
Appendix 6 | Update Report for the Specialized Program for Interdivisional Enhanced Responsiveness August 2017

Coordinated Hoarding Response System Design for the City of Toronto

Briefing Note: Update for System Reform and Innovation Table on Vulnerability in Toronto

Issue

Problematic Hoarding can contribute to the escalation of health and safety risks for vulnerable Torontonians and their neighbours. In addition, the lack of a coordinated system can create significant challenges for City divisions and community agencies. Within this note are recommendations that will support the continued development of a Collaborative Hoarding Response System that will generate collective outcomes and position the City of Toronto and its partners to utilize harm reduction practices and principles to better mobilize around this issue.

Background | Hoarding and Risk

Problematic hoarding behavior includes complex mental health and behavioral challenges. It can lead to serious health and safety risks for both those individuals living with problematic hoarding, and the surrounding community. Although the community prevalence of hoarding disorder ranges between 1.5-6% of the general population, in 2015, problematic hoarding and excessive clutter were identified as a contributing factor in 88% of acutely elevated fire safety risks addressed by City's multidisciplinary program to address vulnerability (SPIDER) – Specialized Program for Interdivisional Enhanced Responsiveness to Vulnerability. In addition to fire safety risks, problematic hoarding is also associated with other public health concerns (e.g. poor hygiene, poor air quality, and pest infestations). Blocked access to living spaces and shared community spaces also creates safety hazards for residents as well as emergency services personnel called upon to provide care.

Background | The Cost of Hoarding

While the economic and social costs of unresolved situations of problematic hoarding have not been estimated in Toronto; the potential for catastrophic outcomes was well-demonstrated by the 2010 fire at 200 Wellesley Street, a 30 storey Toronto Community Housing apartment tower. The fire, which caused more than \$1 million in damage and resulted in over \$4.85 M in compensation being paid out to victims, broke out after a discarded cigarette landed on a balcony filled with an excessive amount of combustible materials.

Background | Current City of Toronto Response to Hoarding

In Toronto, situations involving problematic hoarding may be brought to the attention of City enforcement services in a number of ways including through emergency responders, and calls from City Councillors. Most frequently, City divisions are notified about community concerns through

3-1-1 identified by neighbours, landlords, property managers, etc. Self-referrals are rare. Based on the nature of the risks identified during the 3-1-1 call, complaints are usually forwarded to Toronto Fire Services, Municipal Licensing and Standards, and/or Toronto Public Health for inspection. The objectives of these divisions are to achieve compliance with municipal property standard bylaws, fire protection and prevention legislation, and provincial public health legislation. If during an inspection, medical risks and/or client vulnerability are identified, a Public Health Nurse from the Vulnerable Adults and Seniors Team may be requested to visit the residence and offer linkage to health care or social service supports.

In some situations City divisions may seek legal action and issue Orders. In instances of noncompliance, City divisions may take remedial action by clearing the premises (e.g. Municipal Licensing and Standards may contract private contractors to empty a dwelling of debris and sanitize it.) Fees for these services are invoiced to the entity on Title for the property, as per property taxes.

Background | Service System Gaps

Although service providers from diverse sectors and disciplines in Toronto regularly respond to hoarding concerns, to date there has been no clear understanding or guidelines of how to best coordinate this work and what best practice(s) should be implemented. As a result, efforts are often targeted to address emergency situations. Prevention and long-term risk reduction are not prioritized.

Both research and practice-based evidence have demonstrated that problematic hoarding is very difficult to treat. For many individuals, particularly those who have limited to low capacity and live in high risk situations, a harm reduction approach that focuses on keeping safety concerns within acceptable levels appears to be the recommended approach. We have learned however that regardless of approach - (e.g. using a harm reduction or a more severe approach such as 'extreme cleaning'), longer term supports are required to prevent recidivism. At present, only a small percentage of individuals that are linked with community case management have access to longer term in-home hoarding support (some agencies have funding for personal support workers for ongoing maintenance). The development of a coordinated and more formalized collaborative service system to address both immediate conditions of elevated risk and therapeutic interventions to reduce risk recurrence have been identified as an important deliverable.

Consultation with community partners including case management agencies, housing providers and other Toronto Hoarding Support Service Network partners, have identified clear gaps in accessible supports and services. These gaps include: access to an individual/agency to provide support, assessment and planning of care for both moderate to severe situations, clutter coaching (incorporating a harm reduction approach), longer term maintenance support and access to clinical consultation. Many stakeholders have also indicated the need for more accessible training and education.

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Prepared by: Scott McKean

Examples of hoarding response models from other jurisdictions demonstrate the value of using specialized teams to address hoarding situations. Currently preliminary discussions have begun to explore the possibility of allocating key staff from specific city divisions (e.g. MLS, TFS) along with a hoarding service coordinator to respond to referrals. A preliminary draft proposal was sent to the Toronto Central -Local Health Integration Network for funding to address some of the gaps in services including hoarding coordinator(s), clutter coaches, home support workers and access to clinical consultants. (See Appendix F).

Deliverables and Outcomes

1. Literature review (See Appendix A)
 - A comprehensive literature review of problematic hoarding was conducted. (See Appendix A)
2. Development of clear service definitions, terms and language related to problematic hoarding
 - An inter-sectoral steering committee consisting of City Services and community supports from a variety of disciplines was developed to review and update existing terminology and create consistent definitions that can be utilized by multiple sectors. (See Appendix B)
3. Identification and adaption of two Risk Assessment Tools (Toronto-HOMES and Clutter Image Rating Scale (CIRS) – to guide assessment and referral protocols to appropriate City divisions and community services when situations are determined to be at elevated risk
 - An inter-sectoral steering committee consisting of City Services and community supports from a variety of disciplines reviewed and updated existing assessment tools and has made recommendations regarding their adoption for use. (See Appendix C)
4. Consultations with City divisions and community agencies on the Collaborative Hoarding System Response to determine requirements for the purpose of addressing gaps in service including longer term harm reduction goals
 - Multiple consultations have been conducted with City Services and Community Agencies from a variety of sectors including the Toronto Hoarding Support Service Network.)
5. Development of a flowchart to guide referral processes
 - A flowchart has been developed with multiple sectors to provide a pathway for vulnerable Torontonians experiencing problematic hoarding and those supporting them. (See Appendix D)
6. Clarification of Intervention/management strategies that take into consideration individual capacity and risk

- Consultation with multiple stakeholders have identified recommendations for a coordinated Hoarding Response System. (See Appendix E)
7. Exploration with the LHIN and community partners regarding resources required for implementation
 - Resourcing recommendations have been identified.
 8. Identification of gaps in data collection and opportunities to remedy this (e.g. 2-1-1, 3-1-1, Toronto Fire Services, MLS, and Toronto Public Health data collection)
 - Consistent referral pathways have been recommended.
 9. Identification of partnership opportunities among City divisions, Sunnybrook Hospital and community agencies, community networks and collaboratives regarding capacity building and training of City divisions and community agency staff, in the use of risk assessment tools and harm reduction strategies for hoarding risk mitigation
 - Partnerships identified.
 10. Development of an Ethical Framework
 - Explore incorporating a Public Health Ethical Framework as a foundation for building a collective ethical framework for the Collaborative Hoarding Response System.

Recommendations

1. Approval of language

- a. Pending Legal, City of Toronto, TCHC and all 5 LHINs that represent Toronto approval language and definitions for implementation.
- b. Definition of Acute Elevated Risk: the City of Toronto currently uses multiple definitions and thresholds of "acute elevated risk" which causes disjointed practice by City staff including inconsistent assessments/responses.
- c. Specifically the City of Toronto needs to decide how it mobilizes in extreme risk situations when there are no utilities or potable water in a residence. Current practices are inconsistent and not always in alignment with Municipal Code. Additionally we recommend that an additional legal context be developed to ensure that 3rd party risk is factored into existing assessment tools and the planning of protocols.

2. Approval of Risk Assessment Tools

- a. Upon the approval of language, that the City of Toronto, TCHC and all 5 LHINs that represent Toronto approve the risk assessment tools (Toronto-HOMES and Clutter Image Rating Scale) for implementation.

3. Training

- a. A comprehensive training curriculum be developed for City and community services to build the necessary capacity of the system to understand and respond to problematic hoarding and support implementation.
- b. Such curricula would include how to use risk assessment tools, hoarding-related tools, clutter coaching, and harm reduction and therapeutic communication.
- c. A backbone agency, organization or collaborative be funded to develop and implement a training curriculum.
- d. An online portal for hoarding resources be developed and maintained.

4. Implementation of Joint Assessment Practices

- a. Centralized point of referral with data management component (2-1-1 / 3-1-1).
- b. An interdivisional database be developed to track hoarding referrals and responses.

5. Approval and Implementation of Referral Pathways

- a. Implementation of hoarding management pathways.

6. Development of Hoarding Response Team that includes:

A. Mobilize integrated Hoarding Assessment Teams that would consist of:

- a. a hoarding service coordinator
- b. Four (4) existing dedicated MLS Officers (.25 FTE) and 4 dedicated Toronto Fire Inspectors (.25 FTE) who would be specially trained to act as district hoarding leads for the City of Toronto.

These assessment teams would be responsible for the initial assessment to determine the level of risk and to determine the appropriate care pathway. Once identified, the Hoarding Coordinator would refer on to the most appropriate community supports, who in conjunction with City services, would develop a collaborative harm reduction approach (including safety targets based in legislative requirements) or mobilize enforcement-based interventions where necessary.

B. Existing Community Supports would include

- a. Community mental health agencies would provide case management support
- b. Community support services would provide in-home clutter coaches and home support workers

- c. Community clinicians such as Occupational Therapists and/or Psychiatrists would provide clinical consultation
- d. Where appropriate (high insight, high motivation for change) clients with lived experience hoarding, would be linked to peer-support groups such as the "Buried in Treasures" model organized in partnership with Sunnybrook Hospital and partner community agencies. This model is considered to be an evidence-based treatment intervention.

C. Mobilize Resource Required to Support Request for Funding

- A. Existing Resources - Identify 4 Municipal Licensing & Standards Officers and 4 Fire Services Inspectors
- B. Existing Resources - Identify a Community Health provider who can provide in kind clinical consultation that is specific to Problematic Hoarding and leveraged by the LHIN.
- C. NEW Investment – Create One (1) Clinical fellowship opportunity affiliated with the University of Toronto and supervised through Sunnybrook Hospital Fredrick W. Thompson Anxiety Disorders Centre
- D. NEW Investment - Two (2) Hoarding Service Coordinators,
- E. NEW Investment – Four (4) clutter coaches,
- F. NEW Investment – Four (4) dedicated home support workers.

7. Governance

- a. A steering committee consisting of representation of all 5 LHINS, Toronto Community Housing, community agencies and the City of Toronto be formalized to implement the recommendations.

There are existing leadership tables such as the City LHIN Leadership Table, the SPIDER Steering Committee and others that could be utilized

8. Lead agency

- a. Identify a backbone agency, organization or collaborative such as the Toronto Hoarding Support Service Network to lead the implementation of the newly designed Hoarding System Response and training.

10. System Change

- a. Request Hoarding Harm Reduction Model, Training and Awareness be developed and implemented with the Landlord Tenant Board.
- b. City of Toronto define a corporate risk standard of response related to lack of utilities and potable water in a residence.

- c. City of Toronto develop and implement an Ethical Framework (regarding the support of Vulnerable Torontonians) advance the Guide to Good Practice that extends to all those working with vulnerable Torontonians.

11. Evaluation

- a. An Evaluation plan be developed to enhance current systems and assess effectiveness.

Appendix A | Literature Review

Appendix B | Service Definitions, Terms, Language related to Problematic Hoarding

Appendix C | Risk Assessment Tools (Clutter Image Rating Scale and Toronto-HOMES)

Appendix D | Flowchart to Guide Referral Processes

Appendix E | Intervention / Management Strategies (Individual Capacity Risk Model)

Appendix F | Financial Implications

Appendix A | Literature Review

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What are effective interventions for hoarding?



What you need to know

- Little research exists on the efficacy of interventions specifically designed to treat hoarding disorder, but a number of approaches are demonstrating successful outcomes.
- Many jurisdictions have formed community hoarding taskforces made up of professionals from a broad range of disciplines and are showing particularly promising results.
- A form of cognitive behavioural therapy designed specifically to treat hoarding has proven effective, and adapted versions are being tested for use with specific populations, in groups, in home settings, and via the web, as well as for use with other forms of treatment.
- Approaches must take into account that many individuals who hoard are resistant to assessment and treatment.
- The complex nature of hoarding disorder calls for dynamic treatment approaches, with the precise services required being determined on a case-by-case basis.

What's the problem?

Hoarding is not a new phenomenon; however, it has only recently been classified as a distinct mental disorder in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V, 2013). Hoarding disorder (HD) is characterized by the excessive accumulation of items and a refusal to discard these items, resulting in significant impairment.¹⁰ Recent estimates suggest that 2% to 5% of the adult population engage in some type of hoarding behaviour,^{10, 12} which can create hazardous living conditions for individuals and communities.¹¹

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www.eenet.ca

With awareness of hoarding on the rise, the prevalence of self-reporting and referrals

from service providers is also increasing.^{11, 16} As a result, health practitioners and researchers are focusing on how to treat and remedy the often debilitating symptoms. Attempts have been made to help individuals using various types of interventions, with varying results.

It can be challenging to isolate which interventions are most effective. For this reason, a Local Health Integration Network in Ontario reached out to [EENet](http://www.eenet.ca) to identify what the research says are the most effective clinical and community-based approaches. The purpose of this evidence review is to inform the development of municipal hoarding intervention guidelines.



What did we do?

We conducted a search of academic literature in March 2016 using the following databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, In Process Medline, [PsycINFO](http://www.psycinfo.com), and the Cochrane Database of Systematic Reviews.

For our review of evidence on clinical interventions, we included all relevant peer-reviewed systematic reviews and meta-analyses focused on hoarding or HD published in English after 2010.

Due to the limited number of publications on community interventions for hoarding, our exploration of evidence on this topic was expanded to include single studies (e.g., case examples), as well as grey literature identified via a Google search, published after 2005.

Our review excluded the following types of publications:

- Those focused on symptoms, causation, diagnosis, disease classification, or prevalence of hoarding (i.e., those not focused on intervention, treatment, or management of hoarding);
- Those not specifically focused on hoarding (e.g., studies focused more generally on obsessive compulsive behavior);
- Those exclusively focused on interventions for specific populations (e.g. children, seniors, or people with dementia);
- Those focused only on the hoarding of specific items (e.g. animals or medication).

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What did we find?

Following a review of titles and abstracts, we found a total of 24 articles to be relevant; 14 on community interventions and 10 on clinical interventions. The following section outlines the findings from each of these areas of research.

Community-based Interventions

While hoarding is a complex disorder that requires dynamic interventions, the literature is clear on what a successful intervention does not look like. Evidence indicates that one-time forced removal of clutter, or “clean sweeps”, may exacerbate and perpetuate hoarding¹⁴ because they don’t address the underlying causes.^{16, 20} However, home clean-out remains the most commonly sought form of help, especially for nonextreme cases.¹⁵ Although mental health treatments such as cognitive behavioural therapy are highly recommended, they are used in fewer than 20% of cases.¹⁵ Ultimately, the best evidence-informed approach is to use a collaborative, multi-disciplinary, community hoarding taskforce that includes mental health support.¹³ This appears to be true for all populations, including older adults and individuals who resist help.^{13, 14, 17}

The first hoarding taskforce was formed in Virginia in 1999, and there are now at least 85 across Canada, the United States, and Australia.⁵ Such multifaceted, multi-organizational approaches, designed to address the unique circumstances of each case, are considered the most promising practice for communities to deal with hoarding.^{11, 13, 14, 20, 21} In 2013, Singh and Jones suggested that almost half of hoarding interventions without community taskforce involvement had no signs of improvement and 15% resulted in worsening of hoarding. The 8% of cases that did improve slightly tended to relapse back to baseline.¹⁷

1. How effective hoarding taskforces work

The literature suggests several key steps for successful community hoarding taskforces to take when dealing with hoarding.¹⁸ They include:¹⁸

- Initial referral or case consultation;
- Home visit and development of assessment goals;
- Creation of an action plan through a joint agency case conference;
- Implementation of chosen intervention(s);
- Implementation of a support system and follow-up process;

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- Case closure.

Once a case of hoarding comes to light, the first step is to make an objective assessment to decide if an intervention is necessary.¹⁷ Once a taskforce or individual service provider has been granted access to a hoarding site, one of several tools may be used to assess the severity of the situation:¹²

- the Hoarding Rating Scale (HRS);
- the Clutter Image Rating Scale (CIR);
- the Saving Inventory-Revised (SIR);
- the Service Utilization Questionnaire (SUQ).

According to Chater, Shaw, and McKay the individual assessing the situation should follow four steps:¹²

- Ensuring one's personal safety;
- Assessing the safety of the site;
- Identifying the service goals;
- Convening a team to handle the specific case.

A critical element of the intervention is building trust between the taskforce members (especially mental health service providers) and the client.¹⁷ This can be done using a motivational approach that focuses on harm reduction (rather than solely symptom reduction), promoting safety, minimizing loneliness, empowering the individual, and providing education.¹³ It is also helpful to take the time to build a therapeutic alliance and use a strengths-based, incremental approach to assessment, followed by positive reinforcement for each small gain that is made. There are also potential benefits to working with peer support workers and family members, as well as using legal aid or tenancy tribunals to avoid eviction, if necessary.²⁰ Better results can also be achieved by adapting the approach to the individual's specific circumstances and needs, and by intervening well before the point of crisis.¹²

2. Taskforce composition

Although the literature does not suggest a specific type of taskforce approach or exactly who should be on a taskforce, possibly owing to the dynamic nature of the condition, certain services or organizations should be involved.^{11, 12, 13, 14, 17} The general recommendation is that taskforce composition be based on the needs of

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the individual hoarder.^{14, 13, 17} The most notable services included in community taskforces are: fire services, environmental safety/protection, public health, housing, mental health, ambulance services, nursing, professional cleaning and organizing, social workers, psychologists, general practitioners, landlords, senior services, and animal control.^{14, 12, 13, 17, 20, 21}

Typically, it is recommended that one agency be selected as the central coordinating unit or the single point of entry into the network of supports. A services roadmap is then established, along with common guidelines, protocols, and training material that all collaborating agencies can use.^{22, 24} Several case studies highlight the central role of social workers or community nurses as care coordinators, system navigators, and patient advocates.^{20, 21, 22}

While membership on most taskforces is voluntary, participant organizations report a positive impact, including cost savings, from collaboration. The taskforces accomplish this by meeting regularly to discuss cases and by educating members on both how to intervene and new research developments. By doing so, taskforces report being able to make an impact, despite not having formal power to create or influence policy.

Although the community taskforce is reported to be the best solution to hoarding, several barriers to taskforce implementation have been identified. These include: insufficient funding (related to lack of policies regarding hoarding or hoarding taskforces),^{11, 17} the time required for non-mandated work,¹¹ and a shortage of mental health providers with specific training.^{13, 17}

3. Approaches for resistant individuals

It is estimated that half of hoarders do not recognize their hoarding behaviour as being problematic³ and many individuals with HD are unwilling to accept help. *No Room to Spare*, a report outlining Ottawa's community response to hoarding, provides three suggestions for consideration in these instances:²²

- Initiation or continuation of ordinance (law or by-law) enforcement;
- Emergency placement under guardianship;
- Mental health assessment.

Snowden and Halliday¹⁸ offer more detailed recommendations to address this situation. The Partnership Against Homelessness in New South Wales, Australia, published a succinct set of guidelines based on Snowden and Halliday's recommendations, illustrating different referral pathways for those who have cognitive or decision-making capacity and those who lack it.²³ For those with capacity, they suggest that case managers work to persuade the individual to accept help, but if the attempt fails, an environmental risk assessment should be requested from the police, fire brigade, or animal control services.^{18, 23} For individuals

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remain closer to the HD range than the normal range.⁹ As is true with CBT for hoarding as a symptom of OCD, treatment refusal and non-compliance significantly influence outcomes and the duration of those outcomes.³ There are better outcomes when individuals participate in peer-facilitated support groups and in-home assistance from people who are not counselors.³ Group CBT also shows positive outcomes. It is slightly less effective than individual treatment, but more cost-effective.³

2. Pharmacotherapy

A large proportion of individuals with HD have responded well to medication (37-76%)² and antidepressants seem to be as effective as CBT-based treatment.³

The following medications have been effective:

- Selective serotonin reuptake inhibitors, such as paroxetine (Paxil) and sertraline (Zoloft);²
- Serotonin and norepinephrine reuptake inhibitors, such as extended-release venlafaxine (Effexor XR).²

More research is needed on the use of medication,⁶ as well as on the combination of medication and counseling or CBT³ and on the use of stimulant medications such as methylphenidate (i.e., Ritalin and other medications used for attention deficit hyperactivity disorder).^{6, 8}

3. Novel Approaches

The following approaches show promise, either combined with CBT or as alternatives when CBT is not an option:

- Home-based webcam interventions;⁴
- Web-based CBT group intervention;⁴
- Book-based self-help groups;⁴
- Experiential, visual methods (e.g., use of photography and video to stimulate motivation to change and facilitate organization).

For older adults, CBT combined with cognitive rehabilitation strategies that target memory, organization, problem solving, and cognitive flexibility have been shown to double treatment response rates in comparison to CBT alone.⁴

What are the limitations of this review?

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Only 24 studies met our inclusion criteria. The findings are limited by the parameters of our methods, including the research question and the timeframe of the search strategy. As a result, this rapid review may not present a comprehensive view of knowledge on this topic.

Although hoarding has been studied for several decades, little research exists on the efficacy of interventions to treat hoarding.³ Also, most research is limited with respect to the number of participants, ethnic and cultural diversity, and study replication,³ with the majority of research having been conducted on highly educated, Caucasian women.³

The research is also limited because of a lack of consistent outcome measures. Many studies use the Yale-Brown Obsessive-Compulsive Scale (Y-BOCS), which does not specifically measure hoarding severity.³ Additionally, research has not sufficiently explored several moderators of treatment outcomes. For example, studies have not investigated how treatment of various commonly concurrent mental health conditions may impact hoarding behaviour.³

As is true in the literature on clinical interventions, much of the literature on the outcomes of communitybased interventions is from qualitative case studies with anecdotal evidence rather than quantitative data.²⁰ Future longitudinal studies will need to illustrate explicit action plans.

What are the conclusions?

Hoarding is recognized as a growing concern among all age groups, but particularly in older adults who choose to live independently.¹³ Increased awareness and research may bring more effective interventions to treat the disorder. Although no single treatment exists, consensus has emerged that using a communitybased taskforce approach that includes the provision of mental health support and hoarding-specific CBT appears to have the most success. Instances of hoarding must be assessed on a case-by-case basis to determine the severity of the situation, the willingness and capacity of the individual to receive help, and the composition of the taskforce or the services required to intervene successfully. The complex nature of the disorder calls for a dynamic approach to treatment, and warrants further study. Doing so will help us better understand the underlying issues of individuals who hoard and to help improve their treatment outcomes.

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Disclaimer

Rapid reviews are time-limited ventures carried out with the aim of responding to a particular question with policy or program implications. The information in this rapid review is a summary of available evidence based on a limited literature search. EENet cannot ensure the currency, accuracy or completeness of this rapid review, nor can we ensure the efficacy, appropriateness or suitability of any intervention or treatment discussed in it.

Appendix B | Service Definitions, Terms, Language related to Problematic Hoarding

1. DEFINITIONS

- (i) Vulnerable Resident
- (ii) Compulsive Hoarding
- (iii) Hoarding Disorder
- (iv) Problematic Hoarding
- (v) Types of Hoarding
- (vi) Squalor
- (vii) Harm Reduction
- (viii) Risk/Acute Elevated Risk

2. CONSIDERATIONS

- (i) Competency vs Capacity (related to hoarding)
- (ii) Personal Health Information

3. HOARDING ASSESSMENT TOOLS

- HOMES (Multi-disciplinary Hoarding Risk Assessment - adapted)
- Clutter Image Rating Scale

4. FLOW CHART

5. Literature search

6. Ethical Framework

1. DEFINITIONS

(i) Vulnerable Resident

‘Vulnerability’ - the result of interaction between the challenges a person faces and the resources that they can access when facing those challenges. *(The City of Toronto – Working Group on Vulnerable Individuals).*

A vulnerable resident must be assessed in context - a person's vulnerability or resiliency will depend on their circumstances, environment and resources in the broadest sense.

Vulnerable persons may be isolated, without identified supports, reclusive, have underlying medical problems and/or mental health issues posing a threat of harm to themselves and/or others.

Physical harm to self may be due to reduced ability to manage activities of daily living, substance misuse, isolation, poor insight and/or reluctance to accept support services.

(Toronto Public Health – Vulnerable Adults/Seniors Team Policy 2012).

(ii) Compulsive Hoarding

1. The accumulation of and failure to discard a large number of objects that seem to be useless or of limited value
2. Extensive clutter in living space that prevents the effective use of the spaces, and
3. Significant distress or impairment caused by hoarding

(Frost and Hartl, 1996)

(iii) Hoarding Disorder

A mental health diagnosis that was first identified as separate and distinct from other mental health disorders in the most recent DSM-5.

DSM-5 DIAGNOSTIC CRITERIA

- A. Persistent difficulty discarding or parting with possessions, regardless of their actual value.
- B. This difficulty is due to a perceived need to save the items and to distress associated with discarding them.
- C. The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromises their intended use. If living areas are uncluttered, it is only because of the interventions of third parties (e.g. family members, cleaners, authorities).
- D. The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning (including maintaining a safe environment for self and others).
- E. The hoarding is not attributable to another medical condition (e.g. brain injury, cerebrovascular disease, Prader-Willi syndrome).
- F. The hoarding is not better explained by the symptoms of another mental disorder (e.g., obsessions in obsessive-compulsive disorder, decreased energy in major depressive disorder, delusions in schizophrenia or another psychotic disorder, cognitive deficits in major neurocognitive disorder, restricted interests in autism spectrum disorder).

(iv) Problematic Hoarding

When the health and safety of an individual, and/or animals, and/or the surrounding community is at risk, and may contravene bylaws.

Toronto Fire Service (TFS) - For purposes of applying Fire Prevention and Protection Act:

An excessive accumulation of (usually) personal/acquired belongings and items which are being stored/retained within a dwelling unit...in such quantities and/or location(s) (example: kitchen, bedroom, living room, bathroom, basement, balcony, hallways, stairways, etc.) as to make such area(s) within the premises unsafe and/or unusable for their intended purpose.

Prepared for: December 1, 2016

Prepared by: Scott McKean

Municipal Licensing & Standards – For purposes of applying the Municipal Code, the operationalized definition used by TFS is expanded to:

May also include other structures / premises such as yard, garage, etc. that become unusable for their intended purpose as a result of the excessive accumulation of belongings being stored there.

Toronto Animal Services (TAS) – For purposes of applying Chapter 349 of the Municipal Code: The operationalized definition used by TAS is expanded to:

Animal hoarding involves keeping a higher-than-usual number of animals as domestic pets without having the ability to properly house or care for them. In many cases, the individual is unable to recognise that the animals are at risk and deny this inability to provide minimum care - many feel they are saving the animals. Often, the homes where animal hoarding exists are eventually destroyed by the accumulation of animal feces and infestation by insects. Bylaws stipulate the maximum number of pets allowed as being six cats and three dogs.

(v) Types of Hoarding

There are two main types of hoarding:

Inanimate objects: This is the most common and could consist of one type of object or collection of a mixture of objects, such as old clothes, newspapers, food, containers or papers.

Animal hoarding: involves keeping a higher-than-usual number of animals as domestic pets without having the ability to properly house or care for them. In many cases, the individual is unable to recognise that the animals are at risk and deny this inability to provide minimum care - many feel they are saving the animals. Often, the homes where animal hoarding exists are eventually destroyed by the accumulation of animal feces and infestation by insects.

<http://www.asPCA.org/animal-cruelty/animal-hoarding>

(vi) Squalor

“A state of being extremely dirty and unpleasant, especially as a result of poverty or neglect”.
(Oxford Dictionary)

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.

Individuals living in squalor are most often vulnerable, marginalised and isolated. They may lack awareness of their condition, may be highly suspicious of others and may feel significantly threatened by/actively oppose intervention.

(The Winston Churchill Memorial Trust: Report by Donna Bowe, 2013 Churchill Fellow)

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 is needed to assess the level of squalor.

(Partnership Against Homelessness (2007). Guidelines for field staff to assist people living in severe domestic squalor)

Understanding Hoarding vs. Squalor

Hoarding and squalor are complex and distinct conditions. Severe domestic squalor refers to an extreme living environment, compulsive hoarding (hoarding disorder) refers to a diagnosable mental health condition.

Squalor and hoarding can coexist. In some cases, people who live in squalid conditions due to some form of cognitive dysfunction, may also compulsively hoard. And similarly, people who have a hoarding disorder may live in unsanitary conditions in their home when extensive clutter prevents cleaning and pest infestations develop. Households are more vulnerable to squalid conditions when people hoard food, rubbish, human waste or animals.

Recommended approaches, treatment options and/or other interventions may vary based on an understanding of the situation.

(The Winston Churchill Memorial Trust: Report by Donna Bowe, 2013 Churchill Fellow)

Insight

In addition to the complex mental health concerns, other factors play a critical role in intervention and anticipating outcomes. These factors include emotions and life experiences that contribute to hoarding, as well as the program participant's insight or awareness of the hoarding behaviors.

With respect to hoarding behaviours, insight is subdivided into three categories:

- **Non-insightful.** Those who do not realize that the clutter is a problem.
- **Insightful but not motivated.** Those who are aware that the clutter exists but are not ready to change behaviors.
- **Insightful, motivated and non-compliant.** Those who are aware of clutter and willing to change behaviors, but struggling to move to action.

(Rethinking Hoarding Intervention, Metropolitan Boston Housing Partnership, 2015)

(vii) Harm Reduction

Harm reduction assumes that participants will continue to engage in high-risk behavior and focuses interventions on reducing or mitigating the harm experienced due to these behaviors.

In the case of problematic hoarding behavior, harm reduction mitigates risk by clearing the buildup of clutter in areas such as egress paths or heat sources. Only the minimum amount of clutter necessary to achieve relative safety is removed. While it is likely that clutter will continue to build, this approach is particularly useful for reducing the risk among those with little or no insight into their hoarding behaviors, especially when continued monitoring of the environment is put into place.

In situations of animal hoarding, case-by-case safety planning includes sterilization of pets, instruction regarding care of animals, reduction in the number of animals, primary health care, assessing person's capacity to care, vaccination, and surveillance.

(viii) Acutely Elevated Risk

For the purposes of the collaborative Hoarding Response Model, "acutely elevated risk" refers to any situation, that following an assessment by trained human service professionals, using approved and consistent "Hoarding Risk Assessment Tools" is deemed to negatively affect the health or safety of an individual, family, animals or surrounding community, causing the potential for significant risk of serious bodily and/or psychological harm.

If left unattended and/or unresolved, there is a high probability that these specific hoarding situations will require targeted enforcement and/or other emergency responses. This includes identified concerns regarding possible animal cruelty or neglect. (See Section 2(ii) for context)

(Information & Privacy Commissioner of Ontario, 2016)

2. CONSIDERATIONS:

(i) Competency vs Capacity

“**Competence** is a legal state, not a medical one. Competence refers to the degree of mental soundness necessary to make decisions about a specific issue or to carry out a specific act. All adults are presumed to be competent unless adjudicated otherwise by a court. *Incompetence* is defined by one's functional deficits (e.g. due to mental illness, cognitive impairment, etc.), which are judged to be sufficiently great that the person cannot meet the demands of a specific decision-making situation, weighed in light of its potential consequences (Grisso et al., 1995). **Only a court can make a determination of incompetence.**

Capacity is defined as an individual's ability to make an informed decision. Any licensed physician may make a determination of capacity. Forensic psychiatrists, however, are especially suited to assess a person's mental status and its potential for interfering with specific areas of functioning. An individual who lacks capacity to make an informed decision or give consent may need to be referred for a competency hearing or need to have a guardian appointed. The psychiatric consultation results in an opinion regarding whether such actions are indicated.

Capacity may be diminished as a result of a medical condition or otherwise altered cognitive functioning. **Capacity Assessment** is the formal **assessment** of a person's mental **capacity** to make decisions about property and personal care.

Under the Substitute Decisions Act (SDA) of Ontario, many situations require capacity assessments to be conducted by specially qualified assessors who must follow specific guidelines.

The SDA deals with powers of attorney and guardianship.

A competency assessment is a legal decision and is determined by the court.

http://lawprofessors.typepad.com/elder_law/2006/01/competence_vs_c.html

(ii) Information Sharing and Privacy

MFIPPA and PHIPA

The definition of acutely elevated risk cannot stand on its own. The definition must be assessed in context with existing legislation – specifically MFIPPA and PHIPA.

MFIPPA and PHIPA are intended to protect the privacy of individuals regarding personal information about themselves held by the City while providing them with a right of access to that information. However the Act also provides a right of access to information under the control of the City in accordance with the principles that information should be available to the public, necessary exemptions from the right of access is to be limited and specific and decisions on the disclosure of information should be reviewed independently of the institution controlling the information.

Sharing of personal health information in the custody of health organizations is to be done in accordance with PHIPA and is to be kept private, confidential and secure under rules relating to its collection, use and disclosure and ensuring reasonable measures are undertaken to ensure it is protected against theft, loss and unauthorized use or disclosure. PHIPA also applies to people and organizations that are not health information custodians who have received personal health information from a health information custodian, like TPH. This fact will need to be reflected in any partnership and/or info sharing agreements. Collecting information has distinct criteria conditions for disclosing information and this distinction essentially directs communication processes.

How to share personal information and personal health information both within and between City divisions, and with external community partners is an area that needs to be understood definitively. The City requires a legal interpretation to direct our communication and documentation processes, which in turn will support a coordinated response.

There are two issues that are important with respect to hoarding situations namely the collection of personal and personal health information and the disclosure of same. In general, there are a few reasons where either personal or personal health information can be disclosed:

- **With consent of the individual**
- **To reduce a risk of harm/health & safety**
- **In compliance with legislation**
- **To aid in an investigation/law enforcement activity**
- **In compassionate circumstances (for intention of contacting relatives only)**

In situations where there is a clear danger to others (e.g. fire hazards, infestations affecting others, etc.), disclosure of information is permissible, with the following caveats:

- Only pertinent information is disclosed
- Personal health information is not disclosed unless necessary - if personal information is sufficient (e.g. address and phone number), then personal health information should not be disclosed (for example, anything related to mental capacity, underlying health conditions is considered personal health information)
- Information is disclosed only to the parties that require the information under the circumstances (e.g. ML&S or Toronto Fire Services) but not to a larger distribution list as information sharing correspondence.

It is important to remember that interventions cannot be imposed once due diligence has been discharged by a particular municipal agency and the individual rejects assistance and does not consent to further services. Should circumstances significantly change, re-assessment would be warranted.

The only exception is in situations where it is believed that there is a capacity issue and the individual is not capable of consenting to services. Appointment of a substitute decision maker would have to be pursued under the Substitute Decisions Act.

MFIPPA

If personal information is collected under MFIPPA, the following sections are relevant to the disclosure of personal information (this does not include personal health information):

An institution cannot disclose personal information in its custody or under its control except:

- if the person to whom the information relates has identified that information in particular and consented to its disclosure;
- for the purpose for which it was obtained or compiled or for a consistent purpose;
- if the disclosure is made to an officer, employee, consultant or agent of the institution who needs the record in the performance of their duties and if the disclosure is necessary and proper in the discharge of the institution's functions;
- for the purpose of complying with an Act of the Legislature or an Act of Parliament, an agreement or arrangement under such an Act or a treaty;
- if disclosure is by a law enforcement institution,
 - to a law enforcement agency in a foreign country under an arrangement, a written agreement or treaty or legislative authority, or
 - to another law enforcement agency in Canada;
- if disclosure is to an institution or a law enforcement agency in Canada to aid an investigation undertaken with a view to a law enforcement proceeding or from which a law enforcement proceeding is likely to result;
- in compelling circumstances affecting the health or safety of an individual if upon disclosure notification is mailed to the last known address of the individual to whom the information relates;
- in compassionate circumstances, to facilitate contact with the spouse, a close relative or a friend of an individual who is injured, ill or deceased.

PHIPA

Similar to MFIPPA, PHIPA permits disclosure of personal health information in a similar array of circumstances. Since City divisions may also be receiving personal and/or personal health information from others, it is incumbent on each division to consider whether they have the authority to collect this information. Hence information about an individual should not be collected by any division unless the particular division has a mandate to interact with an individual or be involved in receiving information that is not needed to perform their duties.

A health information custodian cannot collect, use or disclose personal health information about an individual unless:

- it has the individual's consent and the collection, use or disclosure, as the case may be, to the best of the custodian's knowledge, is necessary for a lawful purpose; or
- the collection, use or disclosure, as the case may be, is permitted or required by the Act.

A health information custodian may disclose personal health information about an individual:

- to a health information custodian as described in the Act if the disclosure is reasonably necessary for the provision of health care and it is not reasonably possible to obtain the individual's consent in a timely manner, but not if the individual has expressly instructed the custodian not to make the disclosure;
- for the purpose of contacting a relative, friend or potential substitute decision-maker of the individual, if the individual is injured, incapacitated or ill and unable to give consent personally.

(Coordinated Response to Problematic Hoarding Strategy, City of Toronto, 2013)

Appendix C | Risk Assessment Tools (Clutter Image Rating Scale and Toronto-HOMES)



Hoarding
Center

Clutter Image Rating

In our work on hoarding, we've found that people have very different ideas about what it means to have a cluttered home. For some, a small pile of things in the corner of an otherwise well-ordered room constitutes serious clutter. For others, only when the narrow pathways make it hard to get through a room does the clutter register. To make sure we get an accurate sense of a clutter problem, we created a series of pictures of rooms in various stages of clutter – from completely clutter-free to very severely cluttered. People can just pick out the picture in each sequence comes closest to the clutter in their own living room, kitchen, and bedroom. This requires some degree of judgment

because no two homes look exactly alike, and clutter can be higher in some parts of the room than others. Still, this rating works pretty well as a measure of clutter. In general, clutter that reaches the level of picture # 4 or higher impinges enough on people's lives that we would encourage them to get help for their hoarding problem. These pictures are published in our treatment manual (*Compulsive Hoarding and Acquiring: Therapist Guide*, Oxford University Press) and in our self-help book (*Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding*, Oxford University Press).

Clutter Image Rating Scale: Kitchen

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating: Bedroom

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating: Living Room

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



1



2



3



4



5



6



7



8



9

Toronto - HOMES[®] Multi-disciplinary Hoarding Risk Assessment

Instructions for Use

- **The HOMES** Multi-disciplinary Hoarding Risk Assessment is intended to be used as an initial and brief assessment to aid in determining the nature and parameters of the hoarding problem and to help identify the presence of risk. It helps to guide the need for further action– including immediate intervention, additional assessment and/or referral.
- The highlighted areas are potential indicators of 'acute elevated risk' and a referral **must** be made to the appropriate division. At the discretion of the service provider, referrals may also be required based on the presence of other indicators.
 - **Toronto Fire Services** /**Municipal Licensing & Standards** / **Child Protection** / **Toronto Animal Services**
- **HOMES** can be used in a variety of ways, depending on needs and resources. It is recommended that a visual scan of the environment in combination with a conversation with the person(s) in the home be used to determine the effect of clutter/hoarding on **Health**, **Obstacles**, **Mental Health**, **Endangerment** and **Structure** in the setting.
- The Family Composition, Imminent Risk, Capacity, Notes and Post-Assessment sections are intended for additional information about the hoarded environment, the occupants and their capacity/strength to address the problem.

© Bratiotis, 2009 (adapted for City of Toronto with permission)

© Bratiotis, 2009. [The HOMES Assessment was developed in conjunction with the Massachusetts Statewide Steering Committee on Hoarding. Information about the assessment can be found in [Bratiotis, Sorrentino Schmalisch, & Steketee, 2011. The Hoarding Handbook: A Guide for Human Service Professionals. Oxford University Press: New York.](#)]

Toronto - HOMES[®] Multi-disciplinary Hoarding Risk Assessment

Hhealth

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cannot use bathtub/shower | <input type="checkbox"/> Cannot sleep in bed | <input type="checkbox"/> Presence of feces/urine (human or animal) | <input type="checkbox"/> Presence of pests/rodents |
| <input type="checkbox"/> Cannot access toilet | <input type="checkbox"/> Cannot use stove/fridge/sink | <input type="checkbox"/> Cannot locate medications or equipment | <input type="checkbox"/> Presence of mold or chronic dampness |
| <input type="checkbox"/> Garbage/trash overflow | <input type="checkbox"/> Presence of spoiled food | | |
| <input type="checkbox"/> Cannot prepare food | | | |

Notes: _____

Obstacles

- | | |
|---|---|
| <input type="checkbox"/> Cannot move freely/safely in home | <input type="checkbox"/> Unstable piles/avalanche risk |
| <input type="checkbox"/> Inability for EMT to enter/gain access | <input type="checkbox"/> Egresses, exits or vents blocked or unusable |

Notes: _____

Mental health

- | | | |
|---|---|--|
| <input type="checkbox"/> Does not seem to understand seriousness of problem | <input type="checkbox"/> Does not seem to accept likely consequences of problem | <input type="checkbox"/> Anxious or apprehensive |
| | <input type="checkbox"/> Defensive or angry | <input type="checkbox"/> Unaware, not alert, or confused |

Notes: _____

Endangerment

- | | |
|--|--|
| <input type="checkbox"/> Threat to health or safety of child/minor | <input type="checkbox"/> Threat to health or safety of person with disability |
| <input type="checkbox"/> Threat to health or safety of older adult | <input type="checkbox"/> Threat to health, welfare and/or safety of animal |
| <input type="checkbox"/> Extreme weather (heat or cold alert) | <input type="checkbox"/> Number of pets exceeds more than six cats or three dogs |

Notes: _____

Structure & Safety

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Unstable floorboards/stairs/porch/handrail guards | <input type="checkbox"/> Storage of hazardous materials/weapons | <input type="checkbox"/> Electrical wires/cords exposed | <input type="checkbox"/> No presence/operation of smoke alarm/carbon monoxide alarm |
| <input type="checkbox"/> Combustible items near ignition source | <input type="checkbox"/> Leaking roof | <input type="checkbox"/> No heat/electricity | |
| | <input type="checkbox"/> Caving walls | <input type="checkbox"/> No running water/plumbing problems | |

Notes: _____



Chris Brillinger, Executive Director
Social Development, Finance and Administration

100 Queen Street West
City Hall, 14th Flt East Tower
Toronto, ON M5H 2N2

Tel: 416 392-5207
Fax: 416 392-8403

Toronto - HOMES[®] Multi-disciplinary Hoarding Risk Assessment

Household Composition

of adults _____ # of children _____ # of pets _____
Ages of adults: _____ Ages of children: _____ Person who smokes in home Yes No
Assessment notes: _____

Risk Measurements

Imminent Harm to self, family, animals, public: _____
 Threat of Eviction: _____ Threat of Condemnation: _____

Capacity Measurements

Instructions: Place a check mark by the items that represent the strengths and capacity to address the hoarding problem

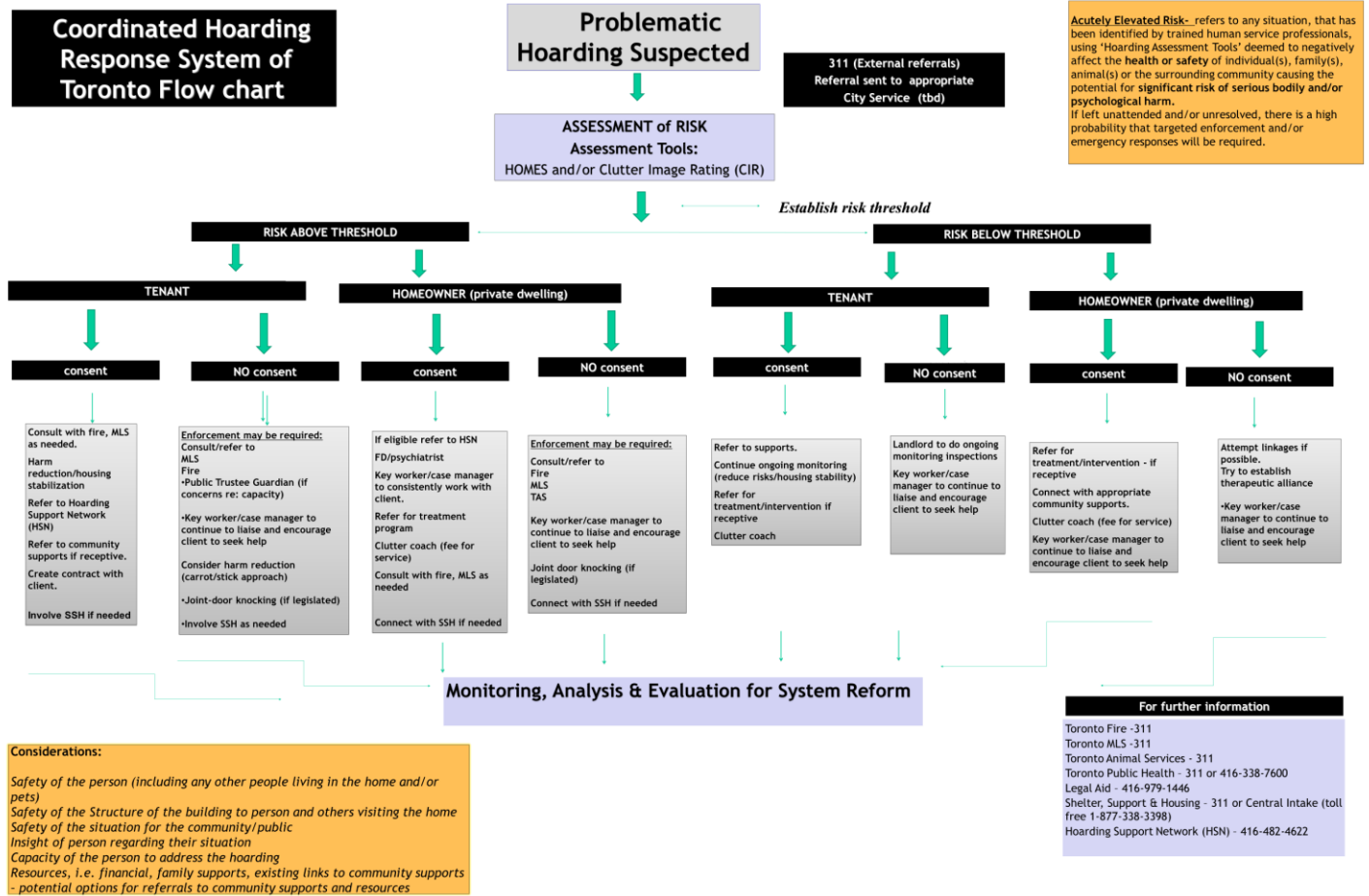
- Awareness of clutter
- Willingness to acknowledge clutter and risks to health, safety and ability to remain in home/impact on daily life
- Physical ability to clear clutter
- Psychological ability to tolerate intervention
- Willingness to accept intervention assistance

Capacity Notes: _____

Post-Assessment Plan/Referral

Date: _____ Client Name: _____ Assessor: _____

Appendix D | Flowchart to Guide Referral Processes



Appendix E | Intervention / Management Strategies (Individual Capacity Risk Model)

Individual Capacity & Risk	Characteristics (individual)	Strategy/Intervention Tenant	Strategy/Intervention Homeowner	Resources
1. High Capacity (client self-determination)	-Insightful -Motivated to change -Receptive to intervention/supports	-Individual/group CBT <u>indiv./group/internet</u> therapy -Clutter coaching (HSN) Peer support	-Individual/ group CBT <u>Indiv./group/internet</u> therapy -Peer support	-Trained clinical professionals -Group/ <u>indiv.</u> CBT (1X/ <u>wk</u> - 20 <u>wks</u>) -Peer groups -Access to internet groups -Clutter coach
2. Moderate Capacity & Moderate Risk interventions increase capacity and reduce risk	-Has some insight (pre-contemplative/contemplative Stages of Change) -Below risk threshold	-Prevention/safety planning -In-home support -Peer support -Motivational interviewing -consider <u>indiv./group/internet</u> CBT -group therapy -Clutter coaching	-Prevention/safety planning In-home support -Peer support -Motivational interviewing -consider <u>indiv./group/internet</u> CBT -group therapy GAP – no in-home supports for clutter coaching	-In-home support (6 <u>mos</u>) (trained support staff/clutter coaches) -Case management -Group/ <u>indiv.</u> CBT -Peer groups
3. Moderate Capacity & High Risk harm reduction	-Has some insight (pre-contemplative/contemplative Stages of Change) -Above risk threshold	-Harm reduction -Collaborative approach -Involve enforcement as needed -safety planning -Motivational interviewing -Consider CBT <u>indiv./group</u> therapy -Peer support	-Harm reduction -Collaborative approach -Involve enforcement as needed -Safety planning -Motivational interviewing -Consider CBT <u>indiv./group</u> therapy -Peer support GAP – no in-home supports for clutter coaching	-Intensive in-home support (6-12 <u>mos</u>) (trained support staff/clutter coaches) -Case management -Access to clinical support -Long term maintenance (HSW/PSW) -Enforcement if needed <u>Indiv./group</u> support/therapy
4. Low Functional Capacity & High Risk enforced harm reduction	-No insight into dangers of behaviour -Actively acquire/hoard -May have comorbid conditions -Not receptive to supports	-Enforced harm reduction -Collaborative approach -Connect with community/ health supports -Housing stabilization -safety planning	-Enforced harm reduction -Collaborative approach -Connect with community/health supports -Housing stabilization -safety planning GAP – no in-home supports for clutter coaching	-Intensive in-home support (12 + <u>mos</u>) -Case management -Access to clinical support -Long term maintenance (HSW/PSW) -Enforcement if needed -extreme clean (if needed)
5. Low Decisional Capacity & High Risk protective interventions e.g. guardianship/con servatorships	-No insight into dangers of behaviour (possible cognitive impairment, complex mental illness and/or inability to care for self -Actively acquire/hoard -Not receptive to supports	-Collaborative approach -Extreme clean -Housing stabilization -Safety planning (may include relocating to more supportive housing) -other community supports (capacity assessment)	Collaborative approach -housing stabilization GAP – no extreme clean service available City-wide (only NY)	-Extreme cleaning services if needed -long term case management -other supportive services -housing supports -case management Enforcement if needed

Focus of Harm Reduction

- **Safety**
 - Removing flammable items from heat sources
 - Reducing trip hazards
 - Increasing egress
- **Health**
 - Improving access to bathroom, kitchen
 - Proper food storage
 - Proper trash/waste disposal
 - Reducing vectors/insects
- **Comfort**
 - Improving heating & cooling
 - Proper place to eat, sleep
 - Place to pursue interests, work

(Tomkins & Hartl, 2009)

Principles of Harm Reduction

- Goal is for unit to be safe and functional
- Does not require hoarding behaviours/symptoms to be eliminated

Principles of Enforced Harm Reduction

- Includes the threat of enforcing codes and regulations (could involve extreme clean/loss of possessions)
- May require other stakeholders (supportive workers) to collaborate with 'enforcement' to reduce the harm of the hoarding.

(Mark Odom, 2012)

Motivational Interviewing

Five principles

1. Express empathy
2. Roll with resistance
3. Develop discrepancy
4. Support self-efficacy
5. Avoid argumentation

*(Harm Reduction Workshop (Mark Odom, 2012)
Hoarding Best Practices Guide)*

Appendix F | Financial Implications

Item	Description	Rationale	Amount Required
New Investments			
FTE Hoarding Support Co-ordinator(s) <i>(2 positions)</i>	<ul style="list-style-type: none"> -Assess situations (using risk assessment tools) -Link to other hoarding support team members and plan most appropriate care pathway -Organize service co-ordination meetings as required (data collection, etc.) -Build capacity of other agency staff 	<p>The Hoarding Support Network (HSN) currently has one funded position (<i>funding through Shelter, Support and Housing</i>) with a waitlist. Additional supports would also increase the potential of working with animal hoarding cases (which to date the HSN has not had the capacity)</p>	<p>80k (includes benefits) X 2 = \$160,000.00</p> <p><i>(salaries are approximate)</i></p>
Clutter Support Coaches 4 positions	<ul style="list-style-type: none"> -Person trained in issues related to hoarding behaviour and sorting of "stuff" (incorporating harm reduction strategies) 	<p>Clutter Support Coaches are a cost effective way to provide support to individuals who are ready to change behavior but require support and life skills training to do so. Coaches would work closely with service coordinator(s) and other partners to ensure they are adhering to outlined goals.</p>	<p>\$40,000.00 X 4 = \$160,000.00</p>
Home Support Worker (HSW or PSW) 4 positions	<ul style="list-style-type: none"> -Would work closely with the clutter coach and/or hoarding services coordinator -Homemaker role (house cleaning as required, on a case-by-case basis) -Check-in visits -Longer term involvement/maintenance of harm reduction targets 	<p>Currently there is a large gap in services for homemaking/cleaning support (HMNS-long waitlist) Promising practice suggests that in some cases, this service is required to ensure that clients are supported longer term to prevent recidivism</p>	<p>\$40,000.00</p> <p>4 X \$40,000.00 = \$160,000</p>

Item	Description	Rationale	Amount Required
<p>Clinical Consultation (OT, psychiatrist, etc. → partnership with Health Links or Family Health Teams)</p>	<ul style="list-style-type: none"> -Partnership with Community Health Providers (e.g. Health Links or Family Health Teams) for clinical consultative support -additional training related to hoarding issues would be provided through Sunnybrook Hospital's Fredrick W. Thompson Anxiety Disorders Centre -consultative support would include consultation with service providers, and in-home assessment of clients where warranted (e.g. psychogeriatric assessment) -Psychiatric assessment and other clinical consultation are often needed to support care planning and harm reduction goal development -case conferencing 	<ul style="list-style-type: none"> -Case management services identify a gap for access to clinical consultants to support the management of complex mental health issues in addition to problematic hoarding behavior -community in-home access to clinical consultation is also helpful when planning care for clients presenting with complex symptoms / co-morbidities -Due to the complexity of the cases, consultation is often needed. Consultants would include include OTs, psychiatrists, etc. 	<p>\$5 000 - \$10 000</p>
<p>OR</p> <p>Clinical Psychiatric Fellowship</p>	<ul style="list-style-type: none"> -Psychiatric assessment and other clinical consultation are often needed to support care planning and harm reduction goal development -case conferencing -Clinical Supervision by Dr. Peggy Richter with Sunnybrook Hospital's Fredrick W. Thompson 	<ul style="list-style-type: none"> -Case management services identify a gap for access to clinical consultants to support the management of complex mental health issues in addition to problematic hoarding behavior -community in-home access to clinical consultation is also 	<p>Clinical psychiatric fellowship:</p> <p>\$60, 000 salary per year</p>

Item	Description	Rationale	Amount Required
	Anxiety Disorders Centre -fellowship parameters would include in-home clinical consultation and consultation with service providers	helpful when planning care for clients presenting with complex symptoms / co-morbidities	
Administrative Coordinator/Intake Worker (.8FTE)	-Accept referrals, assess for initial service eligibility, schedule in home assessment -Schedule client work, schedule coaches, coordinate training, track data, track expenses, organize and coordinate meetings, minutes		\$40,000.00 plus benefits
Education and Training (including interdivisional and intersectoral training)	-What is hoarding? -Clutter coaching/sorting strategies -Harm reduction strategies -Motivational Interviewing/Therapeutic Communication -Assessment/Care Planning -How to lead (CBT) groups	There is a need to build capacity across all sectors re: hoarding strategies, consistent use of risk assessment tools, and collaborative partnerships.	\$10,000.00
Current Hoarding Resources			
Contracted - Group Support Worker	-Sunnybrook Psychiatric Services is currently in discussion with other TCH staff and other supportive mental health agencies that work with TCH tenants, regarding the provision of group facilitation training (based on "Buried in Treasures" model) -Train-the-trainer model <i>(previously completed as a pilot project)</i>	Support groups provide peer support and opportunities for social connection to those individuals who require ongoing maintenance and are willing to attend groups.	In-kind (funding to be determined) Hourly rate \$50/hour or \$40k
Case Management	-Community Mental Health	Community mental	In-kind (some

Item	Description	Rationale	Amount Required
	<p>Support Agencies and/or TPH to provide case management support.</p> <p><i>(TPH currently provides short-term case management around all issues related to vulnerable adults and seniors)</i></p>	<p>health agencies to take on case management role. Currently there is a waitlist – however with increased hoarding supports – there may be more capacity.</p>	<p>reallocation of services)</p>
<p>Extreme Cleaning</p>	<p>-Experienced, trained cleaners who work with clients and family members around the achievement of harm reduction targets (related to health and safety concerns) as part of a safety planning within the home</p>		<p>In-kind VHA/Fresh Start (funded through the City of Toronto)</p>
<p>VHA- Volunteers or Community Partners</p>	<p>-University or College level students or retired health professionals support less complex clients</p>		<p>In-kind</p>
<p>City of Toronto 4 - Dedicated MLS and TFS staff</p>	<p>-Dedicated trained MLS and TFS staff to work closely with hoarding support team</p>	<p>Tailored to meet the specifics of their roles and divisional and legislative safety targets, staff would receive training regarding:</p> <ul style="list-style-type: none"> -Harm reduction strategies and the setting of harm reduction targets (based in legislative requirements) -Motivational Interviewing/Therapeutic Communication -Clutter coaching/sorting strategies with a lens on legislative targets -Assessment/Care Planning for the purpose of achieving legislatively-based harm reduction targets 	<p>In-kind (reallocated)</p>

Item	Description	Rationale	Amount Required
Hoarding Support Network	<p>-The Toronto Hoarding Support Services Network is a group of agencies working collaboratively to effectively address problematic hoarding. The network provides coordinated services to bridge existing support gaps.</p> <p>-Its aim is to help clients manage their clutter and get the emotional support they need to live safely.</p>		<p>1 Hoarding Coordinator position</p> <p>Clutter Coaches</p> <p>Funded through Shelter Support, Housing and Administration (SSHA)</p>