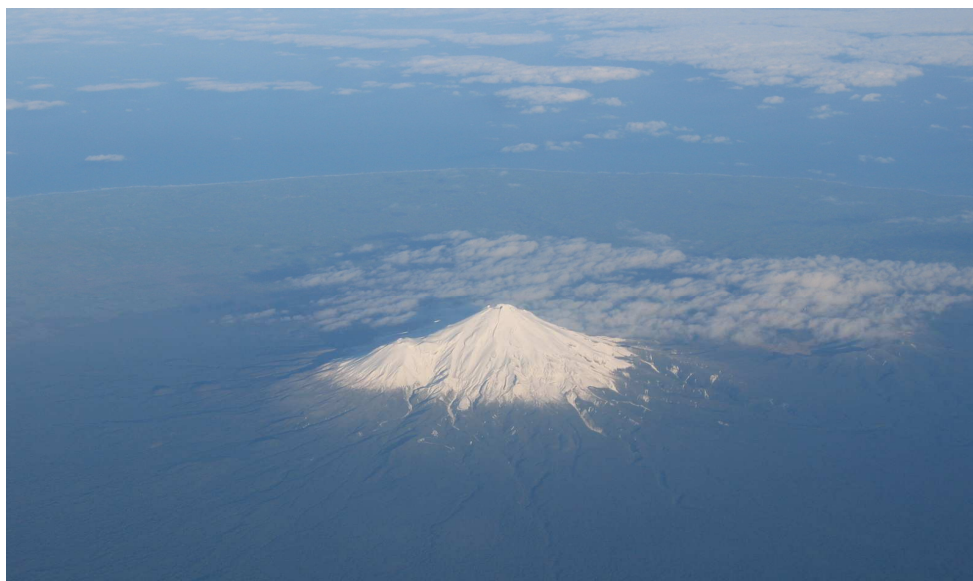




TARANAKI DISTRICT HEALTH BOARD

# **HOARDING & SQUALOR**

## **GUIDELINES**



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# SECTION 1: Introduction

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## 1.1 Background

These Guidelines have been developed principally for personnel who are asked to intervene in cases of hoarding leading to severe domestic squalor.

They are based on the Guidelines previously developed by the Partnerships Against Homelessness (PAH) Committee under the auspices of the Sydney South West Area Health Service. Representatives with experience in assisting people living in squalor, stakeholder groups and Professor John Snowdon, a psychiatrist with a special interest in this area, were consulted and international evidence collated in the development of the original PAH document.

We wish to acknowledge their work in providing the framework which forms the basis of the TDHB guidelines.

## 1.2 Purpose of the Guidelines

These Guidelines are designed to assist front line workers of various government and non-government organisations (NGOs) to constructively intervene and improve the situation of people who are living in severe domestic squalor. Improving the efficiency, speed of action and coordination of work between relevant agencies, has the potential to improve the health and quality of life for individuals who have been living in severe domestic squalor.

These Guidelines provide front line workers with:

- A step-by-step guide
- Simplified procedures to assist people living in severe domestic squalor
- Clear roles and responsibilities of agencies and service providers, to enable improved coordination and integration of services
- Practical information regarding referrals and intervention options

These Guidelines include flow charts to summarise the processes involved. Included in Appendix 8 are a series of case studies which explain the issues and current events arising in typical cases of severe domestic squalor.

## SECTION 2: Explaining Severe Domestic Squalor

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### 2.1 Definition of Severe Domestic Squalor

Dictionary definitions of squalor refer to conditions that are filthy, unclean or foul through neglect. Commonly, this results from a person's failure to remove household waste and other rubbish including papers, wrapping, food products, cooking waste, containers and broken or discarded household items.

Cleanliness varies between homes and between individuals and tends to be influenced by multiple factors including upbringing, peer and family expectations, living arrangements, social and financial circumstances, cultural background and surroundings. Some people live in conditions so filthy and unhygienic that almost all observers, in whatever culture, would consider them unacceptable.

The term 'severe domestic squalor' was chosen in order to emphasise, firstly that the focus is not on cases where people live in somewhat unclean surroundings, even if they have severe physical or mental disorders. The concern is for people who live in disgusting conditions. This word is used advisedly in order to make clear that in all relevant cases the insanitary conditions are extreme. Secondly, the aim is not to provide guidance in cases of self-neglect where squalor is not an issue, nor in cases of hoarding without squalor, i.e. those cases where there has been an accumulation of possessions but in an ordered, clean and manageable way. What is included are cases of hoarding where the accumulation has led to the living environment being unclean, unsanitary or dangerous (e.g., because of fire risk).

There is a range of types of squalor, including:

- *Neglect* involving failure to remove household waste and other rubbish including papers, wrapping, food, cooking waste, containers and discarded household items.
- *Multifaceted self-neglect* 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.
- *Deliberate hoarding* and the excessive accumulation of items such as clothing, newspapers, electrical appliances, etc. This may involve hoarding of animals.

For the purpose of these Guidelines, the term *severe domestic squalor* includes:

- Extreme household unhygienic conditions
- Hoarding, where the accumulation of material has led to the living environment being unclean, insanitary or dangerous e.g. conditions pose a fire risk to persons or emergency services.

The decision regarding whether or not a person lives in severe domestic squalor may be influenced by the attitude, culture, exposure to unclean environments and personal living conditions of the person making the assessment. An objective assessment tool has been developed to assess the level of squalor (see Section 4.4).

### 2.2 International Incidence and Data

In Sydney, NSW, between 2000 and 2005, 120 cases of people living in severe domestic

squalor were referred to old age psychiatry suggesting an annual incidence of 10 people aged over 65 years per 10,000 (Halliday & Snowden, unpublished data 2005). However, since numerous cases of severe squalor are never referred to medical services, the actual incidence is likely to be considerably higher.

In 2000, a study in London of 81 clients visited by a local authority special cleaning service found that:

- 51 % were younger than 65 years
- 72% were men
- 84% lived alone
- 70% had one or more mental disorders
- 32% were diagnosed with substance abuse and around 50% of those who abused substances also suffered from an organic brain disorder (mostly dementia), schizophrenia or a related disorder
- 10% met criteria for a developmental disorder
- 85% had at least one chronic physical health problem
- 26% of the people had a physical health problem, such as immobility or sensory impairment, contributing to the unclean state of their living environment
- 28% regarded their home as 'clean' or 'very clean' when asked about their living conditions (Halliday et al., 2000).

### **2.3 Features of Persons Living in Severe Domestic Squalor**

The evidence suggests that half to two-thirds of all persons living in severe domestic squalor suffer from dementia or alcohol-related brain damage, or mental disorders such as schizophrenia and depression. Most studies refer to individuals who are isolated, suspicious and unfriendly, and have features suggestive of pre-existing personality disorders.

Studies have also shown moderate to high rates of medical problems for people who live in conditions of severe domestic squalor, particularly in relation to mobility, continence, sensory impairment (especially visual) and nutritional deficiencies such as diabetes, obesity, etc.

An individual who lives in domestic squalor may be completely independent. If people are living in squalor and not causing any harm to themselves or others, then no intervention is required.

A person who lives in squalor is frequently opposed to assessment and assistance and may be unaware that there is a problem. The person may be suspicious or evasive, perceiving any intervention to be a potential threat to their independence. Reasons for this vary. In some cases, it results from apathy associated with an underlying mental disorder. In others, longstanding habits and the individual's personality traits, including rigidity, unfriendliness, suspiciousness, anxiety or avoidance could be the cause. There may be a history of unsatisfactory dealings with service providers. Links with social supports and family have often been lost. Cultural and language barriers may also contribute to opposition to assessment and assistance.

If the person does agree to engage, they are unlikely to be prepared to leave the dwelling.

In the most extreme cases, where there is a substantial risk to the individual or others, it may be necessary to refer to agencies and service providers that can intervene to provide assistance (see Sections 7 and 8).

## SECTION 3: Referral

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### 3.1. Sources of Referral

People living in states of severe domestic squalor may be referred for assistance by anyone in the community including relatives, neighbours, concerned local residents, service providers, the fire service, police and shopkeepers. People often come to the attention of various service providers because of the deleterious effect that their living conditions have on themselves and the surrounding community. As an example, see Case Study 1 and Case Study 4 in Appendix 7.

If a person is known to have a health problem or to receive financial benefits or support from service providers, help may be sought from the relevant health service or from agency staff. The person's type of accommodation may determine whether the person is referred for assistance to the likes of Housing New Zealand or to the District Council. Landlords or property managers may need to be approached if utilities (such as water) have been disconnected or the building is in a state of disrepair.

### 3.2 Information Gathering Prior to Initial Contact

Prior to visiting someone who is reported to be living in squalor, attempts should be made to find out as much information as possible about the person. This will assist in determining who the best person is to undertake an initial assessment, and how this assessment should be conducted.

Try to access the following background information from the referrer and any other sources:

- Best time of day to visit
- Length of time the person has been living in unclean conditions
- Type of accommodation e.g., homeowner, private rental, Housing New Zealand
- If the person has a next of kin, carer, supportive neighbours or involvement of any home services
- Any known medical history and/or whether or not the person has a General Practitioner
- Any potential occupational health and safety issues for which special clothing or precautions may be required (see Checklist on page 22)
- History of the person's character, habits, and past medical and mental health history
- Cultural background
- If there are language or communication barriers
- Preferred language spoken and whether an interpreter may be required
- History of substance abuse, aggression or criminal behavior
- Whether the person lives alone or with dependents and any details of dependents
- Whether premises are covered by an existing Council Cleansing Order
- Risk to self e.g. dogs on premises

### **3.3 Gathering Resources for Use at the Visit**

Resources which could be used at the initial visit include the following:

- Health and Safety Checklist (Appendix 1)
- Environmental Cleanliness and Clutter Scale (ECCS) (Appendix 2)
- Impact of Squalor Checklist (Appendix 2)
- Squalor Action Plan (Appendix 3)



## SECTION 4: The Initial Visit

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### 4.1 Purpose

The purpose of conducting a home visit to the person who has been referred is to:

1. Assess whether the person lives in squalor and to rate the extent of the squalor
2. Assess whether the person hoards excessively and/or self-neglects, i.e. does not adequately look after his/her bodily requirements and hygiene
3. Assess the nature and severity of any associated health and lifestyle issues
4. Make a preliminary identification of strategies required to address the issues identified

Obtaining entry to the home, preferably with the consent and involvement of the occupant, is a priority but, if a home assessment is not immediately possible, information available to the initial agency involved may permit identification of the issues to be addressed.

The issue of consent in relation to decision-making capacity is complex and is dealt with in more detail in Section 8. Field staff should also refer to their own agency's consent procedures.

### 4.2 Approaches to Engaging the Person

People living in severe domestic squalor vary markedly in their nature, personality style, acceptance, cooperation, insight and perception of their circumstances. As a consequence, there is a need for flexibility in the approach taken. Some people may respond to a series of initial brief, casual meetings. Others may be more likely to respond to a visit by someone perceived to be in authority, such as a fire officer or the police. However, cultural sensitivity and appropriateness is important here, as some people may feel uncomfortable with authority figures, which may intensify feelings of fear and suspicion.

Generally, the person is more likely to be successfully engaged if an interest is shown in them and their particular reason for needing help. If the person agrees to accept help, the likelihood of achieving significant change and improving conditions for the individual and others is considerably greater.

Options which could be considered include:

- If the person is too fearful to open the door, try leaving a note in the mailbox or under the door, asking them to make contact. Keeping privacy concerns in mind, discrete enquiries with neighbours might be of assistance.
- Repeat visits. Sometimes calling after hours, varying the hours or visiting on several occasions may be helpful.
- Arranging to visit with a worker from a particular cultural background or with an accredited interpreter may be appropriate. Check with the client as to their preference and consent prior to making any arrangements.
- If the person requests an interpreter or has inadequate language skills, a professional interpreter should be used. Refer to the procedures of your organisation regarding the engagement and use of interpreters. Cultural and linguistic factors can impact on the success of engagement with the person.

- Ask the person how he/she considers they could benefit from help and identify the perceived needs.
- Be persistent yet sensitive to the person's needs and careful not to overwhelm them
- Even if the person's initial reaction is negative and they reject any intervention, it is still important to continue to try to establish a relationship.
- Consider meeting at the local coffee shop.
- Avoid imposing your own values. Many people living in squalor often do not even perceive that their home is dirty.
- Take time. An immediate focus on a need for cleaning can cause distress and sabotage chances of achieving a successful alliance.
- Reframe the need for cleaning in terms of the person's perceived needs and preferences. The person might agree to tidy up as a staged process. Where possible, establish an inventory of possessions, identify valuables and arrange for them to be placed securely.
- Ensure that the person has the capacity (p18) to make decisions about giving away property and that service staff do not accept gifts or directly benefit from the clean up.

It is important to note that in situations of extreme squalor, the assessment of 'risk' is likely to vary between the relevant authorities.

When sharing information with other agencies, be sure that disclosure of information is directly related to the purpose for which it was given and collected.

### **4.3 Occupational Health and Safety Requirements**

The Occupational Health and Safety (OH&S) of persons entering premises where squalor is evident and the safety of the person/s living in these conditions are significant issues. Workers providing services to people living in squalor must comply with the OH&S policy and procedures of their organisation.

The checklist at Appendix 1 provides a concise summary of the OH&S issues to be assessed and considered when gathering information and at the initial visit.

In some cases of severe domestic squalor, OH&S concerns may prevent service providers from entering the premises and carrying out a comprehensive assessment. Field staff should contact their employer's OH&S adviser for advice.

### **4.4 Assessing the Level of Squalor**

Having gained access to the premises, it is advisable to assess whether or not the person is living in squalor. The Environmental Cleanliness and Clutter Scale (ECCS) in Appendix 2 provides a method for objectively assessing and recording observations of various aspects of personal and environmental cleanliness.

Validation and reliability data have been collected and are available from the authors of the original PAH document (Halliday and Snowdon). They have provided definitions that allow raters to consider to what degree various aspects of the premises differ from those that would be considered by people from all cultural and social groups as clean and uncluttered. This does not mean to imply 'normality'. It is accepted that people vary in their subjective views concerning cleanliness, and these differ according to circumstance and upbringing.

The definitions aim to achieve consistency in ratings, though undoubtedly subjectivity will affect decisions. For example, some aspects relating to a kitchen might suggest a rating of 1 (somewhat dirty; garbage mainly in the refuse bin) while others (e.g. mouldy food on the table) might suggest a rating of 3 (very dirty and unhygienic). The rater has to decide what is more important, and whether to give a compromise rating. Some features will always require a rating of 3, even if observations of other aspects do not match the definitions provided in the 'very dirty' column.

The ECCS has 10 items, rated between 0 and 3. Where possible, all rooms should be inspected before making a rating. The cleaner and less cluttered the home, the more likely the score is to be 0. The maximum score for these domestic items is 30, and a rating of at least 20 usually means that the person lives in severe domestic squalor. Ratings of less than 10 imply that although the person may need help with cleaning or sorting out possessions, they do not live in severe domestic squalor. It is also relevant to consider whether they live in very cluttered surroundings without being markedly unclean, and this will be indicated by ratings on items A and C of the scale. The issue of 'capacity' is complex and is discussed further in the guidelines.

It must be emphasised that the ratings on the ECCS are mainly for documentation purposes, to record what has been observed in order to relay this to others, and then to be able to rate changes in living conditions over time. They give an indication of what one observer found on a particular day. Co-ratings have revealed that different raters tend to rate similarly. However, scores do not tell raters how to respond to a particular situation. How to intervene is determined by a whole lot of other factors, not just the observed degree of domestic squalor. Supplementary questions allow documentation of observations concerning personal cleanliness, availability of essential services and the structural safety and upkeep of the premises.

## **4.5 Assessing the Impact of Squalor on the Person, Family and/or Local Community**

The impact of squalor on all relevant persons should be assessed. The checklists for this purpose are set out in sections 4.5.1 and 4.5.2 below, and these are combined as one checklist at Appendix 3.

### **4.5.1 Impact of Squalor on the Person's Health and Lifestyle**

The findings of the ECCS should be summarised to identify the issues which are directly relevant to the person and need to be addressed. Considering the high incidence of both mental and physical disorders associated with cases of severe domestic squalor, it may be necessary to organise an immediate review of the person's health and lifestyle needs by experienced staff. The important issues to be considered at the initial visit relate to:

- The need for medical and/or psychiatric intervention
- The need for assistance with activities of daily living
- Whether the person is at risk of homelessness
- The person's decision-making capacity (see Section 8)
- Whether the statutory powers of other agencies ie council might over- ride the wishes of the person

As a first step towards determining whether further urgent intervention by experienced staff from other agencies is required, the following checklist provides a list of the factors which might be

reviewed and services/agencies where additional advice may be sought.

<b>Factor/s</b>	<b>Sources for Further Information/Advice</b>
Self-neglect with poor nutrition, dehydration, probable untreated medical problems	Medical services, NASC Services Specialist Mental Health Services
Confusion, disorientation, memory impairment, wandering and getting lost, delirium, acute psychiatric symptoms such as hallucinations, threatening self harm, suicidal behaviours and symptoms suggestive of severe depression.	Medical, Mental Health Services (see above)
Aggressive behaviour or threatened harm to others.	Medical, Mental Health including Drug and Alcohol Services, Police
Exposure to possible financial exploitation or abuse	Office of the Ombudsman, Elder Protection and Abuse Services, Community Law
Threatened eviction and at risk of becoming homeless	Housing NZ, District Council, landlord/ property manager, NGOs (eg; Salvation Army, Tenancy Tribunal)
Lives alone and/or unable to access help or supervision, marked decline in activities of daily living and functional status	Medical services, intake and referral section of Access Ability (NASC), Older People's Referral Hub.
Limited mobility and risk of falls, incontinence	Medical services, Access Ability, Older People's Referral Hub
Utilities not present or not functional, i.e. water, power, sewerage, heating, telephones	District Council, NGOs, Housing NZ , landlord/ property manager, WINZ ,

Other issues which might be considered include:

- The frequency of contact with family, friends or social supports (if any) as a measure of the person's safety and ability to access help or supervision should it be required.
- Feedback provided by the family and/or the general practitioner, providing the person has given informed consent for this.
- Who owns the premises and the person's attitude towards a clear up? This will influence how the clear up process is carried out and who will undertake this (see Section 6.1 ).

#### **4.5.2 Impact of Squalor on the Family and/or Local Community**

In assessing the impact of squalor on partners and/or family members and the local community, field staff may encounter issues identified below and may need to seek further information/advice from relevant agencies listed in the following table.

Issues	Agencies/Services for Further Information
Excessive hoarding causing health and safety issues for neighbours	DHB (Public Health), District Council
Complaints from adjoining neighbours regarding the mess, invasion of space, excessive smells (from rubbish and/or sewerage), fire hazards or vermin infestation	DHB (Public Health), District Council, Council Contracted Cleaning Services, Fire Service.
Presence of partners or dependents, e.g. children, elderly relatives.	CYFS, Older People's Health, Elder Abuse Service/Tui Ora Ltd.
Pets kept in poor health	SPCA, District Council

## 4.6 Immediate Interventions

The apparent urgency of the situation and the wishes of the individual will determine the next step. The person may be clearly very unwell at the time of assessment and require urgent medical attention, or the person may present a relatively significant public health risk to the local community. *The Health Act 1956 enables councils to respond quickly and effectively to situations that occur on land used for residential purposes that pose a threat to public or individual health. (Ref: Section 29 The Health Act 1956 – 'Nuisances')*

### 4.6.1 Medical and/or Mental Health Review

If it is believed urgent medical attention is required or a domiciliary medical review cannot be arranged within a reasonable timeframe, arrange for the person to be transferred to hospital. Other medical services which should be considered include referral to:

- The local general practitioner
- Community services, including Adult Mental Health Services and Older People's Health specialist medical services. For an example of this see Case Study 2 in Appendix 8.

Under the powers of the *Mental Health (Compulsory Assessment and Treatment) Act (1992)*, people may be taken to and detained in a hospital/place of assessment if they are mentally ill or mentally disordered, permitting a brief period of hospitalisation for further assessment and decisions regarding ongoing management.

This Act is relevant when a person, living in squalor:

- Has symptoms of a mental illness, such as disturbance of mood, thought disorder, sensory misperceptions or behaviour suggesting any of these
- Is unable to adequately care for themselves or at risk of harm to themselves or others.

For further information about the provisions of the *Mental Health Act 1990*, see Section 7.

The Protection of Personal & Property Rights Act (PPPR Act) may be relevant when the person appears to be experiencing a cognitive disorder. See Section 7.

#### **4.6.2 Assistance with Activities of Daily Living (ADL)**

If the person is identified as requiring assistance with personal care, or disability related needs, consider referring the person to the relevant NASC service. Details regarding these agencies are located at Appendix 5.

#### **4.6.3 Assessing the Risk on Dependents**

Assessing the risk to dependent children and young people is a particularly complex task. Where there are dependent children or young people living in the same dwelling who may be at risk of abuse or neglect, a report of risk of harm may need to be made to CYFS or the Police.

If the dependent has a disability or there are no other suitable accommodation options, refer the matter to CYFS or an NGO such as Open Home Foundation as soon as possible.

#### **4.6.4 Relocation of Pets**

In cases of suspected or observed failure to provide adequate care of pets and animals, report the matter to the Society for the Protection and Care of Animals (SPCA), other animal welfare agencies or District Council.

#### **4.6.5 Organise a Clear-Up if an Urgent Health or Safety Risk Presents and the Person Supports this Intervention**

This could include contact with the landlord/property manager(if the person is renting privately), housing provider and other relevant agencies to ensure housing is restored to a habitable standard by making necessary repairs or reconnecting amenities (eg running water, electricity etc.)

The options for a clean up are described in Section 6.1. These options should be discussed with the person, bearing in mind that in cases where the council deems the risk to be serious or the situation to be an emergency, the council may invoke powers under amendments to the Building Act 2004 that override the resident's choice.

In cases where the extent of squalor may not be extreme and there is little apparent risk to the person, neighbours or the fabric of the building, intervention does not need to be immediate but should aim to prevent future problems arising.

## SECTION 5: Interagency Co-operation and the Joint Agency Panel

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For the majority of cases, a number of agencies and services will need to be involved in providing ongoing support to persons living in domestic squalor. It is essential to ensure that all service providers and agencies have a consistent and collaborative approach with the person.

### 5.1 Coordination of services and development of Action Plans

When an instance of extreme squalor has been identified, the service which conducted the initial assessment and collated the necessary information will immediately contact the TDHB Public Health Unit who will convene a meeting of the Joint Agency Panel.

The **Joint Agency Panel** is made up of representatives from the relevant services, including:

- **Taranaki DHB Public Health Unit**
- **District Council** (dependent upon district that client lives in)
- **NASC** (Needs Assessment Service Coordination) service (depending on age and/or needs of client – e.g. Over 65; Under 65 with a Disability; Mental Health client)
- **Clinical Representative** (e.g. Psychogeriatrician, Mental Health professional)
- **Other representatives if appropriate at this stage** (e.g. cultural representative, support worker, partner/family members)

The principal aims of the Joint Agency Panel are to:

- Consider the initial assessment of the person and any immediate interventions that may be required
- Identify any other services/agencies which need to be involved, including cultural representation for Maori clients and whanau
- Determine the course of action, agreed interventions, monitoring arrangements and the individuals responsible
- Identify a key worker or case manager responsible for ongoing liaison with the person living in squalor. On occasion, it may be appropriate for the person who makes the initial contact with the client to assume this role.

**ALL REFERRALS TO THE JOINT AGENCY PANEL SHOULD BE INITIALLY DIRECTED THROUGH TDHB PUBLIC HEALTH UNIT AS FOLLOWS:**

**PHONE 06 753 7798 (calls diverted to main hospital switchboard out of hours)**

**EMAIL [health.protection@tdhb.org.nz](mailto:health.protection@tdhb.org.nz)**

The Joint Agency Panel will convene a multi agency meeting as required, and identify a designated case manager. The designated case manager should complete a Squalor Action Plan (see Appendix 4), which identifies the actions to be undertaken, the person(s)/agencies responsible and review dates. The case manager should then distribute the Squalor Action Plan to all involved agencies. This will enable coordination of the necessary services.

Feedback on progress should be reported regularly to all involved agencies.

## **5.2 Ongoing Monitoring**

When an action plan is successfully implemented and there is a substantial improvement in the person's living conditions, ongoing monitoring or follow-up is highly desirable as there is a high risk of recurrence.

In determining which service or agency should provide on-going monitoring, a further meeting of the Joint Agency Panel should be convened at which the following will be considered:

- The need for a continuing role for the case worker
- The nature of the intervention required
- The need for other services, such as residential support services.

Ongoing monitoring and follow up of the person could be provided by a number of individuals, including the General Practitioner, District Health Board staff, NGOs or District Council. An appropriate medical practitioner should provide ongoing medical care if there are chronic physical health problems or disabilities.



## SECTION 6: Organising Referrals to Relevant Agencies and Service Providers

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### 6.1 Cleaning Up

The need to clean up the premises/property must be discussed with the person so as to determine whether the person supports the need for this to be undertaken (bearing in mind that in cases of extreme domestic squalor, the person's choice may be limited or overridden). Examples of the benefits of a clean up include the following:

- *Makes it possible to invite family, friends or partners back to their home.* While some people who live in squalor are isolated because of personal preference, others may be lonely and desire more contact.
- *Reduces the risk of falling and retains independence.* Some people will accept that reducing clutter, removing excessive possessions and cleaning are necessary to maintain independence and reduce risk. Others may accept cleaning to allow them to remain independent in their own home.
- *Stops a bad habit and saves money.* Some people will know that their tendency to collect things is out of their control and is negatively affecting their quality of life. The offer of help can be presented as an opportunity to break a bad habit, save money and enjoy a more positive lifestyle.
- *Helps find a good home for some of the things they have collected.* People who collect things often do so because they consider these things have great value. It may be argued that the item cannot be valued on an individual basis when part of a vast collection and may be lost or damaged.
- *Contributes to a worthy cause.* It may be possible to convince the person to give away excess property (furniture, appliances, collectibles, for example) if it is being donated to a worthy charity or cause. Emphasise the benefits of recycling.
- *Avoids further complaints.* Sometimes people will agree to make changes just to avoid being hassled again and/or avoid prosecution, fines or legal action. There is a particularly high likelihood of the problem recurring again in this situation, even though this type of client is the least likely to agree to ongoing monitoring or assistance.
- *Avoids the risk of cessation of services.* Some services e.g., community nurses, meals on wheels, personal care and domestic assistance may be at risk, as the continuation of these services is related to OH&S issues.

Cleaning, rubbish removal and pest extermination service providers contracted to undertake work must comply with OH&S requirements and have adequate Public Liability Insurance.

The District Council may arrange for the removal of excess property and clearance of the garden. Councils have powers to recover expenses incurred in carrying out work where there has been a failure to comply with a Cleansing Order. Options that councils may consider for recovery of the costs of cleaning include:

- Charging the owner or occupier of the premises for the removal and disposal of waste services
- Placing a lien on the property, i.e., keep the property until the debt owed is paid
- If a person has a Financial Attorney or Guardian, they should be contacted to seek

approval for a clean up and any necessary repairs which may depend on the funds being available from the person's estate

- Work and Income (Ministry of Social Development) may provide an Advance on Benefit which will have to be repaid.

The District Council may be able to provide information on sub-contractors and private cleaners who provide heavy-duty cleaning services. For further information about the role of local council see Appendix 6.

Some cleaning services may also be able to remove rubbish and excess property and arrange for tradesmen to carry out repairs and fumigate for pests. Field staff, when planning a clean up, need to be conscious of the costs involved and who will pay these costs, including the person's ability to pay.

*Some NGOs, service organisation and community groups may be able to assist with the clean up activities if the person can not afford these.*

Specialist forensic cleaning is required when there is a concern about exposure to human waste, body fluids or excretions, needle stick injuries, or there is an infection risk. These forensic cleaners have training in relation to health and hygiene and use specialised cleaning detergents to ensure sterilisation. They can also provide pest control fumigation when required. The cost of heavy-duty and forensic cleaning is frequently prohibitive.

Most people want to remain in their home while it is being cleaned even though this can be very stressful. They are likely to protest at attempts to dispose of excess or damaged property and disused possessions. In their absence, however, subsequent allegations of loss or theft of valuables may be made.

Before cleaning, where possible, together with the person and any family members:

- Establish an inventory of possessions
- Identify valuables and arrange for them to be placed securely during cleaning
- Estimate the cost of cleaning

For a case study example, see Case Study 3 in Appendix 8.

## **6.2 Service Providers and Agencies**

Services and agencies who can support persons living in domestic squalor include the following:

- Mental Health Services
- Community Health Services
- Residential Care Services
- Maori Health providers
- TDHB Maori Health Unit
- NGOs
- Access Ability
- TDHB Community Support Service
- District Council
- Housing New Zealand

Details of these services are provided in Appendix 5.

## SECTION 7: Strategies to Help People Who Are Unwilling to Accept Assistance

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### 7.1 When the Person Has Decision-Making Capacity

When a person has decision-making capacity but has initially resisted help, the designated case manager and others involved should continue to try to persuade the person to agree to accept assistance. Although this can be time consuming, voluntary intervention is likely to be more efficient and result in a better outcome. Sometimes, people who were opposed to intervention at the beginning will be more accepting when they have had time to consider the potential consequences of this decision.

When there is a concern about a person's living conditions and they cannot be convinced to address the matter voluntarily, it may be necessary to refer the matter to agencies which have the appropriate legal authority to take further action. These organisations include the following:

- District Council
- Housing NZ
- Police
- Public Health

The role of these organisations in gaining access to properties is described at Appendix 6.

### 7.2 When the Person's Decision-Making Capacity Cannot Be Assessed

There may be cases where capacity cannot be assessed because the person refuses to open the door or speak to anyone. Consideration should be given to the relevance of the following:

#### ***The Mental Health (Compulsory Assessment and Treatment) Act, 1992***

*The Mental Health (Compulsory Assessment and Treatment) Act, 1992*, defines a mental illness as a condition that seriously impairs, either temporarily or permanently, mental functioning and is characterized by one or more of the following: delusions, hallucinations, and severe disturbance of mood, serious thought disorder or sustained behaviour that is suggestive of these. *The Act* is relevant when a person living in squalor shows signs of a mental illness and is at risk of harm to themselves or others or is unable to care for themselves adequately. The Act makes provision for an assessment examination to be undertaken. If, following examination, the person is considered likely to be mentally disordered the Act allows for:

- Involuntary admission for further assessment and treatment, initially for a period of 5 days

If the person is admitted to a hospital as a mentally disordered person and not subsequently found to be mentally ill, the detention will end.

Under section 126 of The Health Act 1956 (infirm and neglected persons), a Medical officer of Health may apply to a court to have an “aged, infirm, incurable or destitute person” found to be living in insanitary conditions, committed to an appropriate hospital or institution. The person can be detained there under the order of committal.

## **SECTION 8: Strategies to Assist People Who Have Impaired Decision-Making Capacity**

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### **8.1 Decision-Making Capacity**

Determining a person's decision-making capacity can involve complex issues. In some cases, a person living in squalor who refuses assessment will be aware of the potential consequences of their decision and the risks associated with this. Although their decision to refuse assessment may be considered unwise, as long as they can demonstrate adequate understanding of the choices they could make, and the consequences of these choices, then they would generally be considered to have decision-making capacity.

If there is uncertainty about the decision-making capacity of the person, the advice of the GP can be sought in the first instance.

### **8.2 Guardianship**

Once it has been determined that a person living in severe domestic squalor lacks the cognitive capacity to make decisions about their circumstances such as accommodation, health, lifestyle choices and financial management, decisions may need to be made on their behalf. However, this approach requires careful consideration of the ethical principles involved. It is important to respect the person's autonomy and values, while at the same time protecting the person from further harm and minimising the risk of harm to others.

Some people with impaired decision-making abilities may have family or friends who will provide assistance without the need for a legal order. In other cases, when circumstances are such that there are no family members or friends willing or able to assist in achieving the best interests of the person or there is conflict among family members, the appointment of a substitute decision-maker who holds legal authority is required.

Under the Protection of Personal and Property Rights Act 1988 (PPP&R Act), the appointment of a substitute decision maker can be achieved by the activation of any Welfare and/or Financial Powers of Attorney (EPOA) which may have been put in place before the person lost the capacity to make their own decisions.

In the absence of an Enduring Power of Attorney, the appointment of a substitute decision maker can be achieved by an application to the Family Court and the subsequent appointment of a Welfare and/or Property Guardian who will then have the legal authority to make decisions for the person concerned.

## SECTION 9: Conclusions

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The key points contained in these Guidelines can be summarised as follows:

- Severe domestic squalor may develop in the homes of young, middle-aged and older people.
- The perception of squalor may be affected by the cultural perspectives of both the person and the field staff.
- Language/communication and/or cultural barriers may be impediments to gaining the trust and cooperation of a person living in squalor.
- The evidence suggests that half to two-thirds of all persons living in squalor suffer from one or more mental disorders.
- When assisting people living in severe domestic squalor, it is important to understand the factors which have led to the squalor situation as well as how to assess what needs to be done. Field workers need to be flexible in their approach but conscious of the statutory role of authorities such as the Police and District Councils and DHB.
- The impact of squalor on the person, his/her family and the community should be assessed.
- Following initial assessment of the person living in severe domestic squalor, urgent intervention may be required. In such cases, authorities (such as district councils, DHB, Police) may invoke powers that are contrary to a resident's choice.
- In cases where the squalor is not assessed to be extreme or of risk to the resident or neighbours, referral to other agencies may not need to be immediate but should aim to prevent future problems arising.
- Where more than one agency is involved, information needs to be shared to enable a coordinated approach. In these cases all agencies need to be mindful of privacy considerations.
- There is a high risk of recurrence of severe domestic squalor, even when cleaning has been successfully completed and there is a substantial improvement to the person's living conditions. Therefore, ongoing follow up of involved persons is highly recommended.

# APPENDICES

## APPENDIX 1: Occupational Health and Safety Checklist

- Do you have permission to access the property? **Y/N**
- Is there safe access to the property? **Y/N**
- Is the structure and fabric of the building safe and secure? **Y/N**
- Are the premises safe to enter (floorboards, ceilings)? **Y/N**
- Are there animals on the premises? **Y/N**
- Are there falls or slip hazards? **Y/N**
- Electricity, gas and water supplies connected and available? **Y/N**
- Are there insulated or damaged power lines which could cause electric shock? **Y/N**
- Are there electrical appliances which are unsafe? **Y/N**
- Is there a fire hazard? **Y/N**
- Is special equipment required? **Y/N**
- Protective clothing, gloves, safety helmet, mask, safety spectacles required? **Y/N**
- Is there a health risk such as human or animal contaminants? **Y/N**
- Is there evidence of infestations? **Y/N**
- Are there weapons or explosive materials on the premises? **Y/N**
- Are there booby traps on private property? **Y/N**
- Are there concerns regarding probability of physical attack from the occupant? **Y/N**

**Note:** It would be helpful if as many as possible of the above questions can be answered prior to the first home visit, i.e., at the point when referral is taken (see Section 3).

## APPENDIX 2: Environmental Cleanliness and Clutter – Scale (ECCS)



# ENVIRONMENTAL CLEANLINESS AND CLUTTER

## SCALE (ECCS)



To rate cleanliness of client's accommodation

Raters should circle the box or number that best fits their observations in relation to the different items. These descriptions are meant to be indicative but raters may decide between one category and another based on aspects not mentioned in the boxes.

Rater:

.....

Rater's phone no: .....

Date: ...../...../.....

**A.**

### ACCESSIBILITY (clutter):

0	1	2	3
EASY TO ENTER and move about dwelling.	SOMEWHAT IMPAIRED access but can get into all rooms.	MODERATELY IMPAIRED access. Difficult or impossible to get into one or two rooms or areas.	SEVERELY IMPAIRED access, e.g. obstructed front door. Unable to reach most or all areas in the dwelling.
0-29%	30 to 59%	60 to 89%	90 to 100%

of floor-space inaccessible for use or walking across

**B.**

### ACCUMULATION OF REFUSE or GARBAGE

In general, is there evidence of excessive accumulation of garbage or refuse e.g. food waste, packaging, plastic wrapping, discarded containers (tins, bottles, cartons, bags) or other unwanted material?

0	1	2	3
NONE	A LITTLE Bins overflowing and/or up to 10 emptied containers scattered around.	MODERATE Garbage and refuse littered throughout dwelling. accumulated bags, boxes and/or piles of garbage that should have been disposed of.	A LOT Garbage and food waste piled knee-high in kitchen and elsewhere. Clearly no recent attempt to remove refuse and garbage

**C.**

### ACCUMULATION OF ITEMS OF LITTLE OBVIOUS VALUE:

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

0	1	2	3
NONE	SOME ACCUMULATION but collected items are organised in some way and do not much impede movement or prevent cleaning or access to furniture and appliances.	MODERATE EXCESSIVE ACCUMULATION Items cover furniture in most areas, and have accumulated throughout the dwelling so that it would be very difficult to keep clean.	MARKEDLY EXCESSIVE ACCUMULATION Items piled at least waist-high in all or most areas. Cleaning would be virtually impossible: most furniture and appliances are inaccessible.

### PLEASE INDICATE TYPES OF ITEMS THAT HAVE BEEN ACCUMULATED

☐ Newspapers, pamphlets, etc. ☐ Clothing ☐ Other items  
(what?.....)  
(If known, what items? .....)  
☐ Electrical appliances ☐ Plastic bags full of items



D.	CLEANLINESS of floors and carpets (excluding toilet and bathroom) :			
	0	1	2	3
	Acceptably clean in all rooms.	MILDLY DIRTY Floors and carpets look as if not cleaned or swept for days. Scattered rubbish.	VERY DIRTY Floors and carpets very dirty & look as if not cleaned for months.  Rate 1 if only one room or small area affected.	EXCEEDINGLY FILTHY With rubbish or dirt throughout dwelling.  Excrement usually merits a 3 score.

E.	CLEANLINESS of walls and visible furniture surfaces and window-sills :			
	0	1	2	3
	Acceptably clean in all rooms.	MILDLY DIRTY Dusty or dirty surfaces. Dirt comes off walls on damp rag or finger.	VERY DIRTY Grime or dirt on walls. Cobwebs and other signs of neglect. Greasy, messy, wet and/or grubby furniture.	EXCEEDINGLY FILTHY Walls, furniture, surfaces are so dirty (e.g. with faeces or urine) that rater wouldn't want to touch them.

F.	BATHROOM and TOILET :			
	0	1	2	3
	Reasonably clean.	MILDLY DIRTY Untidy, not cleaned, grubby floor, basin, toilet, walls, etc. Toilet may not be flushed.	MODERATELY DIRTY Large areas of floor, basin, shower/bath, are dirty, with scattered rubbish, hair, cigarette ends, etc. Faeces and/or urine on outside of bowl.	VERY DIRTY. Rubbish and/or excrement on floor and in bath or shower and/or basin. Not cleaned for months or years. Toilet may be blocked and bowl full of toilet excreta.

G.	KITCHEN and FOOD:			
	0	1	2	3
	Clean Hygienic.	SOMEWHAT DIRTY AND UNHYGIENIC Cook-top, sink untidy and surfaces dirty, maybe with some spilt food. Refuse mainly in garbage bin. Food that could go off (e.g. meat, remains of meal) left uncovered and out of fridge.  Rate 1 If no food but fridge dirty.	MODERATELY DIRTY AND UNHYGIENIC Oven, sink, surfaces, floor are dirty, with piles of unwashed crockery and utensils etc. Bins overflowing. Some rotten or mouldy food. Fridge unclean.	VERY DIRTY AND UNHYGIENIC Sink, cook-top, insides of all cupboards filthy. Large amount of refuse and garbage over surfaces and floor. Much of the food is putrid, covered with mould and/or rotten, and unsafe to eat.  Rate 3 if maggots seen.

H.	ODOUR:			
	0	1	2	3
	Nil / pleasant	UNPLEASANT e.g. urine smell, unaired.	MODERATELY MALODOROUS. Bad but rater can stay in room.	UNBEARABLY MALODOROUS. Rater has to leave room very quickly because of smell.

I.	VERMIN (Please circle: rats, mice, cockroaches, flies, fleas, other):			
	0	1	2	3
	None	A FEW (e.g. cockroaches)	MODERATE. Visible evidence of vermin in moderate numbers e.g. droppings and chewed newspapers.	INFESTATION. Alive and/or dead in large numbers.

<b>J</b>	<b>SLEEPING AREA</b>			
	<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
	Reasonably clean & tidy	MILDLY UNCLEAN. Untidy. Bed unmade. Sheets unwashed for weeks.	MODERATELY DIRTY. Bed sheets unclean & stained, e.g. with faeces or urine. Clothes and/or rubbish over surrounding floor areas	VERY DIRTY. Mattress or sleeping surface unclean or damaged. Either no sheets or (if present) extremely dirty bedding/linen. Surrounding area filthy.

Add up circled numbers to provide a **TOTAL SCORE**:

<b>DO YOU THINK THIS PERSON IS LIVING IN SQUALOR?</b>	<b>NO</b>	<b>YES, mild Not clutter</b>	<b>YES, moderate Not clutter</b>	<b>YES, severe Not clutter</b>
(Circle One)	Clutter (lots), not squalor	Yes, mild + clutter (lots)	Yes, moderate + clutter (lots)	Yes, severe + clutter (lots)

### SUPPLEMENTARY QUESTIONS

QUESTIONS (to add to description but not to score)

**SUPPLEMENTARY QUESTIONS ( to add to description but not to score )****Comments or description to clarify / amplify / justify or expand upon above ratings:****PERSONAL CLEANLINESS****Describe the clothing worn by the occupant and their general appearance:**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
CLEAN AND NEAT. Well cared for.	UNTIDY, CRUMPLED One or two dirty marks and in need of a wash	MODERATELY DIRTY With unpleasant odour. stained clothing.	VERY DIRTY Stained, torn clothes, malodorous.

**Is there running water in the dwelling?****YES or NO?****Is electricity connected and working?****YES or NO ?****Can the dwelling be locked up and made secure?****YES or NO ?****MAINTENANCE, UPKEEP, STRUCTURE**

This rates the state of repair and upkeep by owner/landlord. If the accommodation was cleaned up as much as possible, to what extent would the dwelling require painting, refurbishment, structural repairs, etc before it would be reasonably habitable?

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
NONE	A LITTLE Minor repairs & some painting.	A FAIR AMOUNT Some structural repairs plus painting.	LOTS Major structural repairs required, and then painting.

**TO WHAT EXTENT DO THE LIVING CONDITIONS MAKE THE DWELLING UNSAFE OR UNHEALTHY FOR VISITORS OR OCCUPANT(S)?**

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>
NOT AT ALL	POSSIBLE RISK of injury e.g. by falling	CONSIDERABLE RISK of fire, injury or health problem	VERY UNSAFE The dwelling is so cluttered and unhealthy that people should not enter it, (except if specialists with appropriate clothing and equipment) and/or there is a high fire-risk.

### APPENDIX 3: Impact of Squalor Checklist

Issue	Relevant Agency/Service
Excessive hoarding causing health and safety issues for neighbours	Housing NZ, Property Manager, District Council DoH, local council
Complaints from adjoining neighbours regarding the mess, invasion of space, excessive smells (from rubbish and/or sewerage), fire hazards, or vermin infestation	Housing District DoH, local council, some cleaning agencies, local water authority
Presence of dependent others, eg children, elderly relatives	CYFS. DADHC
Pets kept in poor health	RSPCA or other animal welfare agency
Condition	Relevant Agency/Service
Self-neglect with poor nutrition, dehydration, probable untreated medical problems	Medical, Mental Health Services
Confusion, disorientation, memory impairment, wandering and getting lost, delirium, acute psychiatric symptoms such as hallucinations, threatening self-harm, suicidal behaviours or symptoms suggestive of severe depression	Medical, Mental Health Services
Aggressive behaviour or threatened harm to others	Mental Health including Medical, Psychiatric, Drug and Alcohol Services, Police
Exposure to possible financial exploitation or abuse	Elder Abuse, Police NGOs
Threatened eviction and at risk of becoming homeless	Housing Authority (DoH, landlord/real estate agent), Property Manager, NGOs
Lives alone and/or unable to access help or supervision, marked decline in activities of daily living and functional status	Medical Services, Health of Older People (HOP).
Limited mobility and risk of falls, incontinence	Medical Services, HOP, Accessibility.
Utilities not present or not functioning, i.e. water, power, sewerage, heating, telephone	Local council, local water authority, NGOs, DoH, landlord/real estate agent

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## APPENDIX 4: Squalor Action Plan

Client Name:	
Client Address:	
Case Manager:	Employer:
Referral:	
Source:	
Date:	
Initial Visit Date:	
Issues Identified (including language/communication barriers)	
1.	
2.	
3.	
4.	

Actions Required	Agency	Review Date

<b>This Plan will be reviewed on:</b>
---------------------------------------

## **APPENDIX 5: Services and Agencies Supporting People Living in Severe Domestic Squalor**

### **LOCAL GOVERNMENT SERVICES**

It is the duty, under the Health Act 1956, of every local authority to improve, promote and protect public health within its district and for this purpose every local authority is empowered and directed under the Act to cause all proper steps to be taken to secure the abatement of a nuisance that exist or the removal of a condition that is likely to be injurious to health or offensive in its district.

The purpose of the provisions of the Building Act 2004, for local councils, is to reduce the likelihood of dangerous or insanitary buildings causing offence, illness, injury or death to persons. A building is regarded as insanitary if it is offensive or likely to be injurious to health of how it is situated or constructed; or of it is in a state of disrepair; or it has inefficient or defective provision against moisture penetration as to cause dampness; or it does not have a sufficient supply of potable water; or it does not have adequate sanitary facilities.

#### **Contact Details:**

*New Plymouth District Council  
Liardet Street/Private Bag 2025  
New Plymouth 4310  
Phone: 06 759 6060*

*South Taranaki District Council  
105-111 Albion Street/Private Bag 902  
Hawera 4640  
Phone: 06 278 0555*

*Stratford District Council  
61-63 Miranda Street  
PO Box 320  
Stratford 4352  
Phone: 06 765 6099*

## **TARANAKI DISTRICT HEALTH BOARD**

TDHB provides:

- Emergency Department and Acute Care Services
- Health of Older People
- Community Allied Health Services
- Community Support Services for Older People
- Mental Health Services including inpatient, outpatient, community and crisis intervention
- Public Health Services
- Maori Health & Cultural Support Services

**Phone: 06 753 6139**

### **OLDER PEOPLES HEALTH (OPH)**

Health of Older People comprises Older Peoples Health and Rehabilitation Services (OPHRS), Mental Health Services for Older People (MHSOP) and Community Support Services for older people (CSS).

Referral to all components of the HOP service is via the Older People and Community Health Services Referral Hub.

### **OLDER PEOPLE'S HEALTH AND REHABILITATION SERVICES (OPHRS)**

Older People's Health and Rehabilitation Services (OPHRS) provide care to predominantly older people with complex physical, functional, social and psychological problems which are post acute, sub acute or chronic and unstable; utilising a model of comprehensive geriatric assessment, treatment and rehabilitation provided by a multidisciplinary team. Services include:

- Inpatient Assessment, Treatment and Rehabilitation
- Outpatient and Community Services, including domiciliary visits by Geriatricians, Clinical Nurse Specialists and therapists
- ICATT (Intermediate Care Assessment and Treatment Team), offering intensive outpatient assessment, treatment and rehabilitation
- Enhanced ICATT, offering intensive rehabilitation in a contracted residential care setting

### **MENTAL HEALTH SERVICE FOR OLDER PEOPLE (MHSOP)**

The Mental Health Service for Older People (MHSOP) provides assessment, treatment, care and support for people in Taranaki who are over the age of 65 and experience significant mental health problems including dementia. People under the age of 65 who experience age related mental health problems are also supported by the team which is made up of personnel from several disciplines. People are usually seen in their own homes but can attend an outpatient clinic in Base Hospital if this is more convenient.

### **ADULT MENTAL HEALTH SERVICES**

The Adult North Mental Health Service (clients between 18 and 65) is based at Taranaki Base Hospital. Staff are available between the hours of 8.00am and 4.30pm, Monday to Friday, excluding public holidays. The Service aims to reduce health, physiological, financial, and

social problems caused by Mental illness, by providing regular support and connection with community services which provide home based support.

The Adult South Mental health team is based in Hawera and Stratford, and function in the same manner.

The teams consist of health professionals employed by the TDHB to work in the area of Mental Illness. The teams consist of Psychiatrists, Psychologists, Registered Nurses, Social Workers, Occupational Therapists, and Needs Assessment and Service Coordination(NASC). The teams work closely with family and whanau to support clients to remain in their homes, and to maintain independence and a standard of living that other New Zealanders have. Supported accommodation is available for clients that have been assessed and deemed in need of additional support and training geared towards returning to independence with additional skills.

Where squalor has been identified, we work with other agencies which carry out extensive cleaning and follow up with community agencies to maintain the clean environment.

## **DRUG AND ALCOHOL SERVICES**

The Alcohol and Drug Service is based at Taranaki Base Hospital. Staff are available between the hours of 8.00am and 4.30pm, Monday to Friday, excluding public holidays. The Service aims to reduce health, physiological, financial, and social problems caused by alcohol and drug misuse by providing a range of quality treatment and education services.

The Alcohol and Drug service offers a range of services to adults over the age of 18 who are affected by their own or someone else's substance use problems, (as defined in DSM-IV). This includes providing support to individuals, families and groups who have been affected by drug and alcohol use. They also provide screening for gambling & usually refer on to the Problem Gambling Foundation for gambling problems only.

People can access the service as a self referral and or be referred in by a general practitioner, probation, lawyers, Child Youth and Family Services, TDHB Departments or other DHB's and community agencies by phone contact or walk in to be assessed by the duty counsellor. They provide group attendance opportunities in New Plymouth and Hawera including the Getting Started Group, Action Group, Maintenance Group, Tuesday Evening Education Group, Men's Group, Women's Recovery Group and Family Whanau Addiction Support - FADS Group. The person requesting group support makes contact with the duty counsellor in New Plymouth either by phone or walk in prior to attending any of our groups.

The team consists of health professionals employed by the TDHB to work in the area of alcohol and or other drug addictions. All clinicians provide comprehensive assessment, treatment planning, interventions to assist people to achieve their changes to their substance use and provide support to family whanau and concerned others about someone's substance use. Specialist skills within the team include areas such as comprehensive alcohol and drug assessments, detox assessments, comprehensive education about addiction, relapse prevention and group facilitation, opioid substitution (Methadone/ Suboxone) assessment and treatment.

## **HOSPITALISATION AND RESIDENTIAL CARE**

In some cases, depending upon diagnosis and the level of risk, hospitalisation or transfer to alternative accommodation, such as residential care, may be required, e.g., where individuals have severe medical and psychiatric problems or disabilities.

If available, a brief period of hospitalisation or respite residential care can provide ideal temporary accommodation while cleaning is being carried out.



In the case of hospitalisation it can also provide an opportunity for full multidisciplinary assessment, including accurate diagnosis and treatment of medical and psychiatric problems. If hospitalisation is required the person's GP would arrange that with the appropriate service, but respite residential care can only be accessed by contacting the CSS care manager or team leader.

## **COMMUNITY SUPPORT SERVICE**

Older Persons NASC – Needs Assessment & Service Coordination for people over 65 years.

The Taranaki DHB Community Support Service is a needs assessment and service co-ordination (NASC) service that works with older people who have health or disability issues to help support them to live at home. The service supports people aged over 65 years, or those identified by a geriatrician or psychogeriatrician as 'like in age and interest' (i.e. who have a condition or disability more commonly associated with ageing).

Every eligible person who wishes to receive disability support services funded by a District Health Board must have a needs assessment. The service uses the InterRAI assessment tools to assess a person's health and social needs and, from this, develops a care plan in partnership with the person and their family/whanau. The service also refers clients on to other services if needed e.g. to physiotherapy or district nursing services.

If the person has complex needs they will be assigned a Care Manager. The Care Manager is a registered health practitioner eg nurse, physiotherapist, who works alongside the person's GP and staff within Hospital and Specialist Services to ensure the person gets the best response possible.

The service also identifies what support the person's family/whanau can provide and what support they might need in order to be able to help the person.

Examples of funded support services include:

- Restorative services aimed at improving independence
- Therapy services eg Older People's Health rehabilitation programmes
- Home based support services
- Community and Residential Care-Based Day Programmes
- Carer Support Services
- Long term residential care

The Community Support Service is available to older people aged 65 years and over, or those between 50 – 65 years who are considered to be "like in age and interest" (i.e. who have a health condition or disability more commonly seen in older people, such as dementia or stroke).

To be eligible for funded support services the person must have an aged-related disability which is likely to continue for a minimum of six months and results in a reduction of independent function to the extent that on going support is required.

## **Contact CSS**

Phone: 06 759 7214 or email: [olderpersonsnasc@tdhb.org.nz](mailto:olderpersonsnasc@tdhb.org.nz)

## **ACCESSABILITY**

Under 65S NASC - Needs Assessment & Service Coordination for people aged under 65 years.

Access Ability is an independent, not for profit organisation that provides Needs Assessment and Service Coordination (NASC) for people with an Intellectual Disability, Physical Disability, or Sensory Disability. Access Ability also supports people age under 65 years who have Long Term Chronic Health Conditions and who have high support needs.

- **Needs Assessment**

A needs assessment is a process that helps to identify your strengths, abilities, needs and goals.

An Assessment Facilitator will meet with you in the place of your choice. Family/whanau, friends, caregivers, or an independent advocate can be involved for support if you choose.

The Facilitator will discuss your situation with you (including your family/whanau if appropriate). A report will then be put together that identifies your needs.

### **These needs might be:**

What supports do I need right now:

- To look after myself, my family and my home
- To sleep safely at night
- To be in the community
- To be socially active
- To keep in touch with my friends and family

Do I need:

- A place to live
- A break from my family
- Something to do during the day

While a Needs Assessment does not guarantee the provision of all the services you would like, it is a useful process for identifying what needs are most important to you.

- **What is Service Co-ordination?**

Service co-ordination is a separate process designed to find the best solutions to meet as many of your identified needs as possible.

The Co-ordinator will talk to you about your Needs Assessment and the best way to meet your needs within the resources available.

These may include: Family and friends, Service agencies, Government funded support (e.g. Ministry of Health, Education, WINZ); and Non-Government organisations such as service groups, church groups, self-help groups or volunteers.

## What services may I be able to access?

Funded Services may range from:

- Personal care
- Carer support
- Home help
- Supported living
- Residential care
- Other services based on your individual needs

Information and support will be given to access a range of supports available in your community. For more information [www.accessability.org.nz](http://www.accessability.org.nz)

### **Contact Access Ability**

**06 7580700**

**0800 758700**

**Level One Kings Building**

**Devon Street**

**New Plymouth**

## **HOUSING**

### **Housing New Zealand Corporation (HNZC)**

Housing New Zealand provides state houses for those in the greatest need, for their time of need. Housing New Zealand owns or manages more than 69,000 properties throughout the country, including about 1,500 houses used by community groups. Housing New Zealand also helps people make the move from renting to home ownership, by providing a range of home loans and home ownership services.

Housing New Zealand makes every effort to resolve problems in tenancies where unacceptable, unclean or hoarding behaviours are evident by referring clients to support services. These efforts are balanced against threats to tenant safety and the rights of neighbours to have reasonable peace, comfort and privacy.

### **Contact HCNZ**

**Phone: 0800 801 601**

**Email: [enquiries1@hnzc.co.nz](mailto:enquiries1@hnzc.co.nz)**

**315 Devon Street East, New Plymouth**

## **CYFS**

Everyone has a role to play in keeping our children and young people safe. At Child Youth & Family we partner with others to help protect, support and care for children. Together we can help our children be safe from harm and well cared for, strong as part of a loving family and whanau, and to thrive by helping children be the best we can.

We support a multi- agency approach to families living in squalid conditions.

We are committed to working alongside other agencies to respond to cases of Hoarding and Squalor where they involve children and young people.

If there are identified care and protection concerns identified a referral should be made to our call centre 0508FAMILY.

Our contact person in Child Youth & Family - New Plymouth and Hawera would be our Differential Response Co-ordinator, Denise Loveridge 9683336.

Child Youth & Family  
P.O. Box 4043,  
New Plymouth.

**Telephone number 0508FAMILY**

### **SPCA (Society for the Prevention of Cruelty to Animals)**

An SPCA Inspector can enter and inspect properties (ie outside of the house or dwelling) where they have received notification of suspected neglect or hoarding of animals.

To enter a house or dwelling the SPCA Inspector requires the consent of the owner. If there is reasonable evidence of neglect or abuse of animals and the owner does not give consent a Search Warrant may be obtained to enable the Inspector to enter the house or dwelling.

#### **North Taranaki SPCA**

75 Colson Rd  
PO Box 181  
New Plymouth  
(06) 7582053  
[np.spca@xtra.co.nz](mailto:np.spca@xtra.co.nz)  
[www.northtaranakispca.org.nz](http://www.northtaranakispca.org.nz)

#### **South Taranaki SPCA**

62 Beach Rd  
Hawera  
(06)2785605  
[animals99@xtra.co.nz](mailto:animals99@xtra.co.nz)  
[www.spcasouthtaranaki.co.nz](http://www.spcasouthtaranaki.co.nz)

### **NON GOVERNMENT ORGANISATIONS (NGOs)**

#### **Salvation Army Corps**

The Salvation Army Corps in New Plymouth is an integral part of the Christian Church. We are a Church or Worship Centre along with a Community Ministries Centre. We are here to express our Christian faith in serving those within our community who need support in various areas. We look at the person's life with a holistic view to supporting them in the best way we can.

Our Community Ministries focus is on:

- Loving the marginalized
- Advocating for the voiceless
- Befriending those that have no friends
- Empowering those who are powerless

As written in the scriptures, Matthew 25:35-38

**Contact Salvation Army Corps:**

**New Plymouth: (06) 758 9338**

**Stratford: (06) 765 7969**

**Hawera: (06) 278 8516**

**Email: [Fiona\\_Stuart@nzf.salvationarmy.org](mailto:Fiona_Stuart@nzf.salvationarmy.org)**

**Tui Ora Ltd.**

Tui Ora Ltd has an innovative approach to the health and well being of people with varying and complex needs. We are a health and social services organisation established in Taranaki in 1998. Over time our organisation has evolved and grown, so that it now incorporates many services and providers. Some but not all of our services, relate to Māori.

Our services are strengthened by alliances with other health organisations such as the Taranaki District Health Board, Midland Regional Health and National Hauora Coalition. We are governed by a structure that represents the eight iwi in Taranaki, and at our core we aim to have our services accessible to a wider range of people.

**Elder Protection Service**

A free and confidential service that helps protect against abuse and neglect of elderly people, aged over 65 years.

We provide information and support to older people to enable them to make their own decisions about their wellbeing and safety.

We also assist the older person by advocating with family and service providers or refer to other organisations such as health / social services, solicitors and Police.

Also provide support and information for carers

**Contact Tui Ora Ltd.**

**Phone: 06 759 4064**

**Email: [reception@tuiora.co.nz](mailto:reception@tuiora.co.nz)**

## **APPENDIX 6: Organisations Which Can Assist When People are Unwilling to Accept Assistance**

### **LOCAL COUNCILS**

#### **Territorial Authorities Regulatory Roles under the Health Act 1956 and the Building Act 2004:**

A local authority may issue a cleansing order under the Health Act 1956 - to be served to the owners or occupiers of a premises to cleanse such premises, with the time specified, if it is of the opinion that the cleansing of such premises is necessary for preventing of danger to health or for rendering the premises fit for occupation.

A local authority may issue repair notices to the owners (or his agent) of premises requiring repairs, alterations, or works to be carried out with the time specified, where any dwelling house within its district is, by reason of its situation or insanitary condition, is likely to cause injury to the health of any persons therein, or otherwise unfit for human habitation.

Where any such notice is not complied with to the satisfaction of a local authority, the local authority may issue a closing order prohibiting the use of the premises for human habitation or occupation from a time to be specified in the order, until such repairs, alterations, or works as may be specified in the closing order, have been carried out to the satisfaction of the local authority.

A territorial authority may, under the Building Act 2004, if it is satisfied that a building is dangerous or insanitary, put up a hoarding or fence to prevent people from approaching a building nearer than is safe; attached a notice warning people not to approach the building; issue a written notice requiring work to be carried out on the building, within a specified time, to reduce or remove the danger or prevent the building from remaining insanitary. A person failing to comply with this notice commits an offence and is liable to a fine.

Where a owner has failed to carry out the work within the time specified, a local authority may obtain a court order authorizing it to carry out the work.

### **HOUSING NEW ZEALAND CORPORATION (HNZC)**

Housing New Zealand provides state houses for those in the greatest need, for their time of need. Housing New Zealand owns or manages more than 69,000 properties throughout the country, including about 1,500 houses used by community groups. Housing New Zealand also helps people make the move from renting to home ownership, by providing a range of home loans and home ownership services.

Housing New Zealand makes every effort to resolve problems in tenancies where unacceptable, unclean or hoarding behaviours are evident by referring clients to support services. These efforts are balanced against threats to tenant safety and the rights of neighbours to have reasonable peace, comfort and privacy.

## **NEW ZEALAND POLICE**

The Police are often the initial point of contact and the referring body. They are asked to check on an individual when neighbours are concerned that mail is not being collected, or a person has not been seen for some time. Police are empowered to conduct checks on people and can gain access, involving forced entry if necessary. There are however, some restrictions on their powers of entry.

Police work in collaboration with Mental Health services, particularly when dealing with mental health crisis interventions. Police have the responsibility to protect the safety of all parties, and to protect all persons from injury or death, while attempting to preserve the rights and freedom of individuals.

## **FIRE SERVICE**

New Zealand Fire Service (NZFS) has the right to enter buildings where it is believed that there is a fire, or where it is believed that a fire has occurred.

NZFS can take action to render the situation safe. However, the Fire Service cannot inspect residential premises, even if they suspect them to be a fire hazard, without the permission of the owner.

The NZFS does not have official procedures for dealing with a squalor situation.

## APPENDIX 7: Supports for People with Impaired Competency

### **PROTECTION OF PERSONAL AND PROPERTY RIGHTS ACT 1988 (PPPR Act)**

The PPPR Act is the NZ statute which deals with issues of competence.

The Act aims to protect and promote the personal and property rights of adults who are wholly or partially incapable of managing their own affairs. Under the Act, it is presumed that everyone is competent to manage their own affairs unless proven otherwise, based on medical evidence.

Many people, when competent to do so, have granted an Enduring Power of Attorney (EPOA) to a person who then has the right to make decisions on their behalf in the event of them being unable to do so. **The EPOA comes into effect with a medical statement of incompetence.**

*For those with no EPOA, and/or lack the capacity to appoint someone, the matter is directed to the Family Court.*

Once the Family Court has demonstrated, with medical evidence, that competency is lacking, it then has the power to make orders authorizing certain actions, or appointing other suitable and available persons to manage the subject person's affairs.

### **ORDERS AVAILABLE**

The Court must make the least restrictive intervention possible.

*The extent of need has to be assessed.* Where there is significant incapacity, a more restrictive intervention may be necessary.

A medical assessment of competence is always required. This must be provided by a suitable Practitioner who is familiar with the concepts involved.

#### **Personal Orders (S10 of Act)**

These provide for a range of matters, including orders to attend a particular institution, and orders to be provided with particular living arrangements, treatment, or therapeutic services. There are regulations regarding the type of order.

Applicants may be:

1. the subject person
2. A relative or attorney
3. Social Worker
4. Medical Practitioner
5. Property Manager
6. Any other person with the leave of the court



## Welfare Guardian

This allows the court to appoint a person as a Welfare Guardian, giving them the power to make decisions in relation to the subject person's personal care and welfare.

There are stipulations regarding applicants. Paramount consideration is to promote and protect the welfare and best interests of the subject person. They need to consult the subject person, their property manager and others who are involved, including the Court.

## Property Manager (or Administrator, depending on the level of assets available)

A person appointed who can make decisions for the subject regarding property and assets.

Stipulations are similar to those regarding Welfare Guardianship.

In those situations where there is no family/whanau suitable or willing, the Public Trust may be appointed.

All orders have an expiry date, requiring review.

## **APPLICATIONS**

Applications need to be discussed with all relevant people, and appropriate legal representatives.

It is rare for TDHB to be an applicant.

The Family Court website at [www.justice.govt.nz/family/what-familycourt-does/powers-to-act.asp](http://www.justice.govt.nz/family/what-familycourt-does/powers-to-act.asp) is a useful source of information about applications under the Act.

In certain circumstances, there are other Acts which may be appropriate.

Mental Health Act 1992

Alcohol and Drug Addiction Act 1966

Committal Orders under the Health Act 1956 (s126)

Circumstances leading to extreme hoarding and squalor are usually complex, and a comprehensive Multi Agency/ Multi disciplinary approach is essential, particularly to aim to provide the least restrictive intervention.

## **APPENDIX 8: Case Studies**

### **CASE 1**

An elderly man has lived in the same privately owned rental flat for more than 10 years. He receives a pension and although he reliably pays rent, he spends the rest of his income on cigarettes and alcohol, leaving no money to pay for food or medication. He has chronic smoking-related lung disease, high blood pressure and leg ulcers but even though he uses a stick to walk and is unsteady, he goes out every day.

His flat is very dirty, dark and neglected. It requires painting, has several broken windows and only one working power point. There are no carpets or floor covers.

After a recent admission to hospital with a chest infection, he was discharged to a nursing home. When his health improved, he insisted on returning to his home.

A local community group offered assistance and removed a large amount of refuse before he returned home but quite a bit of rubbish soon re-accumulated.

He does not want anyone to approach the owner about repairs in case the rent is increased. He is receiving home-delivered meals but refuses to pay the nominal fee so they may be withdrawn. Community Agencies refuse to provide cleaning because of the condition of the accommodation. Community nurses visit every second day to dress a leg ulcer. He refuses to take prescribed medications even when the purpose for these has been clearly explained. He is disheveled, irritable and suspicious.

During his recent admission to hospital, tests showed he had abnormal liver function consistent with alcohol abuse though he denies drinking alcohol. A brain scan showed changes due to stroke-related or cerebrovascular disease. On testing of memory and orientation he performs well. However, he has significant impairment on tests of frontal lobe function.

His diagnosis is dementia due to alcohol and cerebrovascular disease. He is aware his flat is 'untidy' but isn't concerned and doesn't want to consider alternative accommodation.

### **Discussion**

This man's neglected and unclean living conditions are a concern but do not appear to present a high immediate risk, possibly because of the recent cleaning. The fact that his home is becoming dirty again highlights the importance of ongoing supervision and follow-up where possible. He shows little awareness of any problems or the potential risks of not taking his medication, continuing alcohol abuse, loss of home services or the state of his accommodation so it would be important for an assessment of capacity to be undertaken.

### **CASE 2**

Mr B is 33 years old, experiences chronic schizophrenia and lives alone in a Housing Agency bed-sit. He was admitted to hospital with an acute episode of schizophrenia 18 months ago. He has little insight, is suspicious and irritable and has avoided contact with mental health services since his Community Treatment Order (CTO), compelling him to comply with medication, lapsed over 6 months ago.

The Housing Agency had difficulty organising a routine inspection of his accommodation but when it was conducted, Mr B was found to be in a severe state of self-neglect. There was minimal furniture

but all walls, fixtures and surfaces were severely dirty and damaged by cigarette burns and moisture. The bathroom and kitchen were in a particularly bad state and the floor had been extensively damaged by water. Mr B reported deliberately leaving taps dripping to obscure distressing persecutory auditory hallucinations.

On the threat of eviction, Mr B agreed to see the mental health team but refused to go to hospital.

## **Discussion**

Mr B has active psychotic symptoms possibly associated with non-compliance with treatment. Living in conditions of severe domestic squalor partly results from his psychotic symptoms. The Housing Agency should take advantage of Mr B's consent to see the mental health team and conduct an urgent or priority assessment. Although it is likely that Mr B will require re-admission to hospital until his mental state improves ( which could allow time for cleaning and repairs to be undertaken) it may be possible to recommence treatment in his current accommodation.

Based on his previous response to treatment and his lack of insight, it would probably be advisable for the CTO to be maintained. Educating Mr B about his condition and the need for medication and minimising any adverse affects may improve compliance. Mr B may benefit from community based supports to assist with household maintenance and personal cares.

If Mr B's capacity to maintain his own accommodation remains poor despite resolution of psychotic symptoms and compliance with treatment, consideration may need to be given to supported housing, where he would have more supervision and support. Otherwise, since the risk of relapse is high, ongoing follow-up and monitoring by mental health services and/ or the Housing Agency would be highly desirable.

If Mr B changed his mind and refused assessment by the mental health team, an application to conduct an assessment under the *Mental Health Act 1992* could be pursued. If Mr B continued to resist inspection, the Housing Agency could proceed by contacting the Tenancy Tribunal. The Department of Housing can issue a Cleansing Order enabling follow up visits to be made.

## **CASE 3**

Ms D, who lives in a private tenancy, was hospitalized for an acute episode of mental illness.

In preparation for discharge, the occupational therapist went with Ms D to her home and discovered the severe neglect of property which arose as a direct resulted of her illness. This involved the hoarding and poor disposal of excreta and large amounts of rotten food. There was a major infestation of vermin. In addition, Ms D's electricity and gas supplies had been disconnected. Ms D expressed considerable dismay at the condition of her flat and agreed to industrial cleaning.

An application was made to the Family Court for the appointment of a Guardian for financial management of her affairs and this was approved.

## **CASE 4**

A Housing Agency discovered whilst undertaking a regular inspection of the property that Mr M was living in severe domestic squalor.

Housing Agency staff had previously received complaints from neighbours about Mr M's behavior including his abusive language and threats of violence affected by alcohol abuse. There was concern that his hoarding presented a significant fire risk.

Staff attempted to negotiate the organisation and disposal of some of his hundreds of books and other items. Mr M vacillated between being cooperative and agreeing to the idea of getting rid of some of his things, to outright refusal and hostility towards those attempting to make him do things he didn't want to do. In addition, he thought his place was no more of a fire risk than the bookshop down the road.

Strategies to address his situation included building rapport over a long period of time with the recognition that bringing about change in his home environment would likely be a slow process. However, as the Housing Agency has a duty of care to other residents, if a property poses a significant fire risk, the issue would need to be resolved as quickly as possible.

## **CASE 5**

A 62-year-old woman lives in a state of severe domestic squalor. She has a history of head injury and alcohol abuse resulting in moderate to severe frontal lobe damage. She is also noted to be in poor health and her diabetes is poorly controlled.

She has a long history of refusing access to her home and was verbally and physically aggressive towards workers when access was sought previously. Other residents in the block of units have complained because of the smell. And Community Health Services have received calls from the council. The woman has been served with a notice from the council requesting that the property be cleaned. Failing this, she will be taken to court in accordance with the *Local Government Act*. Under the PPPR Act, a Guardian has been appointed to make welfare decisions on her behalf and to manage her finances. Her GP is of the opinion that, although she is extremely thin and in poor health, she does not need hospitalisation or placement in an aged care facility.

## **Discussion**

In this case the person was recognised to have impaired, decision making capacity and sufficient need such that the Family Court has appointed a Guardian to be a substitute decision maker. A Personal Order is usually limited in time and scope. It is the responsibility of the Guardian to review the person's circumstances and act in the best interests of the person. Although the person may not have the capacity to make decisions, they may still be able to express a view or preference and where possible this should be taken into account.

Although the Guardian has legal authority for making decisions on the person's behalf, the assistance of others such as a care managers or community mental health staff may be required to help implement those decisions.

## **CASE 6**

Mr H. is a 70-year-old man who lives alone in his own home.

He was referred to mental health services by his neighbour, who was concerned that he was in a severe state of self-neglect and that his mental and physical health were declining. The neighbour reported seeing Mr H. talking to himself and stated that he was becoming increasingly pale and losing weight. His house was extremely neglected and dilapidated. There were several holes in the roof, no glass in the windows and no electricity or running water.

Mental health services visited his home on several occasions but Mr H. was never at home or refused to answer the door. He did not respond to written requests to see him sent in by mail. He was not known to have any living friends or relatives. Mental health records confirmed Mr H. had been admitted to hospital 30 years ago with schizophrenia but was not known to have had any

contact since. Mr H was known to the local council, who had received complaints in relation to the neglected state of the property, the yard and the overgrown garden. The council had cleared the yard after his failure to respond to a Cleansing Order under the *Local Government Act*. Mr H's rates were several months in arrears but he made payments from time to time. Otherwise, Mr H. was not known to have caused any problems and was not known to be a danger to himself or others.

## **Discussion**

Based upon the report of his neighbour, Mr H. may be at risk (from untreated mental illness, self neglect, and poor nutrition) and further assessment is warranted. Whether further intervention is required will depend upon whether or not it is possible to see Mr H. at his home (or elsewhere) and his willingness to cooperate. Assuming it is possible to contact him, and he agrees to an assessment, a number of areas need to be addressed.

### *Medical and Psychiatric Assessment*

Sometimes a person may agree to see a general practitioner or a geriatrician. The suggestion of physical health problems and nutritional deficiencies (weight loss and pale appearance) would indicate the necessity of a review of Mr H 's physical health including a physical examination and possibly further investigations, such as blood tests.

The GP or geriatrician would determine the need for further assessment by other medical specialists such as the local Mental Health Service for Older People or crisis team to undertake an assessment.

### *Assessing Capacity*

An important question to be addressed from the outset is whether or not Mr H has the capacity to decide if he needs or wants to receive further medical treatment (e.g. medications, hospitalisation, investigations) and remain in his current accommodation. He needs to be able to understand the options available to him and the potential benefits and risks associated with each of these.

### *Environmental and Public Health Assessment*

Severe domestic squalor can present the following significant health risks to the occupant, to neighbours and to the local community: fire from the accumulation of large quantities of flammable material; rodents and other pests; the spread of disease associated with lack of running water or lack of sewage. If these concerns are apparent in Mr H 's case, it would be necessary to notify Public Health Officers in the DHB.

### *Cleaning*

Cleaning is often difficult to organise and pay for. If Mr H 's living conditions are extreme and there are concerns about exposure to human waste, body fluids, excretions and an infection risk, 'forensic' cleaning may be required. The local council may be able to provide contact details for local cleaning services and assist with removal of property and rubbish. In milder cases, with less infectious risk, particularly if Mr H were to voluntarily accept assistance, some community organisations may assist. A loan may be accessible from the Department of Work and Income.

## **What happens if Mr H. persistently resists assessment and/or intervention?**

Should Mr H. be continually unavailable for assessment and the concerns in relation to his health and living conditions persist, the situation could be addressed in several ways. These are likely to be influenced by which service/s have the most involvement.

A joint approach (taking as much care to maintain confidentiality as possible), with one service taking on the role of the 'lead agency' and identifying a coordinator or 'key worker', is probably the ideal. Continuing efforts should be made to engage Mr H. and convince him to accept help voluntarily. If there is evidence of a likely mental illness but Mr H continues to resist assessment, legal authority to enter his home would be required.

The concerned neighbour could make an application for assessment under the Mental Health Act, 1992. The Crisis Team and a GP could then attend and conduct a medical examination, including an assessment of capacity and risk, but would require Police involvement as only they have the legal authority to force entry when necessary. (Crimes Act,1961).

If it was determined that Mr H was mentally ill and at risk, he could be accompanied to hospital, by the Police if necessary, and be admitted for further assessment and/or treatment under the Mental Health Act 1992.

When there are significant concerns requiring an urgent response, the Crisis Team, GP and Police could attend, assess and then make an application under the Mental Health Act if necessary.

*If there is no evidence of mental illness, then the council could invoke its powers under the amended Local Government Act 1993 and order a clean up without Mr A's consent.*

## **CASE 7**

Mrs P is a 59 year old woman with a diagnosis of major mental illness. She has lived in the same HNZ home for over 20 years with her husband who also has a mental illness.

Over a 3 year period, the state of their home deteriorated. Every room, including the entrance and hall, was filled with rubbish. Newspapers and clothing were piled up the walls. Cigarette butts and ash, dog and cat fur and excreta covered most of the remaining surfaces including some seating. Rotten food covered the kitchen work surfaces.

Although the visiting Mental Health Nurse continued to offer a variety of solutions, Mrs P declined stating she did not want "anyone interfering with her belongings".

Eventually a multi-agency meeting took place which included the HNZ Manager along with the Case Worker, the Public Health Inspector, the Mental Health Nurse and Team Leader and the District Council Manager.

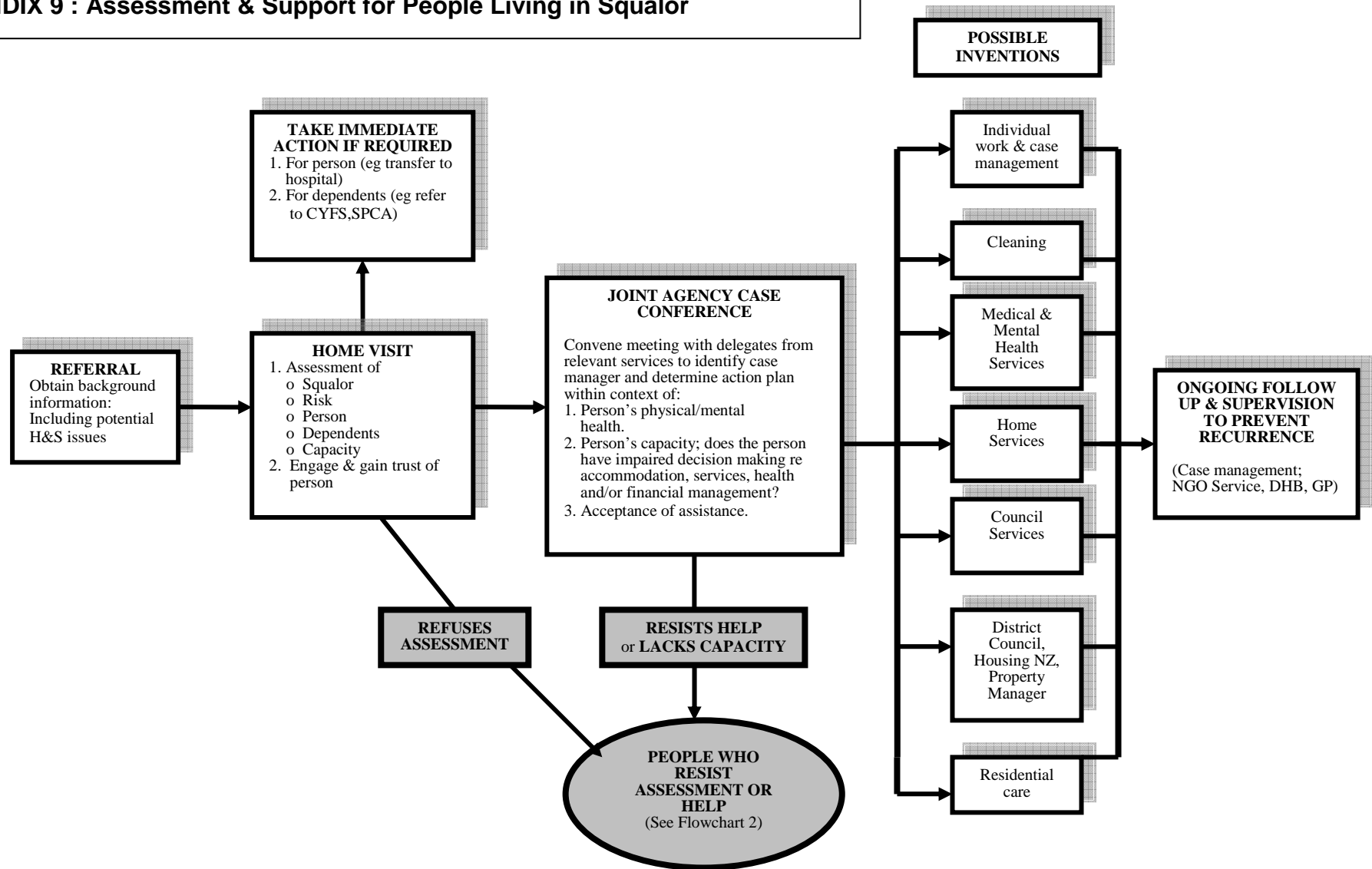
It was decided that a Cleansing Order was required and once HNZ completed a house inspection, the Order was issued.

To minimise the anxiety and stress, the contractors worked with Mrs P and a satisfactory standard was attained in less than 2 weeks.

Mr and Mrs P were instructed to maintain the standard expected by HNZ and they agreed to weekly support from a community agency.

This has largely worked but a recent HNZ inspection identified areas for improvement. Mrs P was compliant and once again assisted with the cleaning process.

## APPENDIX 9 : Assessment & Support for People Living in Squalor



## APPENDIX 10: Support for People Who Are Unwilling to Accept Assistance

