriambiack, Hindmarsh | South West              | Warrnambool, Moyne, Glenelg, Southern Grampians                    | 1300 543 779                |
|              |                   |   | Wimmera                 | Northern Grampians, Horsham, West Wimmera, Yarriambiack, Hindmarsh | 1800 195 114                |
|              |                   |   |                         |  |                             |
|              | Central Highlands | Ararat, Pyrenees, Ballarat, Hepburn, Moorabool, Golden Plains   | Greater Grampians       | Ararat, Pyrenees, Ballarat, Hepburn, Moorabool, Golden Plains      | 1300 783 341                |
|              | Brimbank Melton   | Brimbank, Melton  | Brimbank Melton         | Brimbank, Melton   | 1300 138 180                |
|              | Western Melbourne | Melbourne, Maribyrnong, Wyndham, Hobsons Bay, Moonee Valley   | Western                 | Melbourne, Maribyrnong, Wyndham, Hobsons Bay, Moonee Valley        | 1300 775 160                |

- In the DHS South Division, Southern Melbourne Area, referrals about Aboriginal children and families can be made directly to an Aboriginal organisation.

| 35 Department of Human Services; Department of Health and Department of Justice – Multiple and Complex Needs Initiative (MACNI) |  |
|---|--|
| Service description   | <p>MACNI is a shared service across the Department of Human Services and Department of Health in partnership with the Department of Justice (DoJ). MACNI is managed by the Department of Human Services.</p> <p>The Multiple and Complex Needs Initiative (MACNI) is a time-limited response for people 16 years and older with multiple and complex needs, and is governed under legislation by the <i>Human Services (Complex Needs) Act 2009</i>.</p> <p>MACNI provides a coordinated approach to supporting individuals to achieve stability in health, housing, social connection as well as address high levels of risk management and safety to the individual and the community.</p>   |
| Role in relation to hoarding and squalor  | MACNI has strict eligibility criteria, so in cases where a person has hoarding behaviour or is living in a squalid environment and meets the MACNI eligibility criteria, a service should seek consultation with their local Divisional Coordinator.   |
| Triggers for referral   | <p>Triggers for eligibility include people with a combination of diagnosed mental illness, substance dependence, intellectual disability, cognitive impairment and individuals who present high levels of risk to themselves and to the community.</p> <p>An eligible person for MACNI has attained 16 years of age and appears to satisfy two or more of the following criteria:</p> <ul style="list-style-type: none"> <li>• people with multiple diagnosis who fall through the gaps in the service system, support from funded services has been tried and does not meet the needs of the person. The person requires an individualised wrap around and coordinated response in order to meet their needs</li> <li>• has a mental disorder within the meaning of the Mental Health Act 1986</li> <li>• has an acquired brain injury</li> <li>• has an intellectual impairment</li> <li>• is an alcoholic or drug-dependent person within the meaning of the Alcoholics and Drug-dependent Persons Act 1968</li> <li>• has exhibited violent and dangerous behaviour that has caused serious harm to themselves or some other person, or is exhibiting behaviour which is reasonably likely to place themselves or some other person at risk of serious harm</li> <li>• is in need of intensive supervision and support and would derive benefit from receiving coordinated services in accordance with an action plan under this Act, which may include welfare, health and mental health services, disability services, drug and alcohol treatment services or housing and support services.</li> </ul> |
| Referral requirements   | <p>Referrals to MACNI may come from any source including the following:</p> <ul style="list-style-type: none"> <li>• existing service providers working with the person</li> <li>• self-referrals (people referring themselves)</li> <li>• family members, guardians or significant others</li> <li>• court support or correctional services.</li> </ul> <p>Referrals must be discussed with the MACNI divisional coordinator located with the Complex Clients Unit, in the local Department of Human Services division.</p>   |

How to contact

A gateway to MACNI has been established in each of the four Department of Human Services Division, managed by the local coordinator. This is the first point of contact for discussion and potential referral.

Identify your relevant Department of Human Services office at: <http://www.dhs.vic.gov.au/about-the-department/contact-us/locations> and then identify your relevant coordinator from the list below.

| DHS Division                    | Coordinator contact telephone | Location  |
|---------------------------------|-------------------------------|---|
| West                            | 5226 4540                     | Cnr Fenwick & Little Malop Streets, Geelong 3220              |
|                                 | 5333 6530                     | State Govt Offices, Cnr Mair & Doveton Streets, Ballarat 3350 |
|                                 | 1300 360 462                  | Level 2, 71 Moreland Road, Footscray 3011                     |
| North                           | 5434 5555                     | 74–78 Queen Street, Bendigo 3552                              |
|                                 | 1300 360 408                  | 145 Smith Street, Fitzroy 3065                                |
| East                            | 9843 6000                     | 883 Whitehorse Road, Box Hill 3125                            |
|                                 | 5722 0555                     | 43–47 Rowan Street, Wangaratta 3677                           |
| South                           | 8765 5444                     | 165–169 Thomas Street, Dandenong 3175                         |
|                                 | 5177 2500                     | 64 Church Street, Traralgon 3844                              |
| DOJ<br>Statewide<br>Coordinator | 1300 365 111                  | Level 23, 121 Exhibition Street, Melbourne 3000               |

<http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/cross-departmental-projects-and-initiatives/multiple-and-complex-needs-initiative/multiple-and-complex-needs-initiative-access>

### 36 Department of Health and Ageing; Home Support Program and Home Care Packages (Commonwealth)

|                     |  |
|---------------------|--|
| Service description | <p>The Commonwealth Government introduced changes to the delivery of services for older people as described in the Living Longer Living Better paper (refer to <a href="http://www.livinglongerlivingbetter.gov.au">http://www.livinglongerlivingbetter.gov.au</a>).</p> <p>Home Care Packages are part of these changes. Home Care Packages assist older people (65 years of age and over and 50 years and over for Aboriginal and Torres Strait Islander people) to live in their own homes with more than basic support.</p> <p>From July 2013 there will be four levels of Home Care Packages to enable a more flexible response to an older person's needs. Two new levels have been added (intermediate and basic) which will complement the previous Community Aged Care Package (CACP) at a lower level and Extended Aged Care at Home (EACH) package at a higher level which will then provide a continuum of care at home.</p> |
|---------------------|--|



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| Role in relation to hoarding and squalor | <p>Home Care Packages are designed to assist with activities of daily living, nursing, allied health, social support and complex health care, such as with the higher level package that assists with oxygen and enteral feeding.</p> <p>Case managers link the person and their carer to appropriate supports and assessments as needed; for example, VCAT or OPA, to discuss powers of attorney (financial/medical) guardianship and advance care planning.</p> <p>Home Care Package providers make services available consistent with the following Commonwealth Community Care Common Standards:</p> <ul style="list-style-type: none"> <li>• Expected outcome 1.6: Risk management requires service providers to be actively working to identify and address potential risk to ensure the safety of service users, staff and the organisation.</li> <li>• Expected outcome 1.7: Human resource management requires service providers to manage human resources to ensure adequate numbers of appropriately skilled and trained staff/volunteers are available for the safe delivery of care and services to service users.</li> <li>• Expected outcome 1.8: Physical resources requires service providers to manage physical resources to ensure the safe delivery of care and services to service users and organisation personnel.</li> </ul> <p>In addition and aligned with the above common standards, the Commonwealth Government encourages Home Care Package providers to:</p> <ul style="list-style-type: none"> <li>• include fire safety training materials in training for all personnel</li> <li>• take appropriate action to promote fire safety in the home, such as: <ul style="list-style-type: none"> <li>– ensuring the assessment process includes consideration of fire-related risks to the care recipient's safety</li> <li>– advising the care recipients of smoke alarm legislation relevant to the state or territory</li> <li>– promoting regular testing and maintenance of smoke alarms to care recipients and their family/friends or providing assistance to care recipients to test and maintain smoke alarms</li> <li>– promoting the use of high-sided ashtrays or sealed containers to care recipients who smoke to allow for the proper treatment of discarded smoking materials.</li> </ul> </li> </ul> |
| Triggers for referral                    | <p>Older people who, due to the complexities of their health, social or family circumstances require ongoing case management support and cannot be supported by basic HACC services.</p>  |
| Referral requirements                    | <p>The older person needs to be assessed by ACAS as needing ongoing case management via individually planned and coordinated services.</p> <p>If approved for a Home Care package, the person's name is placed on a local e-waitlist system to be allocated to a community home care service provider when a Home Care package becomes available.</p>   |
| How to contact:                          | <p>National Aged Care Information – phone: 1800 200 422, or<br/>National Aged Care website at My Aged Care (<a href="http://www.agedcareaustralia.gov.au">www.agedcareaustralia.gov.au</a>)</p> <p>To contact your local Commonwealth Respite and Carelink Centre – phone freecall: 1800 052 222.</p>   |

| 37 Department of Health – Community Health Services (CHSs) |   |
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| Service description  | <p>CHSs work alongside general practice, privately funded and other health and support services making up the primary health sector in Victoria.</p> <p>CHSs play an important role in the primary health system and aim to improve the health and wellbeing of Victorians, particularly of people who have, or are at risk of, poorer health. There are 62 CHSs that are part of public health services and 38 that are independently registered. They are all defined and, where appropriate, registered under the Health Services Act 1988 (Victoria).</p> <p>State-funded primary health care predominantly provide a strong platform for the delivery of a range of services, including:</p> <ul style="list-style-type: none"> <li>• allied health services</li> <li>• child health services</li> <li>• chronic disease management that includes support for self-management</li> <li>• dental health services</li> <li>• disability services</li> <li>• drug and alcohol services</li> <li>• family planning</li> <li>• health promotion</li> <li>• counselling services</li> <li>• health promotion</li> <li>• home and community care services</li> <li>• medical services</li> <li>• mental health services</li> <li>• nursing services</li> <li>• post-acute care services</li> <li>• refugee health.</li> </ul> |
| Role in relation to hoarding and squalor                   | <p>CHS operate from a social model of health that acknowledges the social, environmental and economic factors, as well as biological and medical factors that affect health.</p> <p>CHSs prioritises health services to the following population groups:</p> <ul style="list-style-type: none"> <li>• Aboriginal and Torres Strait Islander people</li> <li>• people with an intellectual disability</li> <li>• refugees and people seeking asylum</li> <li>• people who experience or are at risk of homelessness</li> <li>• people with a serious mental illness.</li> </ul>  |
| Triggers for referral                                      | CHS give priority to populations with particular health needs, which often include disadvantaged populations with the poorest health and greatest economic and social needs.  |
| Referral requirements                                      | The use of a SCTT referral form (refer to Section <a href="#">8.9 Templates to assist with service coordination tasks</a> ) might be preferable.  |
| How to contact   | Contact your local community health service to discuss requirements at: <a href="http://www.health.vic.gov.au/pch/commhealth/directory.htm">http://www.health.vic.gov.au/pch/commhealth/directory.htm</a>   |

| 38 Department of Human Services – Disability Services |  |
|---|--|
| Service description                                   | <p>The Victorian disability service system provides supports for people with disability whose impairment meets the definition of disability as defined in the Disability Act 2006 and the priority for access indicators as outlined in the Disability Services Access Policy.</p> <p>Disability support services are based on individualised approaches that support people with disability to live in their community and complement other funded support available through the broader service system such as health, housing and community services.</p> |
| Role in relation to hoarding and squalor              | While the disability services system does not have specific initiatives that target people with hoarding behaviours or who live in squalor, consideration of the potential impairment of a person with a disability in these circumstances is a key indicator in individualised planning processes and whether the disability service system response is the most appropriate or adequate.   |
| Triggers for referral                                 | For a person with a disability to access specific disability services, a support plan is established that outlines their needs and goals as well as the strategies required to meet them. This support plan would include a response to hoarding behaviour or a squalid living environment and, where relevant, referral to other appropriate services such as mental health.  |
| Referral requirements                                 | <p>Specialist disability supports are available to assist people with disability who require case management, therapy or behaviour support: such as case management, criminal justice services, behaviour intervention services and therapy.</p> <p>Specialist supports are also available for people with a disability who are involved in the criminal justice system.</p>   |
| How to contact  | Disability Services Intake and Response – phone: 1800 783 783 or email: <a href="mailto:Disability.Services@dhs.vic.gov.au">Disability.Services@dhs.vic.gov.au</a> .   |

| 39 Personal Helpers and Mentors (PhaMs) – Commonwealth |   |
|--|---|
| Service description                                    | <p>Personal Helpers and Mentors (PhaMs) programs is an initiative of the Council of Australian Governments (COAG) <i>National Action Plan on Mental Health 2006–2011</i>.</p> <p>PhaMs supports people who are 16 years or over whose mental illness severely affects their lives and gets in the way of achieving their goals. PhaMs focuses on what can be achieved, rather than what can't, and works together with individuals towards rehabilitation and recovery. The person is invited to join the program and work with their own personal helper and mentor, who will support them with their individual recovery journey.</p>   |
| Role in relation to hoarding and squalor               | <p>The Personal Helpers and Mentors (PhaMs) Program offers an outreach service for people whose ability to manage their daily activities is impacted by mental illness and who have the skills to live in the community with outreach support.</p> <p>A PhaMs worker can assist with such services as:</p> <ul style="list-style-type: none"> <li>• having someone to talk to</li> <li>• getting the person's family life and relationships back on track</li> <li>• going to a doctor, clinic or hospital</li> <li>• talking to Centrelink or Legal Aid</li> <li>• banking and budgeting</li> <li>• helping with the person's housing needs</li> <li>• being involved in the community.</li> </ul> |
| Triggers for referral                                  | Eligibility criteria do apply; however, you do not need a medical diagnosis of mental illness to join the PhaMs Program.  |
| Referral requirements                                  | A diagnosis is not required. People can self-refer or be referred by family or service providers.   |
| How to contact   | <a href="http://www.jobco.com.au/en/data/mental%20health/phams/files/PhaMsPostcodeProviderListing_VIC.pdf">http://www.jobco.com.au/en/data/mental%20health/phams/files/PhaMsPostcodeProviderListing_VIC.pdf</a>   |

| 40 Department of Human Services – Family violence services |  |
|--|--|
| Service description  | <p>Human service agencies, police and justice services (including family violence services) are required to work together to provide coordinated and streamlined responses at the local level to victims of family violence, regardless of where the support comes from.</p> <p>The <i>Family Violence Protection Act 2008</i> replaces the system of family violence intervention orders established by the <i>Crimes (Family Violence) Act 1987</i> for family members and:</p> <ul style="list-style-type: none"> <li>• seeks to maximise the protection and safety of persons who have experienced family violence</li> <li>• promotes the accountability of perpetrators of family violence for their actions.</li> </ul> <p>A referral pathways protocol between Victoria Police and the Department of Human Services local family violence service providers was established to ensure consistency when responding to violence. Other organisations can be included via local interagency protocols.</p> <p>The definition of family violence includes violent, threatening, patterned and repeated use of coercive or controlling behaviour that occurs in current or past family, domestic or intimate relationships. This includes physical assaults, power and control tactics used along a continuum in concert with one another, direct or indirect threats, sexual assault, emotional and psychological torment, economic control, property damage, social isolation and behaviour that causes a person to live in fear.</p> |
| Role in relation to hoarding and squalor                   | Family violence might be a response component of a situation involving hoarding or squalor.  |
| Triggers for referral                                      | Suspicion or concern about the personal safety of women and children in the context of family violence.  |
| Referral requirements                                      | As above.  |
| How to contact   | Ring the Women's Domestic Violence Crisis Service of Victoria – phone: 9373 0123 (24 hours) statewide.   |

## Animal services

| 41 Commercial pest control operators     |   |
|--|---|
| Service description                      | Commercial pest control operators work with the public to control pests when the situation is too large or difficult to manage or where health and safety of the person or animals is at risk.  |
| Role in relation to hoarding and squalor | <p>When selecting a commercial pest control service a person should:</p> <ul style="list-style-type: none"> <li>• obtain several quotes for the job</li> <li>• talk to neighbours or friends who might be able to recommend services</li> <li>• check that the person who will be applying the pesticides holds a valid Victorian licence to use pesticides</li> <li>• check the authorisation on their licence; if unsure, verify their details with the Department of Health</li> <li>• check that the pest control operator has sufficient insurance</li> <li>• ask questions specific to your situation.</li> </ul> <p>Refer to the publication <i>Are you thinking of using pest control service? Making the right choice</i> for further information: <a href="http://www.health.vic.gov.au/pestcontrol/brochures.htm">http://www.health.vic.gov.au/pestcontrol/brochures.htm</a></p> |
| Triggers for referral                    | When pest control is too large or difficult to manage and where health and safety of the person or animals is at risk   |
| Referral requirements                    | Any person can contact commercial pest control operator.  |
| How to contact                           | <p>Refer to the <i>Yellow Pages</i> online and search for 'pest control' at: <a href="http://www.yellowpages.com.au/">http://www.yellowpages.com.au/</a>.</p> <p>Contact the Department of Health if you are unsure about licence details of service, whether the pest control service is licensed or if the pest control job was not undertaken safely – phone: 1300 887 090.</p>  |

| 42 Local veterinarian services           |  |
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| Service description                      | Local veterinarian services work with the public to address concern about the safety and health status of any animal.  |
| Role in relation to hoarding and squalor | The Victorian Practitioners Registration Board protects the public by ensuring access to veterinary services of an appropriate standard, delivered by veterinary practitioners acting in accordance with appropriate standards of professional conduct through the effective and efficient administration of the <i>Veterinary Practice Act 1997</i> .   |
| Triggers for referral                    | Suspicion or concern about the safety or health status of any animal in the context of a person with hoarding behaviour or a squalid living environment (refer to <a href="#">Table 7 List of questions and answers</a> , questions 3, 4, 5 & 6).  |
| Referral requirements                    | As above   |
| How to contact                           | <p>The Veterinary Practitioners Registration Board of Victoria has a 'Search for a Vet' tool at: <a href="http://www.vetboard.vic.gov.au/search_imis.php">http://www.vetboard.vic.gov.au/search_imis.php</a>, as well as other functions, such as registering complaint about veterinary service provided.</p> <p>The Australian Veterinary Association (AVA) also provides a tool to assist with finding a veterinarian service in Australia where there is at least one AVA member on staff.</p> <p>Refer to the find a vet tool on the AVA website at: <a href="http://www.ava.com.au/findavet">http://www.ava.com.au/findavet</a>, or search for local vet via the <i>Yellow Pages</i> online directory.</p> |

## Legal services

| 43 Victorian Civil and Administrative Tribunal (VCAT) – guardianship and administration orders |  |
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| Service description  | <p>VCAT is established under the <i>Victorian Civil and Administrative Tribunal Act 1998</i> (the VCAT Act) and aims to provide Victorians with a low-cost, accessible, efficient and independent tribunal delivering high quality dispute resolution.</p> <p>Various pieces of legislation allow an application to be made to VCAT or seeking an order from VCAT for a certain purpose; for example, an order appointing someone as guardian or administrator for someone else, under the <i>Guardianship and Administration Act 1986</i> (Victoria).</p> <p>VCAT is made up of three divisions: civil, administrative and human rights.</p> <p>In the Human Rights Division, amongst other functions, VCAT hears applications and makes orders for guardianship and/or administration. They appoint a substitute decision maker when it is in the best interests of an adult with a disability.</p>  |
| Role in relation to hoarding and squalor   | <p>There is sometimes a need to apply for one or both of the following:</p> <ul style="list-style-type: none"> <li>• Guardianship (to make decisions re medical issues, accommodation (for example, where they live) and access to services) and</li> <li>• Administration particularly to address financial and legal issues around property evictions, rental arrears and guardianship</li> </ul> <p>In some cases, family members may already have been appointed as administrator or guardian, so contact needs to be made with them to undertake their responsibilities.</p> <p>VCAT can hear applications and make orders for guardianship and/or administration. These types of orders involve the tribunal appointing a substitute decision maker when it is in the best interests of an adult with disability. Refer to:<br/> <a href="http://www.vcat.vic.gov.au/disputes/guardians-administrators">http://www.vcat.vic.gov.au/disputes/guardians-administrators</a></p> <p>VCAT frequently asked questions re Guardianship list, refer to:<br/> <a href="http://www.vcat.vic.gov.au/sites/default/files/frequently_asked_questions_guardianship_list_2.pdf">http://www.vcat.vic.gov.au/sites/default/files/frequently_asked_questions_guardianship_list_2.pdf</a>.</p> <p>VCAT also hears review applications of an existing appointment.</p>   |
| Triggers for referral  | <p>These orders are only available if the tribunal is satisfied that person has a disability. 'Disability' is defined in the Act as an intellectual impairment, mental disorder, brain injury, physical disability or dementia. This means that before applying for an order you will need evidence that the person who is hoarding or living in a squalid environment has no or limited capacity to make decisions about their health and wellbeing and day-to-day living requirements.</p> <p>Situations in which such orders are sought include the following:</p> <ul style="list-style-type: none"> <li>• when family members are in conflict amongst themselves about how to best care for their family member (mother or father, brother or sister, adult child)</li> <li>• when an objective, skilled and reliable person is needed to make decisions either with the person concerned or at times on their behalf with regard to medical or health, or accessing services, such as secure housing or managing finances</li> <li>• in emergency situations (refer to <a href="#">Table 7 List of questions and answers</a> and <a href="#">Figure 3 Hoarding and squalor service response flowchart (Part A)</a> and <a href="#">Figure 4 Hoarding and squalor service response flowchart (Part B)</a> and <a href="#">Section 3.8 Guardianship and Administration orders</a>).</li> </ul> <p>VCAT can make temporary guardianship orders at very short notice for up to 21 days, which can be extended for a further 21 days if necessary. Temporary orders allow VCAT to act swiftly to protect individuals who are at risk. VCAT can only make a temporary order when the person in question is at immediate risk, and there are no less restrictive options for addressing the situation. Before the end of the temporary order VCAT must hold a hearing to decide if a guardianship order is needed.</p> <p>VCAT also hears residential tenancies Act matters. VCAT can be involved in hoarding cases where tenancies are at risk due to antisocial behaviour (property condition) arrears.</p> |

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| Referral requirements | <p>If there are differences of opinion between family members or other persons about the best interests of the person with disability, there are several organisations that may be able to assist to resolve these differences.</p> <p>Lodging an application to VCAT should be a last resort if families, friends or service providers cannot agree on the best interests of person with disability.</p> <p>The Guardianship List cannot make orders for children under the age of 18.</p>   |
| How to contact        | <p>VCAT has several 'lists' (sections) which specialise in particular types of cases. If you are not sure which VCAT list can help, contact them on any of the phone numbers below and an officer will transfer you to the most appropriate list.</p> <p>55 King Street Melbourne, 3000</p> <p>Office Hours: 9.00 am to 4.30 pm.</p> <p>For Guardianship and Administration orders – phone: 9628 9911 or toll free: 1800 133 055 (country callers only), or email: <a href="mailto:vcat-hrd@justice.vic.gov.au">vcat-hrd@justice.vic.gov.au</a>.</p> <p><a href="http://www.vcat.vic.gov.au/contact-us">http://www.vcat.vic.gov.au/contact-us</a></p> |

#### 44 Office of the Public Advocate (OPA) – guardianship

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| Service description                      | <p>OPA is an independent statutory body established by the Victorian State Government that works to protect and promote the interests, rights and dignity of people with a disability.</p> <p>OPA operates according to the Victorian Guardianship and Administration Act 1986. Under this Act 'disability' means intellectual impairment, mental disorder, brain injury, physical disability or dementia.</p> <p>OPA works closely with VCAT, Victoria Legal Aid (VLA) and other government and community organisations. When requested by VCAT, OPA conducts formal investigations examining the circumstances behind a VCAT application.</p> |
| Role in relation to hoarding and squalor | <p>A person or service may seek advice and information from OPA about powers of attorney, guardianship, VCAT applications (including temporary guardianship orders) and consent to medical/dental treatment.</p> <p>OPA provides statutory guardianship to Victorians who cannot make decisions for themselves, support to private guardians and last resort advocacy for people with a disability.</p> <p>All adults over the age of 18 years, regardless of disability, are entitled to make their own decisions.</p>   |
| Triggers for referral                    | When a person needs assistance with their financial management, day-to-day living decision making (including housing), health management and related decisions.   |
| Referral requirements                    | Any person can contact OPA for support or advice.   |
| How to contact                           | <p>Level 204 Lygon Street, Carlton Victoria 3053</p> <p>Local call: 1300 309 337</p> <p><a href="http://www.publicadvocate.vic.gov.au/">http://www.publicadvocate.vic.gov.au/</a></p>   |



| 45 Environment Protection Authority EPA Victoria – advice about contaminated items |  |
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| Service description  | Environment Protection Authority EPA Victoria identifies the appropriate transport and disposal pathways for clean-up of asbestos and chemicals. |
| Role in relation to hoarding and squalor   | EPA Victoria licenses the individual landfills, but asbestos can only be disposed of at landfill sites that are approved to accept asbestos.     |
| Triggers for referral  | The presence of asbestos-containing building material or stockpiles of chemical containers.  |
| Referral requirements  | EPA Victoria can advise on a case-by-case basis which specific landfills are suitable for transporting asbestos and chemicals to.                |
| How to contact   | EPA Victoria general inquiries number: 1300 372 842  |

| 46 Legal practitioners (private) – estate management, financial management |  |
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| Service description  | <p>The Law Institute of Victoria (LIV) is generally acknowledged by business, government and the general public as the leader of the legal profession in Victoria.</p> <p>LIV membership reflects all sectors of the legal profession. It is important to choose a lawyer with the correct skills for the specific legal issue. For aspects to consider when choosing lawyer go to: <a href="http://www.liv.asn.au/For-the-Community/Choosing-a-Lawyer/Selecting-the-Right-Lawyer">http://www.liv.asn.au/For-the-Community/Choosing-a-Lawyer/Selecting-the-Right-Lawyer</a></p>  |
| Role in relation to hoarding and squalor                                   | <p>LIV also specialise in elder law, which covers:</p> <ul style="list-style-type: none"> <li>• the VCAT Guardianship List and</li> <li>• representing a person in guardianship, administration and enduring power of attorney matters.</li> </ul> <p>Other areas of law relevant to hoarding and squalor might include estate management, financial management, how to appoint an independent administrator, will probate, family law matters.</p>  |
| Triggers for referral  | Where legal services might be required to address a person's life options – particularly if person displays hoarding behaviour or lives in a squalid environment and where specialist and risk assessment indicates heightened concern for the person's health or safety (refer to Section 3.4 Hoarding and squalor service response flowcharts and Section 3.5 Common service coordination tasks).  |
| Referral requirements  | As above, and depending on the type of legal support sought, refer below.  |
| How to contact   | <p>Refer to LIV <a href="http://www.liv.asn.au/For-the-Community/Choosing-a-Lawyer">http://www.liv.asn.au/For-the-Community/Choosing-a-Lawyer</a> for further information about what needs to be considered when seeking legal support.</p> <p>To find a private lawyer in local area refer to the LIV tool: <a href="http://www.liv.asn.au/Referral">http://www.liv.asn.au/Referral</a>.</p> <p>To find a lawyer, legal referral specialist and other associated professionals such as mediators go to <a href="http://www.liv.asn.au/For-the-Community/Find-a-Lawyer-Directories">http://www.liv.asn.au/For-the-Community/Find-a-Lawyer-Directories</a>.</p> <p>For general inquiries – phone: 9607 9311; email: <a href="mailto:lawinst@liv.asn.au">lawinst@liv.asn.au</a>.</p> |

**47 Victoria Legal Aid – community legal aid services**

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| Service description                      | <p>Victoria Legal Aid (VLA) is a statewide organisation that helps people with their legal problems. They focus on helping and protecting the rights of socially and economically disadvantaged Victorians.</p> <p>VLA is funded by the Commonwealth and state governments, but remains independent from government. VLA can assist in areas of criminal law, family law and some civil law matters.</p> <p>VLA have lawyers in offices in most major metropolitan and country regions, and also fund private lawyers to provide legal services to the public. VLA is statutory authority established by legislation called the <i>Legal Aid Act 1978</i> (Victoria).</p> <p>All VLA services would be available, as assessed by VLA, for all members of the community. Free legal services include:</p> <ul style="list-style-type: none"> <li>• information over the phone</li> <li>• public law library</li> <li>• publications and workshops</li> <li>• legal advice</li> <li>• lawyers on duty at many courts and tribunals.</li> </ul> <p>In some cases, VLA can also provide ongoing legal assistance to:</p> <ul style="list-style-type: none"> <li>• pay a lawyer to give advice, help reach an agreement, or speak for a person in court</li> <li>• go to the family dispute resolution service.</li> </ul> |
| Role in relation to hoarding and squalor | All of the above, if assistance is sought in cases that involve hoarding and squalor. VLA assessment would determine whether a service could be provided and what kind.   |
| Triggers for referral                    | Legal concerns or support required for issues affecting person or their dependents living in a squalid or hoarding situation.   |
| Referral requirements                    | As above.   |
| How to contact                           | Victorian Legal Aid (lawyers and legal services) – phone: 9269 0120 or 1800 677 402 (freecall for country areas).   |

**Risk and safety****48 Melbourne Metropolitan Fire and Emergency Services Board (MFB)**

|  |  |
|--|--|
| Service description                      | Melbourne Metropolitan Fire and Emergency Services Board (MFB) responds in a variety of ways to the needs of the community affected by fire risk.  |
| Role in relation to hoarding and squalor | <p>The MFB responds to people affected by hoarding in the Melbourne District. Roles include:</p> <ul style="list-style-type: none"> <li>• emergency response</li> <li>• promotion of risk reduction advice for hoarding</li> <li>• inspection of hoarding properties in some circumstances (contact below for further information – do not contact your local fire station)</li> <li>• a hoarding notification system, which places a discreet electronic alert on a property address to increase fire fighter preparedness and safety in the event of an emergency</li> <li>• referral of affected people identified via emergency response to external agencies for assessment and support.</li> </ul> |
| Triggers for referral                    | <p>Triggers include:</p> <ul style="list-style-type: none"> <li>• fire or other imminent risk (for example, explosion) – phone: 000</li> <li>• request for inspection</li> <li>• risk reduction information</li> <li>• hoarding notification.</li> </ul>   |

|                       |   |
|-----------------------|---|
| Referral requirements | <p>Referral requirements include:</p> <ul style="list-style-type: none"> <li>• a hoarding level that rates 5+ on the clutter image rating scale (refer to Section 8.2 <a href="#">Clutter Image Rating Scale (CIRS)</a>)</li> <li>• smoke alarms installed</li> <li>• inspections can only occur with consent or via requests from VCAT, the Magistrates Court, and so on.</li> </ul> |
| How to contact        | <p>Refer to MFB Community Resilience – phone: 9665 4464</p> <p>Email: <a href="mailto:hoardingnotification@mfb.vic.gov.au">hoardingnotification@mfb.vic.gov.au</a></p>  |

#### 49 Victorian Country Fire Authority (CFA)

|  |   |
|--|---|
| Service description                      | Victorian Country Fire Authority (CFA) responds in a variety of ways to the needs of the community affected by fire risk living in outer metropolitan Melbourne and rural Victoria.   |
| Role in relation to hoarding and squalor | <p>Role includes:</p> <ul style="list-style-type: none"> <li>• emergency response</li> <li>• promotion of risk reduction advice for hoarding</li> <li>• inspection of hoarding properties in some circumstances (contact below for further information – do not contact your CFA local fire station).</li> </ul>  |
| Triggers for referral                    | <p>Triggers for referral include:</p> <ul style="list-style-type: none"> <li>• fire or other imminent risk (for example, explosion) – phone: 000.</li> <li>• request for inspection</li> <li>• risk reduction information.</li> </ul>   |
| Referral requirements                    | <p>Referral requirements include:</p> <ul style="list-style-type: none"> <li>• a hoarding level that rates 5+ on the clutter image rating scale (refer to Section 8.2 <a href="#">Clutter Image Rating Scale (CIRS)</a>).</li> <li>• smoke alarms installed.</li> </ul> <p>Inspections can only occur with consent or via requests from VCAT, the Magistrates Court, and so on.</p> |
| How to contact                           | Residential Fire Safety Coordinator, CFA HQ Burwood – phone: 9262 8444.   |

#### 50 Victoria Police – local police services

|  |  |
|--|--|
| Service description                      | The protection of life and property is a fundamental function of policing to all people.   |
| Role in relation to hoarding and squalor | <p>Police are often called to premises that may fall within the definitions of 'hoarding' and 'squalor' for a range of reasons, including allegations of domestic violence.</p> <p>Where appropriate, police may relay information and work collaboratively with other agencies who may be better equipped to deal with such issues.</p> <p>Where deemed necessary, the police may apprehend a person who appears to be mentally ill if the police have reasonable grounds for believing that the person has either:</p> <ul style="list-style-type: none"> <li>• recently attempted suicide or attempted serious bodily harm to themselves or another</li> <li>• is likely, by neglect or act, to attempt suicide or serious bodily harm to themselves or another (Mental Health Act, 1986, Section 10 and 10.1).</li> </ul> <p>Police may enter premises and use such force as may be reasonably necessary, with such assistance as required, to apprehend under Section 10 or 10.1.</p> |
| Triggers for referral                    | Reasonable grounds for referral are based on a person's behaviour and appearance, and any other relevant information available.  |
| Referral requirements                    | As above   |

|                |  |
|----------------|--|
| How to contact | If the matter is urgent ring 000. If not urgent, contact your local police station in the first instance, at:<br><a href="http://www.police.vic.gov.au/content.asp?Search_Keyword=3122&amp;action=search&amp;Document_ID=7&amp;Region_ID=0&amp;x=24&amp;y=13">http://www.police.vic.gov.au/content.asp?Search_Keyword=3122&amp;action=search&amp;Document_ID=7&amp;Region_ID=0&amp;x=24&amp;y=13</a> |
|----------------|--|

## 51 Ambulance Victoria (AV)

|  |   |
|--|---|
| Service description                      | Ambulance Victoria (AV)   |
| Role in relation to hoarding and squalor | AV responds to people affected by hoarding and squalor identified by AV through emergency response and by external agencies.<br><br>AV may be called to attend premises that may fall within the definitions of 'hoarding' and 'squalor' when responding to a health emergency. |
| Triggers for referral                    | Health emergency  |
| Referral requirements                    | Anyone can make contact   |
| How to contact                           | Phone: 000.   |

## 52 Commercial cleaning and organising businesses

|  |  |
|--|--|
| Service description                      | <p>There are many different types of cleaning and organising businesses many specialise in a mix of commercial, industrial and domestic applications.</p> <p><b>Cleaning:</b> high pressure water and use of steam to clean graffiti; concrete; offices; child care; hospitals, and in the home (one-off or niche client base or specialisation).</p> <p><b>Organising:</b></p> <ul style="list-style-type: none"> <li>• <i>private home moves:</i> when older people are downsizing to a smaller home; preparing for a new baby; file storage; preparing home for sale; hoarding and clutter management; estate sale preparation</li> <li>• <i>businesses:</i> file management electronic and hard copy, office and desk spaces, archiving and storage.</li> </ul>  |
| Role in relation to hoarding and squalor | <p>Choose a cleaning company suitable to meet the needs of the task you have in mind:</p> <ul style="list-style-type: none"> <li>• for assistance (refer to the two flow charts in <a href="#">8.11 Planning for the provision of cleaning (flow charts and cleaning agreement)</a>)</li> <li>• check to see if the business is registered with an appropriate peak body, has industry accreditation or whether they have particular principled use of only green products.</li> </ul> <p>Consider how the business works in sensitive environments, for example, with people who have a mental health conditions, with frail elderly people or people with disability.</p> <p>Some cleaning and organising businesses assist with decluttering hoarding situations and can provide trained staff to work with the person to do this over a period of time.</p> <p>Other cleaning businesses may assist with squalid environments, often one-off cleans, so care needs to be taken not to perpetuate the practice of one-off cleans if it is not appropriate to the needs of the person concerned (refer to <a href="#">Section 1 Introduction</a>).</p> <p>Smaller cleans are preferred, and should be planned for (refer to <a href="#">Section 3 Building service system response capacity</a> and <a href="#">Section 8.11 Planning for the provision of cleaning (flow charts and cleaning agreement)</a>).</p> <p>It is unlikely that a cleaning or organising business would present a business model that could meet the needs of both hoarding and squalor circumstances.</p> <p>Check how the business charges for their time ahead of contracting the service – make sure the cost for the job is clear before commencement; for example, how it is to be paid and by whom.</p> |

|                       |  |
|-----------------------|--|
| Triggers for referral | <p>The person with the hoarding behaviour, or who is living in squalor, has reached a point of agreement with the service provider (public or private) to commence cleaning or organising their property in some way, including the timing and manner. This requirement also covers cleaning or organising with regard to the hoarding of animals.</p> <p>At times there may be a need for a quicker response, should there be immediate safety or risk concerns for the person, their dependents or neighbours.</p> <p>Ensure the type of task needed is clear and planned for, involving other stakeholders as appropriate (refer to Section 3.3 <a href="#">Key coordination stages to consider</a> and Section 3.4 <a href="#">Hoarding and squalor service response flowcharts</a>).</p>  |
| Referral requirements | <p>Due to the fact that the cleaning approach for both hoarding and squalor are generally quite different in terms of the health needs of the person concerned, care needs to be taken as to which company is most suitable (refer to Section 8.11 <a href="#">Planning for the provision of cleaning (flow charts and cleaning agreement)</a>) to assist with accessing cleaning for a person who has engaged or a person who has non-engaging behaviour.</p> <p>Ask about what previous jobs the business has undertaken of a similar nature – seek references from satisfied clients. These things might influence the decision by the person or your service to engage the business for the intended purpose (refer to Section 6 <a href="#">Questions and answers</a>, questions 8 and 9).</p>  |
| How to contact        | <p>Local municipal council environmental health or aged and disability services might be able to assist with referrals as they might have existing internal arrangements or know of appropriate local businesses.</p> <p>Refer to Section 9 <a href="#">Resources and contacts</a>, no. 1, for a sample of cleaning and professional organising businesses that service providers have found useful for hoarding and squalor cases.</p> <p>Refer to the <i>Yellow Pages</i>: <a href="http://www.yellowpages.com.au/vic/cleaning-contractors-commercial-industrial-19062-category.html">http://www.yellowpages.com.au/vic/cleaning-contractors-commercial-industrial-19062-category.html</a> or <a href="http://www.yellowpages.com.au/find/cleaning-home/epping-vic?CSRT=3178950264222325639">http://www.yellowpages.com.au/find/cleaning-home/epping-vic?CSRT=3178950264222325639</a> and filter by suburb.</p> <p>Refer to a peak body such as: <a href="http://www.aapo.org.au/findanorganiser.php">http://www.aapo.org.au/findanorganiser.php</a>, which provides a search tool that includes hoarding specialisation, which may assist with identifying a private organising business.</p> |

### 53 Energy Safe Victoria (ESV)

|  |   |
|--|---|
| Service description                      | <p>ESV is the independent technical regulator responsible for electricity, gas and pipeline safety in Victoria. ESV supports and guides safe practice and direction regarding gas and electricity service response, legislation and emergencies for:</p> <ul style="list-style-type: none"> <li>• consumers of gas and electricity</li> <li>• electricity and gas professionals.</li> </ul> |
| Role in relation to hoarding and squalor | ESV has a team of investigators who respond to gas and electrical safety issues in homes and businesses across the state.   |
| Triggers for referral                    | ESV can be consulted in relation to homes where electrical or gas infrastructure is significantly compromised.  |
| Referral requirements                    | Anyone can make contact.  |
| How to contact                           | <p>General and technical enquiries – phone: 1800 652 563.</p> <p>Licensing and registration – phone: 1800 815 721.</p> <p>Gas emergencies and leaks – phone: 13 2771.</p> <p>Refer to <a href="http://www.esv.vic.gov.au/">http://www.esv.vic.gov.au/</a></p>   |

| 54 Public and private utility services – electricity, gas, oil, water and sewerage |  |
|--|--|
| Service description  | Public and private utility services support the provision of electricity, gas, oil, water and sewerage services to a person's home, business or company.   |
| Role in relation to hoarding and squalor   | <p>Confirm who the service supplier is, particularly if the service is disconnected. Confirm billing arrangements, payment history and who is responsible for making the payments.</p> <p>Some utility companies might assist in extreme cases of financial or social disadvantage.</p> <p><b>The Essential Services Commission</b> provides useful information including a contact list of all the energy providers in Victoria.</p> <p><b>Free home safety inspection: Archicentre Pty Ltd</b> are funded by the Department of Human Services (Housing) to provide a free building inspection by a licensed building inspector for person who:</p> <ul style="list-style-type: none"> <li>owns their own home</li> <li>is renting privately</li> <li>is the holder of current Commonwealth Health Care Card or Pensioner Concession Card</li> <li>is over sixty</li> <li>has a disability</li> <li>is a carer for someone with disability.</li> </ul> <p>Archicentre also provides financial assistance to carry out any health and safety-related building work. Packages can be arranged to suit most financial situations.</p> <p><b>State Concessions:</b> Concessions are available to Victorians with low-incomes who experience difficulty in paying their local municipal council rates, water, gas and electricity bills.</p> <p>For each concession or benefit there is an eligibility criterion. Concessions programs are designed to ensure eligible cardholders have access to essential services.</p> <p>If the person is a health care card holder and is experiencing difficulty paying a utility bill or needs an essential appliance (for example, fridge or washing machine) they may be eligible for a utility relief grant or appliance and infrastructure grant.</p> |
| Triggers for referral  | <p>If you have a concern or a problem with a utility service, contact the service provider.</p> <p>The Energy and Water Ombudsman Victoria (EWOV) may also be of assistance in some cases; however, you must first try to resolve the issue with the electricity, gas (including LPG) or water company.</p>  |
| Referral requirements  | Anyone can make contact.   |
| How to contact   | <ul style="list-style-type: none"> <li>Essential Services Commission: phone 9032 1300 or 1300 664 969 or go to: <a href="http://www.esc.vic.gov.au/Energy/Consumer-Information/Having-Trouble-Paying-Your-Bill">http://www.esc.vic.gov.au/Energy/Consumer-Information/Having-Trouble-Paying-Your-Bill</a></li> <li>The current State concession list has a link to Telstra concession for older people and others, refer State concessions: <a href="http://www.dhs.vic.gov.au/concessions">http://www.dhs.vic.gov.au/concessions</a></li> <li>Archicentre for: free home safety inspection phone: 9815 1900 or 1300 136 513, or request for financial assistance: 1800 133 324. <a href="http://www.archicentre.com.au/about-archicentre/community-involvement">http://www.archicentre.com.au/about-archicentre/community-involvement</a></li> <li>Department of Human Services Concessions Unit phone: 1800 658 521.</li> <li>Energy and Water Ombudsman Victoria (EWOV) phone: 1800 500 509; or email: <a href="mailto:ewovinfo@ewov.com.au">ewovinfo@ewov.com.au</a></li> </ul>  |



**Figure 6 An example of hoarding in a bathroom**





## 6 Questions and answers

This section presents several key questions and answers to guide practice considerations and:

- assists providers, no matter what their role when planning and responding to hoarding and squalor situations
- enables the development of greater understanding of the complexities and sensitivities of these situations
- shows the strengths and advantages of providers working collaboratively.

The questions and answers run consecutively through three broad stages of service response previously mentioned in [Section 3 Building service system response capacity](#) and represented in [Section 3.4 Hoarding and squalor service response flowcharts](#):

- initial contact and identification of needs
- assessment
- action planning.

Not all sectors use these stages when responding to a situation in the course of their work, particularly those with regulatory responsibilities that are not people-specific in the sense that human service providers are.

Agencies that provide people services, may well use these types of building blocks, but may not be working collaboratively with some of the other sectors mentioned in this resource, when responding to hoarding and squalor cases.

For ease of access the questions are listed in the following table.

**Table 7 List of questions and answers**

|  |   |     |
|--|---|-----|
| <b>Initial contact and identification of needs</b> |   |     |
| Question 1   | How should I approach the person living on the property?  | 95  |
| Question 2   | Should children be involved in a hoarding or squalid situation, what do I do?   | 97  |
| Question 3   | What do I do if companion animals or horses are involved?   | 98  |
| Question 4   | What do I do if livestock are involved?   | 99  |
| Question 5   | What do I do if native wildlife or exotic animals are involved?   | 99  |
| Question 6   | What do I do if there are reports or concerns about pest animals, rodents, snakes or feral animals not kept as companions?                | 100 |
| Question 7   | What do I do if there is evidence of hoarding either in the house or in the yard as well as a squalid environment?                        | 101 |
| Question 8   | What other services do I connect with and why?  | 102 |
| Question 9   | How do I find out who lives in this house and whether they currently receive any services?  | 104 |
| Question 10  | What behaviour can I expect?  | 106 |
| Question 11  | How do I and members of my team respond effectively?  | 107 |
| Question 12  | What services can respond, and how, to a person who hoards or lives in squalor and owns their own home?                                   | 111 |
| Question 13  | What do I do if I can't engage with the person living in the house and my service has received a complaint about the clutter in the yard? | 115 |
| Question 14  | How do I know if a person is competent and has the capacity to make decisions?  | 115 |
| Question 15  | What are some practice considerations I would benefit from knowing?   | 116 |
| <b>Assessment</b>                                  |   |     |
| Question 16  | My service only assesses for what we are funded to do – how and where do I refer for more specialist assessment?                          | 118 |
| Question 17  | How does my service assess for urgency, the person's safety and the level of risk?  | 119 |
| Question 18  | Are there costs involved and how do we plan to meet them?   | 121 |
| Question 19  | Does the person want an assessment or referral, or will they self-refer for therapeutic treatment?  | 122 |
| Question 20  | What reliable tools are available to assist with assessing hoarding and squalor situations?   | 122 |
| Question 21  | How do I select and support staff to be able to build relationships of trust with a person with hoarding behaviour?                       | 123 |
| Question 22  | Where do I refer for assessments of competence or capacity for adults?  | 123 |
| <b>Action planning</b>                             |   |     |
| Question 23  | Has an action plan been developed and discussed with the consent of the person concerned?   | 124 |
| Question 24  | Does the person consent to the sharing of their personal information for action planning?   | 124 |
| Question 25  | Does the person require multiple services?  | 125 |
| Question 26  | Would the person benefit from an intra- or interagency action plan?   | 125 |
| Question 27  | How is the action plan to be monitored and reviewed (by which service)?   | 126 |
| Question 28  | Which service will be responsible for service coordination and decision making overall?   | 126 |

## 6.1 Initial contact and identification of needs

### Question 1

#### How should I approach the person living on the property?

#### Aspects to consider

- Establishing and maintaining engagement with the person from the beginning is the key – to do this, allow plenty of time to spend with them. It can be useful to declare the fact of a referral with the person to start with, saying who made the referral (unless the referrer requested that their identity not be disclosed) and conveying the referrer's concerns honestly (for example, 'We thought we might be able to help you with...').
- Work with the person when they are ready, respect and support them, maintain the same professional and respectful approach as you would with any other person. There should be no differentiation and no evidence of censure. Treat the person with dignity, be friendly and engaging with a long-term mindset.
- Focus on the other needs of the person to begin with, rather than the state of the property (for example, assistance with paying for utility accounts, assistance with linking into medical appointments) – basically whatever it is the person is stating they need help with or are unhappy with at the time. This demonstrates that you are there for them, and not coming in and telling them 'how to live'. This approach may assist with the building of trust and rapport and will make the transition to discussions with regard to the state of the property smoother.
- Introduce the fact that you plan to visit. Maybe leave a business card with an introductory letter first, either with the person or in a letterbox or somewhere you think they might find it. Provide reassurance that the visit is supportive and could initially be at a mutually agreed place other than the home environment.
- Consider how you as a worker present yourself. While it may not be how you choose to live, be considerate and non-judgmental when engaging with the person, the initial purpose is to gain rapport and cultivate trust.
- The ideal option is to visit the home with a colleague from the same or a different service. This may not be a colleague from your own team or service, but you could arrange to meet and discuss prior to visiting the property, to plan a mutual approach and outcome of the visit that you both aim to achieve, so you can visit and assess together.
- If you know ahead of time that the environment is squalid and potentially could pose risks, go prepared, dress appropriately and wear the right footwear. Have correct personal protective equipment (PPE) with you, including: phone, disposable gloves, hand wash, garbage bags, vomit bag, a change of clothes and clean newspaper to sit on, stand on or wrap something in.
- Be aware that some properties are set up to deter visitors or have their access restricted due to the impact of clutter or squalor. You may need to leave a note for the person that includes your organisational identification, your name, phone number and date, if they are not home or do not initially answer the door. This way they know you have visited, as they could be inside the property, but not want to or are able to open the door.
- If meeting the person at their property for the first time, approach them carefully and slowly and use patience. You may not be able to enter the property, or only engage with the person on the footpath, the street or in the local coffee shop, but not inside the home. (For example, workers from one service continued to visit a person speaking only through a flyscreen door, until the person let them in after weeks of visiting. Workers took food and take-away coffee to the person as they got to know them

and developed a rapport. These reactions may not be unusual. You may need to revisit the property several times before you actually meet the person and engage them in conversation.

- Expect the person to be suspicious of you visiting. It is very important to be friendly and supportive and not to show any alarm or concern at the state of the property. Focus on the person and not the property when you are initially trying to build rapport and engage them in conversation. If the property is squalid and malodorous, it may be an idea to chat to the person outside in the garden, on the veranda or in the hallway if possible.
- It may take some time before you feel comfortable enough to ask the person if they mind showing you around their home. While speaking with the person, try to make as many observations as you can about their state of wellbeing, and look around the environment without being too obvious or intrusive, as this might impact on whether the person would be willing for you to return.
- Consider all aspects of diversity, including cultural background (for example, Aboriginal person or Torres Strait Islander heritage, or someone from a culturally and linguistically diverse (CALD) background (refer to [Section 2.1 Principles to guide all service response](#)).

### Gather information

- If it is hard to make contact with the person, then you may choose to speak with a neighbour to gather additional information about the person where you assess this is appropriate. Often neighbours know of the person living in the property, but some neighbours may also have an excellent long-term relationship with the person, often developed on the street or in the hallway (that is in flats or apartments), rather than inside the home. Neighbours may know when the best time to speak with the person is, and what their movements are. Neighbours may also know if the property has utilities connected, for example, have they seen lights on?
- When the timing is right (for example, when the person is starting to engage in the discussion, is not as fearful, maybe showing signs of being prepared to talk) commence a more detailed line of enquiry such as attempting to gain information (for example, whether the person has any relatives able to assist, and whether the person has any known medical history, and do they have a GP, and if so, when did they last visit).
- Try to find out if there are any dependent people (including children) or animals living on the property, including how many and who they are. Consider whether there are any neglect or welfare concerns.
- While engaging with the person, your first and ongoing priority is to continue to scan the environment for risks to your own occupational health and safety and other possible risks associated with a hoarding or squalid environment (refer to [Section 4.5 Occupational health and safety considerations](#)).
- If you have reason to suspect the person is living with self-neglect issues and is at imminent risk of physical harm or mental deterioration, then an initial joint home visit with a service provider who can assess capacity and competency should be organised (refer to [Question 14 How do I know if a person is competent and has the capacity to make decisions?](#), [Section 3.7 Mental capacity and competence](#) and [Section 5.2.1 Core services, Clinical Services](#)). You could also ask the person's GP to do a joint home visit, although in such cases, often the person is not engaged with a health service provider.
- It could be that when you meet the person, and see how they are living, there are sufficient levels of concern to take immediate action and remove the person from the property. This is a complicated process, especially if the person refuses to leave their home, and should not be done without consulting relevant authorities or services such as aged care, mental health, a medical practitioner, geriatrician, OPA or emergency services (refer to [Section 3.4 Hoarding and squalor service response flowcharts](#) and [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#)).

- Try to establish if the person is the owner of the property, because different assistance is available for people who are in the public rental market as apart from private owners. If you are working with or for the local municipal council, the rate register will establish property ownership.
- Many visits may be required, so it is important to maintain contact as well as have a capacity to introduce other staff from other services as needed.

## Question 2

### Should children be involved in a hoarding or squalid situation, what do I do?

#### Aspects to consider

- Follow the established procedures of your agency or service that relate to child welfare issues. If there are none, discuss the appropriate next steps and direction with your manager.
- Notify Child Protection service or Child FIRST with documented concerns and evidence (for example, photos of the environment). Those agencies will be able to assist with thinking through the situation. Child FIRST agencies will also refer to Child Protection if they assess there is need (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), nos 33 and 34).
- The Department of Human Services Child Protection program receives reports of children at risk as a result of child abuse or neglect. Sometimes a report may be about the impact on a child of a parent's hoarding behaviour or squalid living conditions, or these issues may be identified during the course of Child Protection involvement.
- Where living conditions pose a significant risk of harm to children, the Department of Human Services will make substantial efforts to assist the family to address the situation.

#### Gather information

The type of evidence that should be collected when first observing the situation at the property that might raise concern about the welfare of the children includes:

- Is there a clean and accessible place to eat?
- Are there safe play areas inside and outside the house?
- Are there clean and accessible bedrooms, and access to healthy and fresh food and clean running water?
- Is there a clean and accessible toileting and personal washing room?
- Are there secure and safe living environments (for example, protection from the weather and strangers, smoke detectors installed, warmth)?
- Are children able to bring friends home to visit or stay, watch TV or play comfortably?
- Have you seen or spoken to the children? What relationship do they have with the adults in the house (for example, parents, grandparents, aunt or uncle, friends, neighbours)? Are you able to engage with them?
- Are children appropriately clothed (including adequate footwear)?
- Take photographs (with permission), make detailed and dated file notes.
- Discuss and present information with your manager as you gather information on the situation.
- Are the children attending school? Does the school have any concerns?

### Question 3

#### What do I do if companion animals or horses are involved?

##### Aspects to consider

- Check for the safety and wellbeing of all animals. If they appear neglected, malnourished, weak or diseased, abused or if overcrowding is evident, or they are living in squalor, refer to RSPCA Victoria (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 20), which has experience and authority in relation to animal welfare issues.
- If you visit a property and you are concerned about an animal, always seek advice from a relevant professional, including the RSPCA and the local municipal council animal investigation officer. Be cautious, because you may not know if the animal presents any risk to you. It is reasonable to request of the person that their animal/ be restrained or contained in the backyard, veranda or bedroom if that is necessary to allow you or other staff to visit the property safely.
- Assess the number of animals, their condition and the housing conditions in which they are kept. Consider requirements such as food, water, shelter, hygiene, grooming, body condition and treatment for medical ailments (refer to [Section 8.6 Contact other local services after receiving an initial referral](#) and [Section 2.2.1 Hoarding](#)).
- Assess the capacity of the person to care for these animals and whether they are accepting of any help. For example, is the person open to assistance from an animal shelter or rescue group?
- Be careful and cautious when discussing or approaching the person to discuss their preparedness to surrender the animals to a shelter if animal hoarding is an issue. While you consider the safety and wellbeing of the animals, be mindful that the person may have a mental health condition that includes hoarding. Plan an approach with other service providers that provide a balance to the expertise of your service.
- When dealing with large numbers of animals contact the local municipal council for advice/assistance. Some local municipal councils have local laws relating to the number of animals a resident can keep on their property.
- Keep in mind that animals can be an excellent way of engaging the person in the process, because more often than not, the animal is of extreme importance to the person living in the property.

##### Gather information

- If in doubt, seek initial advice from animal welfare experts; for example, RSPCA Victoria.
- If you intend to request that RSPCA Victoria conduct an inspection, you must inform the person concerned. The manner in which this information or statement is framed makes a lot of difference. It can build or deplete any trust that is present in the relationship between the worker and the person. It is better not to frame the information as punishment or a consequence of something they have/have not done. Instead have a conversation based on something like the following:
  - ‘I am concerned about your cat or dog or animals and I’d like to get someone to check on your pets.’
  - ‘Your pet might be really unwell and making your other animals very sick.’
  - ‘The animals need treatment and we can try to help you make sure they get a good health check.’
  - ‘I can see how much you love your cat or dog. When was the last time they were checked out by a vet?’
  - ‘I can bring someone here to have a look at the animals to make sure they are well.’
  - ‘I’d like to bring someone to have a look at the animals.’
  - ‘I need to bring someone here to look at the animals just to make sure that they are healthy.’

- Always accurately and factually document on file: the number and type of animals present and their condition, your objective concerns and any evidence you collect (for example, photos [if the person concerned is willing for you to take them] of the hoarding or squalid situation and how it affects the animals and where the animals are living or stabled, any wounds or infections, evidence of malnourishment; written details of any phone discussions with the person or concerned others and so on).
- Attempt to engage services that can be of assistance to the person and begin attempting to build a working relationships between the person and those services in this case RSPCA Victoria and other people or clinical services.

#### **Question 4**

##### **What do I do if livestock are involved?**

#### **Aspects to consider**

If you are concerned about the health, body condition, stocking density or treatment of livestock animals, or the owner indicates there are problems, contact the Department of Environment and Primary Industries (DEPI) (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 22) and ask to speak to the district veterinary officer or animal health officer nearest to the property concerned. These officers are authorised under the Prevention of Cruelty to Animals Act 1986 to act in such matters.

- DEPI's veterinary officers and animal health officers are authorised to euthanase any stock that are suffering. Often the owner will not be in a fit mental state to conduct the euthanasia themselves and may appreciate the assistance of an experienced person.
- DEPI officers can also work with owners to develop plans for feeding, selling and so on, to ensure the welfare of both animals and owners is maintained.
- Local municipal council's animal management officer and local laws officer or the Victoria Police may also be of assistance, but you should call DEPI first.

#### **Gather information**

If possible, in your conversation with the owner of the stock take note of:

- the number and type of animals on the property
- whether the animals are being fed and watered
- whether there are workers/neighbours/family helping to look after the animals
- whether necessary husbandry procedures (for example, shearing, drenching, and so on) are being undertaken.

Any information of this type will be useful to the DEPI officers. Taking notes and photos (if the owner agrees), is a good idea.

#### **Question 5**

##### **What do I do if native wildlife or exotic animals are involved?**

#### **Aspects to consider**

- Contact RSPCA Victoria (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 20) if there are any animal welfare issues with wildlife (native animals) or exotic species being kept by the person.



- Contact the Department of Environment and Primary Industries (DEPI) (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 21) for advice/assistance on whether the person is illegally keeping native wildlife or exotic species in terms of either the type of species or the numbers kept.

### Gather information

- Take photographic evidence of what animals are seen, their living conditions, what they are fed, whether there is drinking water easily accessible.
- Make notes describing what you saw during your initial visit and any consequent visits regarding the treatment and care of the animals on the property.
- Detail the number and type of animals on the property.
- Detail who is looking after them, how and how often.
- Make notes regarding any information told to you by neighbours or other members of the public about the treatment or acquisition of native wildlife or exotic animals.
- Many native wildlife species can only be kept if the person has the appropriate permit or authority under the Wildlife Act 1975. Most exotic species can only be imported and kept with the appropriate authorisation.

### Question 6

**What do I do if there are reports or concerns about pest animals, rodents, snakes or feral animals not kept as companions?**

### Aspects to consider

- When visiting a property ensure your own safety first, to be able to assist the person living on the property. If you do not feel safe or equipped to deal with the presenting situation, it is important to remove yourself from any dangers. Try to engage with the person outside the property.
- Be aware of spider infestations for example under cushions in a lounge room.
- In dark houses or outbuildings be on the look out for snakes, which can easily be hiding in the home if there is the smallest hole for them to access or in the yard or on larger properties in buildings that house equipment and sheds.
- Consider taking with you and having handy to use, clean sheets of newspaper to sit on, to use as a tablecloth or as flooring or for any other purpose.
- Tread warily, in case there are pest animals running loose or excrement on the floor. Small animals can move very quickly.
- Ascertain the facts of the situation where possible – consider and document later.
- Be aware of any possible OHS issues. Discuss concerns with the owner of the animals if possible, liaise with relevant authorities (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 25) and your own supervisor to plan an appropriate OHS response.
- Before you visit the property or access the part of the property that may contain pest animals, make enquires about any information that might indicate what personal protective clothing could be needed.
- Be aware that large colonies of rats can hide in the house very easily. Be aware of the risk of rat disease leptospirosis, which arises from animal urine (including rats).<sup>44</sup> Contamination can occur on utensils or food products. Consider meeting the person outside or in a coffee shop if rat odour is obvious.

44 Refer <http://www.health.gov.au/internet/main/publishing.nsf/content/cda-phlncd-leptospirosis.htm>

- Seek advice if necessary with planning to remove rats or other pests. Some local municipal councils will assist with this process. If this is not possible, contact a private pest exterminator with a licence to deal with the safe removal of rat and mouse excreta. Note that not all pest exterminators have the licence or equipment to deal with this safely.
- After an initial visit, contact other appropriate services such as a local municipal council, to organise a property inspection if this is not your area of expertise. Arrange a joint visit.
- Notify the appropriate landlord if dealing with a public or private rental property.

### Gather information

- If possible, obtain consent from the person living on the property for you to contact and involve the local municipal council environmental health department or private pest control company, who will undertake a property inspection and, where appropriate, notify the landlord or the property manager.
- Attempt to build a working relationship between the property manager (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1, 2 or 3, or [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 29 or 30) and local municipal council environmental health officers (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 25) and the person concerned.
- How to progress will also depend on whether the property is a public or private rental or the person's own home. The first step is to identify the property manager, because aspects such as who is responsible for property maintenance, contractual arrangements, service support will vary, depending on the ownership status of the property.
- Health, housing and community service agencies should document known risks that assessment staff will need to manage, to determine if it is safe to conduct an assessment in the home. If it is not safe, arrange to meet the person at an alternative site or plan a combined approach involving local municipal council environmental health or local laws staff.

### Question 7

**What do I do if there is evidence of hoarding either in the house or in the yard as well as a squalid environment?**

### Aspects to consider

- Attempt to build rapport and a trusting relationship with the person.
- Attempt to build relationships between the person and other services involved; (for example, notify the appropriate the property manager or landlord refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1, 2 or 3, or [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 29 or 30).
- All situations are unique. Gather information, engage with the people involved, and consider an appropriate action plan. Discuss the issues and approach with your supervisor.
- Consider the implications of hoarding and contact local municipal environment health officers for support and guidance.
- Notify and engage the appropriate landlord if dealing with a public or private rental property.
- If the environment is squalid, the competency of the person needs to be assessed (refer to [Section 3.4 Hoarding and squalor service response flowcharts](#), [Section 3.7 Mental capacity and competence](#) and [Table 1 Principles underpinning service response to hoarding and squalor situations](#)). Immediate assistance needs to be put in place, such as: addressing medical issues, considering respite options, obtaining available family assistance.

- Work to a harm minimisation approach (refer to Section [8.6 Contact other local services after receiving an initial referral](#)):
  - ensure working smoke alarms
  - clear entrances/exits
  - clear walkways
  - check that utilities are working
  - reduce fire load around high risk areas (for example, around heater, oven, and stove top).
- Engagement is imperative. You need to decide if there are obvious risks that could affect the safety of the person living in the home or the worker or clinician (for example, home-made electrical lighting, lamps balanced precariously on ledges, risk of the roof falling in, absence of any space to sleep, mould covering the ceilings).

### Gather information

- Utilise a checklist to create a profile (refer to Section [8.4 Squalor and hoarding profile: creating a pathway](#)).
- If information obtained by the worker indicates the person concerned has or may have mental health concerns, the worker should contact a mental health service if the person is unwilling to engage so that risk assessment can take place (refer to Section [3.4 Hoarding and squalor service response flowcharts](#), [3.5 Common service coordination tasks](#) and Section 5.2.1 Core services, [Clinical Services](#)).
- Gather information relating to any animals kept in the squalid environment, because RSPCA Victoria must be contacted to assess animal welfare (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 20).
- Having developed a situational profile of information, involve local municipal council environmental health and local laws departments if, for example, there is concern about public health either on or off the property, or about the safety or amenity of the area, including street frontage of the property or fire risk (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 23 and 25).

## Question 8

### What other services do I connect with and why?

#### Aspects to consider

- For most immediate information refer to Section [3.3 Key coordination stages to consider](#) and Section [3.4 Hoarding and squalor service response flowcharts](#) and the supporting explanations of what each service provides refer to [Table 5 Core services that respond to hoarding and squalor situations](#). For additional assistance with regard to location information refer to the Human Services Directory (HSD): <http://humanservicesdirectory.vic.gov.au/Home.aspx>.
- For assistance to identify other services at the first point of contact or initial referral refer to the checklist in Section [8.6 Contact other local services after receiving an initial referral](#), Section [3.3.1 Initial contact and needs identification](#), Section [3.3.2 Assessment](#) and Section [3.4 Hoarding and squalor service response flowcharts](#).
- Referral to other services depends on what the person requires or consents to. Competency should be established and tested. If there is any doubt refer to Section [3.7 Mental capacity and competence](#) and [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#).
- Contact the person's family, with the person's permission.

- It is critical to determine, at the outset, whether the person is living in a property that they own or rent. If the latter, there will be a landlord or property manager to contact (refer to Section 5.1 A list of service types, no. 1, 2 or 3, or Table 6 Other services that become involved in response to hoarding and squalor situations (specialist), no. 29 or 30). The nature of property ownership and management can greatly determine the path to proceed down to engage the person, but can also provide a range of opportunities and obstacles (for example, it is often more difficult to connect with people who live in their own home. HACC, PHaM's, CHS, housing or mental health outreach services may be able to assist, depending on a person's eligibility for those services). Refer to Table 5 Core services that respond to hoarding and squalor situations and Table 6 Other services that become involved in response to hoarding and squalor situations (specialist).
- Property manager – build this relationship (if public or private rental) and encourage the property manager to have regular contact with the person to ensure monitoring and that the property does not get out of hand again. Encourage the property manager and the person to have an agreement (for example, the property manager will come for an inspection every few weeks and will look at clear exits, active smoke alarms, accessible passageways and a clear perimeter (1 metre) around the heater/stove/oven). Work within a harm minimisation model.
- It may help if the workers from other service to which you have made a referral, have a particular expertise or interest in working with complex cases, in particular, working with people living in squalor or with hoarding behaviour. It may be useful to approach a manager in an organisation, particularly if collaborative relationship building is the goal. Discuss service response approaches and requirements for hoarding and squalor situation such as the need for flexible and sometimes unorthodox courses of action, and that you would like to work collegiately with staff in that organisation who have a capacity to work in this way to address such cases as they arise.
- Psychiatry services and assessment should be arranged if, in your view, there is any possibility that the person is experiencing mental health issues (refer to Section Table 5 Core services that respond to hoarding and squalor situations, nos 11, 12, 13 & 16). This will ensure that appropriate medical advice is available to assist all services to determine a course of action that promotes the person's health and wellbeing and complies with relevant clinical and legal requirements. If the person concerned is over 65, referral should be made simultaneously to ACAS (refer to Table 5 Core services that respond to hoarding and squalor situations, no. 10) so that ACAS can conduct an assessment jointly with the psychiatric service.
- Victorian Fire Services may inspect a hoarding household in a limited number of circumstances (refer to Table 6 Other services that become involved in response to hoarding and squalor situations (specialist), nos 48 and 49). Agencies can develop their own internal inspection process using the clutter image rating scale (refer to Section 8.2 Clutter Image Rating Scale (CIRS)) and apply the risk reduction advice strongly recommended by Victorian Fire Services in relation to the supply and use of utilities and fixed and portable appliances.<sup>45</sup>
- Utilities (such as electricity, gas or water) and related fixed appliances such as ovens, heating, lighting and hot water systems are a significant safety issue in households where hoarding is occurring. Safe supply and usage of utilities is compromised by the large accumulation of items, which may result in poor access to and maintenance of the appliances, which in turn leads to faulty or non-functioning utilities. If a fire has occurred, the responding fire service is required to disconnect these utilities and appliances if they have been damaged. Affected people are unlikely to contact a qualified tradesperson or be able to provide the access required to conduct inspections or repairs. These factors increase unsafe practices related to cooking food, heating and lighting which are the cause of over 70 per cent of fires in homes where people with hoarding behaviour live.

<sup>45</sup> <http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Hoarding-a-lethal-fire-risk.html>

- A referral can be made to a GP (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 9) for:
  - related health issues such as anxiety and/or depression
  - monitoring the person's health, particularly if there are squalor, health and hygiene issues
  - any clinical referrals if needed, such as a mental health plan – a psychologist can assist the person concerned as well as facilitate response with services providers
  - if the person opposes actions that are proposed by a service, and the person's capacity to make their own decisions is questionable, consideration may need to be given for psychiatrist, geriatrician or neuropsychology assessment
  - monitoring the person's mental health and referral through the Better Mental Health Outcomes for therapeutic interventions.
- A referral can be made to a community health centre (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 37) for ongoing case management to address housing and environmental issues, general support and family support services (for example, if children or a spouse is involved).
- A referral can be made to ACAS (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 10) for a clinical holistic assessment, eligibility for an aged home care package or residential aged care service, or general assessment if the older person needs a more supported environment.
- A referral should be made to the appropriate local municipal council services, depending on the expertise required (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 23–28).
- A referral can be made to a regular ongoing corporate cleaning business, one that understands the difficulties and complexities involved in working with people living in these circumstances (refer to [Section 8.11 Planning for the provision of cleaning \(flow charts and cleaning agreement\)](#) and [Section 9 Resources and contacts](#)). Build trust and rapport between the cleaning personnel and the person. Ongoing, regular, short cleaning and sorting sessions will allow the person to better manage their cluttered or squalid environment and will assist with maintenance. Cleaning activities should focus on the main living and high-risk areas, working within a harm minimisation approach (refer to [Section 8.4 Squalor and hoarding profile: creating a pathway](#)).
- Referral should be made to RSPCA Victoria and local municipal council animal management services if there are animal hoarding or squalor issues. These relationships will assist with maintenance (as per the property manager point above).
- Referral can be made to independent living skills workers or professional organisers (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 52) to assist the person to learn cleaning, organising and sorting skills, which might assist with behaviour change and consequently sustain future changes in their every day life.

## Question 9

**How do I find out who lives in this house and whether they currently receive any services?**

## Aspects to consider

There are various situations and process considerations required, as suggested in the table below, to manage a person's personal information. For further information refer to [Section 3.6 Protection of the person's information](#).

**Table 8 Access to a person's personal information**

| Type of situation   | Process   |
|---|---|
| The person is known to the referral source (for example, friend, family, neighbour) who can give the required information   | <p>Ensure the referrer has obtained consent from the person for the referrer to provide information to you.</p> <p>Ensure that the consent applies to the information you are receiving and that the consent allows disclosure of the information for your particular purposes.</p> <p>Exercise particular caution if the referrer has not received a copy of the collection statement of the organisation receiving the information (refer to Section <a href="#">3.6.5 Obtaining consent</a>).</p>  |
| The person is willing to engage, is competent and is willing to provide such information or give permission for your organisation to obtain information from third parties    | <p>Present a copy of the organisation's information collection statement, if applicable (refer to Section <a href="#">3.6.5 Obtaining consent</a>).</p> <p>Consent is not necessary if the person has provided information based on the collection statement; however, if unsure about the collection statement, ask the person to complete and sign a consent form (refer to Section <a href="#">Figure 18 Consent to share information</a>).</p> <p>Make appropriate contact with others living in the house.</p>   |
| The person cannot be contacted  | <p>Ensure actions and decisions are documented on the person's file. Identify and document any risk and safety concerns (refer <a href="#">Appendix 3 Information Privacy Principles</a>, IPP 2.1(d) and Section <a href="#">3.4 Hoarding and squalor service response flowcharts</a>).</p> <p>If there are suspected health and safety concerns, discuss with your manager about the level of risk and whether the police should be contacted (refer to <a href="#">Question 17 How does my service assess for urgency, the person's safety and the level of risk?</a> and Section <a href="#">3.5.1 Risk management</a>).</p> |
| The person can be contacted, but is unwilling to give information or permission for your organisation to obtain information, but you have concerns regarding risks and safety | <p>Consult with your manager about whether there is a need to invoke IPP 2.1d of the Information Privacy Act 2000 (Victoria) (refer to <a href="#">Appendix 3 Information Privacy Principles</a>, IPP 2.1(d) and Section <a href="#">3.6.6 When disclosure is permitted</a>) – keep in mind high thresholds only determine exercise of this legislation.</p>  |

- Privacy legislation states that it is always better to collect information from the individual first hand – if reasonable and practicable. However, if this is not possible, always confirm the information with the person once it is obtained for accuracy (refer to [Appendix 3 Information Privacy Principles](#), IPP 1.4 and 1.5).
- Information on house occupancy and what services are received by particular individuals is generally collected as part of the initial contact and information gathering stage as part of the OHS screen. Always include information on whoever is present at an assessment (refer to sample planning forms in Section [8.6 Contact other local services after receiving an initial referral](#), Section [8.9 Templates to assist with service coordination tasks](#) and Section [3.3.2 Assessment](#)).
- First of all ask the person, then check with family members if possible, then with neighbours.
- Provided you have appropriate consent from the person, check with other local services. Generally the GP can contact the local municipal council and the community health centre for additional information. At times this may prove difficult administratively due to the person's privacy and consent considerations (refer to Table 8 above).
- Local municipal council databases may be of assistance, utilising reverse directories; that is, information the local municipal council collects with regard to rates, rubbish collections and so on that might provide some helpful information.
- Check to see if the person is known to police. That is, have the police made any past referrals to services for the occupant?



- As part of an initial investigation, you may:
  - contact the local fire service and ask if they know of the property – on the basis that there may have already been fire previously
  - ask the property manager, if it is a rental property (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), nos 29, 30 & 31)
  - if they are a public housing tenant, the local area Housing Office or the Department of Human Services SfhRT may know of them (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1)
  - if there are suspected mental health concerns, you may call the local area mental health service or the aged persons mental health team (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 11, 12 and 13).
  - If gaining access to property is difficult or trying to meet with the person living inside their home is becoming unproductive, as a means of last resort you may consider speaking to neighbours who live close by and who may be able to suggest the person's movements, or provide information about the home and any risks. This should always be done with consideration for the person's right to privacy.
  - Speaking with other providers who have previously tried to visit the property or engage with the person may provide you with invaluable history and information, which needs to be carefully and sensitively managed. The sharing of this information would need to respect the person's privacy and safety (refer to [Section 3.6 Protection of the person's information](#) and [Question 17 How does my service assess for urgency, the person's safety and the level of risk?](#) and [Section 8.6 Contact other local services after receiving an initial referral](#), but you should also ensure duty of care is adhered to should the person be at risk (refer to [Section 3.9 Duty of care](#)).

## Question 10

### What behaviour can I expect?

#### Aspects to consider

- Depending on who you are, the organisation you represent and how the person perceives your presence (interfering and controlling compared to helpful and facilitating), responses may vary from outright hostility through to suspicion, guardedness or indifference. Regardless of the initial response, non-judgmental attempts at engagement should proceed as per [Question 1 How should I approach the person living on the property?](#) and [Question 11 How do I and members of my team respond effectively?](#)
- If the person is suspicious, threatened, wary, embarrassed, resistive, evasive or doesn't acknowledge the problem, then offer an initial visit in a place away from the home or premises where the person may not feel as threatened (for example, a library or coffee shop). If the person is angry, resentful, fearful, or anxious, distrusting, shameful, guilty or displaying avoidance, respond with caution, slowly, tactfully and respectfully.
- Be prepared for the person to demonstrate a lack of insight, resistance to change as well as a high chance of not engaging or disengaging from clinical treatment.
- When animals or dependents are removed or when large clean-ups occur, the person may consider self-harm during or after the removal or clean-up process. RSPCA Victoria and other services find this is a common response from the person to animal removal or clean-ups.
- The necessary people support services must be in place prior to removals or clean-ups in order to support the person through the process. If the person is receptive and ready for change, you must work slowly on agreed and achievable goals, planned with other service providers and the person at their own pace.



## Recognising hoarding behaviour

Not every person who hoards will display all the following symptoms or signs that affect emotions, thoughts or behaviour. However, should several symptoms or signs be evidenced, this is cause for concern:

- excessive attachment to possessions
- extreme clutter throughout the home's living spaces
- inability to discard items
- stacking of magazines, newspapers, miscellaneous items
- moving items or possessions from one pile to another, without ever discarding anything
- acquisition of seemingly useless items, including weekly rubbish collection
- organisational difficulty
- perfectionism
- difficulty permitting others to touch or move accumulated items
- procrastination
- difficulty making decisions
- not able to manage daily tasks
- limited or poor socialisation skills
- the behaviour of the person varies, depending on their mental capacity, level of competency and who else is present.
- Focus on harm minimisation and your concern for the person once you have built some sense of trust.

### Question 11

#### How do I and members of my team respond effectively?

### Aspects to consider

- Meeting someone face to face presents the opportunity to engage, assess willingness to accept help and provide information for the person to digest and understand ways you can support them.
- Be reassuring, non-threatening, and clearly explain the purpose of the visit. Listen and attempt to establish a relationship first.
- Statements used by staff like, 'It's your home, what changes would you like to see?' can be effective. It is important to be aware of the language used when responding to people living in these circumstances.
- If animal hoarding is evident, there is a high risk of decompensation or worsening of the persons mental health status when the animals are removed, even when the removal is planned and agreed to. As part of the interagency action plan involve an appropriate people service such as professional mental health or counselling assistance (refer to [Section 5 Collaborating with other services](#)) to ensure the person is supported before, during and after the planned removal of animals.
- Inform the person that you are not there to tell them what they have to keep or throw away, you just want to make their house as safe as it can be because you have concerns for their wellbeing. For example, if they had a fall what would happen to them? Would an ambulance be able to get to them, and so on. Tell them you won't touch their possessions without permission or make any decisions for them.
- Where people refuse assistance and are competent, you need to refocus and set up a community 'safety net' or monitoring system. In other words, service providers shift their focus from the person to the person's neighbours or acquaintances and people who know of them, supporting their capacity

to keep an eye out for the vulnerable person. As service providers we need to make sure the neighbours know where to ring should the person's health or situation change for the worse.

- The initial needs identification (for example, awareness of the property) often comes through a local municipal council environmental health officer (EHO) or building department, not a community or people support service. These initial contacts made in partnership with the EHOs, have proven to be very helpful for all concerned. The 'enforcement' services are then able to take a more supportive role and can gain from the 'weight' that comes from working with officers from other sectors.
- For those households where service providers have entered the house or commenced engagement with the person, aim to install smoke alarms (for example, if the person is eligible for Home and Community Care (HACC) through local municipal council home maintenance). This helps to build trust and develop a relationship.
- Risk reduction as an initial engagement activity may assist in establishing trust and the return of a functional capacity to key areas of the home where risk is at its highest (for example, kitchen, around heating and lighting), refer to Section [8.5 Fire risk reduction flyer](#).

### Some coaching tips to consider when planning how to approach a case<sup>46</sup>

Your role can be like a coach:

- **Meet as a team with the person with the hoarding behaviour.** Service providers from different sectors working together as a coordinated team, with an agreed action plan is more likely to achieve sustainable results when working with people who live with complex health circumstances (refer to Section [3.3 Key coordination stages to consider](#)).
- **Help the person to remain focused on the task.** People with hoarding behaviour often find themselves easily distracted, especially when they are trying to reduce clutter, make decisions about possessions or resist the urge to acquire things. A coaching approach can be very helpful: politely remind the person what they are supposed to be doing right now.
- **Provide emotional support.** Acting like a taskmaster or drill sergeant just makes people feel nervous or angry and interferes with their ability to learn new approaches. The person may feel even more isolated and misunderstood, and retreat into bad habits. Use a gentle touch. It is often very helpful to express empathy with statements such as, 'I can see how hard this is for you or understand that you have mixed feelings about whether to tackle this clutter'. The person with the hoarding behaviour is going through major stress, and often needs a sympathetic ear or even a shoulder to cry on.
- **Help the person make decisions:** However, DO NOT make decisions for them. The person with the hoarding problem is learning to develop new rules for deciding what to keep and what to remove. The coach can remind the person of these rules by asking questions, not telling them what to do. Be very aware of language used and encourage others to do the same. Good questions include:
  - Is it useful?
  - Can you do without it?
  - In the long run, are you better off keeping it or letting it go?
  - Can you make time each day to do the sorting and discarding?
  - Decision making questions: people who have trouble controlling their possessions often keep things without thinking much about them. Sometimes this response might be to avoid the unpleasant experiences associated with getting rid of things; that is, it's easier to keep something for later, or 'just in case' it might be needed later on.

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<sup>46</sup> Tolin et al. 2007.

- To counteract the above process, a series of questions could be asked about each item, prompting thought about their true value. These include:
  - How many do I already have, and is that enough?
  - Do I have enough time to actually use, review or read them all?
  - Have I used this in the past year?
  - Do I have a specific plan to use this item within a reasonable timeframe?
  - Does this fit with my own values and needs?
  - How does this compare with the things I value highly?
  - Does this seem important just because I'm looking at it now?
  - Is it current?
  - Is it of good quality, accurate, and/or reliable?
  - Is it easy to understand?
  - Would I buy it again if I didn't already own it?
  - Do I really need it?
  - Could I get it again if I found I really needed it?
  - Do I have enough space for this?
  - Will not having this assist with solving my hoarding problem?
- **Be a cheerleader.** Sometimes we all need an extra boost when things get difficult.
- **Help with moving items.** Many people who hoard have accumulated so much clutter that it would take them a year or more to discard it all by themselves, which can cause discouragement because progress is slow. Offering assistance to remove items, ensuring the person with the hoarding behaviour makes all the decisions and remains fully in charge of the process, can be helpful.
- **Accompany the person on non-acquiring trips.** Similar to homework, go to tempting places and not acquire anything – go with them as support.
- **Don't argue with the person about what to get rid of and what to acquire.** Long debates about the usefulness of an item or the need to get rid of it will only produce negative emotional reactions that don't facilitate progress. Instead, whenever you feel conflict, take a break, relax a bit, and remind yourself how difficult this is for the person with the hoarding behaviour. You can always come back to it later.
- **Don't take over decision making.** It doesn't teach people how to manage their problem. The clutter will just build up again. The person who hoards must be in charge at all times, with support and guidance.
- **Don't touch or move anything without permission.** How would you feel if someone came in to your home and handled your things without permission? Doing this can damage the trust between you and make it very difficult for the person to proceed.
- **Don't tell the person how they should feel.** Their own feelings have developed for reasons even they may not understand. Be patient, even though it can be frustrating.
- **Don't work beyond your own tolerance level.** Take care of yourself first, and then help others. It is important to set limits on how long and how much work you can do on any given occasion. Be proud of your own efforts, because assisting someone who hoards is very hard work.

Suggested techniques for relationship building are:<sup>47</sup>

- expressing empathy, through respectful, active listening, to understand the person's perspectives
- supporting self-efficacy to increase the person's belief or confidence to successfully make choices or changes in their own life. Service providers can support self-efficacy by recognising small positive steps that the person is taking to change their behaviour. Even when the person is simply contemplating a change, there is an opportunity to provide recognition and support. Supportive statements can be as simple as "It's great to hear that you are interested in getting more information about your diabetes." It is important that the service provider believes that the person can achieve the goal. This belief in the person can have a powerful positive effect on the outcome.
- developing discrepancy – creating discrepancy. The principle of developing discrepancy is based on the understanding that motivation for change is created when the person perceives a discrepancy between their present behaviour and important personal goals. This often involves identifying and clarifying the person's own goals which need to be those of the person and not those of the service provider, otherwise the person will feel as though they are being coerced and may become more resistant to change. An important objective may be to assist a person recognise the discrepancy between their behaviour and their personal goals.
- avoiding arguments, by using gentle persuasion rather than confrontation, thereby increasing the person's awareness of the problems that exist and the need to attend to them
- rolling with resistance, acknowledging the person's perception, not confronting the resistance head on. Resistance can take several forms, such as negating, blaming, excusing, minimizing, arguing, challenging, interrupting, and ignoring. A person's resistance is expected and should not be viewed as a negative outcome. In fact, a person who resists is providing information about factors that foster or reduce motivation to adhere to behavioural change. Rolling with resistance, then, includes involving the person actively in the process of problem solving.
- agreements or contracts can be useful tools once the person is in the action stage and the decluttering work has been scheduled, although the person may still refuse to go through with decluttering. If this happens, then the case manager or service coordinator may return to the contemplation stage of the cycle of change model and follow through at the person's pace (refer to [Appendix 4 Sample 'cycle of change' model](#)).

Decluttering appears to last longer when techniques similar to the above are used, rather than an enforced decluttering under the threat of eviction. The person requires other forms of coping with their stressors for the decluttering to be long lasting.

Replacement for the learned behaviour is required, so that the person does not revert back to hoarding. This is usually achieved via trial and error, with the relationship between the person and workers as a key component. The person may need to go through a process of grief over the loss of their belongings, often assisted by them talking to someone like a counsellor, support worker, or a trusted member of their community such as a minister of religion.

## Gather information

- Staff may need to have access to specialist hoarding advice and management (refer to [Section 8 Tools to assist](#) and [Section 9 Resources and contacts](#)).
- Utilise the Clutter Image Rating Scale (refer to [Section 8.2 Clutter Image Rating Scale \(CIRS\)](#)) so the person can monitor their own progress, providing an objective measure of the state of their rooms, maybe negating any judgmental experiences of the past. The scale is a useful reference when discussing action planning with other agencies, because it establishes a common visual reference point with less need for descriptive language.
- Expect the unexpected, try to remain impartial and maintain a professional approach.

<sup>47</sup> Miller and Rollnick 2002. Modified motivational interviewing techniques adapted to assist people to manage their hoarding and squalor situations.

- Work to small, achievable goals so the person can experience some successes.
- Utilise positive reinforcement and use encouragement and acknowledgment when the person has made gains, even if they are very small.

## Question 12

### What services can respond, and how, to a person who hoards or lives in squalor and owns their own home?

#### Aspects to consider

What role can the police/ambulance/ fire services/local municipal council/VCAT and OPA take, under what circumstances and with what authority?

#### Animal services

##### *Which animal services have the right to enter a property or a building without consent?*

Under the Prevention of Cruelty to Animals Act 1986, inspectors have emergency powers to enter a property, but not residences under certain circumstances. Inspectors include police, DEPI, RSPCA and some local municipal council officers. Inspectors have wider powers of entry, including access to residences, with a warrant.

##### *On what grounds can they enter; that is, what are the triggers?*

Under the Prevention of Cruelty to Animals Act 1986, inspectors can enter premises (that is not a person's dwelling) if they have reasonable belief that:

- animals have been confined without food or water for more than 24 hours (or after 36 hours for ruminant animals; for example, cattle, sheep, goats, deer, alpacas and so on)
- animals are entangled, tethered or in a bog (though there is a Code of Practice for Tethering under the Act which permits tethering under certain conditions)
- animals are showing pain or suffering as a result of injury or disease
- animals have been abandoned, or are distressed or disabled
- an animal is likely to cause death or serious injury to a person or animal.

Warrant powers under the Prevention of Cruelty to Animals Act 1986 are broader, and inspectors can be granted warrants by magistrates to enter residential premises (dwellings) to investigate contraventions of various sections of the Act which are occurring or have occurred; for example, those outlined above, cruelty, aggravated cruelty and so on.

In these situations, the inspector is permitted to enter the premises (that is not a person's dwelling) and:

- feed and water the animals
- free animals from any entanglement, tether or bog
- inspect animals to determine whether they require veterinary treatment
- destroy an animal if the inspector reasonably believes the animal's condition is such that it would continue to suffer if it remained alive, or immediately seize the animal, or leave notice that the inspector intends to seize the animal at the end of two days after giving notice
- contain or destroy animals that are likely to cause death or serious injury to people or other animals.

It would be up to an Inspector at the scene to make a judgement call or assessment on the specific circumstances in front of them and to determine an appropriate course of action.

## Local municipal council

No one has the power to go inside a person's home based solely on a complaint.

- Local laws/rangers/animal management officers and environmental health officers can only gain entry with a warrant that is obtained from the Magistrates Court (as mentioned above) via a formal process that requires the provision of evidence as to why a warrant is required. The warrant has a limited time period for execution and is normally for a one-time entry only.
- All of these services can enter the property up to the point the general public can. So, if gates are open, entry can be gained to the front door; if they are locked or there are high fences, there is no capacity to enter the property. These services may enter the neighbour's property with permission, and have a look over the fence.
- It is sufficient to have a complaint for these local municipal council services (as above) to begin an investigation. It could be from a fire hazard perspective, dangerous or unsightly land or nuisance under the Public Health and Wellbeing Act, which provides these services with the ability to get to the front door, but not inside the house.
- EHOs would need to prove nuisance exists outside the property that is adversely affecting neighbouring property, and is emanating from inside the house to get a warrant to gain entry; this is the only way to gain forced entry to the inside of the house.

## Victoria Police

Where deemed necessary, police may apprehend a person who appears to be mentally ill, if they have reasonable grounds for believing that the person has either:

- recently attempted suicide or attempted serious bodily harm to themselves or another
- is likely by neglect or act to attempt suicide or serious bodily harm to themselves or another (Mental Health Act 1986, Section 10 and 10.1).

## Fire services

### *Metropolitan Fire and Emergency Services Board (MFB)*

Under Section 31A and 32 of the Metropolitan Fire Brigades Act 1958, the MFB has the right to enter a property to ensure that any laws and regulations in relation to the prevention of fire and the protection of life and property are adhered to.

With regard to hoarding households, current MFB practice is not to utilise the above sections of the Act and enter private residence without evidence of other risks, such as the inappropriate storage of flammable or dangerous goods. These may be additional to or result from the large accumulation of items in the home, or may be related to the types of items being hoarded.

Entry by MFB requires, but is not limited to the following triggers:

- hoarding of hazardous goods such as petrol or dangerous goods
- unsafe electrical or leaking gas supply
- fire, medical or other emergency
- request for assistance from another emergency responder.

In these types of incidents the MFB would undertake immediate action, depending on the situation, and ensure that the relevant authorities are advised of the situation for rectification of risk.

In a life-threatening situation or an actual fire, call 000 for immediate response. For other information refer to Section 5, [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 48.

### **Country Fire Authority (CFA)**

It is not part of CFA's functions under the Country Fire Authority Act 1958 to carry out fire risk assessment reports to assist government departments (for example, Department of Health, Department of Human Services, Department of Environment and Primary Industries) with hoarding inspections of public housing or other residential property fire risk assessments.

While there is no specific provision in the CFA Act which sets out the objects of the CFA, these are to be ascertained from the purpose of express provisions in the Act setting out the duty and functions of the CFA; namely, fire prevention and suppression in the country areas of Victoria (Sections 14 and 20) and improving Community safety under Part IIIA of the Act.

CFA fire safety officers deal with specific issues to mitigate the risk of fire from sources external to a property, which include matters relating to the property site, accessibility and general fire protection requirements.

The CFA does not become involved in enforcement of fire safety practices within private residential homes, nor homes where hoarding or squalor exists.

Some fire safety practices are regulated by building regulation and enforced at local municipal council level. These and other specific issues relating to fire safety within the home are not within the scope of the CFA's fire prevention and suppression enforcement activities.

The CFA provides information and guidance on any specific fire danger issues within private residential homes. Then, as regulator, the CFA is able to offer the following risk reduction advice especially when working with people affected by hoarding:

- identify any use of naked flame and remove (candles and so on)
- installation of smoke alarms and weekly testing  
(refer to [www.cfa.vic.gov.au/plan-prepare/installation-and-replacement/](http://www.cfa.vic.gov.au/plan-prepare/installation-and-replacement/))
- unblock all exits
- clear wider path on internal pathways
- make utilities safe:
  - disconnect any electrical appliances not required for use
  - establish 1 metre clearance around all fixed and portable heating sources
  - identify areas used for cooking and establish 1 metre clearance around all portable and fixed cooking appliances and meal preparation areas
  - identify all utilities such as gas and electricity are connected and safe; if unsafe (for example, gas smells or seeing sparks) call the fire brigade on 000
- ensure all electrical power boards are being used correctly
  - there is only one board per power point
  - there are no power boards plugged into power boards – remove them
  - no double adaptors are plugged into power boards – remove them
  - there are no accumulated items or belongings resting on power boards – remove them.

CFA fire fighters can now respond under the new Act to any emergency or accident, providing it has the approval of the chief officer or any officer exercising their powers (Section 20A CFA Act); for example, assisting by way of access, to rescue the animal or person in hard-to reach places.

Triggers – if a life is under immediate threat of fire or explosion, then CFA will respond to a call to 000. For further information refer to Section 5, [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 49.



## Victoria Ambulance

Ambulance officers are legally able to break into a person's home if there is sufficient concern for the person's safety or risk to the person is heightened:

Paramedics will force entry to premises to gain access to an unresponsive or disabled person. However, if the person is disabled, but can communicate, paramedics will ensure that permission is gained from the person prior to entering.

If paramedic safety may be compromised, they will not force entry, but will request urgent police attendance.

This policy is irrespective of whether the person's home is publicly or privately rented or privately owned.

## Mental health

Where someone thinks a person appears to be mentally ill they should call the local psychiatric triage service ([www.health.vic.gov.au/mentalhealth/services/index.htm](http://www.health.vic.gov.au/mentalhealth/services/index.htm)).

If the mental health service considers the person meets the grounds for involuntary treatment (for example, only if the person refuses voluntary assessment and is deemed to meet involuntary treatment criteria as described below) the service could take the steps outlined below. However, this is an extreme step and every effort should be made to attempt to assist the person on a voluntary basis first.

The grounds for intervention by mental health services in these circumstances would be the criteria for involuntary treatment set out in Section 8 of the Mental Health Act 1986; that is:

- the person appears to be mentally ill (within the meaning set out in Section 1A of the Mental Health Act 1986)  
and
- the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order  
and
- because of the person's mental illness, involuntary treatment of the person is necessary for their health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public  
and
- the person has refused or is unable to consent to the necessary treatment for the mental illness  
and
- the person cannot receive adequate treatment for the mental illness in a manner less restrictive of their freedom of decision and action.

While the Act allows mental health services to enter premises for the purpose of taking a person to an approved mental health service (Section 9B 2a), if the person who is the subject of concern is not a known client, mental health services would be unlikely to attend without police assistance.

Ambulance services may be required if the person needs to be transported to an approved mental health services, and police may be required to attend to assist mental health staff. Police could also apprehend a person under Section 10 of the Mental Health Act 1986 if they believed the person to be mentally ill.

**Question 13**

**What do I do if I can't engage with the person living in the house and my service has received a complaint about the clutter in the yard?**

**Aspects to consider**

- Is it the role of your service to respond to complaints with regard to clutter or squalor in the first instance? If not, you should direct the referrer to the relevant local municipal council environmental health service (refer to Section [Table 5 Core services that respond to hoarding and squalor situations](#), no. 25) or the public housing office or whoever the property manager or landlord might be if it is a rental property (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#)).
- If there are concerns with regard to the person's competence, refer for a joint assessment with the local psychiatric service with GP involvement. Consider involving the community policing unit (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#)).
- Don't assume that your failure to engage the person means that the person cannot be engaged. There are services (such as ACAS and psychiatry services) which have skills in engaging with difficult people and situations – they may be able to offer some suggestions about how to move forward.
- If the appropriate referrals have been made and there are concerns about the safety of the person, their dependent others or animals, contact the psychiatric triage service (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 8). If refusal to engage is still evident and the person is deemed well by mental health services, the person cannot be treated involuntarily (refer to [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#)). There may be little alternative but to proceed down a legal pathway. This action should be discussed with the original referrer (keep in mind that psychiatric triage may assess that the person needs involuntary treatment).
- Try to focus on other needs first to commence engagement (for example, checking to see if the person has a working smoke alarm, or whether they might like a free flu shot at their local GP, or making sure the power is connected and working). If this does not work, you may need an alternative strategy, such as divulge the name of the service or person who has made the complaint (with prior permission) to gain leverage for your service to come in and help them, to advocate and assist them.
- It is best to respond via a multidisciplinary team, perhaps introducing the person to another worker. If that fails, incorporate another agency that specialises in a different approach, a different personality, gender or cultural background.
- The service that has received any complaint should keep the complainant informed of progress, including how other services and authorities are or will be involved. The privacy of the person about whom the complaint was made needs to be respected at all times while managing a complaint.

**Question 14**

**How do I know if a person is competent and has the capacity to make decisions?**

**Aspects to consider**

- You don't know if a person is competent and has the capacity to make decisions until they have been assessed by a service that has the professional skills to assess competency (for example, GP, ACAS). Capacity is not an all-or-nothing phenomenon; it is decision specific (refer to Section [3.3.1 Initial contact and needs identification](#), Section [3.7 Mental capacity and competence](#) and [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16).

- Question whether the person is able to make informed decisions and whether they have a full understanding of the consequences of these decisions. Just because a service provider may disagree with a decision does not mean that the person does not have capacity.
- While the fact of living amidst squalor would appear to provide prima facie evidence of impaired capacity to make reasonable decisions about one's environment, the law does not accept this assumption. Many people living in such circumstances can present well to the untrained or casual observer, and the requirement for an expert's cognitive assessment is almost invariable. Problems arise when the assessment is refused. It may be ultimately mandated by a court order if the legal pathway is pursued. That pathway may be appropriate in order to prevent the legal system adopting a punitive stance in respect of someone who acts by virtue of impairment.
- Coordinate meetings with co-workers; make referrals to appropriate services if there are no supports in place. Provide briefing support to any worker making inspections to ensure that the most appropriate referrals are made. Seek secondary consultation from services who are specialist in their area of expertise (for example, mental health, SfhRT – refer to [Table 5 Core services that respond to hoarding and squalor situations](#)).
- Seek information regarding any previous diagnosis that may indicate cognitive impairment (for example, mental health, acquired brain injury (ABI), intellectual disability, neurological degeneration conditions).
- With the consent of the person, seek direction from a clinical service (such as a GP, or ACAS if the person is older for medical/psychiatric/neuropsychologist assessment) which may previously have been undertaken (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16).
- If the person is unable to consent, consider contacting their next of kin, or seek the consent of the person's nominated representative, if known. Note that the next of kin may or may not be able to provide consent on behalf of the person. If not, approach the person's GP. However, the GP may not be able to give consent on behalf of the person, but they might be able to provide medical services and links or referral to other appropriate services.
- If it is determined via an assessment (refer to Section [3.7 Mental capacity and competence](#)) that the person has no or little capacity, contact the Office of the Public Advocate (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 44) for advice about applying for guardianship and administration orders.

## Question 15

### What are some practice considerations I would benefit from knowing?

#### Aspects to consider

- Social isolation is often identified as one of the biggest issues for a person who hoards or lives in squalor (refer to [Case study 9](#)).
- Standard practice is generally not to provide any storage units to people who hoard, due to the risk of continuing financial pressure on them, and the potential for a storage unit arrangement to enforce hoarding behaviours (for example seemingly providing more space to fill), unless there are clear agreed boundaries in place, for example:
  - a limited timeframe
  - no daily disposable waste can be stored in them
  - with agreement that they will seek clinical treatment
  - as a transition arrangement
  - all stored articles are to be disposed of at the conclusion of the timeframe.

- Consider having a regular cleaner (either public or private) who comes once a week on an ongoing basis to assist with maintaining the main living areas of a property. Ensure the cleaner is aware of the need for safety and is sensitive regarding the person's belongings (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 17 and 18, [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), nos 36 and 52).
- It is important for service providers to be aware of the language they use when responding to people living in these circumstances. Maintaining respect and dignity towards the person is essential, because the person may already be feeling judged and vulnerable. Simple words or expressions used generally everywhere else may offend. For example:
  - what is seen: 'Look at that mess', 'There's stuff everywhere', 'It's only broken bits and pieces'
  - what is smelt: 'This place stinks or reeks'
  - what organic matter might be on the floor or surrounds: 'This makes me want to throw up'.

Instead say, for instance:

- 'These are your personal belongings, what would you think if...'
- 'How would you like us to treat the items in this room or space?'
- 'What is OK for me to touch in this area?'
- 'Some of this property belongs to you'
- 'How would you like to clean or tidy some of this space, so that you can move about more safely?'
- Timing can be vital, and workers need to carefully assess the person's pace and readiness.
- The person needs to express some willingness to participate with services and indicate commitment and preparedness to share confidential information. Usually this will come following robust engagement that assists with the building of trust.
- Stalling and avoidance techniques by the person are common.
- There is often an absence of cleaning products and equipment, so purchasing these for the person can be a useful engagement tool.
- A sense of disempowerment is common for a person with hoarding behaviour, and particularly if they have experienced full-scale cleans in the past, it is vital to ensure they are directing the cleaning process and are able to participate in decision making.
- It is essential not to throw anything out without the person's consent, and this takes more time, due to the need to show the person everything prior to disposal. If this doesn't occur, it is easy to lose the person's trust (refer to [Section 1.1 What doesn't work?](#)) and may well be breaching the person's right to privacy, or other rights they have in respect of their home and property.
- It is important to acknowledge that the items collected do have a purpose for the person who saves them. This connection needs to be teased out and worked through, when required. In addition, the emotional attachment also needs to be worked through without dismissing the genuine emotions experienced by the person.
- It is also important not to take anything away without replacing the emotional gap it might leave. If belongings are removed, consideration needs to be given as to how the person might be linked or connected in to form new relationships, interests or activities with something or someone else, to replace the importance of attachments they would have had to those items. These new connections need to be planned and in place prior to taking items away.

Possible actions for the worker and supervisor to consider in the context of a duty of care (refer to [Section 3.9 Duty of care](#)) that may be owed by the organisation include:

- leaving an open opportunity for further contact with the person stating that if they do have any health or living concerns, you are available to discuss it with them if they wish
- providing the person with the means of contacting appropriate support organisations

- looking for or gathering any further information (including photographs) the next time you meet with the person, and document them clearly in the person's file
- consulting your supervisor if concerned about high-level risk (such as homicide or suicide) or where there is evidence of neglect, including that of animals
- using open-ended, non-judgmental questions about care-giving, family relationships and dependencies
- assessing a person's adaptive behaviour and perception of risks involved
- asking the person to relate in their own words how they would respond to a particular situation.

## 6.2 Assessment

### Question 16

**My service only assesses for what we are funded to do – how and where do I refer for more specialist assessment?**

#### Aspects to consider

- Management of these complex cases can really only proceed appropriately once the relevant service and clinical assessments for whatever purpose have been completed.
- Due to the complexity of some cases, several program-specific assessments may be needed, depending on the expertise required (for example, a combined assessment between animal, people or environmental health services would need to be prioritised, planned and undertaken – refer to [Section 8.7 Shared action plan checklist](#) and [Figure 19 Shared support plan](#)).
- Specialist clinical assessment should encompass medical and psychiatric referrals (refer to [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#) and [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16).
- Services should have a document that outlines pathways to make referral (refer to [Section 8.4 Squalor and hoarding profile: creating a pathway](#)).
- Whether the premises are covered by an existing local municipal council order for example building demolition or fire safety (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 23, 24 or 25 and [Section 3.5.1 Risk management](#)).
- Assess the person's capacity to live independently (for example, cooking, shopping, cleaning, washing, state of the home, personal care, care of any dependents). If these skill levels are low, consider contacting a community health service for advice on how to engage an occupational therapist or an independent living skills worker to become involved and teach skills such as maintaining a home in terms of cleaning, organising, shopping and budgeting skills (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 37 Community health centres).
- The person should be encouraged to take the first steps to address their hoarding behaviour and work with staff to begin the cleaning process. After commitment has been demonstrated, further cleaning or organising assistance from a service such as the Disability, Independent Living Skills Program could be initiated.

## Question 17

### How does my service assess for urgency, the person's safety and the level of risk?

#### Aspects to consider

- Complete all the initial information forms, because data fields provide relevant information for assessing urgency (for example, does the person have capacity? Is the person living alone? Is this information known?). Refer to [Figure 16 Consumer information](#) and [Figure 17 Summary and referral information](#) and [Figure 18 Consent to share information](#).
- Information should be collected from as many services as possible to guide an appropriate response. The person referred also needs to be contacted and referral discussed (if this is possible) (refer to [Figure 18 Consent to share information](#)). Their response (or lack of it) will also guide the degree of urgency needed to connect with the household more quickly.
- Further screening at referral and intake points (including triggers) should be in place in each service to adequately pick up on suspicion for possible hoarding behaviour and squalid living conditions and then gather further details once a hoarding or squalor situation has been identified. This could include requesting a police welfare check (refer to [Section 3.5.1 Risk management](#) and [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 50) or referral to psychiatric triage (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 8) where suicidal or homicidal threats might be made.
- If there is no response from the person and available evidence raises concern, a visit to the property is needed as soon as possible to assess the situation initially.
- Urgency – is this crisis driven? For example, is the person's life or general health at risk? Are they at risk of losing their housing? Are dependents such as children or animals safe?
- Prompts for urgent referrals to an appropriate service should include the presence of animals or children within the environment, or the presence of obvious malnourishment or disease or infirmity in an occupant of the premises. Suicidal or homicidal threats also require urgent assessment.
- Assess the level of risk:
  - **low risk** is generally when there is some concern for the person or animals, but there is no impending crisis. There are usually working smoke alarms, clear exits and working utilities
  - **medium risk** is generally when there is a high concern for the person or animals, but there is no immediate harm to the person or others
  - **high risk** is generally when there is a high concern for the person and the risk of harm to the person or animals or others is imminent. High risk often involves people who are difficult to engage with, and harm minimisation strategies have not been successful.
- If you assess the person is at immediate urgent risk (as in high above) pursue the following actions as appropriate (refer to [Section 3.4 Hoarding and squalor service response flowcharts](#)):
  - contact your supervisor
  - work with a human service organisation (refer to [Table 5 Core services that respond to hoarding and squalor situations](#) and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#))
  - contact 000 (fire, ambulance, police) if required
  - contact the police for a police welfare check
  - contact OPA for advice – this service has an information/advice line (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 44)
  - contact the RSPCA regarding animal management.



- if the person shares your concern, they may agree to an immediate treatment of the property regarding environmental concerns. If this is the case, you could offer to contact the local municipal council environmental health officer on the person's behalf to discuss what needs to happen (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 25).
- If the person is older, contact the local ACAS (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 10) and seek urgent advice regarding the person's safety. Depending on the circumstances, the advice may be to call an ambulance, or to remove the person if, for example, they are living in a squalid environment in a state of self-neglect, appear malnourished and at risk personally or have health concerns.
- A full and comprehensive bio-psycho-social assessment may be of benefit – refer to an appropriate clinical service (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16).
- Safety – assess for working smoke alarms. Are there accessible internal pathways? Are entrances and exits clear enough to provide quick and safe egress for members of the household and worker/s? What utilities are connected and are they being used safely? If not, what practices are being used by the person to replace them? (refer to [Section 8.1 Environmental Cleanliness and Clutter Scale \(ECCS\)](#) and [Section 8.4 Squalor and hoarding profile: creating a pathway](#) and [Section 8.6 Contact other local services after receiving an initial referral](#)).
- A home visit is always required to fully assess risk; however, people living like this are often reluctant to be assessed, so their right to refuse assessment is respected, competence being assumed in the absence of evidence to the contrary (refer to [Section 3.3.1 Initial contact and needs identification](#) and [Table 5 Core services that respond to hoarding and squalor situations](#) and [Section 3.5.1 Risk management](#) and [Section 3.6 Protection of the person's information](#) and [Section 3.7 Mental capacity and competence](#)).
- Squalid environments take years to develop, and any risks are usually chronic (albeit high). The imminence of any risk is often therefore low. It is rare that something has to be done immediately.
- Assess whether the person's squalid environment is in relation to poor living skills, hoarding that has gotten out of hand or some other causal factor, such as a mental health condition.
- If poor living skills are the cause, consider referral to an independent living skills worker or occupational therapist via a community health service (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 37), which, having established an action plan, might engage an ongoing cleaner to assist with maintenance of the main living areas.
- In squalid situations where the person has limited attachment to the items (as distinct from hoarding) and due to a deterioration in health and living skills, it may be possible to arrange for an industrial clean and to follow up with regular cleaning arrangements – either public or private (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 52, [Section 8.11 Planning for the provision of cleaning \(flow charts and cleaning agreement\)](#) and [Section 8 Tools to assist](#)).



**Question 18****Are there costs involved and how do we plan to meet them?****Aspects to consider**

- Costs are not limited to clean-up costs. Assessment itself can consume professional resources, and a comprehensive assessment is the first step to appropriate management (refer to [Section 3.3.2 Assessment](#)).
- Many funded services have a limited capacity to provide additional or prolonged resources. Access to limited discretionary funds might be utilised in these situations, and with a collaborative effort between services, the sharing of available resources might more effectively contribute to sustainable outcomes.
- It is often difficult to assess until further investigations are performed. Repairing infrastructure damage may require further assessment after a clean-up is performed. Several different services can be involved in this type of discussion, and these could share costs for discrete purposes.
- The person may not have sufficient funds to purchase assistance; however, they may be able to contribute partly to costs over a period of time. How expenses are to be met needs to be included in action planning – it might be, for example, that smaller clearances of clutter occur at more regular intervals, and in different ways, rather than planning to arrange a large skip and a bevy of workers on one occasion. The cost of storage – either on or off the site – so that cleaning can occur is also an expense to be factored in.
- A quick-fix clean-up is often implemented for squalor situations because it is efficient and less costly, but this approach has been shown to be ineffective for a person with hoarding behaviour, and may result in a high rate of relapse and increased costs over time. If a one-off clean-up is planned and funded for either a squalid environment or a person with hoarding behaviour, consider how the person will then maintain the environment in the long term as part of an action plan and what other supports need to be put in place.
- Large clean-ups, including industrial cleans, can be very expensive. It might be useful for service providers to develop resource lists of relevant agencies who can contribute in some way to costs on a case-by-case basis.
- Some local municipal councils may be able to accrue costs against the value of a property, with the aim of reimbursement when the property is sold. This can only apply to people who own their own homes.
- For rental properties where the tenancy is at risk due to the state of the property a service provider can refer the person to the Department of Human Services Support for High Risk Tenancy Coordinator (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1), which has some funding available and can ensure appropriate supports or coordination are in place, which may include longer-term planning.
- Some local municipal council services can assist on a case-by-case basis, particularly if the person is already an existing client (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 23–28).
- Some funded services have a small amount of brokerage money if the person meets the eligibility criteria for that particular program (for example, aged home care packages, low-cost accommodation support programs (CCP, HSA). Refer to [Table 5 Core services that respond to hoarding and squalor situations](#), nos 1, 5, 6 and 17 and [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#).

### Question 19

#### Does the person want an assessment or referral, or will they self-refer for therapeutic treatment?

##### Aspects to consider

- The person is unlikely to self-refer (evidence indicates a very low rate of self-referral). People are more often referred due to legal reasons (for example, threat of eviction, physical health issues, and complaints from others).
- Some people who hoard have lived with shame and embarrassment due to their condition for many years, on the basis of an incorrect assumption that no help is available. Once this misperception has been corrected, they may appreciate having a pathway presented for assistance, such as therapeutic treatment (for example, The Anxiety Clinic Richmond or Swinburne Hoarders Clinic – refer to Section 9 [Resources and contacts](#), nos 11 and 12).
- A person may accept being recommended for referral and support if they have insight or accept their situation is beyond their capabilities. However, it would be safe to assume this is not the usual response. If a person declines to consent, a legal or statutory process may need to be invoked, including the Mental Health Act.
- Some people may be open to referral if a worker from a service suggests help and works with them to follow it through.
- Some people will not be interested at all, which may indicate something about their readiness to change and their level of insight, or it can also be about the perceived intention of the worker seeking the assessment (for example the worker or officer's main purpose might be to get the property cleaned up which leads to resistance).
- Evidence suggests that one-half to two-thirds of people living in severe domestic squalor suffer from dementia, alcohol-related brain damage, or a mental disorder such as schizophrenia and depression. They often live in isolation, are suspicious and unfriendly, and have features suggestive of pre-existing personality disorders.
- Studies have also shown moderate to high rates of medical problems for people who live in conditions of severe domestic squalor, particularly in relation to mobility, continence, sensory impairment (especially visual) and nutritional deficiencies such as diabetes and obesity.

### Question 20

#### What reliable tools are available to assist with assessing hoarding and squalor situations?

##### Aspects to consider

- For a professional clinical assessment referral should be made to clinical and mental health services (refer to Section 5 [Collaborating with other services](#), nos 8–16).
- To assist with practical service assessments refer to Section 8 [Tools to assist](#) for tool examples and templates.
- Use the Clutter Image Rating Scale (refer to Section 8.2 [Clutter Image Rating Scale \(CIRS\)](#)) as a tool for gauging the level of hoarding. It encourages objectivity and a common language or reference between services, so that each service knows what the other is talking about.

- The use of photos taken by service providers for example at three monthly intervals, placed in client files along with documented achievements and action plans, are useful to assist ongoing engagement and ensure regular positive reinforcement with the person. Copies of dated progress photos can be provided to the person maybe in an album for their reference, to encourage pride and motivation with their achievement.

### Question 21

**How do I select and support staff to be able to build relationships of trust with a person with hoarding behaviour?**

#### Aspects to consider

- The goal is for all staff to take an interest in these situations and to build their skills and capacity to respond.
- Important personal qualities include being non-judgmental, tolerant, flexible and adaptable. Staff need to be genuine in their capacity to communicate with empathy and understanding, displaying unconditional positive regard (refer to [Section 4 Agencies supporting an appropriate response](#)).
- If a natural ability and interest is present, then training and education certainly assists; however, the goal should be to build capacity in all workers to be able to recognise these situations and be confident in knowing how to prepare, plan and respond appropriately.
- You might undertake informal interviewing to determine if a staff member understands the issues that could be associated with this work, to provide them with the opportunity to show capacity to engage and work on a case over the long term, to work at the person's pace (which is often very slow) with patience, and be able to understand the 'process' along with undertaking the tasks (refer to [Section 4 Agencies supporting an appropriate response](#) and [Appendix 4 Sample 'cycle of change' model](#)).
- Any member of staff may express an interest in working with people with hoarding behaviour or living in squalor as well as requesting training and professional development in this area, which should be made available for all staff.
- These types of opportunities can build staff and management experience and understanding, develop core discipline, further enhance finely attuned interpersonal skills as well as planning and organisational ability to respond effectively to hoarding and squalor situations.

### Question 22

**Where do I refer for assessments of competence or capacity for adults?**

#### Aspects to consider

- Refer to ACAS, aged psychiatry and psychiatrists, private and public geriatricians, public and/or private neurologists, neuropsychology assessment, GPs, psychiatric triage (refer to [Figure 4 Hoarding and squalor service response flowchart \(Part B\)](#), [Section 3.7 Mental capacity and competence](#) and [Table 5 Core services that respond to hoarding and squalor situations](#), nos 8–16).
- Often the challenge is getting the person to agree to the assessment, and then there are additional considerations with regard to attendance, particularly if this is away from the person's home. ACAS and aged psychiatry services can perform home assessments, but not all ACAS teams have a neuropsychologist or will do an assessment of capacity – they may recommend neuropsychological assessment as part of their ACAS assessment.
- ACAS will not accept a referral to undertake only a capacity assessment, but they would consider undertaking such an assessment in the context of a broader holistic assessment.

- To assist with testing for capacity, the taking of pre-treatment pictures (with permission of the person) at an initial home visit is a useful form of assessment and can be used as reference material in subsequent visits or sessions, and as comparison points for pictures taken later on to track progress.

## 6.3 Action planning

### Question 23

**Has an action plan been developed and discussed with the consent of the person concerned?**

#### Aspects to consider

- Due to a person's lack of insight or concern, many action plans may have to be developed in the absence of involvement from the person referred (refer to [Figure 19 Shared support plan](#), Section 4.4 [Supporting those involved in the direct response](#) and [Appendix 3 Information Privacy Principles](#), Privacy Information Act Principle 2.1d).
- An action plan needs to be undertaken carefully with the person's goals and behavioural tasks clearly identified. The timeframe needs to be carefully considered, left flexible and reviewed where possible with the person's input (refer to Section 8.7 [Shared action plan checklist](#) and [Figure 20 Review of shared support plan](#)).
- An action plan must always be developed. Even if service intervention is not ongoing, it helps to define the situation and provides a basis for regular review.
- While an action plan may be developed without the involvement of the person concerned, there are limitations on what actions service provider organisations can take without the consent of the person concerned. If consent has not been obtained, it will not always be possible to obtain or share information, to access the property, to undertake particular activities on the property, or to arrange or administer medical or other treatment.

### Question 24

**Does the person consent to the sharing of their personal information for action planning?**

#### Aspects to consider

- The worker with the most effective engagement style should discuss the information and the purpose of an action plan with the person. Even where that person does not have capacity, the worker with the rapport should seek to convey the information and gain consent.
- Refusal may occur for a range of reasons. In order to ethically override refusal to consent, a demonstration of lack of capacity to refuse is required, which emphasises the importance of a valid capacity assessment to the action planning process or as per the duty of care Privacy Principle 2.1(d) (refer to [Appendix 3 Information Privacy Principles](#)).
- Be aware of any language or communication barriers. The intention of your messages really needs to be understood by the person. If necessary involve an interpreter – it doesn't need to be a family member.
- A person must have consent to share information clearly explained to them, with an emphasis on maintaining confidentiality and privacy rights, which are different concepts (refer to Section 3.6 [Protection of the person's information](#)).

- Most community and health service organisations, including local municipal councils, will have a privacy collection statement, which can be given to a person prior to engagement of services, and which covers the person providing consent to share information (refer to [Section 3.6.5 Obtaining consent](#)).
- Outcomes depend on a person's capacity (refer to [Section 3.7 Mental capacity and competence](#)). If they do not have the capacity to engage and establish working relationships that will support them and their issues, then a joint action plan should be developed. This should identify required interventions, services and other agencies (refer to [Section 3.4 Hoarding and squalor service response flowcharts](#) and [Question 8 What other services do I connect with and why?](#) and [Section 5 Collaborating with other services](#) and [Section 3.3 Key coordination stages to consider](#)).

### Question 25

#### Does the person require multiple services?

##### Aspects to consider

- It is important not to overwhelm the person with too many service providers at the same time. Introduce new workers gradually – preferably with the guidance from a service coordinator or case manager as part of the action plan.
- Whether the person requires multiple services depends on the situation, but almost invariably they do. Multiple services should be identified as to what their purpose and role is as well as when and how they are to be engaged (refer to [Section 3.4 Hoarding and squalor service response flowcharts](#), [Section 5 Collaborating with other services](#) and [Section 8.6 Contact other local services after receiving an initial referral](#)).
- Should there be concern about any animals on or in the property a planned response must be part of the overall action plan to equally address the needs of the person and the animals.
- It is important to have a multidisciplinary team where possible; that is, practical and therapeutic support – not one worker, from one service trying to do everything.

### Question 26

#### Would the person benefit from an intra- or interagency action plan?

##### Aspects to consider

- The identified lead key service worker, in conjunction with their service team, should create the action plan, involving other providers (refer to [Section 3 Building service system response capacity](#)).
- This key worker role is identified and agreed to at the outset when it is established that more than one agency will be involved, but the person should always be notified of this.
- Ideally, the interagency action plan is developed to incorporate the work and goals of each worker involved. That way, everyone is working from the same plan, and multiple plans and goals don't overwhelm the person (refer to [Section 3.5 Common service coordination tasks](#) and [Section 8.9 Templates to assist with service coordination tasks](#)).
- These cases require regular review with an eye on maintenance. This maintenance role could be shared by the core services involved, or a case management service could also be engaged if appropriate. Depending on the need of the person, this may include animal monitoring, personal care, regular small clean-ups or visits to the GP, allied health services and so on.

**Question 27****How is the action plan to be monitored and reviewed (by which service)****Aspects to consider**

- A lead agency or service may be nominated and agreement reached to coordinate the action plan by consensus following an interagency meeting, with each service having their own areas of responsibility or action agreed (refer to Section [8.7 Shared action plan checklist](#)).
- A lead case manager or other lead worker is identified from that lead agency or service to coordinate the development of the action plan and provide regular communication to all services involved. The action plan should be reviewed at regular intervals by the service teams, led by the service coordinator (refer to and [Figure 20 Review of shared support plan](#)).
- For service coordination to be effective, decisions should be made about what the individual service roles and functions are, how services will ensure a coordinated response and what the communication mechanisms are.
- As Medicare locals become more established, exploring local inks with regard to the management of complex cases might be of interest (for example, Department of Human Services Gippsland).

**Question 28****Which service will be responsible for service coordination and decision making overall?****Aspects to consider**

- Numerous services can be involved in cases particularly over time with different perceptions of issues, resulting in possible confusion between services with regard to who is doing what.
- The service that receives the contact or initial referral takes the initiative to contact other providers who need to be or are involved. This may be a process of discovery in some cases (refer to Section [3 Building service system response capacity](#), Section [5 Collaborating with other services](#), Section [8.6 Contact other local services after receiving an initial referral](#) and Section [8.7 Shared action plan checklist](#)). Not all sectors provide the worker with a local team environment, particularly in rural, regional and divisional settings (for example, local laws, animal welfare inspectors, CFA). In these instances the building up of connections with other services is paramount, once connections have been established, decisions are made as to which service takes on a coordination role, which takes responsibility for the scheduling of meetings, communication between services and the development of a unified action plan (refer to Section [3.3 Key coordination stages to consider](#) and and [Figure 19 Shared support plan](#)).
- A service coordination approach will identify the service most appropriate to remain engaged in the long term on a case-by-case basis. Good practice may involve the development of a local network agreement or MOU that supports a coordinated model of care for those with specific needs. The agreement (which should be kept simple) identifies what role each agency holds, and ensures that each has responsibility for engagement and participation – whether that be short or long term, episodic or sustained.
- Decision making at one level will occur in the context of each discrete service. At another level in some cases, a decision may need to be made together with other services to ensure there is an agreed approach and no duplication of effort, because this would impact on the person needing the support and possibly have a detrimental effect on their progress.
- Professional meetings including some that involve the person and others significant to them, will ensure planning remains focused on the persons needs and progresses at their pace.
- Case conferences are often required to confirm a joint tenancy and case management approach.



**Figure 7 An example of the 'sorting' phase which is often needed**



This photo is an example of the 'sorting' phase which is often needed. This is a Public Housing property showing a bedroom no longer being used for its intended purpose. Often things need to get packed into boxes and moved between rooms to begin the process of sorting without removing too many items. Rooms can then be filled with boxes of items, so these need to then be gone through. This is not an unusual scene.



## 7 Interagency case studies

These case studies provide examples of interagency, multidisciplinary service responses to situations involving hoarding and squalor from a range of perspectives. Such cases are diverse, complex and affect a broad range of age and diverse life circumstance.

The case studies have been de-identified – any character references used are fictitious.

Good interagency and multidisciplinary practice would include the identification, coordination and provision of services appropriate to meet the assessed need of a person living in a hoarding or squalor environment, taking into account the needs of primary carers, family members and animals (refer to [Section 3 Building service system response capacity](#)).

Interagency practice aims to bring about a coordinated, person-centred approach and requires:

- a shared understanding of the aims of a response or intervention
- a prompt response to the situation to determine whether hoarding behaviour or squalor is part of the circumstance
- appreciation of and respect for the different roles and contributions of agencies from different sectors
- commitment to partnership between agencies
- an understanding of the context in which agencies work, while acknowledging their respective constraints.

When working with people, no matter what age, it is important to maintain:

- respect for their autonomy and right to privacy (refer to [Section 3.6 Protection of the person's information](#)).
- recognition of the right of a competent person to refuse intervention based on the principles referred to in [Table 1 Principles underpinning service response to hoarding and squalor situations](#)

The following case studies have been grouped under three broad headings (Building and property, People and Animals) to assist ease of reference. The headings are consistent with those used in [Figure 3 Hoarding and squalor service response flowchart \(Part A\)](#)

### 7.1 Building and property (inside, outside, structures and ownership)

#### 7.1.1 Fire risk in a multiple dwelling situation

This challenging hoarding case demonstrates the application of service coordination and duty of care principles, good team work, preparedness to share risk, good practice and long-term commitment from the care team. Unfortunately this tenant was evicted after over 3 years of engagement with service providers trying to reduce fire risk, due to the impact on all the surrounding tenants.

#### Case study 1

##### The situation

J in his mid-50s, was referred as a tenant by a housing officer to the Support for High Risk Tenancies (SfHRT) program (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1) due to hoarding and antisocial behaviour. J had severe long-term hoarding behaviour, and his unit had been assessed as a fire risk to himself and his neighbours because he shared adjoining walls with neighbouring tenants.

J had a history of receiving support from mental health services, having been diagnosed with post-traumatic stress disorder and personality disorder. J had multiple hospital emergency department presentations for chronic health issues.

J had high anxiety about his housing issues and the need to address the amount of hoarded material in his property. While he had positive links to his GP and local church he found it extremely difficult to engage with support services in a meaningful way to address the high fire risk of his home. J could be very intimidating and threatening towards staff and services and showed a lack of insight into the way his behaviour affected those around him. This presentation often led to police involvement.

While J wanted housing issues to be resolved, he was unable to take the actions necessary to reduce risk. Over time J exhibited a decreased ability to express his wants and needs. He stopped paying his rent and the Director of Housing began taking legal action for both his hoarding and rental arrears.

### **The service response**

A range of local services assisted over time, including Department of Human Services SfHRT, Care Coordination, SHASP, the former Department of Human Services Housing Division, a GP, hospital social workers, Opening Doors, PDRS, community health services, material aid, Area Mental Health, a private clinical psychologist, the Office of the Chief Psychiatrist, Forensicare and Department of Human Services privacy officers. Several services closed their interventions due to Js aggression, complaints and worker safety issues.

Housing service officers conducted regular inspections of the home to monitor the fire risk along with legal action. A fire risk assessment was conducted by the Department of Human Services emergency services unit and a report was compiled.

Care coordination was implemented on a duty of care basis due to the number of services involved, risk to J and service providers and the need for a key contact due to a lack of consistency of a key worker.

Advice regarding duty of care action was sought and J was informed in writing and given an opportunity to decline the service. Prior to care coordination service taking the care coordination role, SfHRT coordinated services, monitored the risk, developed a management plan and provided ongoing guidance to housing service officers and other service providers.

An application for guardianship and administration was made. An administrator was ordered by VCAT, which secured the tenancy in relation to the rental arrears. Services continued to work in a coordinated manner, guided by the care coordinator to assist J to decrease the fire risk of his property.

### **The outcome**

A care team of service supports worked with J for over three years. The team worked in a collaborative and coordinated way, demonstrating the benefits of good team work and preparedness to share risk.

Despite the significant injection of supports and several different interventions that tried to engage in decreasing the risk within his home, J was unable to undertake this work and as an absolute last resort was evicted from his property.

The team actively worked with housing service officers to identify an alternative housing option so that J would not enter homelessness; however, J relocated to a family property in another part of Victoria and ceased contact with the care team.

### **Practice note**

This case study displays coordinated and planned service provider effort over a prolonged period.

Even with this degree of service support, the person with the hoarding behaviour may still not be able to engage at that point in time, in a way that service providers might suggest.

This case study highlights the choices and decision-making rights of the person with hoarding behaviour who has decision making capacity, and is able to make their own decisions.

### 7.1.2 Local municipal council environmental health – a happy outcome

This hoarding example highlights the experience of a woman who had received many support services (environmental health, private psychological hoarding support, private hoarding support group, housing services and community services) to assist her to come to terms with her situation, but who then had to move to live in another house.

#### Case study 2

##### The situation

After a range of support services (see above) had already been provided to F, an 84 year old woman, who eventually left her house due to severe environmental health concerns identified by local municipal council environmental health officers.

As a result F was supported to move into a two-bedroom unit in another suburb.

##### The service response

F was already involved with a hoarding support group and participated in a course of treatment at Swinburne University (refer to Section [9 Resources and contacts](#), no 12) prior to the local municipal council becoming involved. She had a good understanding of her behaviour, what was occurring and why.

##### The outcome

F wrote to the community services worker, letting her know how she was managing her life in her new unit.

F stated she was very happy in her new home, enjoying the neighbourhood and local shops. She was learning how to use the new equipment in her modern kitchen. Her previous facilities had been old and run down. Her new home had heating, running hot water and a working toilet.

F had joined a gardening and plant propagating group and had plans to join a tai chi and walking group. F had a new lease on life after 34 years of living in her previously rundown house that was full of old treasures.

##### Practice note

This case study indicates the place a clinical treatment program might have along with a practical service response from several service providers.

The woman was mindful of her behaviour and was able to progress her new life. This is a sample case and does not necessarily intend to indicate that all people who are involved with treatment programs will achieve a similar direction. Each person is unique and their situation is dependent on a broad number of factors and circumstances.

### 7.1.3 Rural and metropolitan Melbourne property ownership

This hoarding example shows a response from local municipal council environmental health officers to a rural property where the person collected old cars, other types of vehicles and other items. This case would benefit from services from different sectors working together to further the desired outcome.

## Case study 3

### The situation

The site of the hoarding situation is on a medium sized bush block located in a rural conservation zone, in a rural area with the block surrounded by similar allotments. There is no dwelling on the property and bush coverage is around 80 per cent.

The hoarded objects were made up of approximately 200 vehicles stored, a large number of other collected and stored materials containing many electrical items, white goods, furniture and recreational equipment.

Many of the vehicles were filled with domestic items, including clothes, electrical items and soft toys. There were other, smaller piles of collected items on the property, including caravans and boats. It is likely that the items were gathered during a local municipal council hard rubbish collection or through the owner's advertisements as a scrap metal merchant.

The vehicles were mostly write-offs purchased from auctions. Most of the items appeared to have been on the property for some time. It appeared that the items were stored temporarily, although an advertisement offering cars for sale was found.

The property was owned jointly by father and son. The son is referred to in this case study as W who presented as the owner and was responsible for the hoarding. The joint owners had separate addresses in suburban Melbourne.

W identified as having a mental illness and throughout the course of the investigation and assessment had made statements such as 'You've ruined my life'. The father and mother were worried about W's mental health, resulting in the father being the main contact for negotiation.

W lived on the property for extended periods (for up to a couple of months), staying in at least one caravan, with bottled gas and an electrical generator.

### The service response

In 2006 a large fire on the property burned approximately 90 vehicles, resulting in the condition of the property being brought to the attention of the local municipal council.

In 2010 after initial inspections, local municipal council environmental health officers negotiated the removal of the burned vehicles and large piles of other items. After these actions the local municipal council informed the owners that continued removal of the remaining items needed to occur.

Nothing further changed, so the local municipal council environmental health officers began further investigations into the collection of vehicles and other items.

W believed that his collection had considerable monetary value and was worried about it being stolen, so created a corrugated iron compound where the majority of the vehicles were stored. To access this compound iron sheets needed to be removed. W also fixed down the bonnets of many of the vehicles so that access to parts was not easily gained. W placed signs near the entry point of the property depicting a skull-and-crossbones with the words 'Warning – traps'. Actual traps; that is, boards with nails protruding from them, had been placed on the ground on the property.

In the past W advertised cheap accommodation (for example, a caravan) on his property, noting that the tenant would be able to keep an eye on the property for him. W's suburban property had fewer than five vehicles stored on it and he had been observed collecting hard rubbish in suburban Melbourne.

W continued to answer advertisements where cheap vehicles were offered for sale or wanted, and advertised leases on rural properties for grazing/cropping, suggesting that he may have owned other rural properties.

## The outcome

Due to W's perceived mental illness, local municipal council environmental health officers applied a cooperative and staged response to what was happening at the property, negotiating mostly with W's father.

## Practice note

Service response considerations for the future:

- local municipal council environmental health officers might benefit by not limiting their communication and negotiation to W's father as the process, which had been drawn out over a long period of time, moves forward.
- partnering and involving other services (for example, mental health, a private industrial cleaning business and a people service or a hoarding behaviour specialist) who are skilled in working with people living with complex life situations would be appropriate, developing a coordinated action plan to assess and support W (refer to [Section 5 Collaborating with other services](#))
- incorporating additional strategies in an action plan to determine whether W is receiving and understanding the message from the local municipal council via his father to continue to remove the collection on his property, or whether W perceives his behaviour as acceptable. It would help with the assistance of a clinical service to determine W's degree of insight?
- consider the possible impact a combined interagency action plan may have on W's mental health if enforcement strategies were applied in the future.

Joint action planning is the mechanism that will decide how to include W in planning, decision making and agreed actions to achieve a more sustained outcome (refer to [Table 5 Core services that respond to hoarding and squalor situations](#)).

### 7.1.4 VCAT

This hoarding example involves VCAT and the *Residential Tenancies Act 1997* to assist a person who was a public housing tenant.

## Case study 4

### The situation

T (75 years old) was living in an older persons' Department of Human Services housing property. He was referred to the local ACAS (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 10) team by a local area housing services officer, who was concerned about the state of the property, which was virtually inaccessible except for a narrow path to crawl through, with no rooms usable for their original purpose.

T had a long history with the housing office. Prior to this he had moved several times over his adult life, due to landlords evicting him, because he used the property to store his possessions to an unsafe or inaccessible level. He had never had any involvement with support services or local municipal council care into any of these properties.

Housing services officers had supported T in the past providing skips for T to 'clean up his place'. Each time T verbally told them this would be done, and although T did clean up over the years in short dedicated bursts, the property continued to return to an unsafe state and generally got worse after each enforced clean-up.

T continued to live on his own with no long-term supports in place. T never had any rental arrears. Although T had a suspected mental health condition, he did not want to engage in an assessment or have anyone visit him from mental health services – despite many offers to arrange this, with his consent.

There were no immediate concerns for his safety. He did not live in squalor and he had no known history of self-harm to warrant a mental health service involvement without his consent. A referral to mental health services was flagged, although those services did not see the need to assess or offer consultancy at the time.

### The service response

T was assessed as eligible and placed on a Commonwealth Home Care Package (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 36), although he has never signed any paperwork, and had only ever giving his verbal consent to accepting this support package.

Despite working for some time with weekly visits from his carers and case manager, T (who is physically agile) continued to accumulate donated and found items off the street and from op shops, refilling his property on a daily basis, especially when he felt energetic or manic.

Although the property reached a stage of safety and risk that the housing services officers were pleased with, once inspections slowed down and pressure was reduced, T returned to the accumulating behaviour with renewed vigour. The entire time, the community aged home care provider was working with the local area Department of Human Services housing office and SfHRT (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1) program to continue to maintain T's tenancy, but also to address ways to reduce the hoarding behaviour, which was increasingly challenging, especially for the workers with weekly face-to-face contact.

After trying all other strategies it was decided that the housing services officers would begin using breach of duty notices under the Residential Tenancies Act. A series of breach notices were carefully written and delivered assisting T and the case manager to focus on particular areas to work on.

The breach notices also reinforced the seriousness of the issues, and gave a timeline and tangible consequence if he did not comply. It was not expected that T would remedy the breach notices on his own, but it would mean he was forced to work alongside his care providers with a specific purpose in mind.

T did not fully comply with the breach notices, so it was agreed that an application to VCAT's Residential Tenancies (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no 43) be made to hopefully seek a compliance order to ensure T had a continued expectation about the state of the property reinforced.

This was reluctantly done by all parties, the decision being reached after a long period of time characterised by constant relapse and noncompliance, despite enormous amounts of support being offered. It also meant T was able to be linked to appropriate and sensitive legal representation, which was of great support to him.

### The outcome

T was determined to keep his 'home' and hence the VCAT notice and hearing gave him the motivation and focus he had been lacking. He now had timelines and had to accept support to work on removing many of the items that were filling up his unit and blocking safe exits and room use.

Some of this assistance was paid for by SfHRT and the rest from T's Commonwealth Home Care Package. It was acknowledged by all parties involved with T that his hoarding behaviour would be ongoing unless he recognised and wanted to change, which he did in a very limited way. It will be a lifelong issue that T will need support with, especially if he continues to rent.

T now has contact with people every week, including people coming into his home. He has ongoing specialised case management and support with the other aspects of his life and is engaged with a range of social supports and community groups, which for so long were missing from his life. His home is still chaotic, but lifelong work is in progress.

## Practice note

T will continue to accumulate possessions and refill his property, but his Commonwealth Home Care Package will continue to support him.

The VCAT compliance order will hopefully be a tangible strategy to keep T's focus, but also reinforce the consequences of noncompliance. He will need regular inspections and ongoing decluttering support, and potentially may be called back to VCAT throughout his tenancy.

### 7.1.5 Private rental

This hoarding and squalor example presents a situation where a private real estate agent responded to the needs of a long-term tenant, a woman with hoarding behaviour that contributed to a squalid living environment. The woman was employed and worked night shifts.

## Case study 5

### The situation

H (aged in her 50s) worked night shifts and rented a bedsit in an inner city apartment block. She had lived there for 20 years.

A neighbour had complained to the local real estate agent that there were cockroaches coming into their unit from the neighbouring property's shared wall. The real estate agent, who was new to the role, arranged to visit the property and issued the appropriate inspection notice.

The property had not had an official inspection for approximately 10 years. H paid her rent on time and never requested any maintenance, so the real estate agent and the owner never had any concerns about her as a tenant.

The real estate agent followed through with an official property inspection and found H at home. H, though reluctant and distressed, provided access. The property was full of a range of collected materials and cockroaches and H was sleeping on a pile of raised clothing and papers, her bed was no longer visible.

H admitted household rubbish nor collected items had not been removed from the property for many years. H was a chain smoker and the property was full of cigarette packets and butts. H realised that her home had now become unliveable and that she needed help.

### The service response

The real estate agent was understanding and empathetic and immediately sought H's permission to call the local municipal council environmental health team for advice and guidance. The team organised a joint home visit with the local municipal council's aged and disability team leader.

Together with H's consent, they planned a referral to a specialised cleaning team. The local municipal council offered to pay this cost of a few thousand dollars. The specialist cleaning company was contracted to undertake a large-scale clean – mainly due to the urgency of the cockroach infestation and the squalor in the property. H agreed to proceed and to be involved in the actual clean-up itself.

The real estate agent liaised with the property's owner, who was notified of the state of the property. The real estate agent asked the owner to allow some time for H to cooperate, return the property to a clean and hygienic state and for H to accept ongoing support.

H was told the clean-up would only happen with her being present at all times, that it would be slow and progress depending on how she was feeling, as H was prone to feelings of depression.



## The outcome

The local municipal council environmental health officer recognised that H might benefit from longer-term assistance. H agreed to accept ongoing short-term home care and social support via the local municipal council's HACC program (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 17).

The real estate agent was thanked for their sensitivity and advocacy with the owner. The real estate agent arranged to do regular inspections with H's consent, to ensure H maintained the expectations of her lease.

Over time, with regular visits from the contracted HACC service, it was evident that H was able to maintain her own property.

A monitoring and assertive outreach support service had been engaged to keep regular contact with H to ensure she didn't face the risk of homelessness again.

H refused the offer of mental health support and assessment, preferring ongoing support from her GP (who may not have seen her home).

The assertive outreach service kept in regular contact with the real estate agent, whose management learned of the positive outcome and expressed an interest in learning more about the management of such issues.

## Practice note

This case highlights the value of public and private services from quite different sectors working in partnership to achieve a sustainable outcome for the person concerned.

## 7.2 People (clinical, capacity, health and dependents)

### 7.2.1 Health – the complexity of labelling Diogenes syndrome<sup>48</sup>

The following three cases highlight the complexity and diversity of people who may have been labelled as having Diogenes syndrome.

The first two cases (6 & 7) had underlying conditions, chronic schizophrenia and frontal lobe dysfunction, which can be associated with self-neglect, squalor and hoarding. In these instances, the use of the term 'Diogenes syndrome' might distract from the fact that there were underlying conditions that may have explained their clinical situation and would be deemed as inappropriate.

## Case study 6

### The situation

The manager of a post office referred L, a woman (79 years old) to ACAS ([Table 5 Core services that respond to hoarding and squalor situations](#), no. 10) with concerns about L's health and state of mind. L was described as malodorous, unwashed and dishevelled.

Footage from the security surveillance video revealed L voiding in the post office in full view of customers, seemingly indifferent to their reactions. L was known to have chronic schizophrenia and had long been estranged from her family.

### The service response

An ACAS assessment indicated L was dyspnoeic on exertion, unsteady on her feet and appeared unwell. L wore multiple layers of dirty clothes despite the warm weather.

<sup>48</sup> Lee et al. 2012.

The ACAS assessor engaged with L on the street before gaining permission to enter the house, which was filled with rotting food, human excrement, massed garbage from daily living and dirt. The stench was nauseating. The house was sparsely furnished, there was no fresh food and no utilities were connected.

### The outcome

On admission to hospital, L was dehydrated, disorientated, doubly incontinent and in atrial fibrillation with rapid ventricular response. Further tests revealed L had multiple nutritional and vitamin deficiencies and significant anaemia. L deteriorated rapidly during her inpatient stay and eventually died of hospital-acquired pneumonia.

### Practice note

- Underlying condition: chronic schizophrenia.
- Predominant symptoms: self-neglect and domestic squalor.
- Other symptoms: social withdrawal, apparent lack of shame.
- Absent: hoarding.

## Case study 7

Refer to introduction before Case study 6.

### The situation

A neighbour referred B, a man (87 years old) who was frail, forgetful and described as eccentric to ACAS. B had a history of bilateral frontal lobe haematomas from a previous road accident and alcohol-related dementia. The neighbour also reported vermin infestation and hoarding of items in the house and garden.

### The service response

When ACAS arrived at the house, B was seen wearing soiled pyjamas and emptying a bucket of urine on the nature strip. B's hair was matted and his fingernails were unkempt. B was malodorous and had long and curled onychogryphotic toenails with black cheesy material between his toes, highly suggestive of a longstanding fungal infection.

The property contained large numbers (maybe thousands) of bicycles and machinery, the house was in a state of disrepair with a narrow passageway filled with newspaper, pieces of wood, bicycles, tins of paint and solvents.

The ACAS assessors needed to turn sideways and step over piles of newspaper to move in the house. The stove had a thick layer of blackened grease as well as spilt food. The exhaust fan dripped grease and the sink was extremely dirty. The kitchen table and chairs were not visible because of the amount of material stacked on them. The rest of the house was in a similar state, packed with hoarded items and unclean.

### The outcome

B was facing prosecution from local municipal council environmental health officers for not responding to a clean-up order on the property. An application to VCAT (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 43) by ACAS for a guardian and administrator was successful.

### Practice note

- Underlying condition: frontal lobe dysfunction and alcohol-related dementia.
- Predominant symptoms: hoarding, self-neglect and domestic squalor.

## Case study 8

In contrast to the previous two cases, standard assessments of the couple in this third case failed to demonstrate cognitive impairment or any Axis 1 psychiatric illnesses.

### The situation

An elderly couple were referred to ACAS by their local doctor. The initial assessment was performed at the doctor's clinic on the couple's request. They were articulate, but their embarrassment about the state of their house had prevented them from seeking help earlier, even though they had difficulty coping at home.

### The service response

Several meetings between the couple and ACAS took place at a fast food outlet before the couple agreed to allow ACAS assessors into their house. At that time, to complicate matters, the wife became unwell and was admitted into hospital.

The three-bedroom house was full of hoarded material (books, magazines, board games, soft toys, sewing material and clothes) from floor to ceiling. The front door was completely barricaded and the kitchen and shower could not be identified.

The couple had not been able to make a cup of tea, cook a meal or wash themselves in their own home for 20 years. They had been eating at fast-food outlets and sponging themselves in public toilets.

Both had diabetes, hypertension, obesity and obstructive sleep apnoea. They did not fulfil the criteria for Axis 1 psychiatric disorders and their neuropsychological assessments did not detect any dementia or cognitive impairment.

The husband (O) repeatedly said that he could not understand how the hoarding situation had become so extreme. O was ashamed of the state of his home and agreed to declutter the passageway, one bedroom, the kitchen and bathroom. He understood that decluttering was necessary for service providers to provide home cleaning services, meals and hygiene assistance.

O was brought up in an orphanage and did not wish to live in a residential aged care facility. He signed a consent form before the intervention proceeded and was on site during the clean-up. His approval was sought before any item was discarded.

However, on the second day of the intervention, O became distressed and concerned about some missing items. He accused cleaning staff of stealing and said he had been 'raped'. O wrote numerous complaint letters and reported the matter to the police.

### The outcome

A Commonwealth Home Care Package case manager was appointed for ongoing management and was able to continue the cleaning process at a much slower rate, which was more acceptable to O. His wife was discharged home when they were able to utilise living spaces that were not accessible previously.

### Practice note

- Underlying condition: nil noted.
- Predominant symptom: hoarding with strong emotional attachment to possessions. There was secondary loss of use living areas required for self-care, resulting in squalor living arrangements and unconventional strategies for food and hygiene.

## 7.2.2 Metropolitan local municipal council aged and disability service

### Case study 9

This case study presents a squalid living environment resulting from the lifestyle of a couple with underdeveloped living and social skills. The couple owned their own home. Trust was established with support workers and partnering with other services involved disability, local municipal council and community health services over a two-year period with quite intensive contact.

There had been earlier attempts by the couple and a social worker from the CHC to engage other services on the couple's behalf, but this effort was not successful at the time.

#### The situation

A married couple (in their mid-50s), both with an intellectual disability, were resided in their own home which had been partly purchased following receipt of an inheritance. The local municipal council aged and disability service (HACC program) received a request for delivered meals from a family friend, who was a former teacher at the specialist school that both people attended when younger.

V (the woman) had a strained relationship with most of her family except one sister who lived in rural Victoria. X (the man) had a strained relationship with his family, who disapproved of his decision to marry and his lifestyle. The couple had a small dog which they kept inside which wasn't house trained.

#### The service response

Observations at HACC assessment indicated the house was in a strongly disordered state. The bedroom in particular was very cluttered. V and X spent much of the day in this room on the bed, watching TV. The dog also slept and ate in this room. Food was not properly stored in the kitchen (for example, meat and dairy items were not refrigerated).

The couple were receptive to contact. V in particular said she often felt lonely and enjoyed service provider visits, although the couple were reluctant to accept services initially. X was usually in bed when HACC assessment officers visited. He would be smoking and at times drinking beer. He always seemed relatively coherent and was never abusive. Repeated visits were required to build rapport and trust – initially with V and later with X.

The couple eventually accepted a heavy duty industrial clean provided by the local municipal council HACC home maintenance contractors provided at the HACC rate. The contractors were introduced to the couple by the HACC assessment officer. This was closely followed by a weekly HACC home care service with a carefully matched worker who was briefed and introduced to the couple by the HACC assessment officer prior to the home care service commencing.

The couple were referred for respective reasons to:

- Department of Human Services Disability Intake for short-term case management and planning
- Community Health because they both had health conditions requiring attention:
  - The visiting community nurse was an invaluable resource for both of them. X received treatment for a condition which had previously rendered him housebound. In addition, once he developed a relationship of trust with the community nurse, he decided to gradually reduce his drinking habits, which meant he was more alert and responsive.
  - The occupational therapist assisted V to receive treatment for her unsteady gait (for example, bathroom aids and physiotherapist for a walking aid).
- A volunteer from a HACC social support program worked with the couple teaching them to set limits for the dog with regard to appropriate feeding, toilet training and walking/exercise patterns.

## The outcome

V became more independent and started to walk the dog around the neighbourhood, re-engaging with neighbours and shopkeepers with whom she'd had contact with years ago.

The couple received reinforcement from the local municipal council HACC home support worker with regard to:

- positive messages about food storage and the need to discard food that was past its use-by date
- encouragement to participate in daily chores (for example, V to wipe down the bench while the worker was there and X to empty the bins and to pick up the dog litter).

Both were involved in the gradual decluttering of the bedroom. This process was reinforced by the local municipal council HACC home support worker and the visiting community nurse.

The original referrer (the former teacher) maintained contact with the local municipal council HACC service, but was unable to provide ongoing support to the couple due to other commitments in her life.

With the couple's permission both the local municipal council HACC assessment staff and the community health community nurse liaised with the treating GP, keeping him informed of progress.

## Practice note

The case did not involve hoarding behaviour. The service response issues involved a squalid environment as well as health and living skills concerns.

Information was provided in a meaningful and non-judgmental way. The couple had been unhappy and possibly embarrassed about how they were living, but did not know how to change.

### 7.2.3 Aged Care Assessment Service (ACAS)

This hoarding and squalor example involves ACAS (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 10), several other health and community services, family, friends and neighbours. Best efforts were made by all practitioners to engage and provide support to this woman, but success or engagement is not always possible. The person refused all offers of service assistance.

## Case study 10

### The situation

G, a woman (69 years old) was referred to ACAS by Victoria Police, which had been asked to attend to her property by the local municipal council to execute a warrant for unpaid rates. After several visits and concern about the woman's welfare, the police attempted to force entry to the premises.

G spoke to them through the window. The outside of the premises was extremely overgrown, there was a strong odour coming from within the house through the window and the woman presented as unkempt.

A next of kin was unable to be located. G gave the name of a female friend 'S' in rural Victoria. When contacted by ACAS, S advised she had not seen G for several years, but agreed to visit her the next week.

S provided service providers with limited background family history. G was possibly born in the late 1930's and had a brother who died at a young age, S could not recall when the woman's parents died, but confirmed that it was likely G had been living off the parents' estate. S was concerned that the woman now no longer had any income. S advised that G had previously lived in another area of town, but that the government purchased the family's land to build a TAFE institution, which was thought to be the origin of G's great dislike of the government.

## The service response

At the initial ACAS visit, with S, G came to the window and was happy to talk. She subsequently climbed out through the front window and the assessment commenced on the front porch. G advised that she used the window due to having lost her keys and that she stacked boxes against the door, so she could tell if someone had been in the house. G appeared paranoid about her neighbours, stating that they were watching her and that they were involved with drugs. This could not be discounted because G's house was in an area of high socio-economic disadvantage with a significant known drug community.

G had spent most of her life caring for her sick mother, who was thought to have died 15 years earlier. She had worked as a secretary. G did not have a telephone and had stopped paying her utility bills due to her dislike of the government. She had not applied, nor did she wish to receive an Aged Care Pension. G confirmed financial difficulties and struggled to purchase food and basic items.

G admitted her house needed a good clean, that she had 'let it go' and described clutter and boxes in the house. She also mentioned a recent fall over some clutter, but strongly declined any offers of assistance.

ACAS undertook several more visits together with the Aged Person's Mental Health (APMH) team, including the psychiatrist. General observations were that G had some paranoid features; however, she declined to have any assessments. G presented as malodorous and unkempt.

At the end of the visits G climbed back through the window. The APAT clinician went to the window and noted that the floor level was elevated as result of multiple layers of debris and the inside of the house was offensively malodorous. G presented several young kittens, stating her cat had recently had a litter. She refused to let anyone enter the house. APAT and ACAS clinicians received significant flea bites while at the property window.

Extensive searching of local health files by ACAS, to confirm identity or establish a past medical history, revealed no concrete results. The only admission found was for a female of the same name, but a different date of birth, who had a psychiatric admission with a drug overdose.

S recalled there were issues raised in the past about G living in unhygienic conditions and that the RSPCA had been involved to remove several animals.

G said she worked part time as a home carer, but could not state who she worked for. She did not have a doctor and did not take any medication; however, she had been placed into the local hospital for 'a rest' after her mother died, but denied having had any mental illness.

G had lived in a privately run supported residential service (SRS)<sup>49</sup> following her 'rest' in hospital, but left because she was constantly propositioned and alleged that one resident attempted to rape her.

APAT received information from another of G's friends, M, who confirmed the woman's family had been known to M for many years and that G attended M's home every week providing her with some 'home care' which in essence was a meal and shower for the woman at M's home. This had been occurring for several years.

APAT advised G had no psychiatric issues that required formal or compulsory intervention and there was no evidence to support an application for guardianship.

G declined all offers of support from ACAS, including support with her impending legal case for non-payment of local municipal council rates, refusing to let anyone enter her property.

## The outcome

Three years later G was placed in residential aged care, following an acute hospital admission and appointment of a guardian via VCAT.

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49 See: <http://www.health.vic.gov.au/srs>

## Practice note

This case indicates a multiple service response to address the health care and accommodation needs of an older woman with hoarding behaviour.

The woman decided not to accept any offers of support from any service. Life events determined the services able to be provided.

Initially G was assessed as having capacity to make her own decisions and did not require a guardian, though after a number of years her health status changed which then required the appointment of a guardian.

## 7.2.4 Metropolitan Fire and Emergency Services Board (MFB) operations emergency response

This hoarding example involves an elderly couple and their two adult sons who maintained a fairly isolated lifestyle in their home. The MFB emergency response was activated due to the way the family accessed electricity, which was a major safety concern.

### Case study 11

#### The situation

MFB operations received a call with regard to a couple, C, the woman (aged 70+) and V, man (aged 70+ both presenting in poor health and their two adult sons (aged 40+). The couple had a cultural and linguistic background other than English.

Electricity was supplied to the house via a lead and power board plugged into the electricity meter at the front of the house. At least one extension lead ran around the external side of the house and back into the home through holes made in the external wall.

Using the Clutter Image Rating Scale (refer to Section [8.2 Clutter Image Rating Scale \(CIRS\)](#)) the hoarding level was rated as 7+. Vermin (rats) were clearly visible inside the home.

#### The service response

MFB contacted the daughter, who did not live with the parents. The daughter was able to provide additional information.

C had terminal illness, V experienced depression and one of the brothers had undiagnosed mental health issues.

The family were socially isolated, financially disadvantaged with C and V receiving one Australian pension between them.

The daughter was unaware of what assistance might be available and thought cost and her parents' suspicion could be an issue, but was very concerned about all members of the family.

The daughter was advised that MFB was obliged to refer the electrical safety issue to either the local municipal council or Energy Safe, but could also make a dual referral to local municipal council – both local municipal council building inspection and aged and disability services.

The daughter requested that MFB refer the concern to the local municipal council and for herself to be the contact point to engage the family.

MFB contacted the local municipal council aged and disability HACC intake worker as well as local municipal council building inspection and recommended that a dual inspection be arranged through the daughter.



## Outcome

An assessor from local municipal council HACC aged and disability services and local municipal council building inspection visited the property and confirmed the extreme high risk conditions.

In consultation with the family, they discussed and coordinated a range of services, support and referrals to address the health and daily living needs of the family.

## Practice note

MFB operations often refer situations that come to their attention into the broader service system and work in partnership with agencies to address emergency and other concerns.

This case shows the effectiveness of a range of sectors working together. Additional services were also engaged in the medium to longer term based on consultation with C and V, the family via joint action planning.

### 7.2.5 Victoria police request for welfare check

#### Case study 12

This example presents a request from Victoria Police to MFB to gain entry to an apartment so that Victoria police could conduct a welfare check on E (the occupant).

#### The situation

After gaining entry through the front door, fire fighters and police were confronted by a wall of accumulated items to just under the roof line.

Attempts by fire fighters to access the inside of the property to identify if someone was inside were unsuccessful due to hoarding, and there was a strong odour coming from inside the apartment.

E appeared at the roof line and slid out and down onto the floor. E was deaf, used Auslan and confirmed he lived inside the apartment.

Fire fighters were unable to establish if the apartment had working smoke alarms and if these were smoke alarms for the deaf.

The apartment was on the second floor of a three-storey apartment block. Half the apartments in the entire block shared a single enclosed point of egress with the apartment with hoarding.

E's sister contacted MFB and advised that their father died in a hoarding-related fire and that she was unable to get assistance for her brother, but consented to being a contact point to negotiate assessment and assistance.

#### The service response

Contact was made with the local municipal council aged and disability services HACC intake and assessment worker as well as the local municipal council environmental health officer to advise of the case and provide contact details for the sister.

Local municipal council environmental health advised that there was not enough evidence (infestation/odours) for them to pursue, because the odour was not apparent when the door to the apartment was closed.

Local municipal council aged and disability services contacted the sister and attempted to work with E with assistance from the sister, but this was unsuccessful.

Local municipal council aged and disability services attempted to contact E directly to advise of services and support, but this was unsuccessful.

Local municipal council aged and disability services engaged local municipal council building inspectors and attempted to engage E.

## Outcome

Local municipal council building inspectors prepared a case for the Magistrates Court to gain access to the property due to structural concerns about the building due to the weight of hoarded materials in the apartment.

The MFB provided a report from the initial incident as a supporting document. If a court order is made allowing access to the property, MFB will work directly with local municipal council aged and disability services to support E. The outcome of the case was unknown at the time of writing this publication.

## Practice note

This case study highlights the risk for fire fighters and others when entering a building filled with hoarded material.

This case unfolds multiple strategic efforts to find a means to engage with E to assess safety and health concerns as well as structural concerns in the apartment and potentially neighbouring apartments in the block.

## 7.3 Animals (pets, livestock, wildlife and pests)

### 7.3.1 Department of Health (DH) Hospital Admission Risk Program (HARP)<sup>50</sup>

This hoarding and squalor example presents an older woman who owned her own home and hoarded cats. The service response involved multiple service types and funding challenges to manage the hoarding and squalor situation. HARP funds the TRAAC program at a large health service in Melbourne.

## Case study 13

### The situation

A granddaughter referred her grandmother K to the local municipal council aged and disability service, she was concerned about K's living conditions and the welfare of K's animals.

At the same time neighbours rang the same local municipal council environmental health service, due to concern about odour from the property, the number of cats living inside and increasing problems with rodents.

Two workers (TRAAC and a local municipal council environmental health officer) visited to assess K's situation, then jointly planned priorities and related issues to be addressed. Multiple visits occurred before K agreed to speak to the service providers, and even then it was through the closed front wire door.

Over months an action plan was negotiated with K, which included making contact with the GP due to concerns about her skin integrity, poor breathing and possible dementia.

The neighbours were assured that local municipal council was managing their complaint as well as endeavouring to address broader health and service concerns. The neighbours reported approximately 40 cats living in the property since the woman's husband died. The neighbours were stressed by the local municipal council's perceived lack of action to the point that every time a cat was found outside, the neighbours would trap it and take it to an animal welfare organisation or remove the cat themselves.

<sup>50</sup> See: <http://www.health.vic.gov.au/harp/about.htm>

Communication was maintained with the granddaughter, but it became apparent she could no longer be involved due to disengagement with other family members, including her own mother, who was K's daughter.

### The service response

Local municipal council (environmental health) could have legally requested the clearance of the external property due to the mouse plague. There was significant hoarding of furniture in the back yard and numerous cars, which couldn't be seen due to fence height and tall grass.

Ministry of Housing (MOH) provided maintenance assistance to clear the grass and rubbish in the back yard, with family attending to the removal of cars and hard waste.

A GP performed routine blood tests on K, reporting general good health but poor endurance. The GP was not aware of the living situation until the action plan was presented seeking clinical support. The GP thought cognitive screening was not required as K's cognition was good and there was no clear response to grief and loss issues.

Eventually K let the TRAAC worker into the property, where approximately nine cats and one dog were in a small living room. Most appeared to be in reasonably good shape, some were territorial with evidence of fighting between themselves. The TRAAC worker negotiated with K to have local municipal council (animal management) assess the cats, discuss animal registration, tagging and vet checks because of the significant number of fleas everywhere.

Using the Environmental Cleanliness and Clutter Scale (ECCS) tool (refer to [Section 8.1 Environmental Cleanliness and Clutter Scale \(ECCS\)](#)) the house was squalid to level 10, made up of wet and dry hazardous material, including animal excrement, flies, fleas and lice.

K presented with significant personal neglect, evidenced by strong urinary odour on her person and clothing, skin infections, oedema of her legs and poor breathing. The TRAAC worker engaged the family to accompany to GP visits because she was not informing the GP of health issues nor keeping pre-arranged appointments.

The TRAAC worker negotiated with the RSPCA, Cat Protection and local municipal council animal management services, which attended the property and removed each cat one by one for check-ups. Local municipal council agreed K could keep three cats and a dog (which was above the acceptable level) if the animals were registered. Six of the cats were removed, three were put down due to serious diseases and three were put up for adoption. TRAAC and the local municipal council paid for all cat treatments.

During the following 16 months engaging multiple services that made up K's support system, including arranging multiple case conferences, was challenging. SfHRT (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 1) and local municipal council (animal management) workers attended the meetings, with Department of Human Services Housing Division coming on board responding to tasks that required follow-up or delegation for completion.

A negotiated clean-up of the property occurred using a private business (refer to [Table 6 Other services that become involved in response to hoarding and squalor situations \(specialist\)](#), no. 52). Further funding was negotiated to enable local municipal council HACC home care services to be provided once the property was at a hygienically reasonable level (for example, no excrement on walls or floor).

ACAS commenced engagement, although whether K would give consent for geriatric assessment was unknown, due to her level of anxiety based on past behaviour towards health professionals.

K was eventually able to be assessed by ACAS for case management and a Commonwealth Home Care Package, as well as the commencement of local municipal council HACC services, which included home care and a weekly cleaning service, which eventually moved to fortnightly.

Further services were required for K's son, who moved into the property to support and assist with cleaning. Furniture was also donated. The Department of Human Services Housing Division Officers established regular contact.

The son purchased new furniture and threw out K's old clothes, with her permission because of the odour and bugs. K now had a new wardrobe, new clothes to wear.

### **The outcome**

There are now no cats on the premises. The last two went to live with K's daughter, which provided an additional reason for K to visit her daughter, because K receives comfort from the cats. K's visits to her daughter also provides respite for K's son.

Referrals were completed by the TRAAC worker for the memory clinic, podiatry and continence services, and physiotherapy also provided mobility assessment. Recommendations were made to the Department of Human Services Housing Division.

K was discharged from TRAAC after 465 days on their program. K has one healthy and happy dog.

K experiences early stages of dementia, but is able to look back and wonders how she managed to become so irrational in her reasoning and lifestyle, deducing it was most probably about grief and loneliness.

### **Practice note**

This case emphasises the amount of time required to progress a complex case, address the hoarding of animals and link K and eventually her son into the appropriate service systems to support them.

Services were engaged and provided from a very broad range of sectors over the 18 months of engagement. Each service, including the GP and animal services, had a role to play, working cooperatively in accordance with a joint action plan.

Case coordination and engagement of appropriate services by the case coordinator was key to the progress of this case.

This case highlights the importance of managing the needs of neighbours and understanding the family context at the same time as endeavouring to address the needs of the person concerned.

### **7.3.2 Public housing (mental health and animal hoarding)**

This hoarding example involves a Department of Human Services Housing Division tenant who required a mental health assessment and hoarded cats. Her adult son lived with her.

## **Case study 14**

### **The situation**

P and her adult son first came to the attention of the Housing Unit via the housing services officer (HSO), who had received complaints from neighbours regarding the smell of the property. The HSO became concerned for the family when they could not meet with them or gain access to the property.

When attending the home the HSO observed an overgrown garden with damage to the property and animal faeces, and experienced a strong odour coming from the property.

After many attempts by the HSO to contact P and consultation with the SfHRT worker, a police welfare check was arranged. Police attended and found P and her son inside the property along with more than 50 cats.

There was severe property damage due to cat faeces and urine.

## The service response

An ambulance attended to provide first aid to P and her son. P was taken into hospital for psychiatric treatment after being assessed as suffering from a psychotic illness.

Local services acted quickly to ensure support issues for the family, and the property issues were managed appropriately and in a timely manner.

The Department of Human Services Public Housing worked alongside local municipal council environmental health officers (EHOs) and the RSPCA to manage the damaged property, environmental health issues as well as capture and treat the animals. The property was assessed as uninhabitable by the local EHO.

SfHRT provided initial care coordination to services involved with the case and acted as a central point of contact and liaison between the Department of Human Services, the Department of Health, area mental health services and community service organisations.

When P was well enough to return to independent living with her son, the Department of Human Services Housing Division relocated the family to an alternative property more suitable to their needs. The property was furnished by a local homelessness and transitional housing organisation because the family was unable to salvage many of their belongings due to damage from the animals.

Care coordination services took over long-term care coordination which was required to ensure a holistic and coordinated care team and a plan was put in place for the tenant's transition back to independent living.

Services worked well together to accommodate the needs of the family. P received extended care in an inpatient unit, then transitioned to a prevention and recovery care facility (PARC) for rehabilitation in preparation for return to independence.

A Psychiatric disability rehabilitation support service (PDRS) (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 18) was engaged, along with a GP and mental health nurse program to monitor P's mental health in an ongoing capacity.

P's son was also linked with support services to assist him to integrate back into the community.

Secondary consultation was provided to the team by a clinical specialist (refer to [Table 5 Core services that respond to hoarding and squalor situations](#), no. 15 and [Section 9 Resources and contacts](#), Clinical treatment and support options, nos 9–12).

## The outcome

P maintained links to a mental health outreach worker (PDRS) and is now accessing the community. She is also still supported by a mental health nurse and a GP.

The Housing services officer is conducting regular inspections of the property. The family are doing well, with multiple agency service support and have no tenancy or hoarding issues.

## Practice note

This case study highlights the importance of a mental health assessment, but also the fact that P and her son decided to accept the services offered.

### 7.3.3 Local municipal council environmental health acting on the nuisance provisions of legislation (hoarded material and animal collection)

This hoarding and squalor example shows how local municipal council investigated, prosecuted and arranged for a clean-up under the nuisance provisions of the Health Act 1958, which has now been surpassed by the Public Health and Wellbeing Act 2008, where the same provisions still apply.

#### Case study 15

##### The situation

Q, a woman (in her 60s) lived in family-sized house and collected bottles, cans, old furniture and other material. The entire house was full of this material to the point that Q could only move from the outside to the kitchen, bedroom and bathroom – the rest of the space was floor to ceiling refuse.

Q also kept several cats and chickens. The chickens were free to fly, walk and breed in the yard.

##### The service response

The local municipal council environmental health officer (EHO) had several discussions with Q about cleaning up the yard, which proved to be futile. Local municipal council environmental health decided to issue a nuisance notice, which was followed up in the Magistrates Court, and an order was received indicating that local municipal council environmental health could clean up the property.

The police were in attendance at the site because Q displayed irate behaviour. The clean-up took two and half days to clean the front, sides and back yard only. The garage and house were untouched.

130 chickens were removed from the property, and due to the faeces, sandy loam was laid over the back yard to cover the odour. Five local municipal council outdoor staff attended the property to assist in the clean-up.

The nuisance notice was written only to deal with refuse as stated in the legislation. The household items (a fridge, wardrobe, lounge and an organ) that were not rotten and were not included in the clean-up order and, because the owner, refused permission for their removal, had to remain and were left under the carport.

Within two years this property was back to a cluttered condition; however, most of the items were household items – not the bottles and cans and other waste as before.

At the time that an application was first made to the Magistrates Court in relation to this property, the court did not often grant orders against people who hoard under the nuisance provisions of the (then applicable) *Health Act 1958*. However, an application was made again and was successful.

Q, the owner, had made considerable effort to clean up the front yard and it was decided that the local municipal council would not clean the property up given the previous clean-up cost (approximately \$10,000), which is still sitting against the value of the property. The property remains in an unkempt and cluttered condition.

##### The outcome

Victoria Police, the Department of Health (then the Department of Human Services) Public Health Unit (who were involved in helping with the notice issued under the act and provided advice), the local municipal council EHO and outdoor staff as well as the Magistrates Court all worked well together.

There were no other services involved in this case as the woman was in full time employment, drove car and appeared publicly to function well.

The Magistrates Court did not issue a written document for the court order, so the local municipal council's EHO, due to inexperience, did not bring this to the site, which was a source of confusion for the police who are used to issuing warrants and orders that are written.

### Practice note

The clean-up was successful to some extent, but did not address a sustainable outcome for Q and her hoarding behaviour. As a result the property soon returned to its original condition.

At the time it was determined there was no perceived need to involve a health or psychiatric service to address Q's hoarding behaviour, this decision could be reviewed and reconsidered in the future.

There may have been benefit for local municipal health environmental health to seek the support of a clinical service at the same time, to be present to support when the clean-up was occurring, which might have assisted with Q's irate behaviour due to her mental health condition – hoarding behaviour. The police may not have needed to attend if Q had been supported to deal with the clean-up prior to and while it was occurring and planned support via an action plan afterwards.

Even though Q was employed, able to drive and presented well publicly, did not mean that she was not eligible for service support to address her mental health condition.

### 7.3.4 RSPCA Victoria

This example presents a severe case of animal hoarding (the rescuer type: refer to Section [2.2.1 Hoarding](#)), which occurred over several years and involved local municipal council environmental health officers (EHO) and RSPCA Victoria.

## Case study 16

### The situation

Local municipal council environmental health received several complaints from neighbours of adjoining properties of odour and wandering cats. R (aged in his 60s) had lived on three different properties over the years and allowed full access of his home to cats.

R attracted stray cats to his home by leaving out large amounts of food, including roast chicken, bags of commercial cat food and milk. The number of cats increased due to uncontrolled breeding.

R genuinely believed he was helping the cats and did not see any problem, claiming he always had pets when he was growing up. He was well positioned financially. Over a period of time R had bought all new kitchen appliances, bulk amounts of commercial flea treatments and spent up to \$5,000 weekly hiding favourite cats in local catteries away from RSPCA inspectors.

### The service response

Initial negotiation efforts by the local municipal council EHO to reduce the number of cats failed and R was taken to court several times, with clean-ups and seizure of animals ordered on three occasions.

A total of 172 cats were seized from this man over time. Ninety cats were removed from the first property, of which 87 were euthanased due to cat flu, ringworm and general poor health. Fifty-one cats were removed from the second property, and 31 from the third property, all of which were euthanased due to behavioural problems. Deceased cats' remains were also found throughout all three properties.

Local municipal council EHO undertook clean-up of the properties, two of which were deemed unfit for human habitation, due to a build-up of clutter, high levels of ammonia and animal waste. The first instance took four days, 70 m<sup>3</sup> of rubbish was removed and cost in excess of \$7,000.



R then moved to a second property that was owned by an elderly family member who lived amongst the cats and squalor before passing away. This property was cleaned on three occasions by the local municipal council, one instance costing \$4,000 with the costs of the other instances unknown.

Utilities were not functioning at the first two homes.

### **The outcome**

R was charged on one occasion, yet did not receive any fines or receive a banning order. He is still living in the third property.

Local municipal council received complaints of smell and wandering animals with regard to the second property. R will be informally monitored by local municipal council EHO for the remainder of his life.

### **Practice note**

This case study highlights the importance of managing the welfare of hoarded cats, and indicates scope in the future for animal services to partner with appropriate human services to address the behaviour needs of R. Joint action planning might provide a broader range of strategies and professional expertise to address the overall situation.

### **7.3.5 RSPCA Victoria Inspectorate**

This animal hoarding and squalor example is from the RSPCA Victoria Inspectorate, and shows a response to D a rescuer type animal hoarder (refer to Section [2.2.1 Hoarding](#)) which resulted in a conviction of animal cruelty.

## **Case study 17**

### **The situation**

In 2010 a local municipal council environmental health officer (EHO) contacted RSPCA Victoria, reporting a concern about cats being confined in unhygienic conditions in a home and adjoining caravan of a property. There were reports of a strong smell of urine emanating from the caravan and dwelling, but only two cats were registered at that address.

An RSPCA inspector attended the address and found no one at home, but saw four caravans in front of the premises with rubbish bags piled between them and noticed the strong smell of cat urine coming from one of the caravans. A kitten was heard meowing from inside, but the inspector could not see inside the caravan because the windows were closed and covered. There was no apparent ventilation.

The inspector also investigated the outside of the house and noted flies present on the inside of the windows and a strong smell of cat urine. Not permitted to enter the caravan or the house at that time, the inspector left a calling card.

### **The service response**

The next day D, the resident contacted the inspector. The inspector expressed concerns about the welfare of the cats, particularly that they were being held in unhygienic conditions in both the house and caravan, and asked D to remove them from that environment.

D said that he caught and attempted to rehabilitate feral cats and was searching for another property in order to create sanctuary for them. He said that the cats were owned by him and his elderly mother. He stated that there was one cat, unable to be caught in the caravan, and that he would leave the caravan unlocked so that the inspector could attend the following morning to catch and remove it.

The next day the inspector attended the property accompanied by several local municipal council EHOs. They found the caravan was cluttered with accumulated debris, paper plates, fresh food, litter trays and

empty and full cans of cat food. One end of the caravan floor was covered with cat faeces and urine-soaked towelling and newspapers.

The inspector and EHO reported they were unable to breathe without retching. The inspector sighted three kittens on a cat bed, five adult cats, two newborn kittens and one dismembered kitten. While the cats were of antisocial behaviour, they were in a reasonable condition and were transported to the RSPCA Burwood shelter for assessment and care. D agreed to surrender the cats from the caravan to the RSPCA.

A few days later a warrant was executed to enter and search the house and seize animals at immediate risk from living in unhygienic conditions. Police, local municipal council EHOs, RSPCA inspectors, a veterinarian and a representative from the Department of Health's Environmental Health Unit were all in attendance. The team's eyes and throats burned from the high levels of ammonia inside the dwelling, meaning they could only operate within the house for short periods. Both the veterinarian and an inspector had problems breathing, similar to an asthma attack (later in the evening), due to the conditions within the dwelling. The local municipal council EHO stated that the house was clearly unfit for human habitation due to the cat faeces, rubbish and offensive, strong odours.

There was no ventilation and no working lights, making it difficult for the team to work, and clutter impeded the ability of the team to move freely within the house. They found approximately eight cat enclosures in the front room which were surrounded by clutter and items covering them. While the cages were empty of cats it was clear from the faecal matter, urine-soaked towels, rubbish bags and water bowls that cats had been held in them until very recently.

All rooms were checked and were found to have poor sanitation with flies present everywhere. It was clear that cats had been held in the rooms for long periods and no attempt had been made to prevent the unsanitary conditions. One bedroom was full of flies and held a cage with a cat inside it. Though the cat was in a reasonable condition it was sitting on faecal matter and urine-soaked paper towelling.

Seven cats were found to be confined to a rear bathroom and another two cats were found in other bedrooms. A total of 10 cats were found inside the dwelling, all of which were taken to RSPCA Victoria's Burwood shelter to be examined by a veterinarian. While most of the cats were in a reasonable body condition, they all had flea issues and displayed antisocial behaviour.

### **The outcome**

The RSPCA veterinarian stated that the condition of both the dwelling and caravan from where the animals were removed was detrimental to the health and welfare of the cats. The conditions would have caused unreasonable suffering due to fear and distress from confinement and overcrowding. The conditions would also have inflicted unreasonable pain due to poor sanitation, exposure to parasitic infection and ammonia poisoning.

A few days later D agreed to surrender all of the cats from the house to the RSPCA.

D was charged with animal cruelty, was convicted and fined \$500 with \$145 costs. He was banned for five years from keeping any animal.

### **Practice note**

This case study indicates the care for the welfare of the animals. The welfare of D might also have been better addressed by being linked into appropriate health support services, at the time the first response was initiated.

## 8 Tools to assist

To assist sectors, agencies, services and businesses to further develop a common means of responding to hoarding and squalor situations, the following range of tools has been drawn together for reference and use.

Most of these tools are pre-existing resources and are intended for active use (for example there are forms to be completed or templates to be customised). For service provider convenience, all the active tools are available for download as individual standalone documents on the Department of Health website. With the permission of respective authors, some tools have been reformatted so they present as a related suite, and are badged as supplementary documents to this publication. For reference purposes, all pages of the standalone documents are presented in this section as page images. Tools which are not intended for completion or customisation (for example some flow charts) are not provided as standalone documents.

To download the standalone versions of the tools, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

The tools in Section [8.9 Templates to assist with service coordination tasks](#) are pre-existing Department of Health templates, and have not been rebadged. To download the standalone versions of these templates, visit: <http://www.health.vic.gov.au/pcps/coordination/sctt.htm>

The first three tools (refer to the table on the following page) were selected due to their international standing and reliability. Circumstances involving hoarding and squalor need to be assessed objectively and these tools assist greatly in achieving that goal.

**Table 9 Rating tools**

| Ref                 | Situation | Name of tool   | Purpose of tool  |
|---------------------|-----------|--|--|
| <a href="#">8.1</a> | Squalor   | The Environmental Cleanliness and Clutter Scale (ECCS) | <p>This scale rates the degree and various aspects of uncleanness in rooms. Areas with varying functions (such as toilet, kitchen, bedroom) are rated, along with other indicators of squalor (for example, odour, vermin) and reduced to ten items, each rated on a four-point scale, with succinct descriptions of anchor points.</p> <p>The ECCS can be used by workers to gain an objective rating of the degree of squalor in a living environment. It also provides a measure of risk of entry for workers.</p> <p>Ratings (from none to severe) are indicated on a scale; a total score of greater than 12 usually indicates moderate or severe squalor.</p> <p>The ECCS has proved reliable and useful in rating cases where elderly people were living in severe domestic squalor.</p>  |
| <a href="#">8.2</a> | Hoarding  | The Clutter Image Rating (CIR) Scale                   | <p>The CIR scale was developed to overcome problems associated with people who over-report or under-report the severity of their hoarding symptoms.</p> <p>This tool is one of the most effective for objectively recording a change in clutter in the standard rooms of the home (living room, kitchen and bathroom).</p> <p>The CIR living room pictures (<a href="#">8.2 Clutter Image Rating Scale (CIRS)</a>) can also be used to make ratings on a dining room, hallway, garage, basement, attic or car.<sup>51</sup></p> <p>To gain an accurate perspective of a clutter situation, this series of nine pictures in each room was developed in various stages of clutter from completely clutter-free to very severely cluttered.</p> <p>People (either the person themselves, a worker or both simultaneously) can select the picture in each sequence that they think comes closest to the clutter in the living room, kitchen and bedroom.</p> <p>This decision requires some degree of judgment, because no two homes look exactly alike and clutter can be higher in some parts of the room than others. This rating works well as a measure of clutter. It also eliminates reliance on language, which works well for many people, enhancing its ease of use.</p> <p>In general, clutter that reaches the level of picture # 4 (in all CIRS Parts 1, 2, and 3) or higher impinges enough on people's lives that the person should be encouraged to seek assistance for their hoarding behaviour.<sup>52</sup></p> |
| <a href="#">8.3</a> | Hoarding  | The Hoarding Rating Scale (HRS-I)                      | <p>This brief (5–10 minute) five-item semi-structured interview assesses the features of compulsive hoarding (clutter, difficulty discarding, acquisition, distress and impairment).</p> <p>The HRS-I is a promising measure for determining the presence and severity of compulsive hoarding.</p> <p>The worker asks the person with the hoarding behaviour the interview questions.</p>  |

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51 Bratotiis et al. 2011.

52 Frost & Steketee 2006.

The tools above are already used by many service providers in Victoria, providing strong evidence of their usefulness for the following reasons. The tools:

- provide a common reference point between services when referring cases
- act as descriptive communication tools (for example, if an environment is described by the CIR as a 4, clarity exists between services as to what degree of clutter is being referred to)
- assist with assessing for the degree of risk
- are an educative, practical teaching tool.

The CIR is used by many services across all sectors in the following ways:

- it acts as a trigger, providing an objective measure to indicate a service provider's capacity to sustain a certain level of response and (if up to a level five, or maybe a six) to review the action plan
- one community nursing service identifies level 5 as then needing to refer for clinical/other assessment. The nursing service also decides at level 5 they will no longer enter inside the persons home which means their treatment is provided external to the home in the yard or on porch.

The MFB uses the CIR to identify a level of hoarding for all fire and emergency events identified through the MFB Operational Response (refer to Section [3.5.1 Risk management](#)), in order to:

- assess a fire risk level in accordance with the MFB/WPI research studies – level 5 was identified as the first level of hoarding at which fatalities occur. In the research studies the fatalities relate to an older person and it was clear that the risk was increased through the effect of hoarding on mobility and the capacity to safely self-evacuate
- identify a level of risk in each incident
- prioritise a referral from MFB to another agency
- quantify the level of hoarding in an MFB referral to an external agency
- quantify the level of hoarding when responding to external inquiries regarding risk
- assess whether a property or person fulfils the eligibility requirement for the MFB Hoarding Notification System, which is level 5.

A local child protection service uses the CIR to refer to other services such as Department of Human Services SfHRT, Housing, Disability and other child protection support workers to:

- ascertain the level of support required for such referrals
- support workers and clients (at the time of initial assessment, during the service provision period, and at the closure of service provision) to show progress and change
- be retained by the client to compare the actual environment with a rating scale to ensure that their hoarding level does not increase again over time
- include the CIR photographs in their outreach kit, which the staff find very useful to describe a home environment when conducting visits. This practice is in relation to environmental risks to the children in the home, which are assessed at each visit
- hand out the resource information to all its workers, who now have a better understanding of 'working at the person's pace' and are better able to manage their need (the workers) to clean up the place or expect the home to be clean. The workers now ask families to work on one area at their own pace, which seems to work well, as the families don't seem so overwhelmed.

Several other tools in this section have been developed by local networks in Victoria, all of which were prepared to share their expertise with others to minimise duplication of effort and contribute to service capacity building (refer to Section [8.4 Squalor and hoarding profile: creating a pathway](#), Section [8.5 Fire risk reduction flyer](#) and Section [8.7 Shared action plan checklist](#)).

A range of forms have been presented so that service providers can cut, past and modify the forms to suit local conditions, service mix and requirements (refer to Section [8.6 Contact other local services after receiving an initial referral](#) and Section [8.8 Local hoarding and squalor service directory](#)).

In other cases, links to forms that have already been developed for the collection of consumer information, referral forms, shared action planning forms might be useful for agencies or services that would like to use these and don't already have forms available (refer to Section [8.9 Templates to assist with service coordination tasks](#)).

### 8.1 Environmental Cleanliness and Clutter Scale (ECCS)<sup>53</sup>

This form has been designed for service providers to respond to situations involving squalor. The form assists with rating the cleanliness of a person's accommodation.

Please refer to [Table 9 Rating tools](#) at the front of this section for a more detailed explanation.

To download this tool in Microsoft Word or PDF format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

### Figure 8 Environmental Cleanliness and Clutter Scale (ECCS)

## Environmental Cleanliness and Clutter Scale (ECCS)\*

This form has been designed for service providers to respond to situations involving squalor. The form assists with rating the cleanliness of a person's accommodation.

This first page may be removed if it is desirable to de-identify the person when communicating with other agencies.

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

\* Source: Halliday G, Snowden J, 2006 Environmental Cleanliness and Clutter Scale (ECCS) based on the version devised by Snowden (1996), which mostly used items listed by Macmillan & Shaw (1996). Some descriptions used by Samios (1996) in her adaptation of the scale have been included.

Figure 8 Environmental Cleanliness and Clutter Scale (ECCS)

Figure 8 continues next page

53 Developed by G. Halliday and J. Snowdon (2006), this scale is based on the version devised by Snowdon (1986), which mostly used items listed by Macmillan & Shaw (1966). Some descriptions used by Samios (1996) in her adaptation of the scale have been included.



**Figure 8 Environmental Cleanliness and Clutter Scale (ECCS) (continued)**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.1 Environmental Cleanliness and Clutter Scale (ECCS)

Department of Health

Raters should circle the box or number that best fits their observations in relation to the different items. These descriptions are meant to be indicative, but raters may decide between one category and another based on aspects not mentioned in the boxes.

Name of rater: \_\_\_\_\_

Rater's phone no: \_\_\_\_\_ Date: \_\_\_\_\_

|   |   |  |   |   |
|---|---|--|---|---|
| A | <b>Accessibility (clutter)</b>                              |  |   |   |
|   | 0   | 1  | 2   | 3   |
|   | <b>Easy To enter</b> and move about dwelling.               | <b>Somewhat Impaired</b> access, but can get into all rooms. | <b>Moderately Impaired</b> access. Difficult or impossible to get into one or two rooms or areas. | <b>Severely impaired</b> access, for example, obstructed front door. Unable to reach most or all areas in the dwelling. |
|   | 0–29%   | 30–59%   | 60–89%  | 90–100%   |
|   | _____ of floor space inaccessible for use or walking across |  |   |   |

|   |  |  |  |  |
|---|--|--|--|--|
| B | <b>Accumulation of refuse or garbage</b>   |  |  |  |
|   | In general, is there evidence of excessive accumulation of garbage or refuse, eg, food waste, packaging, plastic wrapping, discarded containers (tins, bottles, cartons, bags) or other unwanted material? |  |  |  |
|   | 0  | 1  | 2  | 3  |
|   | <b>None</b>  | <b>Little</b><br>Bins overflowing and/or up to 10 emptied containers scattered around. | <b>Moderate</b><br>Garbage and refuse littered throughout dwelling. Accumulated bags, boxes and/or piles of garbage that should have been disposed of. | <b>Lots</b><br>Garbage and food waste piled knee-high in kitchen and elsewhere. Clearly no recent attempt to remove refuse and garbage |
|   |  |  |  |  |

|   |  |   |  |  |
|---|--|---|--|--|
| C | <b>Accumulation of items of little obvious value</b>   |   |  |  |
|   | In general, is there evidence of accumulation of items that most people would consider are of little use or should be thrown away? |   |  |  |
|   | 0  | 1   | 2  | 3  |
|   | <b>None</b>  | <b>Some accumulation</b> , but collected items are organised in some way and do not much impede movement or prevent cleaning or access to furniture and appliances. | <b>Moderate excessive accumulation</b> : items cover furniture in most areas, and have accumulated throughout the dwelling so that it would be very difficult to keep clean. | <b>Markedly excessive accumulation</b> : items piled at least waist-high in all or most areas. Cleaning would be virtually impossible: most furniture and appliances are inaccessible. |
|   |  |   |  |  |

Please indicate types of items that have been accumulated:

☐ Newspapers, pamphlets, and so on      ☐ Clothing      ☐ Other items

(what? ..... )

☐ Electrical appliances      ☐ Plastic bags full of items

(If known, what items? ..... )

Figure 8 Environmental Cleanliness and Clutter Scale (ECCS)

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Figure 8 continues next page

Figure 8 Environmental Cleanliness and Clutter Scale (ECCS) (continued)

|   |   |  |  |  |                      |  |  |  |  |
|---|---|--|--|--|----------------------|--|--|--|--|
| Hoarding and squalor – a practical resource for service providers (June 2013)<br>Section 8.1 Environmental Cleanliness and Clutter Scale (ECCS) |   |  |  |  | Department of Health |  |  |  |  |
| D   | <b>Cleanliness of floors and carpets (excluding toilet and bathroom)</b>    |  |  |  |                      |  |  |  |  |
|   | 0   | 1  | 2  | 3  |                      |  |  |  |  |
|   | Acceptably clean in all rooms.  | <b>Mildly dirty</b><br>Floors and carpets look as if not cleaned or swept for days. Scattered rubbish.   | <b>Very dirty</b><br>Floors and carpets very dirty look as if not cleaned for months. Rate 1 if only one room or small area affected.  | <b>Exceedingly filthy</b><br>With rubbish or dirt throughout dwelling. Excrement usually merits a 3 score.   |                      |  |  |  |  |
| E   | <b>Cleanliness of walls and visible furniture surfaces and window sills</b> |  |  |  |                      |  |  |  |  |
|   | 0   | 1  | 2  | 3  |                      |  |  |  |  |
|   | Acceptably clean in all rooms.  | <b>Mildly dirty</b><br>Dusty or dirty surfaces. Dirt comes off walls on damp rag or finger.  | <b>Very dirty</b><br>Grime or dirt on walls. Cobwebs and other signs of neglect. Greasy, messy, wet and/or grubby furniture.   | <b>Exceedingly filthy</b><br>Walls, furniture, surfaces are so dirty (for example, with faeces or urine) that rater wouldn't want to touch them.   |                      |  |  |  |  |
| F   | <b>Bathroom and toilet</b>  |  |  |  |                      |  |  |  |  |
|   | 0   | 1  | 2  | 3  |                      |  |  |  |  |
|   | Reasonably clean.   | <b>Mildly dirty</b><br>Untidy, uncleaned, grubby floor, basin, toilet, walls and so on. Toilet may be unflushed.   | <b>Moderately dirty</b><br>Large areas of floor, basin, shower/bath, are dirty, with scattered rubbish, hair, cigarette ends, and so on. Faeces and/or urine on outside of toilet bowl.                | <b>Very dirty</b><br>Rubbish and/or excrement on floor and in bath or shower and/or basin. Uncleaned for months or years. Toilet may be blocked and bowl full of excreta.  |                      |  |  |  |  |
| G   | <b>Kitchen and food</b>   |  |  |  |                      |  |  |  |  |
|   | 0   | 1  | 2  | 3  |                      |  |  |  |  |
|   | Clean. Hygienic.  | <b>Somewhat dirty and unhygienic</b><br>Cooktop, sink untidy and surfaces dirty, maybe with some spilt food. Refuse mainly in garbage bin. Food that could go off (eg, meat, remains of meat) left uncovered and out of fridge. Rate 1 if no food, but fridge dirty. | <b>Moderately dirty and unhygienic</b><br>Oven, sink, surfaces, floor are dirty, with piles of unwashed crockery and utensils and so on. Bins overflowing. Some rotten or mouldy food. Fridge unclean. | <b>Very dirty and unhygienic</b><br>Sink, cooktop, insides of all cupboards filthy. Large amount of refuse and garbage over surfaces and floor. Much of the food is putrid, covered with mould and/or rotten, and unsafe to eat. Rate 3 if maggots seen. |                      |  |  |  |  |
| Figure 8 Environmental Cleanliness and Clutter Scale (ECCS)   |   |  |  |  | Page 3 of 5          |  |  |  |  |

Figure 8 continues next page

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Figure 8 Environmental Cleanliness and Clutter Scale (ECCS) (continued)

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.1 Environmental Cleanliness and Clutter Scale (ECCS)

Department of Health

**Supplementary questions – to add to description, but not to score**

Comments or description to clarify, amplify, justify or expand on above ratings:

|  |
|--|
|  |
|  |
|  |
|  |
|  |
|  |
|  |

**Personal cleanliness**  
Describe the clothing worn by the occupant and their general appearance:

|  |   |   |   |
|--|---|---|---|
| 0                                      | 1   | 2   | 3   |
| <b>Clean and neat.</b> Well cared for. | <b>Untidy, crumpled:</b> one or two dirty marks and in need of wash | <b>Moderately dirty:</b> with unpleasant odour, stained clothing. | <b>Very dirty:</b> stained, torn clothes, malodorous. |

Is there running water in the dwelling? YES or NO

Is electricity connected and working? YES or NO

Can the dwelling be locked up and made secure? YES or NO

**Maintenance, upkeep, structure**  
This rates the state of repair and upkeep by owner/landlord. If the accommodation was cleaned up as much as possible, to what extent would the dwelling require painting, refurbishment, structural repairs and so on before it would be reasonably habitable?

|             |  |   |   |
|-------------|--|---|---|
| 0           | 1  | 2   | 3   |
| <b>None</b> | <b>Little</b> – minor repairs and some painting. | <b>Fair amount</b> – some structural repairs plus painting. | <b>Lots</b> – major structural repairs required, and then painting. |

**To what extent do the living conditions make the dwelling unsafe or unhealthy for visitors or occupant(s)?**

|                   |   |   |   |
|-------------------|---|---|---|
| 0                 | 1   | 2   | 3   |
| <b>Not at all</b> | <b>Possible risk</b> – of injury for example, by falling. | <b>Considerable risk</b> – of fire, injury or health problem. | <b>Very unsafe</b> – the dwelling is so cluttered and unhealthy that people should not enter it, (except specialists with appropriate clothing and equipment) and/or there is high fire-risk. |

Figure 8 Environmental Cleanliness and Clutter Scale (ECCS)

Page 5 of 5

## 8.2 Clutter Image Rating Scale (CIRS)

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

Please refer to [Table 9 Rating tools](#) at the front of this section for a more detailed explanation.

To download this tool in Microsoft Word or PDF format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

**Figure 9 Clutter Image Rating Scale (CIRS)**

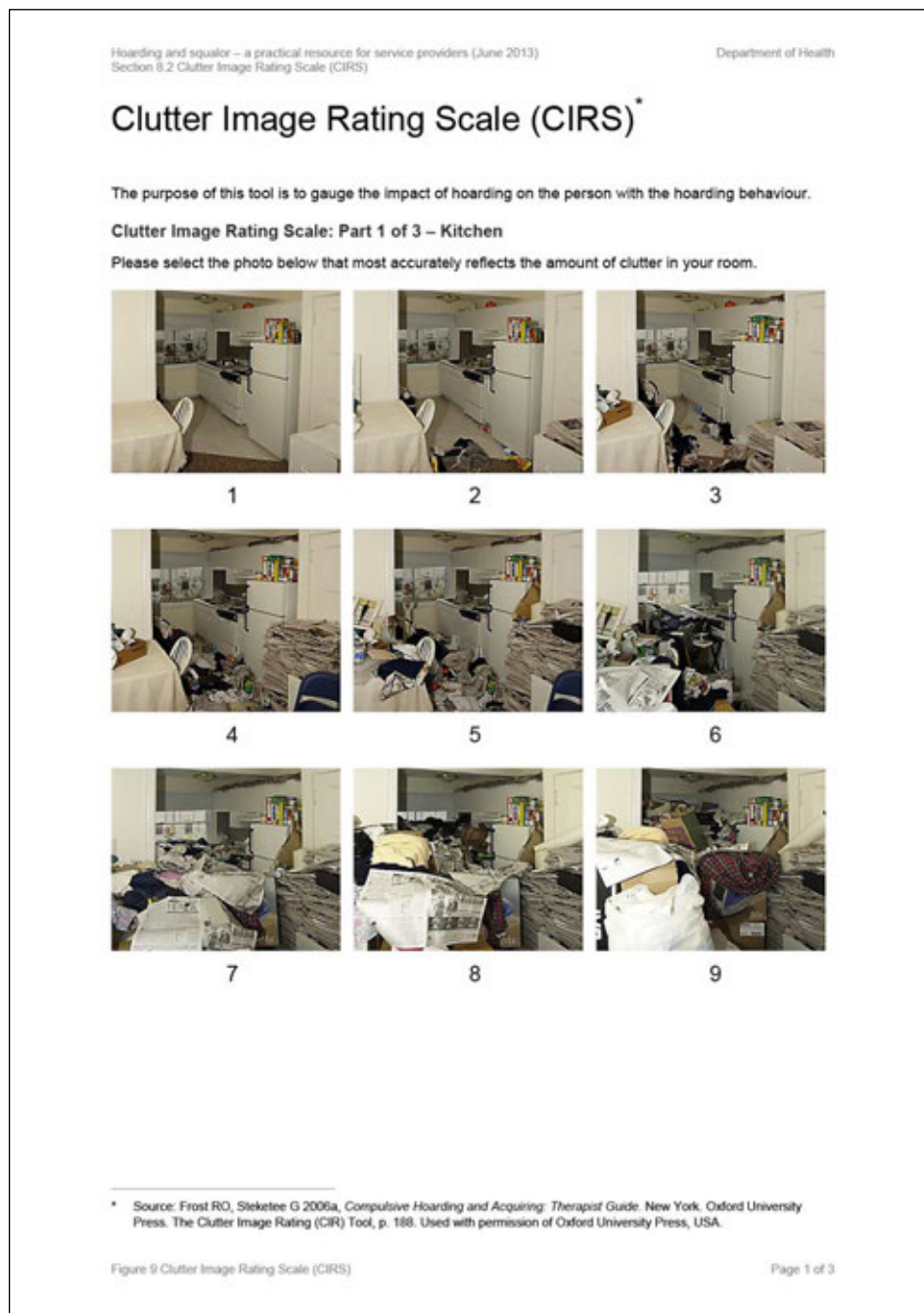


Figure 9 continues next page

**Figure 9 Clutter Image Rating Scale (CIRS) (continued)**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.2 Clutter Image Rating Scale (CIRS)

Department of Health

**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  |

Figure 9 Clutter Image Rating Scale (CIRS)

Page 2 of 3

Figure 9 continues next page

**Figure 9 Clutter Image Rating Scale (CIRS) (continued)**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.2 Clutter Image Rating Scale (CIRS)
Department of Health

**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

Figure 9 Clutter Image Rating Scale (CIRS)
Page 3 of 3



## 8.3 Hoarding rating scale interview (HRS-I)<sup>54</sup>

Please refer to [Table 9 Rating tools](#) at the front of this section for an explanation of the purpose of this tool.

The second page of this tool provides a brief summary of how the total HRS interview scores<sup>55</sup> can be interpreted and the criteria for clinically significant hoarding.<sup>56</sup>

To download this tool in Microsoft Word or PDF format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

**Figure 10 Hoarding rating scale interview (HRS-I)**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.3 Hoarding rating scale (HRS-I)
Department of Health

### Hoarding rating scale (HRS-I)\*

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        |

1. 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 |
2. 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 |
3. 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 |
4. 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 |
5. 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 |

\* Source: Tolin DF, Frost RO, Steketee G, Gray KD, Fitch KE 2008, The economic and social burden of compulsive hoarding. *Psychiatry Research* 160, 200–211.

Figure 10 Hoarding rating scale (HRS-I)
Page 1 of 2

Figure 10 continues next page

<sup>54</sup> Tolin et al. 2008.

<sup>55</sup> Tolin et al. 2010.

<sup>56</sup> Tolin et al. 2008.

**Figure 10 Hoarding rating scale interview (HRS-I) (continued)**

|  |  |
|--|--|
| <p>Hoarding and squalor – a practical resource for service providers (June 2013)<br/>Section 8.3 Hoarding rating scale (HRS-I)</p> <p><b>Interpretation of HRS total scores*</b></p> <p>Mean for nonclinical samples: HRS total 3.34, standard deviation = 4.97.</p> <p>Mean for people with hoarding problems: HRS total 24.22, standard deviation = 5.67.</p> <p>Analysis of sensitivity and specificity suggest an HRS total clinical cut off score of 14.</p> <p><b>Criteria for clinically significant hoarding†</b></p> <p>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.</p> <p><small>* Source: Tolin DF, Frost RO, Steketee G 2010, A brief interview for assessing compulsive hoarding: The Hoarding Rating Scale-Interview. <i>Psychiatry Research</i>, 178, 147–152.</small></p> <p><small>† Source: Tolin DF, Frost RO, Steketee G, Gray KD, Fitch KE 2008, The economic and social burden of compulsive hoarding. <i>Psychiatry Research</i> 160, 200–211.</small></p> <p>Figure 10 Hoarding rating scale (HRS-I)</p> | <p>Department of Health</p> <p>Page 2 of 2</p> |
|--|--|

## 8.4 Squalor and hoarding profile: creating a pathway<sup>57</sup>

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 11 Squalor and hoarding profile: creating a pathway**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.4 Squalor and hoarding profile: creating a pathway

Department of Health

### Squalor and hoarding profile: creating a pathway

|                       |                 |
|-----------------------|-----------------|
| Property:             | Account number: |
| Tenant:               | Phone number:   |
| Tenancy commencement: |                 |

#### Environment profile

|  |                              |                             |
|--|------------------------------|-----------------------------|
| Cluttered:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Squalid:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Animal hoarding:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes number and type of animal(s):   |                              |                             |
| Number of rooms involved:  |                              |                             |
| Clutter Image Rating Scale (CIRS):   |                              |                             |
| Current OoH legal actions – including expiry dates, e.g. Breach Notices:   |                              |                             |
| Is the person willing to cooperate with the process of a squalor/hoarding intervention? Yes <input type="checkbox"/> No <input type="checkbox"/> |                              |                             |
| Is there an accumulation of rubbish? Yes <input type="checkbox"/> No <input type="checkbox"/>  |                              |                             |
| Is rubbish contained to one part of the property?<br>Yes <input type="checkbox"/> – If yes please indicate area of concern                       |                              |                             |
| No <input type="checkbox"/> – All of property internally and externally  |                              |                             |
| Unsure <input type="checkbox"/>  |                              |                             |
| Are there items suitable for donation (i.e. op shop)? Yes <input type="checkbox"/> No <input type="checkbox"/>                                   |                              |                             |

#### Health and safety hazard profile

|  |                              |                             |                                 |
|--|------------------------------|-----------------------------|---------------------------------|
| Rodents (rats, mice):  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Vermin (including fleas, birds, cockroaches etc.):   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| All utilities functioning:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| If no, which utilities require action?   |                              |                             |                                 |
| Bio hazards within property (including sewerage, animal or food waste): Yes <input type="checkbox"/> No <input type="checkbox"/> |                              |                             |                                 |
| Public safety threat: Yes <input type="checkbox"/> No <input type="checkbox"/>   |                              |                             |                                 |
| If yes, details (extreme fire hazards, sewerage, vermin):  |                              |                             |                                 |
| Other:   |                              |                             |                                 |

\* Source: Department of Human Services, Southern Division, Gippsland Area, Housing and Community Building, Social Advocacy and Support Program (Support for High Risk Tenancies (SfHRT) program).

Figure 11 Squalor and hoarding profile: creating a pathway

Page 1 of 3

Figure 11 continues next page

<sup>57</sup> Source: Department of Human Services, Southern Division, Gippsland Area, Housing and Community Building, Social Advocacy and Support Program (Support for High Risk Tenancies (SfHRT) program).

**Figure 11 Squalor and hoarding profile: Creating a pathway (continued)**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.4 Squalor and hoarding profile: creating a pathway

Department of Health

**Fire hazard profile**

|  |                              |   |
|--|------------------------------|---|
| Overgrown gardens:   | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Combustible items, e.g. papers, plastics:                                | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Clear pathways for entry and exits (for emergency services, not tenant): | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Heating units obstructed:  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Cooking units obstructed/unclean:  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Building structurally safe:  | Yes <input type="checkbox"/> | No <input type="checkbox"/>                                 |
| Exposed electrical wiring present:                                       | Yes <input type="checkbox"/> | No <input type="checkbox"/> Unsure <input type="checkbox"/> |
| Cigarettes smoked in property:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> Unsure <input type="checkbox"/> |

**General living and health conditions**

|   |                              |                             |                                 |
|---|------------------------------|-----------------------------|---------------------------------|
| Previous episodes of hoarding/squalor:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| If yes, provide details:  |                              |                             |                                 |
|   |                              |                             |                                 |
| Health concerns for occupant:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Physical health assessment required:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Mental health assessment required:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Aged Care Assessment required:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| DHS – Disability registered (not DSP):  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| State Trustees/Power of Attorney client:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Assistance required for person to manage intervention: *  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| * Hoarding/squalor intervention can be very stressful and invasive. Therefore assistance to manage this additional stress may be required.) |                              |                             |                                 |
| Temporary accommodation required:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| If temporary accommodation is required, is the person able to arrange (i.e. with family members/friends):                                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Animal(s) surrender acknowledged by the person:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Ability to manage hoarding behaviours after intervention:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| Dependants living at property:  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| If yes, provide the number and ages of each dependant:  |                              |                             |                                 |
|   |                              |                             |                                 |
| DHS – Child Protection involvement:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |
| DHS – Child Protection report required:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Unsure <input type="checkbox"/> |

Figure 11 Squalor and hoarding profile: creating a pathway

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Figure 11 continues next page

Figure 11 Squalor and hoarding profile: Creating a pathway (continued)

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.4 Squalor and hoarding profile: creating a pathway

Department of Health

### Person supports

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Family members:                         | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                        |                              |                             |
| Relationship to person (list below)     |                              |                             |
|   |                              |                             |
| Friends:                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                        |                              |                             |
| Health supports, i.e. GP, case manager: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                        |                              |                             |
| Agency supports, e.g. HACC, MIND:       | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                        |                              |                             |
| Church groups:                          | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                        |                              |                             |

### SfHRT assistance required (please supply photos)

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Specialist referral required, e.g. mental health: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Skip bin:   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Garden work :                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Internal clean:                                   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Repair/replacement of items:                      | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Ongoing supports required, e.g. HACC:             | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, details:                                  |                              |                             |
| Other – please provide details:                   |                              |                             |
|   |                              |                             |

### SfHRT use only

|   |  |            |
|---|--|------------|
| Referral complete: <input type="checkbox"/> | CP: <input type="checkbox"/>               | Details:   |
| SHARP referral: <input type="checkbox"/>    | Disability: <input type="checkbox"/>       | Details:   |
| Person's consent: <input type="checkbox"/>  | MH: <input type="checkbox"/>               | Details:   |
| Photos: <input type="checkbox"/>            | Previous history: <input type="checkbox"/> | Details:   |
| OoH current legal actions:                  | Previous SfHRT: <input type="checkbox"/>   | Brokerage: |
| HV details:                                 | Case management:                           |            |

Figure 11 Squalor and hoarding profile: creating a pathway

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## 8.5 Fire risk reduction flyer<sup>58</sup>

This flyer was developed at a local municipal level to give to older people or people with a disability to assist with their understanding of fire risk in their home. It could contribute to discussion with regard to actions required to reduce fire risk.

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 12 Fire risk reduction flyer**

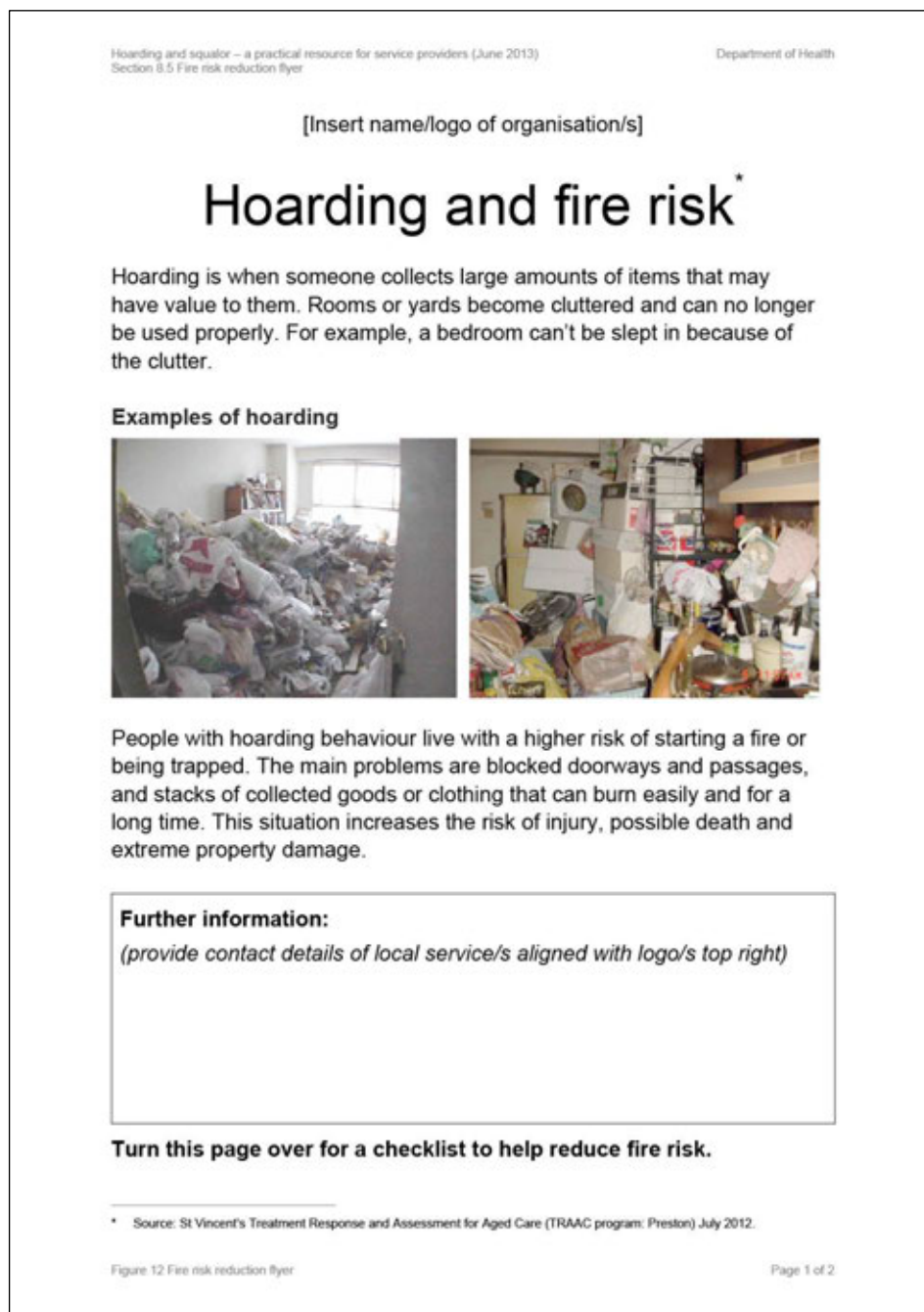


Figure 12 continues next page

58 St Vincent's Treatment Response and Assessment for Aged Care (TRAAC program: Preston) July 2012.

Figure 12 Fire safety flyer for local use (continued)

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.5 Fire risk reduction flyer

Department of Health

**Fire risk reduction advice**

To reduce fire risk you need to:  
*Check that all fixed and portable appliances including power boards and extension leads are in working order and operating without clutter on top or near them.*

| Actions  | Low risk  | High risk   |
|--|---|---|
| Install smoke alarms and test them.  |       |        |
| Unblock exits and clear pathways in house.   |       |        |
| Check all water, gas, electrical wires and plugs are connected and operate safely. |     |      |
| Remove clutter from cooking areas; for example, stovetops.                         |   |   |
| Remove clutter from electrical items; for example, heaters.                        |   |    |

Figure 12: Fire risk reduction flyer

Page 2 of 2



## 8.6 Contact other local services after receiving an initial referral

This chart aims to assist service providers think through which other local service providers to contact in relation to information received at the initial point of contact. Simply complete the local contact details (refer to Section 5 [Collaborating with other services](#) for additional service information; also refer to [Acronyms and abbreviations](#) in this document).

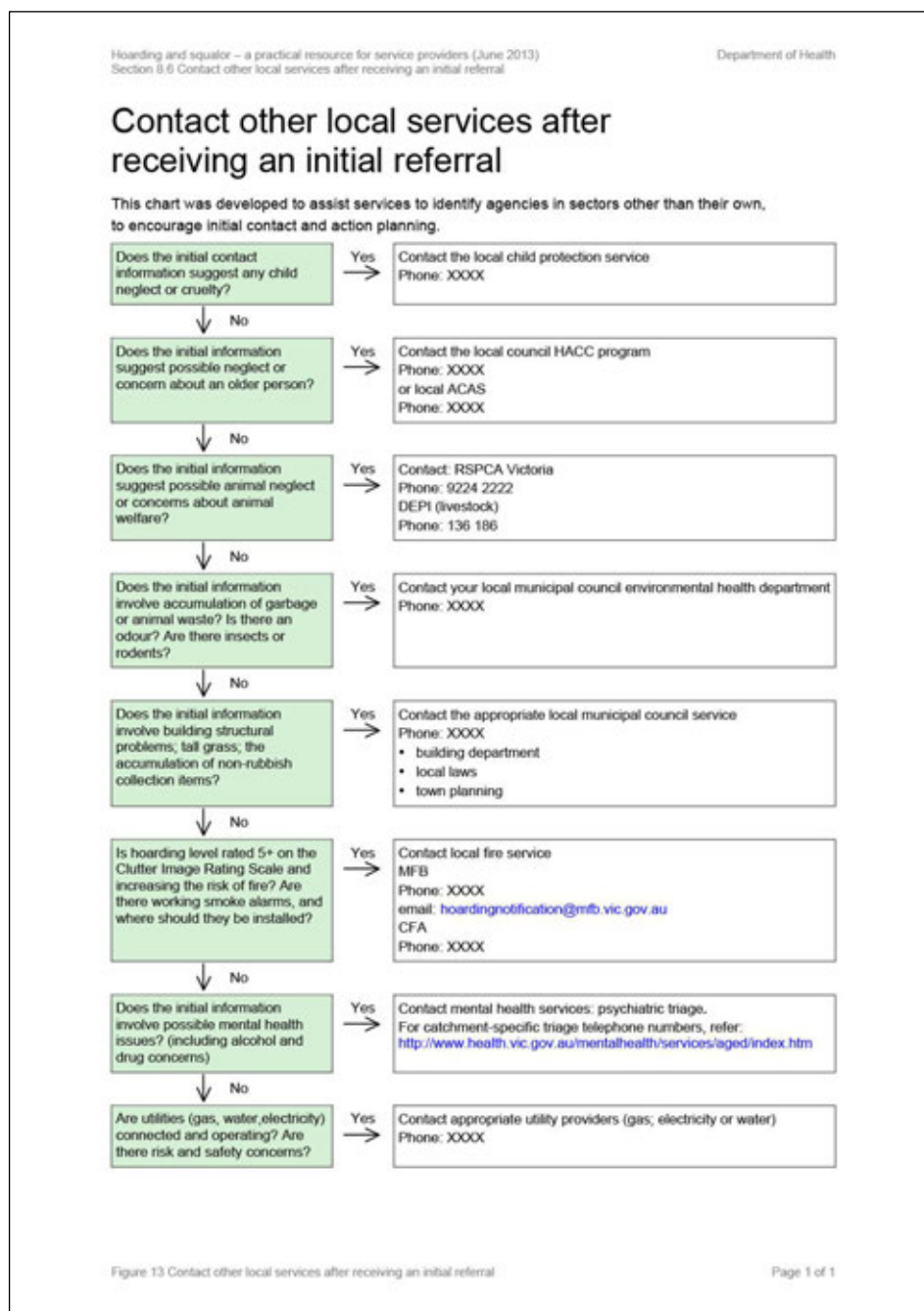
When receiving the referral or initial contact, record as much information as possible about the situation. This will assist your thinking about which other services to approach and involve.

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 13 Contact other local services after receiving an initial referral**



## 8.7 Shared action plan checklist

This checklist aims to assist agencies to work together, plan, deliver and review services provided to people with complex needs (refer to Section 8.9 [Templates to assist with service coordination tasks](#) for other sample templates).

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 14 Shared action plan checklist**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.7 Shared action plan checklist
Department of Health

### Shared action plan checklist

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<br>(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?  |                         |         |

Figure 14: Shared action plan checklist
Page 1 of 2

Figure 14 continues next page

**Figure 14 Shared action plan checklist (continued)**

| Hoarding and squalor – a practical resource for service providers (June 2013)<br>Section 8.7 Shared action plan checklist |   | Department of Health    |         |
|---|---|-------------------------|---------|
|   | Key elements or principles  | Achieved<br>(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?                                    |                         |         |

Figure 14: Shared action plan checklist

Page 2 of 2

## 8.8 Local hoarding and squalor service directory

This template can be copied or replicated to list service contact details at a local level.

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 15 Local hoarding and squalor service directory**

Hoarding and squalor – a practical resource for service providers (June 2013)  
Section 8.8 Local hoarding and squalor service directory
Department of Health

### Local hoarding and squalor service directory

Locality:

|                |              | Contact details |       |
|----------------|--------------|-----------------|-------|
| Contact (name) | Service type | Phone           | Email |
|                |              |                 |       |
|                |              |                 |       |
|                |              |                 |       |
|                |              |                 |       |
|                |              |                 |       |
|                |              |                 |       |
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|                |              |                 |       |

Figure 15 Local hoarding and squalor service directory
Page 1 of 1

## 8.9 Templates to assist with service coordination tasks

The following documents are part of a range of Service Coordination Tool Templates (SCTT) developed for broad use by multiple service providers to assist with improving the coordination of service response to a person living in the community.

The templates shown on the following pages have been selected for use by services who may wish to improve their coordination role with other services in the context of responding to hoarding and squalor situations, and who may not already have access to such forms:

Page images of the templates are provided in:

- [Figure 16 Consumer information](#) (1 page)
- [Figure 17 Summary and referral information](#) (2 pages)
- [Figure 18 Consent to share information](#) (1 page)
- [Figure 19 Shared support plan](#) (2 pages)
- [Figure 20 Review of shared support plan](#) (1 page)
- [Figure 21 Sample accommodation and safety arrangements](#) (1 page)

You can download the templates from the Department of Health website at:  
<http://www.health.vic.gov.au/pcps/coordination/sctt.htm>.

Figure 16 Consumer information

| Consumer information   |  |
|--|--|
| <p>Purpose: to collect common demographic and other essential consumer information that can be shared with another agency.</p>   |  |
| <p><b>Consumer</b></p> <p>Name: _____</p> <p>Date of Birth: dd/mm/yyyy / /</p> <p>Sex: _____</p> <p>UR Number: _____</p> <p>or affix label here</p>  |  |
| <p><b>Consumer details</b></p> <p><b>Family name:</b> _____</p> <p><b>Given names:</b> _____</p> <p><b>Preferred name/s:</b> _____</p> <p><b>Date of birth:</b> dd/mm/yyyy / /</p> <p>Is the date of birth estimated? <input type="checkbox"/> Code: <input type="checkbox"/></p> <p><b>Sex:</b> _____ Code: <input type="checkbox"/> <b>Title:</b> _____</p> <p><b>Home address</b></p> <p>_____</p> <p>Post code: _____</p> <p><b>Postal address</b> (if different from above):</p> <p>_____</p> <p>Post code: _____</p> <p><b>Contact phone numbers</b> (tick preferred number)</p> <p><input type="checkbox"/> Home: ( ) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Work: ( ) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Mobile: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Email: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you a carer or care recipient? <input type="checkbox"/> Code: <input type="checkbox"/></p> <p><b>Employment/student status</b> Code: <input type="checkbox"/></p> <p>Comments: _____</p> <p>Country of birth: _____ Code: <input type="checkbox"/></p> <p>Indigenous status: _____ Code: <input type="checkbox"/></p> <p>Are you of Aboriginal and/or a Torres Strait Islander origin?</p> <p>Refugee status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown</p> <p>If yes, year of arrival: _____</p> <p>Need for interpreter services: _____ Code: <input type="checkbox"/></p> <p>Preferred language: _____ Code: <input type="checkbox"/></p> <p>Communication method: _____ Code: <input type="checkbox"/></p> <p><b>General Practitioner (GP)</b></p> <p>GP name: _____</p> <p>Practice name: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p>Fax: _____</p> | <p><b>Who the agency can contact if necessary</b></p> <p>(for example, carer, parent, next of kin, guardian, friend, emergency contact, case manager, support worker)</p> <p><b>Contact 1 Name:</b> _____</p> <p>Address _____</p> <p>Post code: _____</p> <p><b>Phone numbers</b></p> <p>Home: _____</p> <p>Work: _____</p> <p>Mobile: _____</p> <p>Relationship to consumer: _____ Code: <input type="checkbox"/></p> <p><b>Contact 2 Name:</b> _____</p> <p>Address _____</p> <p>Post code: _____</p> <p><b>Phone numbers</b></p> <p>Home: _____</p> <p>Work: _____</p> <p>Mobile: _____</p> <p>Relationship to Consumer: _____ Code: <input type="checkbox"/></p> <p><b>Government pension/benefit status:</b> Code: <input type="checkbox"/></p> <p>If on a disability support pension:</p> <p>nature of disability _____ Code: <input type="checkbox"/></p> <p><b>Health care card holder status:</b> Code: <input type="checkbox"/></p> <p>Card number: _____</p> <p><b>Medicare card &amp; status:</b> Code: <input type="checkbox"/></p> <p>Card number: _____</p> <p><b>Health insurance status:</b> Code: <input type="checkbox"/></p> <p>Insurer name: _____</p> <p>Card number: _____</p> <p><b>DVA card entitlement:</b></p> <p>DVA card type: _____ Code: <input type="checkbox"/></p> <p>DVA card number: _____</p> <p><b>Compensable funding source:</b> Code: <input type="checkbox"/></p> <p>Comments _____</p> |
| <p>Produced by the Victorian Department of Health, 2012</p>  |  |
| <p>This information collected by: _____ Cl pg 1 of 1</p>   |  |
| <p>Name: _____ Position/Agency: _____</p>  |  |
| <p>Sign: _____ Date: dd/mm/yyyy / / Contact number: _____</p>  |  |

Figure 17 continues next page



Figure 17 Summary and referral information (continued)

| <h2 style="margin: 0;">Summary and referral information</h2> <p style="font-size: 0.8em; margin: 5px 0;">Purpose: to record and share a summary of the consumer's presenting and identified issues and other information to assist in a referral.</p>   | <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px;"> <b>Consumer</b><br/>         Name: _____<br/>         Date of Birth: dd/mm/yyyy / /<br/>         Sex: _____<br/>         UIR Number: _____<br/> <div style="text-align: center; margin-top: 5px;">or affix label here</div> </div> |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|---|--|---|-----------------------|---|---------------------|-------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>Alerts</b><br><div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Allergies: _____       </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Risks: (attach any available risk assessments) _____ Code: <input type="checkbox"/> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Risk management strategies: _____       </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         There are concerns that the consumer is not capable of making their own decisions _____ Code: <input type="checkbox"/> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Enduring powers of attorney are in place _____ Code: <input type="checkbox"/> </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Access to the referred service has been discussed with the consumer? <input type="checkbox"/> Yes <input type="checkbox"/> No       </div> <div style="border: 1px solid black; padding: 5px; margin-bottom: 5px;">         Barriers to Service: _____       </div> <div style="border: 1px solid black; padding: 5px;">         Support required to address barrier to service: _____       </div> |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Current services</b><br><i>Services used in the last twelve months. Consider all health and community services.</i> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 15%;">Agency</th> <th style="width: 15%;">Service type<br/>Code:</th> <th style="width: 70%;">Record contact details or other information as appropriate (eg key contact)</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>   |  | Agency  | Service type<br>Code: | Record contact details or other information as appropriate (eg key contact) |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Agency  | Service type<br>Code:  | Record contact details or other information as appropriate (eg key contact) |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>Referrals sent</b><br><table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 15%;">Agency</th> <th style="width: 15%;">Service type<br/>Code:</th> <th style="width: 20%;">Contact details</th> <th style="width: 25%;">Purpose of referral</th> <th style="width: 25%;">Feedback required</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>   |  | Agency  | Service type<br>Code: | Contact details   | Purpose of referral | Feedback required |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Agency  | Service type<br>Code:  | Contact details   | Purpose of referral   | Feedback required   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|   |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <div style="text-align: right; font-size: 0.8em; margin-bottom: 5px;">Produced by the Victorian Department of Health, 2012</div> <div style="border: 1px solid black; padding: 5px;"> <div style="display: flex; justify-content: space-between; font-size: 0.7em;"> <span>This information collected by:</span> <span>SRI Page 2 of 2</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>Name: _____</span> <span>Position/Agency: _____</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span>Sign: _____</span> <span>Date: dd/mm/yyyy / /</span> <span>Contact number: _____</span> </div> </div>  |  |   |                       |   |                     |                   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Summary and referral information

Figure 18 Consent to share information

## Consent to share information

Purpose: to record freely given informed consumer consent to share their information with a specific agency/ies for a specific purpose/s.

**Consumer**

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

**Section 1: Personal/health information to be shared**

| Service Type                                 | Name of Agency  | Type of Information   | Purpose/s   |
|--|---|---|---|
| Examples:<br>– physiotherapy<br>– counseling | Examples:<br>– Strawberry Community Health centre<br>– Blueberry City Council | Examples:<br>– all relevant information<br>– exceptions as stated by consumer | Examples:<br>– referral<br>– shared care/case planning<br>– informing services participating in consumer's care |
|  |   |   |   |
|  |   |   |   |
|  |   |   |   |
|  |   |   |   |

**Section 2: Record of consent**

☐ **Written consumer consent**

The worker/practitioner has discussed with me how and why certain information about me may be shared with other service providers, as above. I understand this and I give my consent for the information to be shared.

Signed: \_\_\_\_\_

Dated (dd/mm/yyyy): / /

or

☐ **Verbal consumer consent**

I have discussed with the consumer how and why certain information may be shared with other service providers. I am satisfied that this has been understood and that informed consent for the information to be shared as detailed above has been given.

or

☐ **Consumer does not have the capacity to provide consent**

(that is, they do not understand the nature of what they are consenting to, or the consequences)

☐ Consent given by authorised representative \_\_\_\_\_ (name of authorised representative)

☐ There is no Authorising representative or they were uncontactable; therefore, the information will be shared as set out in the *Health Records Act 2001*\*

\*If it is not reasonably practical to obtain consent from an authorised representative or the consumer does not have an authorised representative, health information can still be shared in the circumstances set out in the *Health Records Act 2001*. This includes where the sharing of information is done by a health service provider and is reasonably necessary for the provision of a health service or where there is a statutory requirement.

To ensure that the consumer's authorised representative can make an informed decision about consenting to the sharing of information as detailed above, the worker/practitioner should (tick when completed):

1. Discuss with the consumer the proposed sharing of information with other services/agencies

2. Explain that the consumer's information will only be shared with these services/agencies if the consumer has agreed and, when referring, advise that referral for service can still proceed if the consumer does not want information disclosed

3. Provide the consumer with information about privacy, such as the brochure *Your Information – It's Private*

4. Provide the consumer with a copy of this form once completed.

☐  
☐  
☐  
☐

Consent obtained/witnessed by:

Name: \_\_\_\_\_

Sign: \_\_\_\_\_

Position/Agency: \_\_\_\_\_

Date: dd/mm/yyyy / /

Contact number: \_\_\_\_\_

Produced by the Victorian Department of Health, 2012

CSI Page 1 of 1

Consent to Share Information

Figure 19 Shared support plan

### Shared support plan

Purpose: for a consumer who requires multiple services, to support a coordinated approach. It shows who is involved in the consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action.

**Consumer**

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

**Consent to share information**

Before developing this plan, ensure consent to share information has been given using the *SCTT: Consent to Share Information*.

I (or support person) understand and agree to this plan: ☐ Yes ☐ No

I (or support person) have a copy of the plan: ☐ Yes ☐ No

Reason for this plan:

**Who is involved in the shared support plan?**

| Name | Role or area of support<br><small>(for example person receiving support, care coordinator, carer, GP)</small> | Contact details | Participant in planning process<br><small>(Yes/No)</small> | Has a copy of plan<br><small>(Yes/No)</small>            |
|------|---|-----------------|--|--|
|      | Main Contact (for example Care Coordinator)   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|      |   |                 | <input type="checkbox"/> Yes <input type="checkbox"/> No   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Shared support plan

What other plans are in place?

This information collected by:

Produced by the Victorian Department of Health, 2012

|             |                        |                       |
|-------------|------------------------|-----------------------|
| Name: _____ | Position/Agency: _____ | SSP Page 1 of 3       |
| Sign: _____ | Date: dd/mm/yyyy / /   | Contact number: _____ |

Figure 19 continues next page

Figure 19 Shared support plan (continued)

| Shared support plan   |  | Consumer   |        |                       |
|---|--|--|--------|-----------------------|
| Purpose: for a consumer who requires multiple services, to support a coordinated approach. It shows who is involved in the consumer's care, the main issues, agreed goals developed together, planned actions and who is responsible for each action. |  | Name: _____<br>Date of Birth: dd/mm/yyyy / /<br>Sex: _____<br>UIR Number: _____<br>or affix label here |        |                       |
| What I would like to improve?<br>(Area of concern - list in order of priority)  | What I would like to achieve?<br>(Agreed goal) | Agreed actions to be taken   | By who | By when               |
| 1   | 1.1  |  |        |                       |
|   | 1.2  |  |        |                       |
| 2   | 2.1  |  |        |                       |
|   | 2.2  |  |        |                       |
| 3   | 3.1  |  |        |                       |
|   | 3.2  |  |        |                       |
| Other considerations  |  |  |        |                       |
| <div style="border: 1px solid black; height: 20px;"></div>  |  |  |        |                       |
| Case conference (Service provider use only)   |  |  |        |                       |
| Who will coordinate it? _____   |  |  |        |                       |
| Who needs to be invited? _____  |  |  |        |                       |
| If a case conference has occurred, what were the key decisions? _____   |  |  |        |                       |
| Plan developed: dd/mm/yyyy / /  |  | Review date: dd/mm/yyyy / /  |        |                       |
| Append more sheets as necessary.  |  |  |        |                       |
| Produced by the Victorian Department of Health, 2012  |  |  |        |                       |
| This information collected by:  |  |  |        |                       |
| Name: _____   |  | Position/Agency: _____   |        |                       |
| Sign: _____   |  | Date: dd/mm/yyyy / /   |        | Contact number: _____ |

Shared support plan

Figure 20 Review of shared support plan

| <h2 style="margin: 0;">Review of shared support plan</h2> <p style="font-size: 0.8em; margin: 5px 0;">Purpose: for use when the shared support plan is reviewed. It shows the outcomes/progress of agreed goals and planned actions.</p> |   | <b>Consumer</b><br>Name: _____<br>Date of Birth: dd/mm/yyyy / /<br>Sex: _____<br>UIR Number: _____<br><div style="text-align: center; font-size: 0.8em;">or affix label here</div> |
|--|---|--|
| <b>What I would like to improve?</b><br><i>(Area of concern - refer to Shared Support Plan):</i>   | <b>How is it going?</b> <i>(what has been the progress towards the goals)</i> |  |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |

Shared support plan

What other plans are in place?

**Case conference** *(Service provider use only)*

Who will coordinate it? \_\_\_\_\_

Who needs to be invited? \_\_\_\_\_

If a case conference has occurred, what were the key decisions? \_\_\_\_\_

Initial Plan date: dd/mm/yyyy / /
Review date: dd/mm/yyyy / /

New Plan required: ☐ Yes ☐ No

**This information collected by:**

Name: \_\_\_\_\_ Position/Agency: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: dd/mm/yyyy / /

Produced by the Victorian Department of Health, 2012

SSP Page 3 of 3

Contact number: \_\_\_\_\_

Figure 21 Sample accommodation and safety arrangements

| Accommodation and safety arrangements  |   |
|--|---|
| Purpose: to screen for consumer's accommodation risk of homelessness and their safety needs, including family violence and personal emergency planning.  |   |
| <b>Consumer</b><br>Name: _____<br>Date of Birth: dd/mm/yyyy / /<br>Sex: _____<br>UR Number: _____<br>or affix label here   |   |
| <b>Accommodation</b><br>Code: <input type="checkbox"/><br>Comments on accommodation: _____<br>Is the consumer <b>homeless</b> (nowhere to stay tonight)? Code: <input type="checkbox"/><br>Is the consumer in housing/ accommodation that is:<br><b>At risk</b> (for example eviction, behind in their rent)<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><b>Unsafe</b> (for example family violence, physical danger or other threats)<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><b>Insecure</b> (for example, temporarily staying with friends/ family or using other temporary accommodation)<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><i>If yes to any of the above, refer the consumer to the homelessness support service in their area or specialist family violence service, via <a href="http://www.dhs.vic.gov.au/for-individuals/crisis-and-emergency/crisis-accommodation/homelessness-and-family-violence-getting-help">www.dhs.vic.gov.au/for-individuals/crisis-and-emergency/crisis-accommodation/homelessness-and-family-violence-getting-help</a></i><br><b>Is the consumer currently living in public/community housing (also known as social housing) and are:</b><br><input type="checkbox"/> <b>At risk</b> (for example eviction, behind in their rent)<br><input type="checkbox"/> <b>Unsafe</b> (for example family violence, physical danger or other threats)<br><i>If yes to any of the above, refer to their local housing officer on <a href="http://www.housing.vic.gov.au/about-us/contact-us/local-housing-offices">www.housing.vic.gov.au/about-us/contact-us/local-housing-offices</a></i><br><b>Living arrangements:</b> Code: <input type="checkbox"/><br>Comments on living arrangement: _____<br>Other relevant information: _____ | <b>Safety</b><br><b>Family violence</b><br><b>Is the consumer afraid of someone close to them who controls, hurts, insults or threatens them, or who prevents them from doing what they want?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><b>If yes, proceed with the following questions:</b><br>Who is the consumer afraid of? (including the relationship to the consumer) _____<br>What form does the abuse take? _____<br>Is the abuse becoming worse or happening more often or both?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br>Are any children involved experiencing the abuse or violence directly or by hearing or seeing it?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br>Is the consumer very scared for themselves or any children?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br>Has a safety plan been prepared with the consumer?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><i>For women experiencing family violence — refer to the Women's Domestic Violence Crisis Service on 1800 015 188.</i><br><i>For men experiencing family violence — refer to the Victims of Crime Helpline on 1800 819 817.</i><br><i>For older people experiencing elder abuse — contact Seniors Rights Victoria on 1300 368 821</i> |
| <b>Personal emergency planning</b><br><b>Does the consumer have a personal emergency plan in case of fire, heat wave or flood?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><b>If no, encourage people living in high bushfire or other risk areas to develop personal emergency plans.</b><br><b>Does the consumer have a working smoke alarm in the house?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not stated/unknown<br><b>If no, and the person is unable to do this themselves, discuss options for assistance from families, friends, neighbours.</b>   |   |
| Produced by the Victorian Department of Health, 2012<br>This information collected by: _____ AS pg 1 of 1<br>Name: _____ Position/Agency: _____<br>Sign: _____ Date: dd/mm/yyyy / / Contact number: _____  |   |

## 8.10 Sample sector and local area flow chart response to hoarding

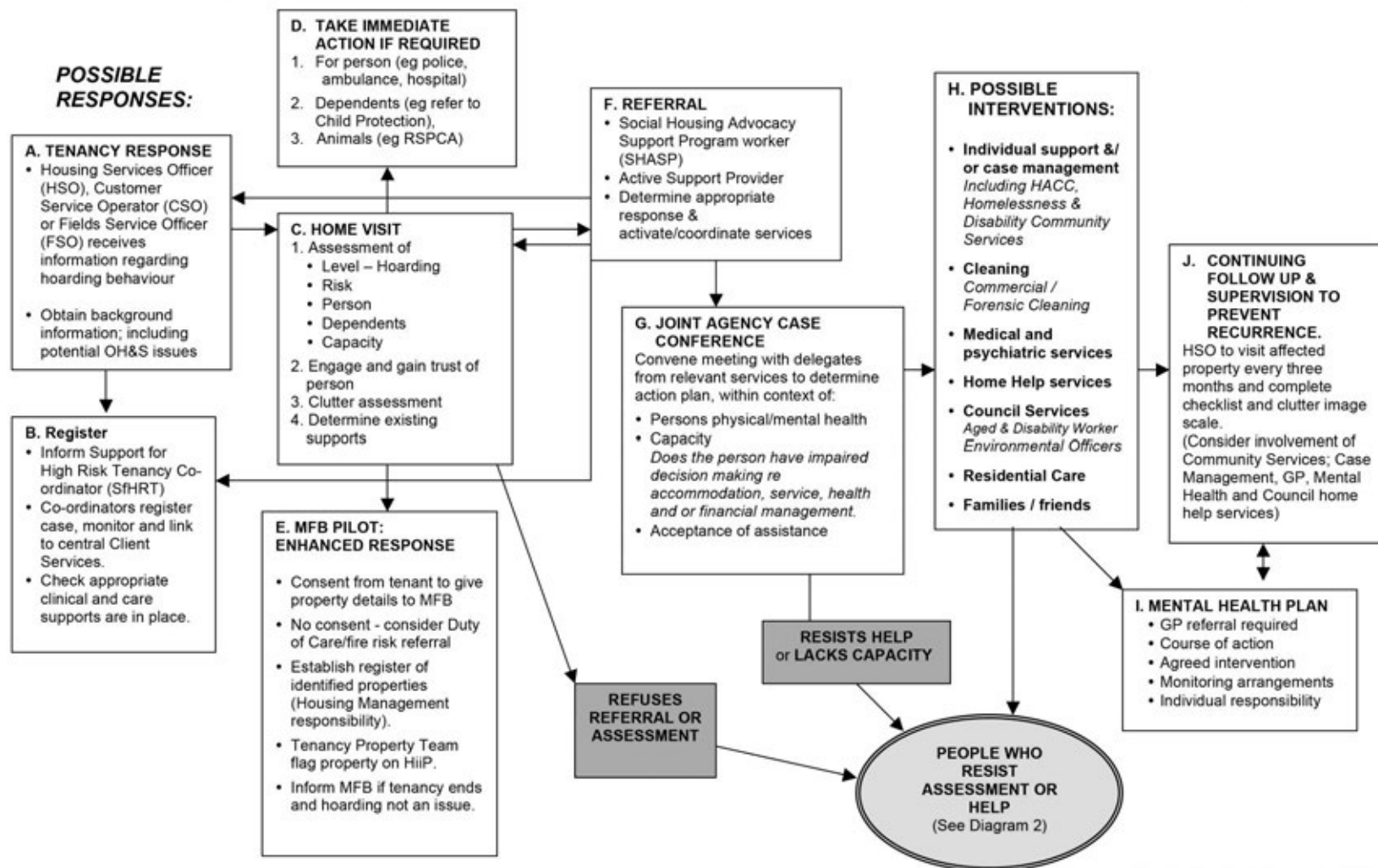
These flow charts provide examples of work already begun in the housing area and demonstrate how the service response to hoarding can be planned by establishing a local working group involving other services and sectors (both public and private).

The following flow charts present:

- Department of Human Services, Housing: Support for High Risk Tenancies (SfHRT) program 2009 – a blueprint housing response to hoarding:
  - Figure 22: Assessment and management of people dealing with hoarding (diagram 1 of 2)
  - Figure 23: Assessment and management of people dealing with hoarding who are resisting assessment or help (diagram 2 of 2)
- Loddon Mallee Region Hoarding Working Group 2012 – a local regional working group response to hoarding:
  - Figure 24: Assessment and management of people dealing with hoarding (diagram 1 of 2)
  - Figure 25: Assessment and management of people dealing with hoarding who are resisting assessment or help (diagram 2 of 2).



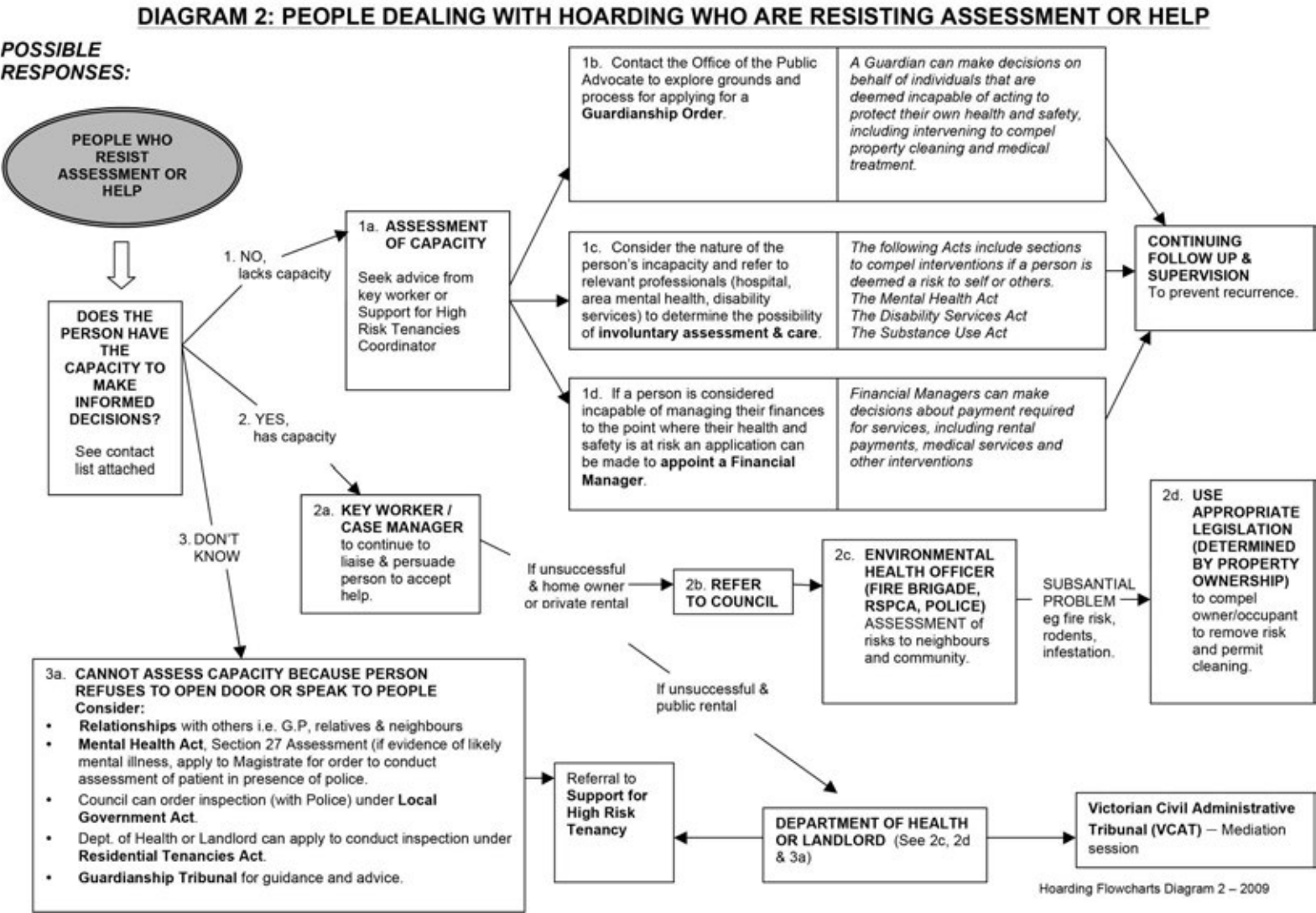
Figure 22 Assessment and management of people dealing with hoarding (diagram 1 of 2)\*

**DIAGRAM 1: ASSESSMENT & MANAGEMENT OF PEOPLE DEALING WITH HOARDING**

Hoarding Flowcharts Diagram 1 – 2009

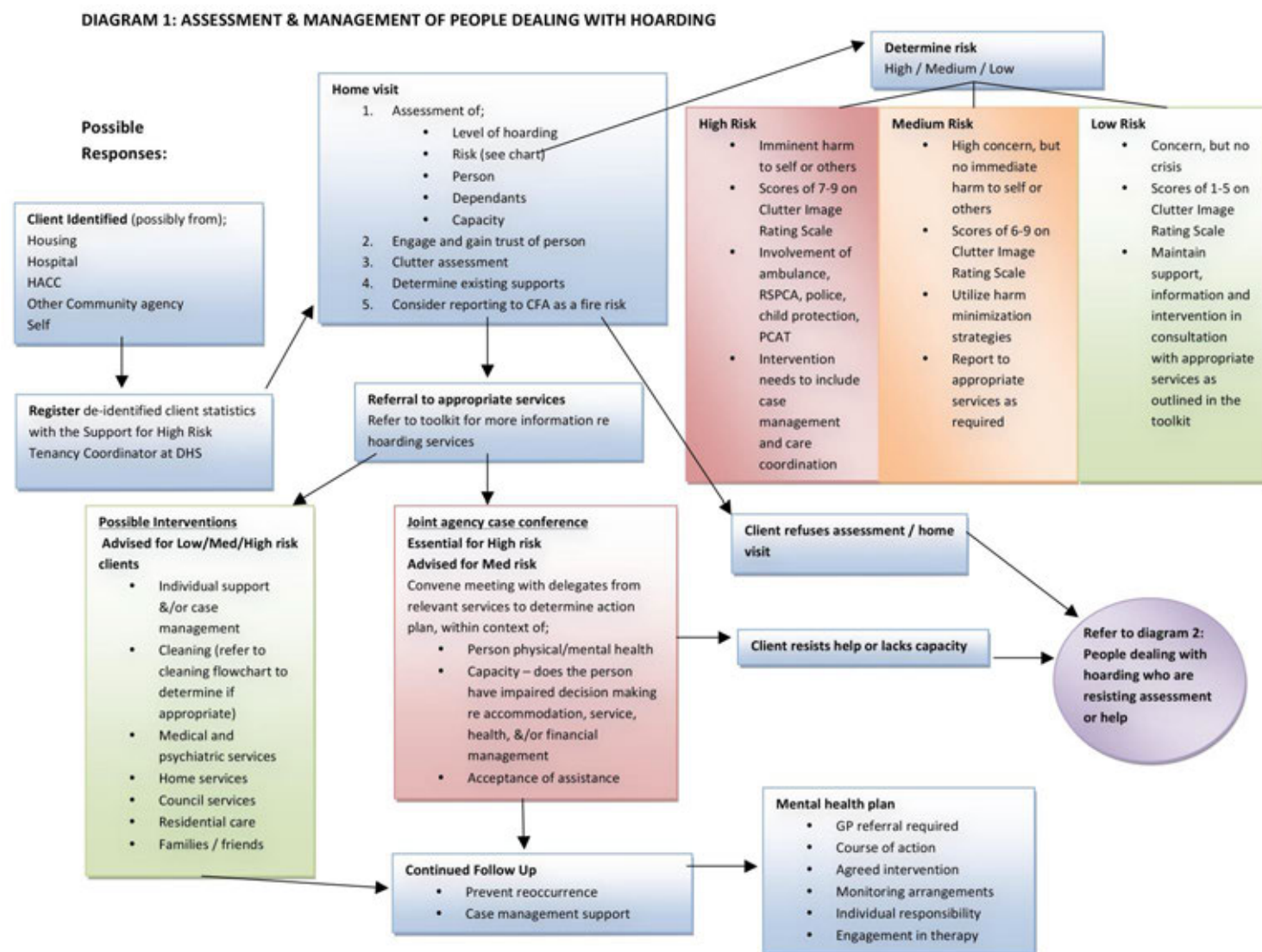
\* Source: Department of Human Services: Housing – Support for High Risk Tenancy (SfHRT) blueprint

Figure 23 Assessment and management of people dealing with hoarding who are resisting assessment or help (diagram 2 of 2)\*



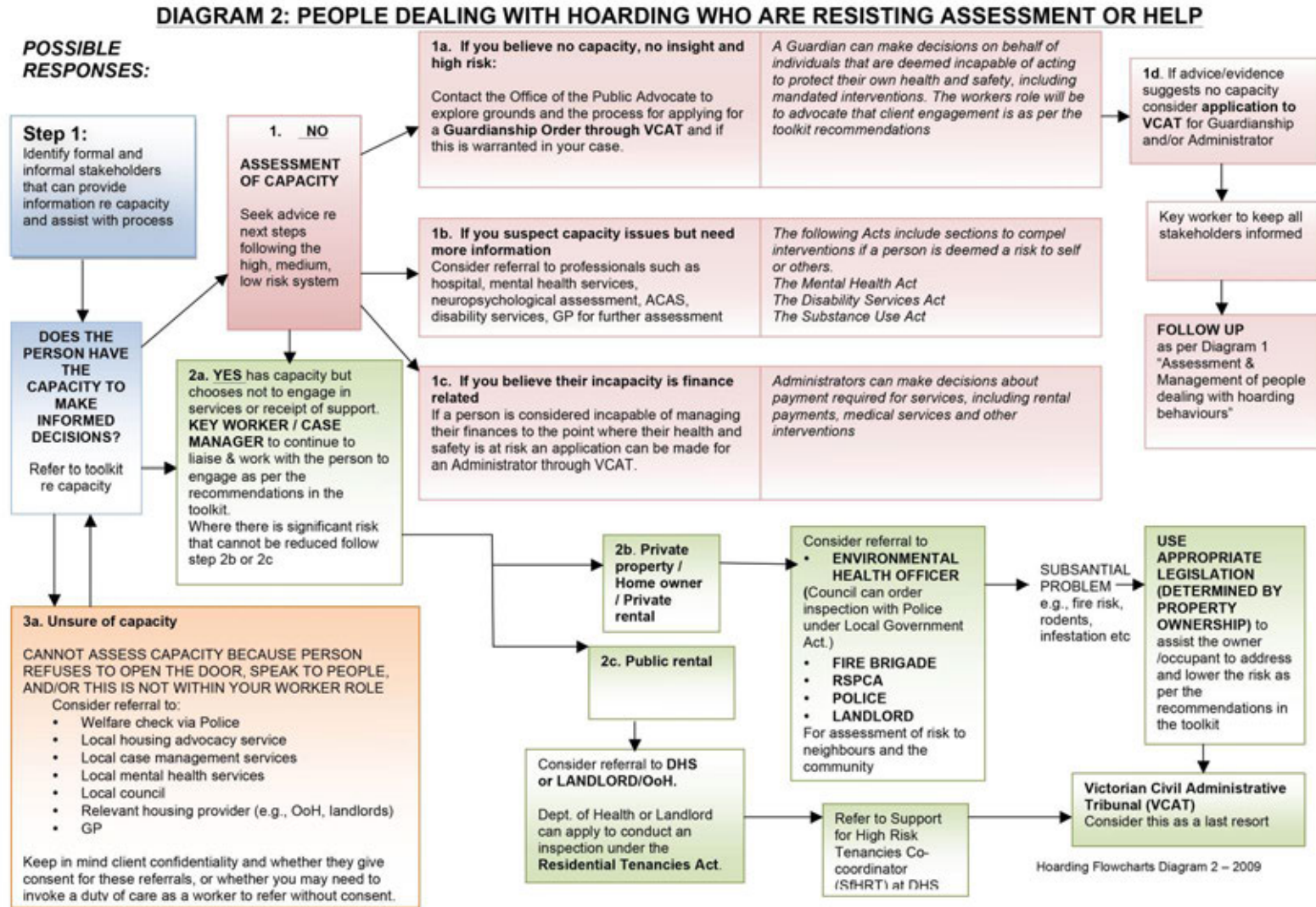
\* Source: Department of Human Services: Housing – Support for High Risk Tenancy (SfHRT) blueprint

Figure 24 Assessment and management of people dealing with hoarding (diagram 1 of 2)\*



\* Source: Loddon-Mallee Region Hoarding Working Group, 2012

Figure 25 Assessment and management of people dealing with hoarding who are resisting assessment or help (diagram 2 of 2)\*



\* Source: Loddon-Mallee Region Hoarding Working Group, 2012



## 8.11 Planning for the provision of cleaning (flow charts and cleaning agreement)

To download this tool in Microsoft Word format, visit:

<http://www.health.vic.gov.au/agedcare/publications/hoarding.htm>

Service providers can tailor the tool for their local use as required. The tool is also available for download in PDF format if preferred, but is not editable in that format.

**Figure 26 Planning for the provision of cleaning (flow charts)**

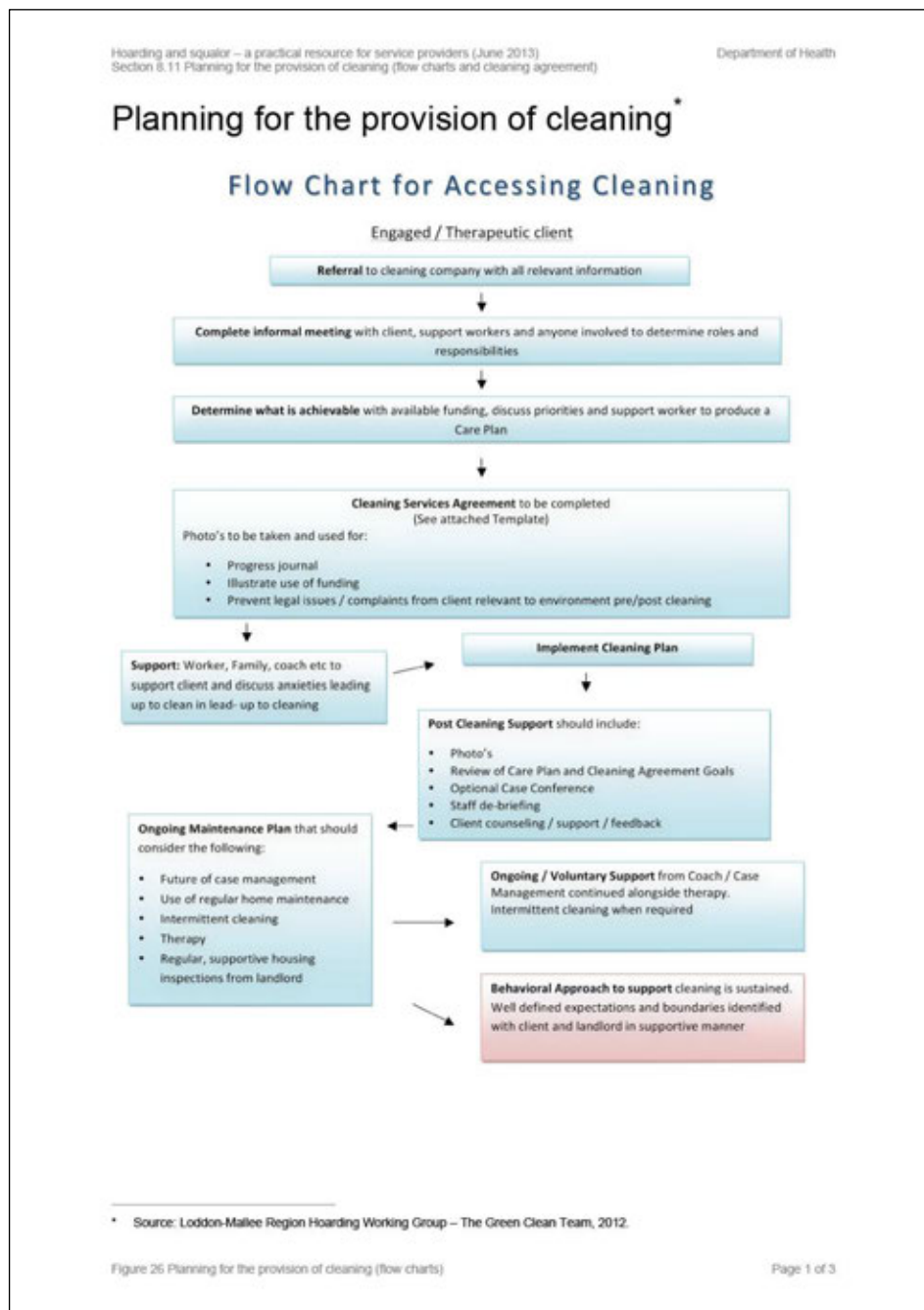
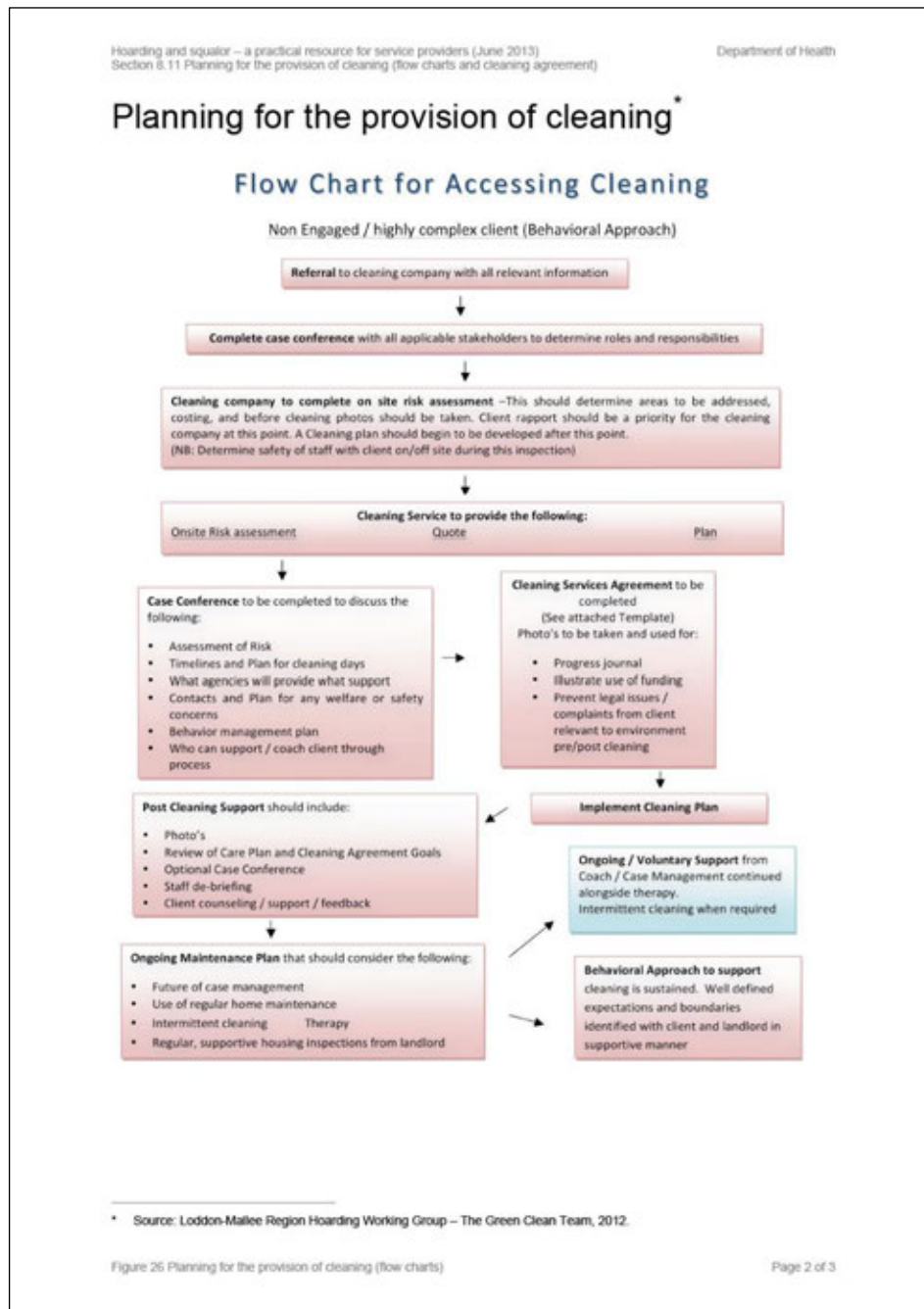


Figure 26 continues next page

Figure 26 Planning for the provision of cleaning (flow charts) (continued)



**Figure 27 Cleaning services agreement**

|   |                      |
|---|----------------------|
| Hoarding and squalor – a practical resource for service providers (June 2013)<br>Section 8.11 Planning for the provision of cleaning (flow charts and cleaning agreement) | Department of Health |
|---|----------------------|

## Cleaning services agreement\*

(to be completed on a case-by-case basis)

This is an agreement between:

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

|  |
|--|
| Client telephone:  |
| Client address:  |
| Date of cleaning visit: <span style="float: right;">Time:</span> |
| Rooms to be cleaned:   |
| Articles/items to be removed:                                    |
| Articles/items not to be removed:                                |

|                             |       |
|-----------------------------|-------|
| Signed (cleaning business): | Date: |
|-----------------------------|-------|

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.

|                  |       |
|------------------|-------|
| Signed (client): | Date: |
|------------------|-------|

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

\* Source: Loddon-Mallee Region Hoarding Working Group – The Green Clean Team, 2012.

Figure 27 Cleaning services agreement Page 3 of 3



## 9 Resources and contacts

| Topic  |   | Source (all publications are listed in the references)  |
|--|---|---|
| Examples of private cleaning companies sourced by some providers in Victoria |   |   |
| 1  | Green Clean Team  | Bendigo and Brunswick<br>Contact: Contact 0407 469 468 or refer <a href="http://www.greencleanteam.com.au/">www.greencleanteam.com.au/</a>  |
|  | Classic Moves   | Metropolitan Melbourne suburbs, Bellarine and Mornington Peninsula<br>Will assist with decluttering hoarding and other situations, working with the person, but will not clean squalid environments.<br>Contact: 1300 738 035 or <a href="http://classicmoves.com.au/about-us">http://classicmoves.com.au/about-us</a>                                |
|  | Skeletons in the Closet   | North west metropolitan suburbs<br>Contact: 0418 186 056 or<br><a href="http://www.skeletonsinthecloset.com.au">www.skeletonsinthecloset.com.au</a>   |
|  | Cleaning by Mark  | Bundoora<br>Contact: 0415 694 969   |
|  | Buzz Cleaning   | St Kilda central<br>Contact: 9563 3534<br><a href="http://www.buzzcleaning.com">http://www.buzzcleaning.com</a>   |
|  | ATC Cleaning Services   | Frankston Heights<br>Contact 5976 3199<br><a href="http://www.atcservices.com.au/">http://www.atcservices.com.au/</a>   |
|  | Thornbear Property Solutions  | Keilor East<br>Contact 9366 0690<br><a href="http://www.thornbear.com.au/thornbear/index.htm">http://www.thornbear.com.au/thornbear/index.htm</a>   |
|  | CCM Cleaning Services   | Cleaning contractors (commercial and industrial) Epping<br>Contact 0411 106 516   |
| Education and Training materials   |   |   |
| 2  | Animal hoarding   | Website of the US Hoarding of Animals Research Consortium. It contains links to several scientific papers.<br><a href="http://www.tufts.edu/vet/hoarding/resource.htm">http://www.tufts.edu/vet/hoarding/resource.htm</a>   |
| 3  | Obsessive Compulsive Foundation – Hoarding Centre                             | Randy Frost, Gail Steketee, USA<br><a href="http://www.ocfoundation.org/hoarding/welcome.aspx">http://www.ocfoundation.org/hoarding/welcome.aspx</a>  |
| 4  | Guidelines for field staff to assist people living in severe domestic squalor | NSW Partnership against homelessness (August 2007)<br><a href="http://www.sa.gov.au/upload/franchise/Housing,%20property%20and%20land/Housing%20SA/CH/Domestic_squalor_guidelines_community_housing.pdf">http://www.sa.gov.au/upload/franchise/Housing,%20property%20and%20land/Housing%20SA/CH/Domestic_squalor_guidelines_community_housing.pdf</a> |

| Topic                                  |  | Source (all publications are listed in the references)  |
|--|--|---|
| 5                                      | <i>The Hoarding Handbook: Guide for Human Service Professionals</i>              | <p>Bratiotis et al. 2011.</p> <p>The first of its kind, organised around the common ways hoarding captures the attention of social service providers (social workers/human service providers in a broad range of fields). This user-friendly guide provides tools to assess the problem, coordinate and delegate tasks required for addressing the problem and working directly with reluctant hoarders and those affected by the hoarding.</p> <p>Chapters provide guidance and decision trees, who should be involved and what strategies are needed for each case.</p> <p><a href="http://www.ocfoundation.org/hoarding/community_services.aspx">http://www.ocfoundation.org/hoarding/community_services.aspx</a></p>  |
| 6                                      | <i>Understanding Compulsive Hoarding</i>   | <p>Thobaben 2006.</p> <p>Compulsive hoarding is the excessive acquisition of material goods and difficulty discarding worthless items until they interfere with day-to-day functions such as home, health, family, work and social life.</p> <p>There are a higher percentage of older adults who hoard compared to younger people. Home health workers will need to assess the functional level, competency, insight and understanding of people who compulsively hoard. Workers may be able to teach techniques that assist with accumulating less clutter.</p>   |
| 7                                      | Victorian Fire Services resources  | <p>Basic home fire safety training materials (developed for community sector workers): <a href="http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety---Training-Materials.html">http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety---Training-Materials.html</a></p> <p>Hoarding lethal fire risk: <a href="http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Hoarding-a-lethal-fire-risk.html">http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Hoarding-a-lethal-fire-risk.html</a></p> <p>Smoke alarms, including information about smoke alarms for deaf and hard-of-hearing: <a href="http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Smoke-Alarms.html">http://www.mfb.vic.gov.au/Community-Safety/Home-Fire-Safety/Smoke-Alarms.html</a></p> <p><i>Home Fire Safety Booklet</i>, including inserts for other languages, at MFB website: <a href="http://www.mfb.vic.gov.au/">http://www.mfb.vic.gov.au/</a></p> <p>Home Fire Safety Aged and Disability insert, including for other languages, at MFB website: <a href="http://www.mfb.vic.gov.au/">http://www.mfb.vic.gov.au/</a></p> <p><i>Home Fire Safety Booklet</i> and Aged and Disability insert Audio, at MFB website: <a href="http://www.mfb.vic.gov.au/">http://www.mfb.vic.gov.au/</a></p> |
| 8                                      | <i>Motivational interviewing</i>   | <p>Miller 2002.</p> <p>Training materials (including online learning), motivational interviewing resources for clinicians, researchers and trainers.</p> <p><a href="http://motivationalinterview.org">http://motivationalinterview.org</a></p>   |
| Clinical treatment and support options |  |   |
| 9                                      | Support for organisations and services and people effected by hoarding behaviour | <p>Private business specialising in responding to hoarding and squalor situations, called <i>For the Crowded House</i>. They provide secondary consultation, support groups for carers, staff supervision and training.</p> <p>Contact Tania Reid on: 042 777 0510</p> <p><a href="http://thecrowdedhouse.net.au/">http://thecrowdedhouse.net.au/</a></p>   |
| 10                                     | Psychology service   | <p>A private registered psychologist who specialises in hoarding assessment, therapeutic counselling for clients, the provision of secondary consultation, training, and workshops.</p> <p>Contact Janelle Nancarrow: 0499 618 599 or email <a href="mailto:janelleNancarrow@internode.on.net">janelleNancarrow@internode.on.net</a></p>  |

| Topic   | Source (all publications are listed in the references)  |
|---|---|
| 11 The Anxiety Clinic,<br>Richmond                            | <p>Clinic provides expertise and support for people living with high levels of anxiety. Hoarding training and treatment workshops, consultation and community education.</p> <p>Dr Christopher Mogan, clinical psychologist, Director, has considerable compulsive hoarding expertise having completed the first major study of compulsive hoarding in Australia.</p> <p>Contact: 03 94201424 or 0419 349 594, <a href="mailto:mogan@theanxietyclinic.com">mogan@theanxietyclinic.com</a><br/> <a href="http://www.theanxietyclinic.com/">http://www.theanxietyclinic.com/</a></p>  |
| 12 Swinburne University of<br>Technology Psychology<br>Clinic | <p>Specialist university-based compulsive hoarding psychological treatment service. Compulsive hoarding and acquiring: group program made up of 12 sessions (x 8 people) addressing problems with compulsive hoarding, individual treatment is frequently added to support individuals. Medicare rebates may be available for participants.</p> <p>Professor Michael Kyrios, Professor of Psychology, Director, Brain Psychological Sciences Research Centre (BPsyC), Chair in Psychology in the Faculty of Life and Social Sciences, Swinburne University of Technology, with world leading expertise in compulsive hoarding. He supervised Dr Mogan's study, collaborates with professors Frost and Steketee from the US who are a leading team of clinicians and researchers focusing on hoarding.</p> <p>Contact: 03 9214 4886, <a href="mailto:mkyrios@swin.edu.au">mkyrios@swin.edu.au</a></p> <p>The Project Officer</p> <p>Contact: (03) 9214 5528, <a href="mailto:psychprojects@swin.edu.au">psychprojects@swin.edu.au</a><br/> <a href="http://www.swinburne.edu.au/lss/psychology/pc/compulsive-hoarding-group.html">http://www.swinburne.edu.au/lss/psychology/pc/compulsive-hoarding-group.html</a></p> |

# Legislation (Acts) mentioned in this resource

Key policy directions and legislation form the background to the delivery of services to people with complex needs. This list provides information on the major legislation that impact on service delivery for people who may require coordinated service response which has informed the development of this document:

Aged Care Act 1997 (Commonwealth)  
Alcoholics and Drug-dependent Persons Act 1968 (Victoria)  
Charter of Human Rights and Responsibilities 2006 (Victoria)  
Child Wellbeing and Safety Act 2005 (Victoria)  
Children, Youth and Families Act 2005 (Victoria)  
Country Fire Authority Act 1958 (Victoria)  
Crimes (Family Violence) Act 1987 (Victoria)  
Disability Act 2006 (Victoria)  
Domestic Animals Act 1994 (Victoria)  
Family Violence Protection Act 2008 (Victoria)  
Guardianship and Administration Act 1986 (Victoria)  
Health Act 1958 (Victoria)  
Health Records Act 2001 (Victoria)  
Health Services Act 1988 (Victoria)  
Home and Community Care Act 1985 (Commonwealth)  
Housing Act 1983 (Victoria)  
Human Services (Complex Needs) Act 2009 (Victoria)  
Information Privacy Act (2000) (Victoria)  
Legal Aid Act 1978 (Victoria)  
Local Government Act 1989  
Mental Health Act 1986 (Victoria)  
Metropolitan Fire Brigades Act 1958  
Planning and Environment Act 1987 (Victoria)  
National Health Act 1953  
Planning and Environment Act 1987 (Victoria)  
Prevention of Cruelty to Animals Act 1986 (Victoria)  
Privacy Act 2001 (Commonwealth)  
Public Health Wellbeing Act 2008 (Victoria)  
Residential Tenancies Act 1997 (Victoria)  
Supported Residential Services (Private Proprietors) Regulations 2012 (Victoria)  
Supported Residential Services Private Proprietors Act 2010 (Victoria)

Veterinary Practice Act 1997 (Victoria)

Victorian Civil and Administrative Tribunal Act 1998 (Victoria)

Wildlife Act 1975 (Victoria)

Wrongs Act 1958 (Victoria)

# Appendix 1 Hoarding and squalor project stakeholder group

Chairs: Jane Herington, Director, Ageing and Aged Care, Karleen Edwards, Executive Director, Mental Health, Drugs and Regions (who was replaced by Paul Smith, Executive Director, Mental Health, Drugs and Regions in July 2012).

| Representing         |   | Participants  |
|----------------------|---|---|
| Department of Health | Health Protection, Environmental Health | Nathalie Allaz-Barnett, Health Scientist, Healthy Environments  |
|                      | Regional Directors, Health Aged Care    | Tony Dunn, Hume, Director, Health Aged Care<br>Mark Stracey, Eastern Metropolitan Director Health Aged Care   |
|                      | Ageing Aged Care Branch                 | Chris Puckey, Manager, Policy and Analysis<br>Alison Beckett, Senior Policy Officer, Policy and Analysis<br>Louise McGuire, (HACC) Manager, HACC Operations<br>Debbie Senior, (ACAS) Senior Project Officer |
|                      | Mental Health                           | Therese Robinson, Principal Program Advisor, Adult and Older Persons Team   |
| DHS                  | Central office                          | Marcus Tansing and Sarah Acreman, Client Services and Programs, Housing and Community Building  |
|                      | Deputy Regional Directors (nominee)     | Hume: Kate Meehan, Service Integration Housing Support Worker   |
|                      |   | Eastern Metropolitan: Andrea Byrne, Deputy Regional Director, Client Outcomes<br>Nominees: Lisa Foley or Belinda Henry  |
|                      |   | North West Metropolitan: Kirsty Carter, Manager, Service Integration Client Outcomes  |
|                      |   | Southern Metropolitan: Rachel Royle, A/Regional Program Advisor, Complex Clients  |
|                      |   | Gippsland: Rochelle Parker, Manager Service Integration, Client Outcomes  |
| DPI                  | Central                                 | Jane Malcolm, Senior Project and Legislation Officer, Bureau of Animal Welfare  |

| Representing                 |  | Participants   |
|------------------------------|--|--|
| DoJ                          | MFB  | Frank Stockton, Commander, Community Education<br>Julie Harris, Community Ageing Strategist, Community Education               |
|                              | CFA  | Gwynne Brennan Manager, Community Development<br>Debbie Andre, Community Safety Project Manager, Fire and Emergency Management |
|                              | Victoria Police  | Peter Brigham, Superintendent, Media and Corporate Communications Department   |
| Peaks                        | MAV  | Derryn Wilson, Policy Adviser<br>Rosemary Handcock, Policy Adviser   |
| Private                      |  | Dr Mogan, Clinical Psychologist, Director of The Anxiety Clinic, Richmond  |
| Private                      | Swinburne University of Technology                                   | Professor Michael Kyrios, Professor of Psychology, Director, Brain Psychological Sciences Research Centre (BPsyC)              |
| Practitioner representatives |  |  |
|                              | Wintringham  | Kate Rice, Community Housing and Support Manager Northern  |
|                              | HAVEN  | Janelle Nancarrow, Assertive Outreach Program, Housing Support for the Aged, Loddon Mallee Housing Services Ltd                |
|                              | Caulfield Aged Persons Mental Health                                 | Associate Professor Stephen Macfarlane<br>Nominee: Gaye Sumsion, Registered Psychiatric Nurse, MAPS                            |
|                              | ACAS   | Kim Dobson, Manager, Mt Eliza ACAS   |
|                              | Western Health   | Dr Sook Meng Lee, ACAS Geriatrician<br>Nominee: Susan Jennings, Manager ACAS, Western Health                                   |
|                              | Local municipal council  | Steve Sodomaco, Manager, Health and Local Laws, City of Greater Geelong  |
|                              |  | Dusan Ivanic, Team Leader, Environmental Health, City of Kingston  |
|                              | St Vincent's Treatment Response and Assessment for Aged Care (TRAAC) | Sharyn Young St Vincent's, TRAAC Acting Manager<br>Aliko Karant, Clinician (Preston) TRAAC Clinician, City of Darebin          |
|                              | RSPCA Victoria   | Sarah Johnstone, Animal Welfare Policy Officer<br>Allie Jalbert, Manager Animal Shelters                                       |
|                              | Merri Community Health Service PhAMS (Northern)                      | Tania Reid, PHaMs Team Leader  |



# Appendix 2 DSM-5 changed the diagnostic criteria of hoarding

## Diagnostic and Statistical Manual of Mental Disorders (DSM)

The American Psychiatric Association first published the DSM in 1952 with several revisions at irregular intervals since then. The DSM is used around the world by health professionals, insurance companies and pharmaceutical companies. The DSM defines and classifies all mental illnesses and is widely used to determine what conditions are considered abnormal, which treatments should be covered by insurance companies, and which warrant special educational services. Consequently, changes to the precise content of the DSM have major social implications.

Compulsive hoarding was coded in DSM-IV-TRTM 2000 as one of the eight symptoms of obsessive compulsive personality disorder (OCPD). The term, '*compulsive* hoarding' is the result of these older diagnostic schemes that put hoarding fully within OCD.

Hoarding disorder is believed to be related to or interconnected with other disorders including bipolar disorder, social anxiety, and depression. Some people who have anorexia nervosa, dementia, schizophrenia or other psychotic disorders may also exhibit signs of hoarding disorder. When hoarding disorder is seen in people it is most often in conjunction with obsessive-compulsive disorder and to smaller extent with attention-deficit-disorder (ADD). Hoarding disorder may run in families.

### The change

The DSM-5 edition (published May 2013)<sup>59</sup> classified hoarding as a distinct disorder with its own diagnostic criteria within the chapter about obsessive-compulsive and related disorders. Before the DSM-5, hoarding could be misdiagnosed as a form of obsessive-compulsive disorder.

Hoarding disorder is new to DSM-5 and is supported by extensive scientific research. The behaviour usually has harmful effects – emotional, physical, social, financial and even legal – for a hoarder and family members.

The classification change isn't just symbolic. The American Psychiatric Association believes it will have a real effect in terms of the diagnosis and treatment of people who have a persistent difficulty ridding themselves of possessions, regardless of their value.

Randy Frost, Smith College (USA) professor of psychology who studies hoarding issues, said the new diagnosis will ease people's access to treatment. "Right now, there are very few clinicians who know how to treat it," Frost states.

Dr Sanjaya Saxena, Director of the University of California San Diego's Obsessive-Compulsive Disorders Program and unofficial advisor in the creation of the DSM-5, said: "Until recently, the general public and certainly the medical community and maybe even the majority of the mental health community did not understand that this was a neuropsychiatric disorder that was treatable, that was describable, that was consistent. And it wasn't a part of something else, and it was a condition that needed clinical attention."

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59 Refer to the American Psychiatric Association, <http://www.dsm5.org/Pages/Default.aspx> *Diagnostic and Statistical Manual of Mental Disorders*.

## Implications in the reclassification of hoarding

Dr Saxena said: “Hoarding will be listed, clinicians will have some awareness of it, people will start screening for it and people with hoarding behaviour will realise it’s a treatable problem.”

Other implications might then include:

- more people seeking treatment and receiving a proper diagnosis
- driving the [mental health] field to educate itself and train incoming trainees and practicing clinicians of all ages
- inspiring pharmaceutical companies to think about doing trials specifically for hoarding disorder (which has never been done before)
- helping mental health professionals develop a better treatment plan
- a big change in the way hoarding is studied
- those people with mental health insurance who seek treatment may be better reimbursed.

This table shows the proposed diagnostic criteria for DSM-5 Hoarding Disorder.

| Proposed DSM-5 – criteria for Hoarding Disorder |   |
|---|---|
| A   | Persistent difficulty discarding or parting with possessions, regardless of <i>their actual</i> value.  |
| 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 are uncluttered, it is only because of the interventions of third parties (for example, 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 (for example, brain injury, cerebrovascular disease).  |
| F   | The hoarding symptoms are not restricted to the symptoms of another mental disorder (for example, 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, food storing in Prader-Willi Syndrome).   |
|   | <p><i>Specify if:</i></p> <ul style="list-style-type: none"> <li>• <i>With excessive acquisition:</i> If symptoms are accompanied by excessive collecting or buying or stealing of items that are not needed or for which there is no available space</li> </ul> <p><i>Specify whether hoarding beliefs and behaviours are currently characterised by:</i></p> <ul style="list-style-type: none"> <li>• <i>Good or fair insight:</i> Recognises that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are problematic.</li> <li>• <i>Poor insight:</i> Mostly convinced that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.</li> <li>• <i>Absent insight:</i> Completely convinced that hoarding-related beliefs and behaviours (pertaining to difficulty discarding items, clutter, or excessive acquisition) are not problematic despite evidence to the contrary.</li> </ul> |

## Appendix 3 Information Privacy Principles

The Victorian Information Privacy Act has ten Information Privacy Principles (IPPs)<sup>60</sup> which are the practical core of the Act. With limited exemptions, all Victorian government agencies, statutory bodies and local municipal councils must comply with the IPPs. Refer to the OVPC 'Guidelines to the Information Privacy Principles for assistance:

[http://www.privacy.vic.gov.au/privacy/web2.nsf/files/guidelines-to-the-information-privacy-principles/\\$file/guideline\\_11\\_11.pdf](http://www.privacy.vic.gov.au/privacy/web2.nsf/files/guidelines-to-the-information-privacy-principles/$file/guideline_11_11.pdf)

The Definitions, IPP 1: *Collection* and IPP 2: *Use and Disclosure* have been provided in the box below to highlight their importance when considering the handling of people's private information (refer to Section 3.6.4 Which privacy laws should I comply with?)

### Definitions

In these Principles "sensitive information" means information or an opinion about an individual's:

- (i) racial or ethnic origin, or
- (ii) political opinions, or
- (iii) membership of a political association, or
- (iv) religious beliefs or affiliations, or
- (v) philosophical beliefs, or
- (vi) membership of a professional or trade association, or
- (vii) membership of a trade union, or
- (viii) sexual preferences or practices, or
- (ix) criminal record –

that is also personal information,

"unique identifier" means an identifier (usually a number) assigned by an organisation to an individual uniquely to identify that individual for the purposes of the operations of the organisation, but does not include an identifier that consists only of the individual's name.

### IPP 1 Collection

- 1.1 An organisation must not collect personal information unless the information is necessary for one or more of its functions or activities.
- 1.2 An organisation must collect personal information only by lawful and fair means and not in an unreasonably intrusive way.
- 1.3 At or before the time (or, if that is not practicable, as soon as practicable after) an organisation collects personal information about an individual from the individual, the organisation must take reasonable steps to ensure that the individual is aware of –
  - (a) the identity of the organisation and how to contact it, and
  - (b) the fact that he or she is able to gain access to the information, and
  - © the purposes for which the information is collected, and
  - (d) to whom (or the types of individuals or organisations to which) the organisation usually discloses information of that kind, and
  - (e) any law that requires the particular information to be collected, and
  - (f) the main consequences (if any) for the individual if all or part of the information is not provided.

<sup>60</sup> Refer to Privacy Victoria, Office of the Privacy Commissioner:

<http://www.privacy.vic.gov.au/domino/privacyvic/web2.nsf/pages/information-privacy-principles#use>

- 1.4 If it is reasonable and practicable to do so, an organisation must collect personal information about an individual only from that individual.
- 1.5 If an organisation collects personal information about an individual from someone else, it must take reasonable steps to ensure that the individual is or has been made aware of the matters listed in IPP 1.3 except to the extent that making the individual aware of the matters would pose a serious threat to the life or health of any individual.

## IPP 2 Use and disclosure

- 2.1 An organisation must not use or disclose personal information about an individual for a purpose (the secondary purpose) other than the primary purpose of collection unless –
  - (a) both of the following apply –
    - (i) the secondary purpose is related to the primary purpose of collection and, if the personal information is sensitive information, directly related to the primary purpose of collection,
    - (ii) the individual would reasonably expect the organisation to use or disclose the information for the secondary purpose, or
  - (b) the individual has consented to the use or disclosure, or
  - © if the use or disclosure is necessary for research, or the compilation or analysis of statistics, in the public interest, other than for publication in a form that identifies any particular individual –
    - (i) it is impracticable for the organisation to seek the individual's consent before the use or disclosure, and
    - (ii) in the case of disclosure – the organisation reasonably believes that the recipient of the information will not disclose the information, or
  - (d) the organisation reasonably believes that the use or disclosure is necessary to lessen or prevent –**
    - (i) a serious and imminent threat to an individual's life, health, safety or welfare, or**
    - (ii) a serious threat to public health, public safety, or public welfare, or**
  - (e) the organisation has reason to suspect that unlawful activity has been, is being or may be engaged in, and uses or discloses the personal information as a necessary part of its investigation of the matter or in reporting its concerns to relevant persons or authorities, or
  - (f) the use or disclosure is required or authorised by or under law, or
  - (g) the organisation reasonably believes that the use or disclosure is reasonably necessary for one or more of the following by or on behalf of a law enforcement agency –
    - (i) the prevention, detection, investigation, prosecution or punishment of criminal offences or breaches of a law imposing a penalty or sanction,
    - (ii) the enforcement of laws relating to the confiscation of the proceeds of crime,
    - (iii) the protection of the public revenue,
    - (iv) the prevention, detection, investigation or remedying of seriously improper conduct,
    - (v) the preparation for, or conduct of, proceedings before any court or tribunal, or implementation of the orders of a court or tribunal, or

- (h) the Australian Security Intelligence Organisation (ASIO) or the Australian Secret Intelligence Service (ASIS), in connection with its functions, has requested the organisation to disclose the personal information and –
  - (i) the disclosure is made to an officer or employee of ASIO or ASIS (as the case requires) authorised in writing by the Director-General of ASIO or ASIS (as the case requires) to receive the disclosure, and
  - (ii) an officer or employee of ASIO or ASIS (as the case requires) authorised in writing by the Director-General of ASIO or ASIS (as the case requires) for the purposes of this paragraph has certified that the disclosure would be connected with the performance by ASIO or ASIS (as the case requires) of its functions.

2.2 If an organisation uses or discloses personal information under paragraph 2.1(g), it must make a written note of the use or disclosure.

## Appendix 4 Sample ‘cycle of change’ model

When we encourage people to become more enterprising we are encouraging them to consider the merits of changing. To consider replacing one pattern of attitudes and behaviours with another.

This Cycle of Change model<sup>61</sup> relates to a person’s patterns of behavioural response with regard to achieving planned goals and actions. This model suggests people react, respond and adjust to change in a sequence of six predictable stages. Navigation can move forwards and backwards while the person endeavours to change their behaviour, there is no one path, we are all unique.

This cycle of change model has six phases:

- In ‘pre-contemplation’, the person does not see any problem in their current behaviours and has not considered there might be some better alternatives.
- In ‘contemplation’ the person is ambivalent – they are in two minds about what they want to do – should they stay with their existing behaviours and attitudes or should they try changing to something new?
- In ‘preparation’, the person is taking steps to change usually in the next month or so.
- In ‘action’, they have made the change and living the new set of behaviours is an all-consuming activity.
- In ‘maintenance’, the change has been integrated into the person’s life – they are now more ‘enterprising’.
- Relapse is a full return to the old behaviour. This is not inevitable – but is likely – and should not be seen as failure. Often people will relapse several times before they finally succeed in making a (more or less) permanent change to a new set of behaviours.

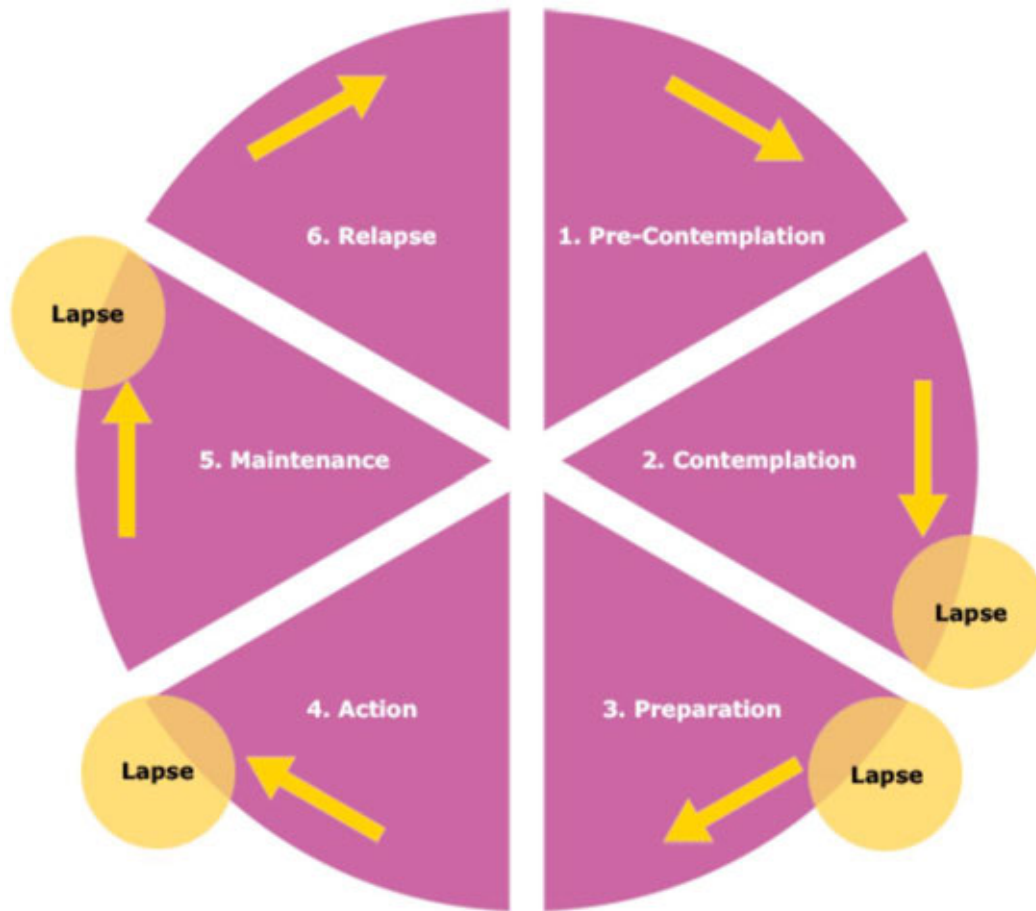
A couple of things require some thought when looking at this model:

- Firstly, many professionals think that the path to change instigated by a person is (or should be) a fairly linear one, based on a few suggestions and ideas. This model of change suggests that there are a whole range of factors that are liable to lead to lapses – if not relapses – on the change journey and we should be aware of this. Lapse or Relapse does not mean failure – and should not be taken as indicators that the person is not capable of making the change. Indeed lapse or relapse should be *expected* as a normal part of the cycle of change in relation to new behaviours.
- Secondly, the change cycle will often operate over a timescale of years rather than months. When we are planning a service response we need to take account of the fact that different individuals move at a different pace.

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<sup>61</sup> Prochaska et al. 1985.

**Figure 28 Sample 'cycle of change' model**





# Acronyms and abbreviations

|             |   |
|-------------|---|
| ABI         | acquired brain injury   |
| ACAS        | Aged Care Assessment Service (Commonwealth and Victoria)                    |
| APATS       | Aged Psychiatric Assessment and Treatment Services                          |
| APMHS       | Aged Persons' Mental Health Services  |
| APS         | Australian Psychological Society  |
| ASIO        | Australian Security Intelligence Organisation                               |
| AV          | Ambulance Victoria  |
| AVA         | Australian Veterinary Association   |
| CACP        | Community Aged Care Package   |
| CALD        | culturally and linguistically diverse                                       |
| CDAMS       | Cognitive, Dementia and Memory Services                                     |
| CFA         | Country Fire Authority  |
| CHC         | Community Health Centres  |
| Child FIRST | Family Information, Referral and Support Teams                              |
| CHS         | community health services   |
| CIRS        | Clutter Image Rating Scale  |
| COAG        | Council of Australian Governments   |
| CPD         | continuing professional development   |
| DAA         | Domestic Animals Act  |
| DH          | Department of Health (Victoria)   |
| DHS         | Department of Human Services (Victoria)                                     |
| DoHA        | Department of Health and Ageing (Commonwealth)                              |
| DoJ         | Department of Justice (Victoria)  |
| DPI         | Department of Primary Industry (Victoria) pre April 2013                    |
| DEPI        | Department of Environment and Primary Industries (Victoria) post April 2013 |
| DSM         | Diagnostic and Statistical Manual of Mental Disorders                       |
| DSR         | Disability Support Register   |
| DVD         | digital video disc  |
| EACH        | Extended Aged Care at Home (Commonwealth)                                   |
| EACHD       | Extended Aged Care at Home Dementia (Commonwealth)                          |
| ECCS        | Environmental Cleanliness and Clutter Scale                                 |
| EHO         | environmental health officer  |
| EPA         | Environment Protection Authority Victoria                                   |
| EPA         | enduring power of attorney  |

|        |  |
|--------|--|
| ESV    | Energy Safe Victoria   |
| EWOV   | Energy and Water Ombudsman Victoria  |
| GP     | general practitioner   |
| HAAG   | Housing for the Aged Action Group Inc.   |
| HACC   | Home and Community Care program (jointly funded Victoria and Commonwealth)       |
| HARP   | Hospital Admission Risk Program  |
| HPP    | Health Privacy Principle   |
| HRS    | Hoarding rating scale interview  |
| HSC    | Health Services Commissioner (Victoria)  |
| HSD    | Human Services Directory   |
| HSO    | Housing support officer  |
| IMYOS  | Intensive Mobile Youth Outreach Services   |
| INI    | initial needs identification   |
| IPP    | Information Privacy Principle  |
| ITAR   | Indigenous Tenancies at Risk Program   |
| LIV    | Law Institute of Victoria  |
| LPG    | liquid petroleum gas   |
| MACNI  | Multiple and Complex Needs Initiative  |
| MFB    | Metropolitan Fire and Emergency Services Board                                   |
| MOH    | Ministry of Housing  |
| MOU    | memorandum of understanding  |
| MSTS   | Mobile Support and Treatment Services  |
| OCD    | obsessive compulsive disorder  |
| OHS    | occupational health and safety   |
| OoH    | Office of Housing (Victoria)   |
| OPA    | Office of the Public Advocate (Victoria)   |
| OT     | occupational therapy   |
| OVPC   | Office of the Victorian Privacy Commissioner                                     |
| PARC   | Prevention and Recovery Care   |
| PCP    | Primary Care Partnerships  |
| PDRS   | Psychiatric Disability Rehabilitation and Support (PDRS) service (mental health) |
| PHaMs  | Personal Helpers and Mentors Programs (Commonwealth)                             |
| PHWA   | Public Health and Wellbeing Act 2008   |
| PMHEI  | Primary Mental Health and Early Intervention                                     |
| POCTAA | Prevention of Cruelty to Animals Act 1986  |
| PPE    | personal protective equipment  |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists                        |

|       |  |
|-------|--|
| REIV  | Real Estate Institute of Victoria  |
| RSPCA | The Royal Society for the Prevention of Cruelty to Animals (Victoria)  |
| SCTT  | service coordination tool templates  |
| SfHRT | Support for High Risk Tenancy Program (Department of Human Services Housing Division and Community Building) |
| SHASP | Social Housing Advocacy and Support Program (Victoria)   |
| SRS   | Supported Residential Service  |
| TAFE  | Technical and Further Education institutes   |
| TRAAC | Treatment Response and Assessment for Aged Care  |
| UN    | United Nations   |
| VCAT  | Victorian Civil and Administrative Tribunal  |
| VLA   | Victoria Legal Aid   |
| WFDS  | Warehousing Fulfilment Distribution Solutions  |
| WPI   | Worcester Polytechnic Institute (Massachusetts) USA  |

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