

A Foot in the Door

Stepping towards
solutions to resolve
incidents of severe
domestic squalor in
South Australia

A guideline



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of South Australia

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A Foot in the Door - Stepping towards solutions to resolve incidents of severe domestic squalor in South Australia

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2. Acronyms and abbreviations

CBT	Cognitive behavioural therapy
CMHC	Community Mental Health Centre
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECCS	Environmental Cleanliness and Clutter Scale
EPG	Enduring Power of Guardianship
GP	General Practitioner
HACC	Home and Community Care
OCD	Obsessive-Compulsive Disorder
SDSAS	Severe Domestic Squalor Assessment Scale
The Act	<i>South Australian Public Health Act 2011</i>
WH&S	Work health and safety



Part 1:

Severe domestic squalor:
background

3. Introduction

In recent years, severe domestic squalor and compulsive hoarding have received national and international attention. There has been a growing appreciation of the complexities involved in each case and the difficulties presented when aiming to achieve successful, sustainable outcomes. People who live in severe domestic squalor are often described as messy or dirty individuals who have no regard for the condition of their property. In most cases, this could not be further from the truth. It is becoming increasingly evident that severe domestic squalor is commonly associated with physical and/or mental incapacity. Therefore, it is important to take a holistic approach when resolving cases of severe domestic squalor, including addressing the underlying cause rather than just the symptom (the squalor).

This guideline, which aims to support local government environmental health officers understand, assess and manage cases of severe domestic squalor in South Australia, promotes this approach by:

- > Explaining the complex nature of severe domestic squalor;
- > Outlining a multidisciplinary approach that focuses on early intervention, treatment and relapse prevention;
- > Providing a tool that assesses the risks associated with cases of severe domestic squalor on a case by case basis; and
- > Providing guidance to local government environmental health officers on the application of the *South Australian Public Health Act 2011* in situations of severe domestic squalor.

This guideline does not mandate a single approach to the management of severe domestic squalor. It is designed to remove value-based assessments by promoting a consistent, supportive, and risk based identification and management framework, which acknowledges that different people have different living standards. It recognises the importance of interagency cooperation in achieving successful outcomes. As such, the guideline may be useful for other agencies that support people in severe domestic squalor. Agencies are encouraged to adopt and adapt this guideline for use within their local communities.

4. What is severe domestic squalor?

Severe domestic squalor refers to households that are extremely cluttered, in a filthy condition, and where the accumulation of items such as personal possessions, rubbish, excrement and decomposing food creates an environment that jeopardises the health and wellbeing of the occupant(s). Furthermore, 'normal' household activities such as cooking, bathing and sleeping are impeded or not possible. In extreme cases, severe domestic squalor may also have an impact on neighbours because the property may be a fire hazard, emit a foul odour and harbour vermin.

Squalor can be defined as either 'wet' or 'dry'. Wet squalor refers to an accumulation of filth and refuse, and dry squalor refers to the accumulation of items and possessions (Snowdon 2009). While it may be possible to distinctly separate cases of wet and dry squalor, they may occur together.

Severe domestic squalor does not refer to properties that are simply unsightly, un-kept or where the accumulation of items does not jeopardise the occupants' health and safety. In such situations, the condition of the property may be associated with a lifestyle choice and failure to remove household waste and rubbish (see Section 8).

In the past, severe domestic squalor has been associated with (or referred to as) senile breakdown, Diogenes syndrome, gross self-neglect, senile recluse, social breakdown syndrome, squalor syndrome, senile self-neglect and extreme self-neglect (The NSW Department of Aging Disability and Home Care 2004). It is now acknowledged that severe domestic squalor is usually associated with one or more health conditions (Table 1). Compulsive hoarding (a component of hoarding disorder), self-neglect, animal hoarding and deliberate hoarding are described in detail within this guideline. Whilst not included in Table 1, it should be noted that other conditions such as brain injuries (lesions), anxiety, depression and some genetic disorders have also been linked with severe domestic squalor (Pertusa et al 2010).

Table 1

Factors that can be associated with severe domestic squalor

Factor	Definition / Symptoms	Reference
Hoarding Disorder	<ul style="list-style-type: none"> > 'Persistent difficulty discarding or parting with possessions, regardless of their actual value. > This difficulty is due to a perceived need to save the items and distress associated with discarding them. > The difficulty discarding possession results in the accumulation of possessions that congest and clutter active living areas and substantially compromise their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g. family members, cleaners, authorities). > The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others). > The hoarding is not attributed to another medical condition (e.g. brain injury, cerebrovascular disease, Prader-Willi Syndrome). > The hoarding is not better explained by the symptoms of another mental disorder (e.g. obsessions in Obsessive-Compulsive Disorder, decreased energy in Major Depressive Disorder, delusions in Schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in Autism Spectrum Disorder). > Specify if there is excessive acquisition, good or fair insight, poor insight, absent insight/delusional benefits.' 	American Psychiatric Association 2013
Self-neglect	<ul style="list-style-type: none"> > 'Where the person fails to maintain aspects of their care, health and lifestyle, such as personal care, eating adequately, or failing to take medications as prescribed.' 	The NSW Department of Aging Disability and Home Care 2007
Deliberate Hoarding	<ul style="list-style-type: none"> > A lifestyle choice whereby there is a failure to remove household waste, rubbish and other items. 	Modified from the NSW Department of Aging Disability and Home Care 2007

Table 1 (continued)

Factors that can be associated with domestic squalor

Factor	Definition / Symptoms	Reference
Animal Hoarding	<p>The combination of:</p> <ul style="list-style-type: none"> > 'Failure to provide minimal standards of sanitation, space, nutrition, and veterinary care for the animals; > Inability to recognise the effects of this failure on the welfare of the animals, human members of the household, and the environment; > Obsessive attempts to accumulate or maintain a collection of animals in the face of progressively deteriorating conditions; and <p>Denial or minimisation of problems and living conditions for people and animals.'</p>	Patronek et al. 2006
Obsessive Compulsive Disorder	<ul style="list-style-type: none"> > Persistent ideas or thoughts. > Repetitive behaviours. <p>(American Psychiatric Association 2000)</p>	See Steketee & Frost 2003
Dementia	<ul style="list-style-type: none"> > Obvious memory impairment. > Deteriorated speech. > Impaired social or occupational functioning. <p>(American Psychiatric Association 2000)</p>	Hwang et al. 1998 & Halliday et al 2000
Schizophrenia	<ul style="list-style-type: none"> > Delusions. > Hallucinations. > Disorganised thinking. > Disorganised speech. > Disorganised behaviour. <p>(American Psychiatric Association 2000)</p>	See Steketee & Frost 2003 & Halliday et al. 2000
Self-neglect	<ul style="list-style-type: none"> > Unable to maintain personal hygiene and cleanliness. > Eccentric behaviour. > Living in an unclean environment. <p>(Day & Leahy-Warren 2008)</p>	Day & Leahy-Warren 2008
Substance Abuse	<ul style="list-style-type: none"> > Various – see Drug and Alcohol Services South Australia: http://www.dassa.sa.gov.au/site/page.cfm <p>(SA Health 2010)</p>	Halliday et al. 2000
Physical Disability	<ul style="list-style-type: none"> > Examples of commonly reported symptoms include poor coordination, poor balance, impaired vision, impaired speech and mobility problems. 	Halliday et al. 2000 & Snowdon et al. 2007

5. Compulsive hoarding

Compulsive hoarding has been well documented in the literature and has now been incorporated into the diagnostic criteria for hoarding disorder. Compulsive hoarding is defined as the combination of:

- > 'The acquisition of, and failure to discard, a large number of possessions that appear to be useless or of limited value;
- > Living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed; and
- > Significant distress or impairment in functioning caused by hoarding.'

Frost & Hartl 1996 (cited in Frost et al. 2004)

Although compulsive hoarding can be confused with collecting, these behaviours differ considerably (Table 2). The act of hoarding is most commonly associated with the elderly, although it has been found in children as young as 10 years old (Samuels et al. 2008; Steketee & Frost 2003).

It is important to note that not all cases of compulsive hoarding result in severe domestic squalor. For example, a case in which a property has a large accumulation of items but is not in a filthy condition would be considered hoarding rather than severe domestic squalor.

Items commonly acquired by people who compulsively hoard include things such as newspapers, promotional giveaways, CDs, videos, magazines, clothing, books, milk bottles, food containers, bottle tops and bags (Halliday et al. 2000; Jones 2004; Steketee & Frost 2003). However, anything may be acquired. Field workers report that the acquisition of scrap building material, such as metal and wood, is common. People who compulsively hoard can also be distinguished as 'generalists' or 'specialists' (The Dane County Hoarding Task Force 2000). A generalist is someone who retains everything and anything, whereas a specialist only retains one type of possession (The Dane County Hoarding Task Force 2000).

Table 2

The difference between compulsive hoarding and collecting (Frost 2010 cited in Sunrise 2010)

Compulsive Hoarding	Collecting
Usually involves the acquisition of many different possessions	Usually involves the acquisition of one type of item (e.g. clocks)
Possessions are stored in a disorganised manner	Collections are stored in an organised manner
People do not like to show other people their possessions	People like to show other people their collections

5.1 How does compulsive hoarding develop?

A series of complex cognitive processes, including a manifestation of compulsive acquisition, the inability to discard possessions, poor organisation skills and avoidance behaviours drive the development of compulsive hoarding (Frost & Steketee 1999). While these cognitive processes (see Table 3) can occur together, severe domestic squalor may occur when a person exhibits only one process. It is important to have an understanding of these processes because attempts to resolve cases of severe domestic squalor involving compulsive hoarding prove ineffective when these underlying behaviours are not addressed.

Table 3

The cognitive processes associated with compulsive hoarding

Cognitive Process	Details
Compulsive acquisition	<ul style="list-style-type: none"> > Can occur through compulsively buying items and / or through collecting free things (Best-Lavigniac 2006; Frost & Steketee1999). > Objects are acquired and saved, even when a use or need for the item has not been determined (Frost & Steketee1999). > People experience grief and distress if an item they feel strongly about is not acquired (Frost & Steketee1999).
Inability to discard possessions	<ul style="list-style-type: none"> > People are emotionally attached to their belongings (Cermele et al. 2001). > Possessions are associated with a feeling of safety and comfort, and people often feel vulnerable and insecure when they part from their belongings (Frost & Steketee 1999). > People can feel as though they have lost their identity when someone else touches, borrows, moves or discards any of their possessions (Frost & Steketee 1999; Steketee & Frost 2003).
Poor organisation skills	<ul style="list-style-type: none"> > People find it extremely difficult to categorise their belongings (Steketee & Frost 2003). > Poor organisational skills can result in extreme clutter because possessions are stored in a disorganised manner throughout the home (Frost & Steketee 1999). > Belongings may be stored in a visible place so that they are not forgotten (Frost & Steketee 1999).
Avoidance behaviours	<ul style="list-style-type: none"> > Involves the inability to make decisions such as 'where shall I put it?' and 'shall I throw it out?' (Frost & Steketee 1999; Steketee & Frost 2003). > The consequences associated with making a wrong decision are feared (Frost & Steketee 1999). > The decision not to throw anything away is viewed more favourably than the possibility of missing the possession after it has been discarded (Frost & Steketee1999).

5.2 Treating compulsive hoarding

Treating compulsive hoarding is complex and usually problematic (Steketee & Frost 2003). In the past, treatment has been based on methods used to treat Obsessive-Compulsive Disorder (OCD) (Mataix-Cols et al 2010; Tolin et al 2007a). These techniques, including behavioural therapy and the use of prescribed medication such as serotonin reuptake inhibitors (e.g. paroxetine) have been largely ineffective for treating compulsive hoarding (Mataix-Cols et al 2010; Tolin et al 2007a). More recently, treatment has been refined and now focuses on the key components of compulsive hoarding.

Cognitive behavioural therapy (CBT) that has been modified to treat the cognitive processes associated with compulsive hoarding (see Section 5.1) has achieved positive results (Mataix-Cols et al 2010; Tolin et al 2007a). For example, Steketee and Frost (2007) developed a CBT treatment program that includes office and in home sessions focusing on treating disorganisation / excess clutter, excessive acquisition and difficulty discarding. Other forms of CBT that focus on treating these behaviours have also achieved positive results (Pertusa et al 2010). Treatment programs often require modification to meet the needs of each person (Steketee & Frost 2003). While the principles of the treatment remain consistent, the specific focus, duration and tools used during treatment often vary (Steketee and Frost 2007). Therefore, it is critical that appropriately trained clinicians conduct treatment programs. It should also be noted that client willingness is crucial to the success of CBT treatment.

6. Self-neglect

Self-neglect, as defined in Table 1, can result in severe domestic squalor because people who are unable to maintain aspects of their personal care can find it difficult to maintain their property in a clean and tidy condition. Self-neglect is complex and multifaceted and can be associated with an underlying psychiatric condition and / or the deterioration of one's ability to function physically or cognitively (Day & Leahy-Warren 2008).

Given the complexities of self-neglect, it is important to identify its nature and extent on a case by case basis because the support required by people differs. For example, in home support may benefit people whose physical capability has declined whereas medical treatment may benefit those who have an underlying psychiatric condition.

7. Animal hoarding

Animal hoarding, as defined in Table 1, typically involves people who are socially isolated, although it can be evident in well-educated and active members of the community (The Hoarding of Animals Research Consortium 2002). Several theories that attempt to explain the human behaviour of animal hoarding include:

- > It is an offset of OCD as some people take unrealistic steps to prevent imagined harm to their animals (Frost et al 2000; Lockwood 1994 cited in The Hoarding of Animals Research Consortium 2002).
- > It is a highly focused form of delusional disorder (Frost et al 2000; The Hoarding of Animals Research Consortium 2002).
- > It is an early warning sign for dementia (Patronek 1999).

Animal hoarding is often misunderstood and not regarded as a significant community problem (Patronek et al 2006). Animal hoarding can jeopardise the health of animals, individuals and the community, and result in situations of severe domestic squalor. For example:

- > Zoonotic pathogens can be transmitted to humans, particularly when animal care and hygiene is poor (Castrodale et al 2010).
- > The surrounding air quality can be poor because there can be high levels of ammonia, hydrogen sulphide, nitrous oxide, methane, carbon dioxide, allergens and particulate matter (Zhao 2007 cited in Castrodale et al 2010).
- > High numbers of animals can create moist conditions that are ideal for mould growth (Castrodale et al 2010).
- > There may be numerous physical hazards that can result in physical injuries (Castrodale et al 2010).
- > Animals may bite or scratch humans and cause physical injuries (Castrodale et al 2010).

In the United States of America (USA), it is estimated that between 700 and 2000 new cases of animal hoarding occur each year (Patronek 1999). Despite this high prevalence rate, it is believed that most communities are unable to resolve cases effectively because animal hoarding is often regarded as purely an animal welfare issue rather than an issue that is central to human behaviour (Patronek et al 2006). Whilst animal welfare organisations recognise this fact, these organisations often find it extremely difficult to engage other agencies that specialise in personal care and treatment (Patronek et al 2006). As a result, the reoccurrence rate is extremely high as the removal of animals does not address the underlying hoarding behaviour (Patronek et al 2006).

Given the multifaceted nature of animal hoarding, it is important that cases are resolved through an interagency approach rather than just by animal welfare agencies. It is important not only to attend to the animals, but also to address the owner of the animals and their underlying behaviour.

8. Deliberate hoarding

Severe domestic squalor, while usually associated with an underlying health condition, may be associated with a lifestyle choice. For the purpose of this guideline, deliberate hoarding is defined in Table 1.

The fact that lifestyle choices may result in severe domestic squalor precludes the automatic assumption that all persons living in squalor suffer from a health condition. In the absence of contributing physical or mental factors, the nature of the intervention may necessitate the use of legislative tools (Section 15.16). It is important to distinguish between cases of deliberate hoarding and cases involving compulsive hoarding, self-neglect and animal hoarding to ensure appropriate treatment or action.

9. Characteristics of people who live in severe domestic squalor

People who live in severe domestic squalor share several common characteristics. It is useful to understand these characteristics because they often influence a person's approachability, receptiveness to help and willingness to change their living environment.

Severe domestic squalor is not limited to the elderly; anyone of any age can live in situations of severe domestic squalor (Halliday et al. 2000; Middlesex-London Health Unit 2000). A situation of severe domestic squalor can develop quite quickly if linked to a sudden behavioural change, or over many years as possessions and household items accumulate throughout the dwelling. It is common for people living in severe domestic squalor to be isolated from the community as family members distance themselves to avoid the stress associated with completing day to day activities such as cooking, cleaning and sleeping (Tolin et al. 2007a; Wheaton et al. 2008; Wilbram et al. 2008). Isolation can also occur as people avoid inviting friends and visitors into their home; they are embarrassed about the condition of their property (Mental Health Association of San Francisco 2009). As a result, many people that live in severe squalor have poor social skills, very few friends, social phobia and depression (Steketee & Frost 2003).

Another common characteristic (mainly associated with compulsive hoarding) is that many people lack the ability to recognise the severity and consequences of their living conditions (Steketee & Frost 2003). These people do not believe the condition of their property is unreasonable and are often unwilling to return it to a suitable condition. It is often extremely difficult to work with people and achieve a positive outcome unless they overcome this lack of insight.

10. The impact of severe domestic squalor

It is difficult to describe and quantify the absolute impact of severe domestic squalor. There are psychological and financial impacts for people, families, carers, service providers and the community. Table 4 summarises some of these impacts but it is important to note that this is by no means an exhaustive list.

As shown in Table 4, there are many financial implications associated with cases of severe domestic squalor. In San Francisco, the estimated financial cost to service providers is \$2.01 million USD annually (Mental Health Association of San Francisco 2009). In addition, the financial burden on landlords for costs such as pest control, foregone rent, cleaning and eviction is an estimated \$3.92 million USD annually (Mental Health Association of San Francisco 2009). In Australia, the Metropolitan Fire Brigade in Melbourne has estimated that hoarding related fires cost on average \$2120 per incident, which is approximately 16 times higher than non-hoarding related fires (Lucini et al 2009).

Table 4

Psychological and financial implications of severe domestic squalor and compulsive hoarding

Potential Impact	Psychological Implications	Financial Implications	Reference
Children can have elevated rates of distress, find it more difficult to make friends, experience an increased strain on family life and feel embarrassed about the condition of their home.	✓		Tolin et al 2008
People can feel as though they have lost normality in their life.	✓		Wilbram et al 2008
People can experience anger and frustration. This can subsequently result in family breakdown.	✓		Wilbram et al 2008 & Mental Health Association of San Francisco 2009
People can feel marginalised, resulting in social withdrawal and isolation (especially with neighbours).	✓		Wilbram et al 2008 & Mental Health Association of San Francisco 2009
Increased risk of eviction.	✓	✓	Mental Health Association of San Francisco 2009
Carers can feel alienated from service providers because they feel unheard and misunderstood.	✓	✓	Wilbram et al 2008
Increased risk of injury and illness (e.g. from falls).	✓	✓	Mental Health Association of San Francisco 2009
Increased risk of fire.	✓	✓	Mental Health Association of San Francisco 2009
Rubbish removal / clean-ups.	✓	✓	Mental Health Association of San Francisco 2009
The use of service provision from government and non-government agencies.		✓	Mental Health Association of San Francisco 2009

11. How common is severe domestic squalor?

The prevalence rate of severe domestic squalor in the community is not well defined. Data is usually collected in an ad hoc manner, and many studies rely on self-reported data or are subject to recall bias (Wheaton et al. 2008). Thus, the prevalence rates are usually under reported. In addition, many people who live in severe domestic squalor never come to the attention of authorities or support services, and subsequently go undetected. Despite this, Table 5 shows that both hoarding and domestic squalor are prevalent within the community, highlighting the need to have programs in place to address these issues.

Table 5

The prevalence rate of severe domestic squalor, compulsive hoarding and hoarding behaviours

Type	Location	Prevalence	Reference
Hoarding	Massachusetts	Over a five-year period, health authorities received 26.3 hoarding complaints per 100,000 residents.	Frost et al. 2000
Hoarding	Baltimore Epidemiologic Catchment Area	In a population of 735 people, hoarding behaviour was evident in nearly 4%.	Samuels et al. 2008
Hoarding / Clutter	USA	An estimated 2-4% of the population suffer from hoarding or cluttering behaviour.	Mental Health Association of San Francisco 2009
Squalor	Central Sydney	An estimated 1.5 people per 1000 over the age of 65 live in moderate or severe squalor.	Snowdon 2009
Hoarding	-	Hoarding behaviour is evident in approximately 22.6% of dementia patients.	Hwang et al. 1998
Compulsive Hoarding	-	Compulsive hoarding is evident in approximately 25% of OCD patients. This is likely to represent a life time frequency of approximately 4 cases per 1000 people (Dinning 2006).	Steketee & Frost 2003

12. Severe domestic squalor in South Australia

There is very little South Australian data showing the prevalence rate of severe domestic squalor. Anecdotal evidence suggests it is a common issue affecting many government and non-government agencies. In an effort to bridge this knowledge gap, SA Health conducted a survey of all South Australian public health authorities (local councils) in 2009. Of the 65 authorities invited to take part, 25 (38%) participated in the survey. Given that squalor related data is not collected routinely, the survey was completed retrospectively for the years 2004–2008 and is subject to recall bias.

12.1 Prevalence of complaints

The survey showed that the total number of hoarding / domestic squalor complaints increased from 126 in 2004 to 642 in 2008 (Table 6). In addition, the number of reoccurring cases and complaints found to be justified (from local government's perspective) increased markedly between the years under investigation. It is particularly concerning that 41 of the 117 justified complaints in 2008 were reoccurring cases, indicating that approximately 35% of cases were not resolved successfully.

Table 6

The rate of hoarding / domestic squalor complaints in South Australia for the years 2004–2008 as indicated by the 2009 local government survey

	Year				
	2004	2005	2006	2007	2008
Total number of hoarding / domestic squalor complaints	126	145	389	548	642
Number of complaints found to be justified / substantiated	66	75	96	97	117
Total number of reoccurring cases previously investigated	18	22	26	28	41

12.2 Challenges

According to the 2009 local government survey, a number of challenges exist when resolving hoarding / domestic squalor cases. The two biggest challenges facing local government are clients failing to recognise the extent of the problem, and difficulty addressing the mental health problems associated with hoarding (Table 7). This highlights the key areas to address when resolving cases in the future.

Table 7

The challenges associated with hoarding / domestic squalor rated as 'extreme' in the 2009 local government survey

Potential Challenge	% of Authorities that Rated the Challenge as Extreme
The client fails to recognise the extent of the problem.	60%
The client is unwilling to accept help.	25%
Lack of interagency cooperation.	10%
Difficulties addressing the mental health problems associated with hoarding.	64.7%
Pressure from the complainant to resolve the issue expeditiously.	20.0%
Time commitment required by staff.	40.0%
Unclear on the roles and responsibilities of relevant stakeholders.	10.5%

12.3 Resources

Resolving cases of hoarding / severe domestic squalor requires a significant commitment in staff time. This was evident in the 2009 local government survey, which showed that 50% of cases required 4–7 home visits to resolve and 47% of cases absorbed between 16 and 25 hours of staff time. Interestingly, 17.6% of cases required more than 31 hours of staff time, indicating the extensive time commitment required for more challenging cases. As shown in Table 7, 40% of local councils consider the time commitment required of staff an 'extreme' challenge.

12.4 Interagency approach

Local government supports resolving cases of hoarding / domestic squalor through an interagency approach. When asked how often they seek assistance from other agencies, 52.6% of the authorities selected 'often' and 10.5% selected 'always'. Although many authorities seek interagency support, 73.3% indicated that they are unsure about which agencies can help. This prevents / limits this approach. In addition, 80% of authorities indicated that lack of a clear framework for interagency cooperation prevents / limits interagency collaboration.

13. National and international guidance for managing severe domestic squalor

Severe domestic squalor is recognised worldwide as a complex and multifaceted issue. Over the past decade, several authorities from around the world have developed specific squalor (or hoarding) guidelines and action plans in an effort to achieve better outcomes. Authorities include the Ottawa Community in Canada, the Middlesex-London Health Unit in London, the Mental Health Association of San Francisco, and the Department of Ageing Disability and Home Care in NSW (Australia).

Each of the above mentioned authorities' guidelines, the key recommendations of which are summarised in Table 8, highlights the need to form interagency partnerships. It is widely acknowledged that severe domestic squalor does not fit under the remit of one single agency and that a multidisciplinary response is required. Furthermore, the ability to achieve successful outcomes is limited when one or more agencies are not involved in the interagency response.

In 2007, a South Australian specific protocol was developed to manage cases of compulsive hoarding (Merkel 2007). The protocol identified the potential roles and responsibilities that several agencies might play in the management of compulsive hoarding. It acknowledged that many agencies find it difficult to achieve successful outcomes. A referral and management pathway was also developed to provide further guidance to relevant agencies.

Currently in Australia, the Catholic Community Services in Sydney, with funding assistance from the New South Wales State Government, are leading the way in the management of severe domestic squalor. They have established a single referral point through the use of a 'Squalor Hotline', which both the community and agencies are encouraged to use. Upon receipt of a referral, staff assess the property and initiate a multidisciplinary response. This usually involves case specific meetings and the development of specific action plans.

Table 8

Key recommendations from guidelines designed to successfully resolve cases of severe domestic squalor and hoarding

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



Part 2:

Managing cases of severe
domestic squalor in South
Australia

14. Current approach to resolving cases of severe domestic squalor in South Australia

In South Australia (SA), an increasing number of agencies recognise the complex nature of severe domestic squalor and use formal and informal multiagency approaches to resolve cases. Despite this, it often remains difficult for them to achieve successful outcomes, due in part to the following commonly reported issues:

- > Severe domestic squalor is often misunderstood and not recognised as a complex and multidisciplinary issue.
- > Some agencies do not regard severe domestic squalor as a priority and do not participate in the multidisciplinary response.
- > People can 'fall through the gap' without assistance if the delivery of services between organisations is not coordinated.
- > Resources dedicated to severe domestic squalor are insufficient and/or inappropriately used.
- > Many agencies do not know which other agencies can offer assistance in the multidisciplinary approach.
- > There are no common assessment tools or agreed pathways that multidisciplinary teams can use to resolve cases of severe domestic squalor.

In order to improve the management of severe domestic squalor in SA, the above mentioned issues must be addressed. In the absence of additional resources, the interagency model described in Section 15 aims to promote effective and efficient intervention through the identification of client needs and the provision of services through relevant agencies. Whilst the model places strong emphasis on case coordination, it is intended to distribute the responsibilities and workload across the relevant agencies.

15. A framework for managing cases of severe domestic squalor in South Australia

Interagency cooperation is crucial to successfully resolving and managing cases of severe domestic squalor. It is fundamental to the following framework. While the proposed framework is set out in a logical order, in reality the investigation and resolution process is not static; it may not occur in the sequential manner presented.

The following framework is summarised in Appendix 1.

15.1 The formation of interagency teams (task force)

Management of severe domestic squalor is a multidisciplinary challenge. Therefore, interagency teams (task force) should be formed at the regional or local level to resolve local cases. A task force should be flexible in nature because support services may vary from area to area. It should contain members from local agencies, sought from the managerial level to ensure that active participation in the task force is a priority. The use of relevant boundaries (e.g. Local Government Area(s)) may assist in defining the geographic area covered by the task force. As agencies are responsible for different geographical areas, some members may participate in one task force while others may participate in several.

Whilst the task force contains membership from many agencies, not all agencies will be required to participate in all cases. Participation will depend on the client's needs. For example, the RSPCA would only be involved when there is an animal welfare concern. As such, it is important that the task force not only convenes to resolve specific cases, but also convenes periodically (e.g. quarterly) to continually develop and refine local procedures, and to develop and sustain interagency relationships.

Resolving cases of severe domestic squalor requires a coordinated effort by many agencies. Therefore, accountability amongst participating agencies is important. Task force members should work together to determine and document the roles and responsibilities of the task force, and those of individual agencies to improve agency accountability and to reduce unrealistic expectations.

15.2 Information sharing and client confidentiality

It is important that all task force members are aware of their responsibilities in relation to information sharing and client confidentiality. The concept of interagency task forces relies on referring and discussing individual cases in order to:

- > Help coordinate required services offered by several different agencies.
- > Avoid the duplication of services.

- > Help protect the health and wellbeing of the client, other occupants and/or community members.

It is important for agencies to ensure that the privacy and confidentiality of clients is respected until it has been determined that the property is in a state of severe domestic squalor (and not simply a neighbourhood dispute). In cases of severe domestic squalor, consent to share client information should be sought from the client in the first instance. If consent is not given or it is not safe to obtain consent, agencies should consider sharing information without the client's consent. It is important to balance duty of care responsibilities with client confidentiality requirements. Task force members should be familiar with, and adhere to, any relevant legislation and policies related to information sharing, including the new information sharing guideline currently being developed by the South Australian Ombudsman (see Appendix 5).

15.3 The initial referral

Relevant agencies receive the majority of severe domestic squalor referrals via the telephone from neighbours, friends, relatives and other service providers. The following information will assist in the investigation process and where possible should be obtained and documented during the referral and/or subsequent home visit:

- > What type of housing is the person living in (e.g. private rental, public housing or owner / occupier)?
- > Are there vulnerable people (e.g. children) living in the dwelling and are there concerns about their safety (this may warrant expediting the investigation and particularly the initial home visit)?
- > Does the person have any family, carers, friends or neighbours that visit regularly?
- > Have there been any neighbourhood disputes recently?
- > Does the person utilise any in home or community services.
- > How long has the person been living in the unclean conditions?
- > What is the person's character, habits and medical / psychiatric history?
- > Does the person live with anyone else or any animals?
- > Are there any language or communication barriers?
- > What is the approximate age of the person?

The following information will also assist trained clinicians understand the underlying factors associated with the client and should be documented when apparent:

- > Does the person consider themselves a perfectionist?
- > Does the person avoid making decisions?
- > Does the person have a compulsive urge to acquire possessions?
- > Does the person have an emotional attachment to their possessions regardless of their actual value?

15.4 The home visit

The purpose of the home visit is to determine whether the home is in a state of severe domestic squalor and if further action is warranted. Whilst the agency that receives the referral often conducts the home visit, in some cases it may be more appropriate for another agency in the task force to undertake the visit based on the following factors (if known):

> Risks:

If certain risks are identified, such as child neglect, poor animal welfare or fire hazards, it may be more appropriate that the relevant agency concerned undertakes or participates in the initial home visit.

> Rapport:

If the client has developed rapport with a particular agency or field worker, it may be beneficial for that agency or field worker to undertake the initial home visit. Similarly, if an agency or field worker has developed a poor rapport with the client, it may be beneficial for another worker or agency to conduct the initial home visit.

It may not be necessary to notify the task force of the referral until the home visit has been conducted as the visit may reveal that no further action is required (i.e. the property is not in a state of severe squalor). However, due consideration should be given to the information gathered in Section 15.3 before undertaking the home visit. Extra precautions may be necessary so that the visit can be undertaken safely (e.g. a police officer accompanying the field worker if the client has a history of violence).

When undertaking the home visit, it is important to be mindful that the nature of the initial contact made with the client is extremely important; it can have a significant bearing on the client's acceptance of help. Therefore, it is important that field workers approach the client with sensitivity and respect. Motivational interview training may help field workers and agencies in this regard.

Agencies should have policies and procedures in place to address the fact that clients often refuse them entry into their property. Policies should consider natural and social justice principles, duty of care responsibilities and legislative responsibilities.

15.5 Work health and safety

Work health and safety (WH&S) is a significant issue for agencies working with clients in severe domestic squalor. A range of hazards must be considered when entering properties, such as the risk of tripping and falling. In some cases, personal protective equipment may be required, for example when animals are present. In extreme cases, the hazards may be so great they prevent staff from entering the premises. Any WH&S risks identified during the referral process should be considered before conducting the home visit. Agencies and staff should be aware of their WH&S responsibilities under relevant legislation and develop specific squalor related policies and procedures (see Appendix 5 for WH&S related resources).

15.6 The Severe Domestic Squalor Assessment Scale

The nature and severity of individual cases of severe domestic squalor can vary significantly; no two cases are exactly the same. Therefore, it is important to thoroughly assess the individual circumstances and associated risks on a case by case basis. Several assessment scales that measure squalor and/or hoarding include, but are not limited to:

- > The Environmental Cleanliness and Clutter Scale (Halliday & Snowdon 2009).
- > NSGCD Clutter Hoarding Scale (National Study Group on Chronic Disorganization 2009).
- > Clutter Image Rating Scale (Steketee & Frost 2007).

In Australia, the Environmental Cleanliness and Clutter Scale (ECCS) is commonly used because it has been demonstrated to be a reliable measure of squalor (Halliday & Snowdon 2009). A modified version of the ECCS called the *Severe Domestic Squalor Assessment Scale* (SDSAS) has been developed to accompany these guidelines (Appendix 2). The SDSAS provides a framework for the identification of individual areas of concern in the dwelling and can be used as a mechanism for referring the case to agencies participating in the task force.

When using the SDSAS, it is important to consider the following:

- > The scale does not address all aspects of the living conditions and additional notes should be provided where possible to aid in the assessment and referral process.
- > The assessment descriptions are not intended to be judgemental. They have been designed to achieve consistent assessment results without the need for specific training on how to use the SDSAS.
- > In some situations it may not be appropriate to complete the SDSAS in front of the client (i.e. the client may view the SDSAS as judgemental and insensitive).
- > A total score of 12 or more is *indicative* of moderate or severe squalor and that some level of intervention is warranted.
- > A total score below 12 usually indicates that immediate intervention is not likely to be required. However, the assessor may identify that there are certain risks associated

with the property that still require attention, or that the client may benefit from relevant support services to prevent the conditions getting worse.

- > Professional judgement should always be exercised when using the SDSAS regardless of the score (i.e. intervention may be warranted when the score is below 12).
- > In some cases it may not be possible to assess all of the living spaces (e.g. if the client refuses access to the property). In such cases, the assessor should complete as many sections in the SDSAS as possible and use professional discretion on whether further action is necessary.
- > The consequences of living in severe domestic squalor may be heightened if vulnerable people (e.g. children, the elderly or the disabled) are living in the dwelling and intervention may be necessary regardless of the total score.
- > Items of little value refer to items that most people would consider useless or should be thrown away. In general, it does not include items that have monetary value or personal significance to the client, such as a birth certificate or family photos. It should be noted that although most people regard items such as bottle caps or old newspapers to be useless, care should be taken when referring to these items as they may be significant to the client.
- > Having utilities that are working correctly is essential for maintaining one's personal hygiene and care requirements. If the utilities are not working correctly, the client may design alternative makeshift arrangements that create additional household hazards (e.g. unconventional cooking equipment can increase the fire risk). If the task force identifies utilities that are not working correctly, they should identify why they are not working (e.g. the client is unable to pay the bills, the infrastructure is damaged / broken) and attempt to resolve the problem in the action plan (Section 15.8).
- > Any WH&S hazards that are identified while completing the SDSAS should be noted so that other task force members can take adequate precautions during subsequent home visits.

15.7 A score of less than 12

A score of less than 12 on the SDSAS indicates the property is not in a state of moderate or severe squalor, and immediate intervention is not required. However, in some cases professional judgement may indicate that some risks are present that require attention (sometimes immediately). It may also be appropriate to provide the client with some basic support services to prevent the situation from escalating.

15.8 A score of 12 or more

A score of 12 or more on the SDSAS is indicative of a property in moderate or severe squalor. When a score of 12 or more is obtained, it is desirable to convene the task force so that the required services can be provided (noting the information sharing requirements in Section 15.2). The agency that completed the SDSAS should convene a case meeting in a timely manner and involve all relevant task force members. No remedial action is generally required until the task force meets unless there are immediate risks requiring urgent corrective action. The task force should undertake the following:

I. Identify a key worker (case worker)

The role of the case worker is to liaise with the client on an ongoing basis and take the lead role in coordinating the interagency response. This is a vital role because it is important that one person builds rapport with the client so the client does not feel overwhelmed or threatened by the presence of many different people from many different agencies. It is important that the case worker also takes the lead role in the interagency response because they are best placed to know when (and in what capacity) interagency collaboration is required. This role is extremely important and sometimes complex, therefore it is imperative that other task force members remain actively involved and assist throughout the process. This continuing involvement by other task force members is especially important once the case worker has developed rapport with the client and the action plan (see III below) is being followed. The task force should develop specific criteria to determine who will undertake this role, giving consideration to the client's health status, prior working relationships and the support services previously, or likely to be, utilised by the client.

II. Identify the associated risks

The risks associated with the case (e.g. fire, public health, animal welfare, child protection etc.) should be identified, discussed and used to inform the development of the action plan (see below).

III. Develop an action plan

The aim of the action plan is to identify and prioritise the client's needs and to minimise the associated risks. The exact nature of the action plan will be determined by the SDSAS result, whether the client accepts help and the agencies participating in the task force. The action plan should also identify the roles and responsibilities of each agency as it relates to resolving the case.

15.9 Vulnerable people (e.g. children)

The risks associated with severe domestic can be heightened when vulnerable people such as the elderly, disabled and children are present. If vulnerable people are present, the associated risks (e.g. welfare concerns, unmet needs) should be identified, reported to the relevant agency and addressed in the interagency action plan.

Children can be particularly vulnerable and domestic squalor can be an indicator of child abuse or neglect. It can be a sign that parents or carers have been, or are unable to, provide the conditions necessary for children's health, safety and wellbeing. There are a number of signs that could indicate a child is being, or has been abused or neglected. These can include individual factors such as physical injuries, delays in children's development, being consistently unwashed, unsupervised, hungry, and behaviour that is destructive or fearful. Environmental signs can include conditions that are hazardous to their health and safety.

Children have the right to be emotionally and physically safe from harm. The *South Australian Children's Protection Act 1993* recognises that both organisations and individuals have a role to play in keeping children safe and protected. Therefore, it is essential that the assessment of households identifies if there are any children living in the household, or who regularly stay there.

It is common for families experiencing domestic squalor to be extremely isolated, with very limited contact with services and extended family. This can significantly enhance the vulnerability of children, particularly when this occurs over a length of time. People working with these families are in a unique position to identify and respond to concerns relating to children experiencing domestic squalor and prevent further vulnerability.

If it is suspected on reasonable grounds that a child or young person has been, or is being abused or neglected, people can notify Families SA via the Child Abuse Report Line (phone 13 1487). Certain people are obliged by law to make a notification when the suspicion is formed in the course of their work (whether paid or voluntary) or in carrying out official duties.

Interagency action plans should clearly identify the roles and responsibilities of relevant agencies in addressing the welfare of vulnerable people.

15.10 The client accepts help

Although rare, efficient and sustainable outcomes are achieved when the client accepts help. A willingness to accept help often stems from the development of a trusting relationship with the client. If the client accepts help, the task force should endeavour to address the client's needs by supporting them and providing them with services such as:

I. Cleaning

Cleaning may be warranted in the following circumstances:

- > To reduce or eliminate specific risks associated with the condition of the property.
- > When it is part of a treatment program.
- > When the client agrees and is happy for the cleaning to occur.

When the task force decides a clean-up is required, the clean-up should be carefully planned in consultation with the client (if possible). In most circumstances a targeted clean-up that addresses the immediate risks are preferred over large whole of house cleans. Support services should be in place before and after the clean-up to minimise client distress and reduce the rate of reoccurrence. Clean-ups are an extremely stressful event for the client. Therefore, the task force should consider having someone present to support the client such as a family member or a friend. Alternatively, the task force may decide that it is more appropriate to clean the property without the client present. The following should be considered before a clean-up is undertaken:

- > The financial cost

Clean-ups can be extremely expensive, so it is important to consider the financial cost and who will pay (The NSW Department of Aging Disability and Home Care 2007). The client may not have the ability to pay and in some circumstances an alternative arrangement may be required (e.g. obtaining assistance from volunteer organisations and/or family and friends). If using a private cleaning company, the task force should engage a company that offers best value for money (considering factors such as cost, if the company is reputable and insured, and whether they are able to address the points below).

> Valuable items

Valuable items should be identified and stored in a secure location before and during the clean (The NSW Department of Aging Disability and Home Care 2007). This includes items of monetary value (e.g. jewellery) as well as items of personal significance (e.g. photos, important paper work and clothing).

> Keeping an inventory

An inventory of all possessions should be made during the clean (The NSW Department of Aging Disability and Home Care 2007). All items that are discarded should be documented so that the client and task force have a record of what has been removed. This is particularly important in the event of legal action and if the client claims that items have been lost or stolen.

II. Medical treatment

Although people who live in situations of severe domestic squalor may not suffer from a mental health disorder, many have some underlying medical problem (see Table 1). It is important to identify clients who have an underlying medical condition so that an appropriate form of treatment can be considered. An appropriately trained clinician must undertake all medical assessments and treatment. Cleaning a property without addressing the underlying behaviour will inevitably result in the property returning to a state of squalor post clean. In situations where the client is willing to accept help, the client should be encouraged to see their local General Practitioner (GP) because some medical related matters, such as treatment, are covered under the Medicare benefits scheme. Alternatively, obtaining consent from the client to talk directly to their GP may be beneficial when seeking appropriate treatment. It is also important to note that people who live in severe domestic squalor often have other health related issues as a result of the living conditions (e.g. allergies and lung dysfunction) that should be assessed by a medical professional.

III. Home services

In cases where the client finds it difficult to maintain their property, it is important to provide in home support. This may include supporting the client with household activities such as cooking, cleaning, washing and gardening. The task force should identify with the client what services would be beneficial and then engage the appropriate agencies (e.g. Domiciliary Care, Meals on Wheels, HACC services provided by some local councils) to deliver these services (noting that eligibility criteria may apply). Providing these services on an ongoing basis may be a critical part of the relapse prevention plan (see IV below).

IV. Relapse prevention strategies

A large percentage of severe domestic squalor cases reoccur, as indicated in Section

12.1. Relapse prevention is very important and the task force should endeavour to implement strategies to prevent reoccurrence of cases. Many of the support services outlined in this section may form part of the relapse prevention strategy for clients who are willing to accept help.

V. Vulnerable people (e.g. children)

If vulnerable people (e.g. children) are present, refer to Section 15.9.

15.11 The client does not accept help

Despite the best efforts of the task force, clients may be unwilling to cooperate or accept help. This commonly occurs because:

- > The client does not recognise that their living conditions are in a state of squalor, particularly in cases involving compulsive hoarding (Steketee & Frost 2003).
- > The client is ashamed of the condition of their property and does not want others to see it.
- > The client is fearful that the condition of their property will lead to undesirable outcomes such as eviction (Mental Health Association of San Francisco 2009).

When the client is unwilling to accept help, the task force should aim to determine why. This may be difficult to determine but more favourable outcomes are achieved when the client accepts help.

It should be noted that in cases of severe domestic squalor involving deliberate hoarding, the following investigation process is not suitable because deliberate hoarding refers to a lifestyle choice. Whilst it can be difficult to distinguish cases of deliberate hoarding, it may be identified by the absence of the symptoms listed in Table 1 (noting that a formal health assessment may be required). In cases of deliberate hoarding, Section 15.16 should be followed.

15.12 Advocacy services

In cases where the client does not accept help, the task force should consider engaging an advocacy service on the client's behalf. In addition to supporting the client, the advocacy agency may be able to convince the client to undertake specific actions that minimise the risks associated with the condition of their property.

15.13 Underlying factors

When the client is not willing to accept help, the task force, under the guidance of an appropriately qualified clinician (e.g. psychologist), should endeavour to identify whether the client suffers from an underlying health condition that influences the condition of their property. This may not always be possible, but knowing the client's physical and mental

health status is useful when developing and refining action plans, and identifying what services will assist the client. The task force may be able to obtain this information through a local community mental health centre, the client's family or the client's GP (noting that confidentiality requirements may prevent information sharing).

In the event that the information regarding the client's health status cannot be obtained, the task force may wish to undertake an informal assessment using Table 1 and any relevant information obtained during the referral or home visit (see Section 15.3). The purpose of the informal health assessment is to make an educated decision about what services will best support the client.

15.14 Evidence of mental ill health

When there is evidence of mental ill health, the provision of appropriate support services is important, particularly in cases of extreme squalor and when the client is putting themselves and others at risk. Mental health support can vary in the mode of delivery and can be accessed through:

I. The client's family

The preferred option when accessing mental health support services is to work with the client's family. Although contact with the client's family is not always possible, it is the preferred pathway because family members may be able to convince the client to accept help and initiate less invasive and threatening forms of treatment. Family members can seek support services through the following avenues:

> The client's GP:

In cases of severe domestic squalor, GPs may have a role in assessing the client and providing ongoing medical care. In some cases, the client's family may be able to approach the GP directly to initiate this support and care.

> An Enduring Power of Guardianship (EPG):

An EPG is a legal document that gives family members the power to act on behalf of the client for health and lifestyle related matters. This can be beneficial because the relevant family member can undertake necessary actions to improve living conditions for the client. An EPG may not be suitable in all cases. It can only be granted if the client is assessed to have mental incapacity and agrees and understands its role.

II. A Community Mental Health Centre (CMHC)

Public community mental health services are available in metropolitan and country South Australia. They provide a range of service options to meet the needs of people with mental health ill health, including mental health assessment, treatment, care coordination and support services. If a CMHC representative is not on the task force, the task force should contact their local centre for further information.

III. A Guardianship Order

A guardianship order is often the least preferred option for obtaining mental health support because it takes away the client's right to self-determination and autonomy. However, a guardianship order may be sought in extreme situations such as when the client lacks the mental capacity to make important decisions regarding their health, safety, wellbeing and living conditions. The appointed guardian's role is to respect the client's wishes while ensuring the client has proper care and protection. In cases of severe domestic squalor, it may be appropriate for the task force to initiate the appointment of a guardian. Applications must be heard at a guardianship board hearing and they are only issued in certain circumstances (e.g. when there is medical evidence of mental incapacity).

If the above mentioned pathways do not achieve support for the client and the client remains unwilling to accept help, the only option remaining to negate the risks associated with the client's property is to use relevant legislation (Section 15.16).

In some cases of severe domestic squalor, there may be evidence of both mental and physical ill health. In such circumstances, the task force should strive to obtain both mental and physical support services.

15.15 Evidence of physical ill health

If the client has been diagnosed with a physical disability or there is sufficient evidence of a physical impairment, it is vital to obtain appropriate support. Members of the task force are encouraged to identify and locate relevant services even when the client is unwilling to accept help. Some agencies may still be able to offer some level of support. Support services commonly required by clients with a physical impairment include:

- > Cleaning.
- > Organising.
- > Shopping.
- > Cooking.
- > Gardening.
- > General household maintenance.
- > Transport (e.g. to attend appointments).

If support services are unable to assist and the client remains unwilling to accept help, the only option remaining to negate the risks associated with the client's property is to use relevant legislation (Section 15.16).

15.16 Using legislation

In instances of deliberate hoarding or when the client is unwilling to accept help, the situation may necessitate the use of legislation to minimise the associated risks. Many

different pieces of legislation can be used to resolve cases of severe domestic squalor depending on the nature and severity of the case (see Appendix 3). Whilst the task force should consider which legislation is appropriate under the circumstances, the application and administration of legislation is at the discretion of the relevant agency. This includes ensuring that the principles, intent and purpose of the legislation are upheld at all times.

When the use of legislation is necessary to resolve cases of severe domestic squalor, it should be incorporated into the interagency action plan which contemplates issues such as cleaning, relapse prevention and vulnerable people (Section 15.10).

16. Investigating situations of severe domestic squalor under the *South Australian Public Health Act 2011*

The *South Australian Public Health Act 2011* (the Act) provides a modernised and flexible legislative framework that enables South Australia to better respond to both new and traditional public health challenges. Pursuant to Part 5 of the Act, the Minister for Health and Ageing has published the South Australian Public Health (Severe Domestic Squalor) Policy 2013 (the Policy). The Act and Policy provide relevant authorities (defined in Part 12 of the Act to mean *the Chief Public Health Officer or a Council*) with two primary pathways for resolving cases of severe domestic squalor, namely:

- > General Duty (Section 56 of the Act).
- > Risk to Health (Section 92(1)(b) of the Act).

The Policy requires the relevant authority to, where applicable, have regard to this Section (Section 16) of the Foot in the Door Guidelines (the Guidelines) when identifying and managing the public health risks associated with severe domestic squalor. However, given the importance of an interagency approach, regard should also be given to Section 15 of the Guideline. Whilst there are several pathways under the Act to resolve cases of severe domestic squalor, this Section focuses on the use of the General Duty because:

- > It provides a thorough risk assessment framework.
- > Natural justice principles are emphasised throughout the process (e.g. through the issue of preliminary notices and consideration of any responses received).
- > Notices served to secure compliance with the general duty can be appealed to the Public Health Review Panel (which is reflective of the administrative framework of the *South Australian Public and Environmental Health Act 1987* (now repealed)).
- > Enforcement action can be expedited if required (e.g. Section 92(4)(a) of the Act).

In determining the most appropriate pathway to address cases of severe domestic squalor using the *South Australian Public Health Act 2011*, authorised officers should have regard to the Principles set out in Part 2 of the Act.

16.1 Assessing severe domestic squalor

There are a number of tools and assessment scales that authorities can use to assess severe domestic squalor (see Section 15.6). This includes the SDSAS (Appendix 2) which was developed to promote a consistent and objective framework for the

assessment of severe domestic squalor on individual premises. In measuring the risks associated with individual cases, the SDSAS also assists in the identification of other agencies that have a role to play in supporting the person in the resolution process.

When using the SDSAS, it is important that authorities refer to Section 15.6 of the Guideline. In addition, it should be noted that the SDSAS measures the extent of severe domestic squalor and does not necessarily measure the public health risk. As such, **a SDSAS score of 12 or more should not be taken to represent a breach of the General Duty**. The use of professional judgement and officer discretion is important when determining the risk to public health. The typical public health related matters associated with severe domestic squalor include (but are not limited to):

> Impacts associated with the keeping of animals, including zoonotic disease risks

The keeping of animals in domestic settings can result in a number of impacts on residents and neighbours. Where there is overcrowding, inadequate care or poor animal husbandry, there may be increased risks associated with zoonotic diseases and pests of public health significance (e.g. bird mites, fleas, mites). Refer to Section 7 for more information.

> Waste

Putrescible and hazardous waste can pose a risk to public health. Putrescible waste can attract vermin and promote other hazards (such as mould growth) while hazardous waste is by nature a potential health risk (includes waste that is explosive, flammable, poisonous, toxic or infectious). Waste such as building material (e.g. wood and metal), plastic, bottles and newspapers generally do not pose a risk to public health but they may cause other hazards such as a risk of fire.

> Sewage

Sewage can pose a risk to health if not disposed of correctly. Domestic premises should have functioning facilities (e.g. shower and toilet) and infrastructure (e.g. sewerage) for personal hygiene.

> Vermin

Rats, mice and cockroaches are common pests, particularly in built up environments. They can be a risk to health because they can carry a range of diseases such as

leptospirosis and typhus fever as well as disease producing organisms such as staphylococcus. Active and heavy infestations are of particular concern in domestic premises (they are usually linked to a reliable source of food, water and shelter).

> Odours

The odours associated with severe domestic squalor do not normally cause direct ill health but they can be a nuisance and a cause of psychological harm or distress for people in the vicinity. Direct health risks may arise through exposure to toxic chemicals, gasses, vapours and particulates.

Under the Policy, severe domestic squalor can be taken to constitute harm to public health for the purposes of the General Duty in Part 6 of the Act. As this is not an offence under the Act in itself, when situations of severe domestic squalor are identified (e.g. using the SDSAS), the relevant authority must determine whether the person has taken all reasonable steps to prevent or minimise any harm to public health under Section 56 (2) and (3) of the Act.

16.2 Has there been a breach of the General Duty?

Table 9 outlines the General Duty process as it relates to situations of severe domestic squalor. Relevant authorities should have regard to the considerations in the table when determining whether a breach of the General Duty has occurred. Regard should also be given to the SA Health Guideline: *South Australian Public Health Act 2011 – General Duty, Notices and Emergency Situations, and Offences*.

Table 9

Using Section 56 (General Duty) of the *South Australian Public Health Act 2011* (the Act) in situations of severe domestic squalor

Element	Reference in the Act	Question	Considerations
Identifying harm and person responsible s56(1)	s56(1)	Is there harm? Is there harm to public health? (note <i>harm</i> is defined broadly – see s3(3) & (4) of the Act)	<ul style="list-style-type: none"> > Severe domestic squalor, as defined in the South Australian Public Health (Severe Domestic Squalor) Policy 2013 (the Policy), constitutes harm to public health for the purposes of the Act. > A SDSAS score of 12 or more is indicative of 'severe domestic squalor' as defined in the Policy.
	s56(1)	Is it caused (or likely to be caused) by a person?	<ul style="list-style-type: none"> > Yes, severe domestic squalor is caused by a person.
Exclusions s56(3)	s56(3)(c)	Is the person acting in circumstances prescribed by the regulations?	<ul style="list-style-type: none"> > N/A
	s56(3)(b)	Is the person acting in accordance with a policy or code of practice published by the Minister?	<ul style="list-style-type: none"> > The South Australian Public Health (Severe Domestic Squalor) Policy 2013.
	s56(3)(a)	Is the person acting in accordance with accepted practice, taking into account the community expectations and prevailing environmental, social and economic practices and standards?	<ul style="list-style-type: none"> > Whilst there may be different expectations as it relates to amenity, the community's expectation of severe domestic squalor should not differ according to social or economic status.
Reasonable Steps s56(2)	s56(2)	Are the actions of the person inconsistent with or detrimental to any of the objects of the Act? Are the proposed measures consistent with the objects of the Act?	<ul style="list-style-type: none"> > See s4(1) of the Act (Objects of Act).
	s56(2)(a)	What is the potential impact of failing to comply with the General Duty?	<ul style="list-style-type: none"> > What is the risk to public health? Consider, for example, zoonotic diseases, waste, sewage, vermin and odours. > The SDSAS findings, particularly questions C, F, G, H and I. > To what extent will a notice address the risks to public health?

Element	Reference in the Act	Question	Considerations
Reasonable Steps s56(2) (cont)	s56(2)(b)	Are there environmental, social, economic or practical implications?	<ul style="list-style-type: none"> > The SDSAS findings. > Refer to Section 10 of the Foot in the Door Guidelines. > Are there other agencies involved? How will the situation impact on other agencies' assistance / services? > Is the person at risk of homelessness? > The costs associated with action required to mitigate the risks to health (e.g. a clean-up of the property)? > Do the compliance costs outweigh the public health benefits? > How will a notice affect the environmental, social, economic or practical implications?
	s56(2)(c)	What is the degree of risk involved?	<ul style="list-style-type: none"> > Refer to the SA Health Guideline: <i>South Australian Public Health Act 2011 – General Duty, Notices and Emergency Situations, and Offences</i> (Appendix 3 – Risk assessment guide and template).
	s56(2)(d)	What is the nature, extent and duration of harm?	<ul style="list-style-type: none"> > The SDSAS findings, particularly questions C, F, G, H and I. > Who is at harm – the residents, immediate neighbours or the wider community? > Is the risk associated with zoonotic diseases, waste, sewage, vermin or odours? > Is the harm due to acute or chronic exposure?
	s56(2)(e)	Is guidance provided by a relevant policy?	<ul style="list-style-type: none"> > The South Australian Public Health (Severe Domestic Squalor) Policy 2013
	s56(2)(f)	Is guidance provided by a relevant code of practice?	<ul style="list-style-type: none"> > N/A
	s56(2)(g)	Is guidance provided by a relevant regulation?	<ul style="list-style-type: none"> > N/A
Conclusion	S56(1)-(3)	<p>Have all the requirements of s56 been considered?</p> <p>Have all relevant Objects and Principles been considered?</p>	<ul style="list-style-type: none"> > Part 2 of the Act (Objects, principles and interactions with other Acts). > The proportionate regulation principle, participation principle and partnership principle are particularly relevant for situations of severe domestic squalor.

16.3 Serving a notice to secure compliance with the General Duty

If the relevant authority believes a breach of the General Duty has occurred, securing compliance is achieved by serving a notice under Section 92 of the Act. However, before a notice can be served, the authority must undertake the prescribed procedure in Section 92 (2) (a) of the Act. Table 10 outlines this process and highlights some factors to consider in situations of severe domestic squalor. When serving notices under Section 92 of the Act, the relevant authority should also take into account the SA Health Guideline: *South Australian Public Health Act 2011 – General Duty, Notices and Emergency Situations, and Offences*.

Table 10

Using Section 92 (Notices) of the *South Australian Public Health Act 2011* (the Act) to secure compliance with the general duty

Element	Reference in the Act	Question	Considerations
Notice serving to secure compliance with the General Duty	92(2)(a)(i)	How many people are affected, or potentially affected by the breach of the duty?	<ul style="list-style-type: none"> > The SDSAS findings. > Does it affect the residents, immediate neighbours or wider community?
	92(2)(a)(ii)	What is the degree of harm, or potential degree of harm, to public health on account of the breach of the duty?	<ul style="list-style-type: none"> > The SDSAS findings, particularly questions C, F, G, H and I. > What is the degree of harm associated with the public health risks? > Consider any vulnerable people affected (refer to Section 15.6 and 15.9 of the Foot in the Door Guidelines).
	92(2)(a)(iii)	What steps has the person(s) responsible taken, or proposed to take to avoid or address the impact of the breach of duty?	<ul style="list-style-type: none"> > Has priority been given to minimising the immediate public health risks? > Are the time frames reasonable? > Does the person require assistance to minimise the public health risks?

17. Conclusion

Despite the lack of robust local statistics, preliminary investigations and data demonstrate that severe domestic squalor impacts significantly on many people, families and service providers in South Australia. Severe domestic squalor impedes daily life. The threat of relationship breakdowns, community isolation, injury, illness and eviction are common factors facing many people living in squalid conditions.

Severe domestic squalor is generally symptomatic of an underlying illness or condition, the identification and management of which can significantly improve the effectiveness of interventions aimed at remediating the squalor.

This guideline aims to serve as a framework for agencies to use when dealing with cases of severe domestic squalor. Forming and sustaining local relationships between agencies and service providers is critical in the management of severe domestic squalor and optimising outcomes for the people affected by this complex issue.

South Australian agencies are encouraged to work cooperatively and collaboratively when working towards resolving cases of severe domestic squalor.

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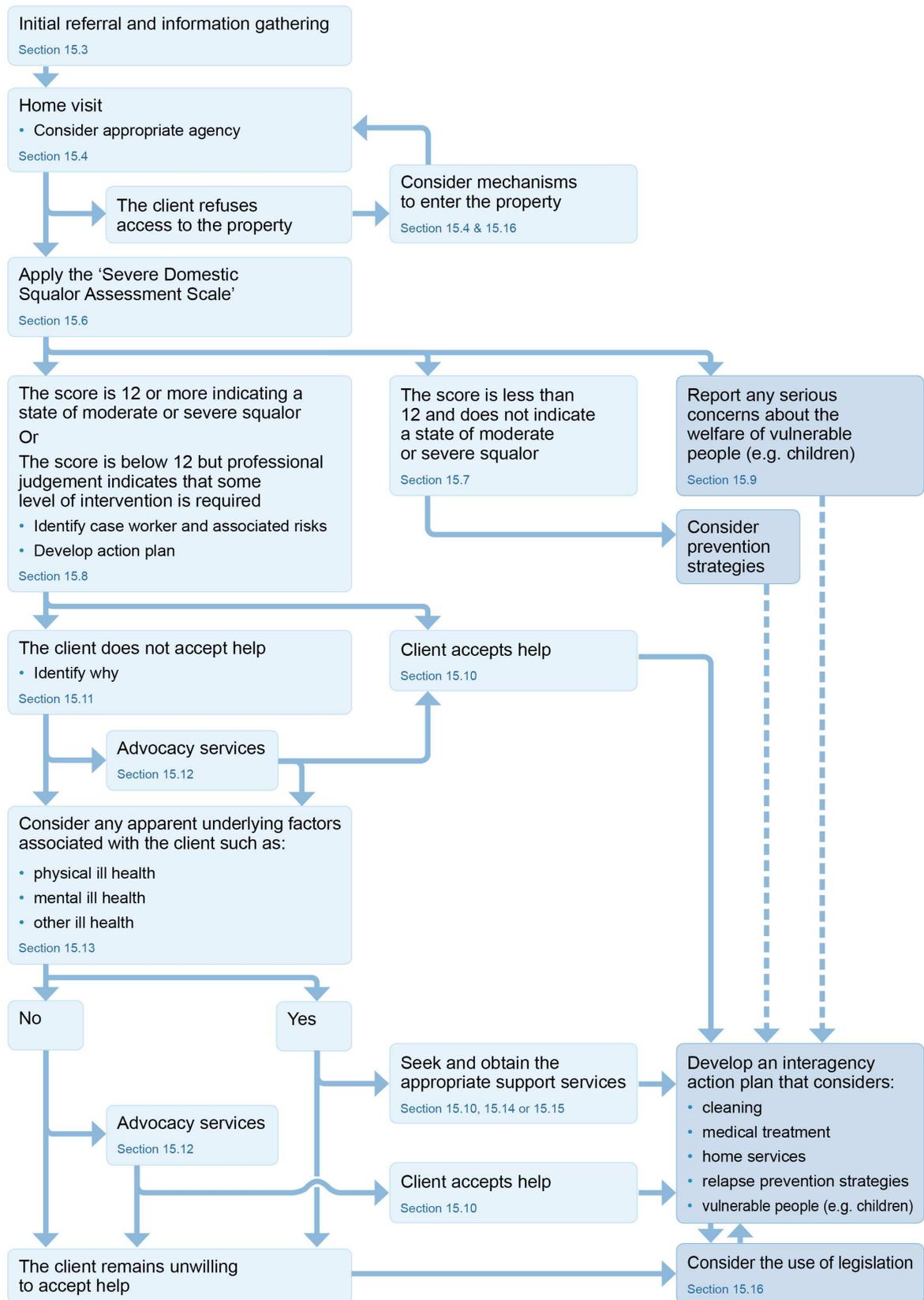
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19. Appendix 1 – Severe domestic squalor investigation process



Sections refer to 'A Foot in the Door: Stepping towards solutions to resolve incidents of severe domestic squalor in South Australia'



Government of South Australia

SA Health

Severe Domestic Squalor Assessment Scale

Based on the Environmental Cleanliness and Clutter Scale¹

Date	
Name of assessor	
Organisation / Agency	
Name of client	
Address of client	

A				
Is there reduced accessibility due to clutter?²				
Note that a reduction in floor space due to excrement is not to be considered as a reduction in accessibility.				
	0	1	2	3
	EASY TO ENTER and move about the property.	SOMEWHAT IMPAIRED ACCESS but I can get into all rooms.	MODERATELY IMPAIRED ACCESS It is difficult or impossible to get into one or two rooms or areas.	SEVERELY IMPAIRED ACCESS Access to the front door is heavily / fully obstructed and/or I am unable to reach most or all areas inside and/or outside the dwelling.
	0 – 29%	30 – 59%	60 – 89%	90 – 100%
	of the ground space is inaccessible for use or walking across.			
Notes				
B				
Is there an accumulation of items that have little obvious value?³				
In general, is there an accumulation of items that most people would consider to be useless or should be thrown away?				
	0	1	2	3
	NONE <i>Rate 0 if there is a small circumscribed part of the dwelling (e.g. a back room) that has been used or is designated for the storage of 'junk'.</i>	SOME ACCUMULATION but collected items are organised in some way and do not impede movement, or prevent cleaning or access to furniture and appliances.	MODERATE ACCUMULATION Items cover the furniture in most areas and have accumulated throughout the dwelling, making it very difficult to keep clean.	EXCESSIVE ACCUMULATION Items are piled to at least waist high in all or most areas inside and/or outside ⁴ the dwelling.
Notes	Please describe the types of items that have been accumulated:			
C				
Is there an accumulation of waste or recyclables?				
In general, is there evidence of excessive accumulation of waste or recyclables such as food waste, packaging, plastic wrapping, discarded containers (tins, bottles, cartons, bags) or other unwanted material?				
	0	1	2	3
	NONE	A LITTLE There is a scattering of waste and recyclables throughout the property.	MODERATE Waste and recyclables are piling up throughout the property. There is a substantial accumulation of waste that should have been discarded.	EXCESSIVE Waste and recyclables are piled knee high inside and/or outside the dwelling. Clearly no recent attempt to remove waste or recyclables.
Notes				

1 Halliday, G & Snowdon, J 2009, 'The Environmental Cleanliness and Clutter Scale (ECCS)', *International Psychogeriatrics*, vol 21, no. 6, pp 1041 - 1051.

2 A reduction in access and egress is an enabling fire hazard because the occupant escape time increases and access for emergency personal is impeded. Consider the extra time it would take occupants to exit the property and any access difficulties for emergency personal.

3 Accumulated items can increase the fuel load of a property. Take special note of items that are highly combustible such as wood, clothes, paper, books and magazines.

4 Items stored in the yard can increase the severity and consequences of a fire, especially when items are located in close proximity to the boundary of the property. Take note of items that are located within 2-3 metres of the property boundary.

D				
Are the floors and carpets (excluding the bathroom) clean?				
0		1		2
YES Acceptably clean in all rooms.		MILDLY DIRTY The floors and carpets look as if they haven't been cleaned or swept for weeks. There may be scattered rubbish.		VERY DIRTY The floors and carpets are very dirty and look as if they haven't been cleaned for months. There may be mould growth. <i>Rate 1 if only one room or small area is affected.</i>
				3
				EXCEEDINGLY FILTHY There is rubbish or dirt throughout the dwelling. <i>Excrement usually merits a score of 3.</i>
<i>Notes</i>				
E				
Are the walls, visible furniture & other surfaces clean?				
0		1		2
ACCEPTABLY CLEAN IN ALL ROOMS		MILDLY DIRTY There are mildly dusty or dirty surfaces.		VERY DIRTY The walls, furniture and/or surfaces are heavily soiled with grime or dirt. Signs of neglect indicated by lots of cobwebs and/or greasy, messy, mouldy or wet furniture.
				3
				EXCEEDINGLY FILTHY The walls, furniture and surfaces are filthy (e.g. covered with faeces and urine) and the assessor does not want to touch them.
<i>Notes</i>				
F				
Is the bathroom clean?				
Including the floor, walls, basin, shower, bath and toilet.				
0		1		2
REASONABLY CLEAN		MILDLY DIRTY The bathroom has not been cleaned for weeks and there is a build-up of mould, mildew, hair and/or grime. The toilet may be unflushed.		MODERATELY DIRTY The bathroom has not been cleaned for months and there is an extensive build-up of mould, mildew, hair and/or grime. Faeces and/or urine are on the outside of the toilet bowl or localised to a small part of the bathroom.
				3
				VERY DIRTY There are piles of rubbish and/or excrement throughout the bathroom. The toilet may be blocked and bowl full of excreta. The condition of the bathroom impedes / prohibits normal use of fixtures.
<i>Notes</i>				

G				
Is the kitchen clean and is the food safe to consume?				
	0	1	2	3
	CLEAN AND HYGIENIC	SOMEWHAT DIRTY AND UNHYGIENIC The cook top and sink are untidy. Surfaces are dirty and there may be some spilt food. Refuse is mainly in the garbage bin. Food that could go off has been left uncovered and out of the fridge.	MODERATELY DIRTY AND UNHYGIENIC The oven, sink, surfaces and floors are dirty with piles of unwashed crockery and utensils. Refuse/garbage is on the floor and surfaces. There is some rotten or mouldy food. The fridge is unclean. The walls, floor and ceiling may have mould growth.	VERY DIRTY AND UNHYGIENIC The sink, cook top, and the inside of all the cupboards are filthy. Much of the food is rotten, putrid, covered with mould and unsafe to eat. A lot of garbage and refuse is over the surfaces and floor. <i>Rate 3 if maggots are seen.</i>
Notes				
H				
Is there an odour emitting from the property?				
	0	1	2	3
	NIL / PLEASANT	UNPLEASANT The dwelling is unaired or there is a smell of urine.	MODERATELY MALODOROUS There is a stench (e.g. faecal / putrid) but the assessor can stay in the room.	UNBEARABLY MALODOROUS The assessor has to leave the room because of the smell and/or the smell is potentially impacting on neighbouring properties.
Notes				
I				
Is there evidence of a vermin infestation?				
For example rats, mice and cockroaches.				
	0	1	2	3
	NONE	MINOR There is evidence of current vermin activity (e.g. a few droppings) but it is confined to one area of the property and control measures are in place.	MODERATE There is an accumulation of droppings in multiple areas of the property and/or the assessor has physically seen living vermin. Control measures are absent or ineffective.	EXTREME An active heavy infestation that is potentially impacting on neighbouring properties. Indicated by visually observing many live vermin, rub marks, runs, gnawed surfaces and/or active burrows.
Notes				
J				
Are the sleeping areas clean and hygienic?				
	0	1	2	3
	REASONABLY CLEAN AND TIDY	MILDLY UNCLEAN The sheets and/or the mattress are mildly stained or dirty, indicating they have not been washed for weeks.	MODERATELY DIRTY The bed sheets are unclean and stained (e.g. with faeces or urine). Clothes and/or rubbish are over the surrounding floor area.	VERY DIRTY The mattress or sleeping surface is unclean, damaged or non existent. There are no bed sheets or linen present or they are extremely dirty. The surrounding area is filthy.
Notes				

TOTAL SCORE =

The score is less than 12 indicating the person(s) is not living in moderate or severe squalor ⁵	<input type="checkbox"/>
The score is 12 or more indicating the person(s) is living in moderate or severe squalor ⁶	<input type="checkbox"/>
The score is less than 12 but my professional judgement indicates further action is required	<input type="checkbox"/>

⁵ Consider strategies that will prevent the situation escalating (see section 15.7 in 'A Foot in the Door' guidelines).

⁶ Commence interagency collaboration (see section 15.8 in 'A Foot in the Door' guidelines).

Other considerations	
Are the utilities working correctly? For example water, gas, electricity and sewerage.	
YES <input type="checkbox"/>	No <input type="checkbox"/>
<i>Notes</i>	
Are there vulnerable people living in the dwelling?⁸ For example, children, the elderly and the disabled.	
YES <input type="checkbox"/> Contact the relevant agency or service provider if the score is greater than 12 or if there are serious unmet needs or inadequate care.	No <input type="checkbox"/>
<i>Notes</i>	
Are there animals living on the property?	
YES <input type="checkbox"/>	No <input type="checkbox"/>
DO THE ANIMALS APPEAR TO BE NEGLECTED? (e.g. animals are thin, sick, injured or in pain; or have dirty or matted coat, inappropriate shelter, poor hygiene).	
YES <input type="checkbox"/> Contact the RSPCA.	No <input type="checkbox"/> Contact the local animal control officer (local council) if the number of animals exceeds what is normally expected or permitted.
<i>Notes</i>	
Is there an increased fire risk associated with the property? Consider the fire risk associated with questions A and B. Also consider that occupants may use temporary measures when household appliances are not working correctly (e.g. use an open fire to cook when the oven / stove does not work).	
YES <input type="checkbox"/> Contact the local fire authority.	No <input type="checkbox"/>
<i>Notes</i>	
Does the dwelling appear to be structurally unsound?	
YES <input type="checkbox"/> Contact a building inspector from the local council for technical advice.	No <input type="checkbox"/>
<i>Notes</i>	
Are there WH&S risks associated with the property?⁹	
YES <input type="checkbox"/> Please describe all the risks below.	No <input type="checkbox"/>
<i>Notes</i>	

7 See section 15.6 in 'A Foot in the Door' guidelines for more information.

8 See section 15.6 & 15.9 in 'A Foot in the Door' guidelines for more information.

9 See section 15.5 in 'A Foot in the Door' guidelines for more information.

21. Appendix 3 - Relevant legislation

- > *The South Australian Advanced Care Directives Act 2013*
- > *The South Australian Animal Welfare Act 1985*
- > *The South Australian Children's Protection Act 1993*
- > *The South Australian Development Act 1993*
- > *The South Australian Environment Protection Act 1993*
- > *The South Australian Fire and Emergency Services Act 2005*
- > *The South Australian Guardianship and Administration Act 1993*
- > *The South Australian Housing Improvement Act 1940*
- > *The South Australian Local Government Act 1999*
- > *The South Australian Mental Health Act 2009*
- > *The South Australian Public Health Act 2011*
- > *The South Australian Residential Tenancies Act 1995*
- > *The South Australian Work Health and Safety Act 2012*

22. Appendix 4 - Agency directory

Animals

- > Royal Society for the Prevention of Cruelty to Animals (RSPCA)
- 1300 4 77722
- <http://www.rspcasa.asn.au/home/>

Children

- > South Australian Department for Education & Child Development
- Families SA (protecting children)
- 131 478 (Child Abuse Report Line)
- (08) 8463 6468 (general enquiries)
- decdochildsafe@sa.gov.au
- www.families.sa.gov.au/childsafe

Client Advocacy Services

- > Office of the Public Advocate
- (08) 8342 8200
- <http://www.opa.sa.gov.au/cgi-bin/wf.pl?pid>
- > Aged Rights Advocacy Service (South Australia)
- (08) 8232 5377
- <http://www.sa.agedrights.asn.au/>

Client Support Services

- > South Australian Department for Communities and Social Inclusion
- Domiciliary Care
- 1300 295 673 (general enquiries)
- www.domcare.sa.gov.au/
- > South Australian Department for Communities and Social Inclusion
- Disability SA
- 1300 786 117
- <http://www.sa.gov.au/subject/Community%20support/Disability>

Community Services

- > Anglicare
- (08) 8305 9200
- <http://www.anglicare-sa.org.au/>

- > Uniting Communities
 - (08) 8202 5111
 - <http://www.unitingcommunities.org/>

- > Western Linkages
 - (08) 8440 6737
 - <http://www.westernlinkages.org.au/index.aspx>
- > Royal District Nursing Service of SA (RDNS)
 - 1300 364 264
 - <http://www.rdns.org.au/index.php>
- > Australian Red Cross (Homelessness)
 - (08) 8100 4500
 - <http://www.redcross.org.au/homelessness.aspx>

Emergency Services

- > Metropolitan Fire Service
 - (08) 8204 3600 (general enquiry)
 - <http://www.samfs.sa.gov.au/site/home.jsp>
- > Country Fire Service
 - (08) 8463 4200 (headquarters)
 - <http://www.cfs.sa.gov.au/site/home.jsp>
- > South Australian Police
 - 131 444
 - <http://www.sapolice.sa.gov.au/sapol/home.jsp>

Housing

- > South Australian Department for Communities and Social Inclusion
 - Housing SA
 - 131 299 (general enquiry)
 - <http://www.dfc.sa.gov.au/pub/Default.aspx?tabid=256>
- > South Australian Government Consumer and Business Services
 - Tenancies (renting and letting)
 - (08) 8204 9544
 - <http://www.sa.gov.au/subject/Housing,+Property+and+Land/Renting+and+letting>

Local Government

- > Find your local council:
- <http://www.lga.sa.gov.au/site/page.cfm?u=210>

Mediation

- > South Australian Community Legal Centres
- Community Mediation Services
- http://www.saccls.org.au/centre_details.php?centre_id=20

Mental Health

- > SA Health
- Mental Health
- <http://www.health.sa.gov.au/mentalhealth/>
- > Guardianship Board SA
- (08) 8368 5600
- <http://www.guardianshipboard.sa.gov.au/homepage>

Treatment

- > Find a Psychiatrist
- The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- <http://www.ranzcp.org/Resources/find-a-psychiatrist.aspx>
- > Centre for Treatment of Anxiety & Depression (CTAD)
- (08) 8222 8100
- ctad@health.sa.gov.au
- > Health on Grange Psychology (Julia Merkel)
- 256 Grange Road Flinders Park 5025
- (08) 8443 4613

23. Appendix 5 - Further resources

Animals

- > The Hoarding of Animals Research Consortium
– <http://www.tufts.edu/vet/hoarding/index.html>

Books

- > Tolin, D, Frost, R & Steketee G 2007, *Buried in Treasures – Help for Compulsive Acquiring, Saving, and Hoarding*, Oxford University Press, Oxford
- > Steketee, G & Frost, RO 2007, *Compulsive Hoarding and Acquiring Therapist Guide*, Oxford University Press, New York
- > Steketee, G & Frost, RO 2007, *Compulsive Hoarding and Acquiring Workbook*, Oxford University Press, New York
- > Frost, RO & Steketee, G 2010, *Stuff – Compulsive Hoarding and the Meaning of Things*, Houghton Mifflin Harcourt, New York

Information Sharing

- > Information Sharing Guidelines
– <http://www.ombudsman.sa.gov.au/isg/>

Work Health and Safety

- > Safe Work SA – Occupational Health, Safety and Welfare Guidelines for Community Workers
– http://www.safework.sa.gov.au/uploaded_files/OHSWGuidelinesForCommunityWorkers.pdf
- > NSW Government – Family and Community Services (note that NSW legislation does not apply in SA):
– http://www.hacchohs.adhc.nsw.gov.au/common_risk_areas/domestic_squalor#risk_factors

Severe Domestic Squalor Related Guidelines

- > Beyond Overwhelmed – The Impact of Compulsive Hoarding and Cluttering in San Francisco and Recommendations to Reduce Negative Impacts and Improve Care.
– <http://www.sfaa.org/pdf/hoarding-report-2009.pdf>
- > The Middlesex-London Health Unit – Task Force on Senile Squalor
– <https://www.healthunit.com/uploads/mlhu-senile-squalor-report.pdf>
- > ‘No Room to Spare’ – Ottawa’s Community Response to Hoarding Plan
– http://www.hoarding.ca/pdf/SCPI_FINAL_Report4.pdf

- > Partnerships against homelessness – Guidelines for field staff to assist people living in severe domestic squalor
 - http://catholiccommunityservices.com.au/squalorandhoarding/pdf/Squalor_Guidelines.pdf
- > Blue Mountains City Council
 - <http://www.bmcc.nsw.gov.au/yourcommunity/communityservices/domesticsqualor>

Web Sites

- > Catholic Community Services and The City of Sydney squalor and hoarding toolkit
 - <http://catholiccommunityservices.com.au/squalorandhoarding/>
- > National Hoarding and Squalor Conference 2012
 - <http://www.hoardingsqualorconference.com.au/>

For more information

Health Protection Programs
Public Health Services
Department for Health and Ageing

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<http://www.health.sa.gov.au/>



www.ausgoal.gov.au/creative-common



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