



Professional Practice Note:

Hoarding and how to approach it

- guidance for Environmental Health Officers and others¹

That a person's environment can affect his mental health is well-known but the phenomenon of hoarding can provide examples of the reverse – of a sufferer's mental ill-health affecting their immediate environment. Hoarding, described as the collecting of excessive quantities of goods and objects, arguably including animals, coupled with an inability to discard them is surprisingly common in varying degrees. It becomes problematic for the subject when it is extensive enough to inhibit the use of the home or personal function. Even before that point, however, depending on its presentation, it may be brought to the attention of the authorities as causing, or being likely to cause, a hazard to health or a nuisance to others.

In such circumstances, the law may oblige them to take some action but that action can be uninformed about the phenomenon, inappropriate and, at least on its own, doomed ultimately to failure. This paper therefore sets out to provide an overview of hoarding and its aetiology, in particular considering Diogenes syndrome and hoarding as a symptom of obsessive-compulsive disorder; it notes the growing list of statutory powers available to address hoarding and by means of a case study and the results of a survey, reviews the incidence and diversity of cases coming to the attention of environmental health authorities in the hope that, eventually, that may lead to better ways to resolve them.

1 Introduction

1.1 Hoarding can be described as collecting and being unable to discard excessive quantities of goods or objects. As a behaviour, it is quite common and most people who hoard possessions do not suffer from any psychiatric disorder, however, in some cases the problem may progress to become so severe that it causes significant distress and impairment. Though usually covert, hoarding can also become a concern for others when health and safety are

threatened by the nature or amounts of 'clutter' accumulating within, and sometimes overflowing from, the sufferer's environment.

1.2 This paper aims firstly to provide some insight into the clinical problem of hoarding, briefly presenting studies on the prevalence and nature of the condition together with information on treatment and management of the behaviour. Secondly, it reviews the various statutory

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powers available to health agencies and especially local authorities to control the consequences. Finally, some practice guidelines are offered for Environmental Health Officers (EHOs) who come into contact with people with hoarding problems.

SUMMARY POINTS

Hoarding behaviour is relatively common though problematic hoarding is rarer. Every case is different.

It presents across the population in association with many psychiatric disorders, most frequently with elderly self-neglect and OCD, or none but apparently often following life trauma. There may be organic causes and non-medical models emphasise the role of personal choice.

Both clinical and statutory interventions are often resisted and success rates are low. Recurrence rates are high but multi-agency approaches involving long-term support are recommended.

Cases may raise difficult practical and professional problems and the law is not always helpful.

Some guidelines for good practice by EHOs are offered.

2 The problem of hoarding

Definition

2.1 Problematic hoarding is a complex behavioural phenomenon usually, if imprecisely, described by researchers in the field as consisting of three components:

- the acquisition of and failure to

discard possessions that appear to be of little use or value

- living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed, and
- significant distress or impairment in functioning caused by the hoarding (*Frost & Steketee, 1999*).

The scope of the problem

2.2 Hoarding behaviour is relatively common in the general population (*Frost & Hartl, 1996*) but though shortly to be listed in DSM-5, is not yet regarded in the UK as a disorder in its own right. It presents across a wide continuum of severity but only a small number of people will suffer from hoarding to an extent which meets the clinical criteria outlined above.

2.3 Hoarding as a clinical symptom can occur in many different psychiatric disorders - in dementia, schizophrenia and depression and with learning disability, eating and personality disorders and post-traumatic stress disorder - so it is impossible to collate overall figures on the incidence and prevalence of the problem but the two conditions in which hoarding is most likely to occur are elderly self-neglect (or 'Diogenes Syndrome') and obsessive-compulsive disorder (OCD). These two conditions are described in more detail below.

3 Diogenes Syndrome

3.1 The term 'Diogenes syndrome' was established by Clark and others to describe a condition of extreme self-neglect, domestic squalor, social withdrawal and apathy, with a tendency to hoard (*Clark et al., 1975*). The name is taken from that of the 4th century BC Greek philosopher who advocated a life of self-sufficiency, freedom from social norms and the rejection of personal comforts but it is questionable whether it is a suitable name as subjects are often far from self-

sufficient or happy in their surroundings and Diogenes did not neglect himself.

3.2 Referring predominantly, although not exclusively (*Grignon et al., 1999; Snowdon et al., 2006*), to the condition in the elderly population, it describes a set of characteristics which often presents problems for Older Adults Services and other agencies rather than a discrete mental disorder. Patients with Diogenes Syndrome compulsively hoard a variety of objects but may be particularly drawn to rubbish. The term *sylllogomania* (Gk. *sylloge*, collecting) is sometimes used to describe this form of hoarding.

3.3 The annual incidence of Diogenes syndrome is estimated at 0.5 per thousand people aged over 60 living at home. It occurs equally in both men and women, with an average age of around 77 years. Most sufferers live alone, suffer poor physical health and a high mortality rate. Other typical features include higher than average intelligence and personality characteristics of aloofness, suspiciousness and aggressiveness. Most patients, believing their behaviour to be within normal bounds or, at least, 'their business', will resist any sort of intervention.

3.4 Between 50% and 65% are likely to suffer a formal psychiatric disorder, most commonly dementia, but patients may also present with other organic brain disorder, alcohol dependence, psychosis, depression, OCD or personality disorders (*O'Shea & Falvey, 1997*). There is no single 'cause' of Diogenes syndrome and whereas in some cases there is an obvious causal link with a psychiatric condition, it is unclear why the significant proportion of sufferers who do not have a mental illness develop a syndrome which can be so incapacitating and problematic for them but some researchers believe Diogenes syndrome represents a reaction to stress in an elderly person with certain personality characteristics. Such stress may result from the loss of a partner or

other bereavement, but may also follow an episode of psychiatric illness, physical ill-health or other life event. Alternatively, the person may have had a disorganised lifestyle for many years which becomes exaggerated and problematic through ageing and physical infirmity.

Treatment issues with Diogenes syndrome

3.5 One of the key features of Diogenes syndrome is that, while it presents numerous serious problems for the subject and others, sufferers themselves will often reject any form of help offered. One study of 233 'service refusers' revealed that 47% met the criteria for Diogenes syndrome (*Scallan et al., 2000*). A wide variety of supports including meals-on-wheels, home-help and house cleaning had been declined. In another study, nearly half of the people referred for self-neglect to an older adults psychiatry service were hospitalised or placed in nursing homes (*Wrigley & Cooney, 1992*). This illustrates the frequent difficulty experienced by professionals in dealing with this problem: as early offers of help are rejected, more drastic action is likely to be required later on as a result of escalating physical, mental or environmental risk.

3.6 Unfortunately, the mortality rate for those in an acute condition (for example after a fall or collapse) is very high in the period immediately following their hospitalisation. Even if help is accepted initially, the problem usually recurs after the house has been cleaned and tidied or the person returns home.

3.7 For those subjects with Diogenes syndrome who also have a diagnosed psychiatric disorder, treatment may be offered by the relevant psychiatric services. For example, someone suffering a psychotic illness may respond to a course of anti-psychotic medication and a person with alcohol dependence may improve if they receive help with their substance misuse.

3.8 If the individual suffers OCD as part of their condition, medication and psychological interventions are potentially helpful, nevertheless, what is clear from the literature is that whenever Diogenes syndrome co-presents with other problems, the prognosis is very poor. One study attempted to treat hoarding in three people who displayed all the characteristics of Diogenes syndrome and fulfilled the criteria for OCD. Despite expert in-patient treatment, the subjects' hoarding did not improve (*Drummond et al., 1997*).

3.9 What is also clear is that even if treatment might be helpful, it is likely to be refused by most individuals concerned. In the face of that, early assessment, easy access to help, persistent encouragement and contact with the person concerned, and working alongside friends and families, are the only sensible options available to health agencies (*Wrigley & Cooney, 1992; Jackson, 1997*).

4 Obsessive-Compulsive Disorder

4.1 Obsessive-compulsive Disorder (OCD) is a form of anxiety disorder characterised by either obsessions (recurring thoughts or images that cause distress) or compulsions (repetitive behaviours or mental acts that the patient is driven to perform to reduce distress or avoid a feared situation) or, commonly, both. Typical obsessions include fears of being contaminated by germs and fears of causing harm to oneself or others. Compulsions can be acts or rituals such as repeatedly checking or washing and putting objects into order. Hoarding, seen as another ritual, has been considered to be a distinct sub-type of OCD and, in fact, some researchers have suggested that the hoarding behaviour in Diogenes syndrome may actually be explained by OCD which has just not been diagnosed as such (*Drummond et al., 1997; Rosenthal et al., 1999; cf Wu, 2005*).

4.2 Several studies have been carried out on hoarding from an OCD perspective (*Frost and Hartl, 1996; Frost and Steketee, 1999*). Many, avoiding confusion with Diogenes syndrome, have focussed on a distinct population of hoarders who are not usually elderly and do not suffer problems of self-neglect or squalor. Compulsive hoarding of the OCD type can, nevertheless, be an equally severe and disabling clinical problem and may at times result in risks to the health and safety of the sufferer, being associated with greater impairment and more co-morbidity than other forms of OCD, as well as those around them. While the research into compulsive hoarding has looked at a very specific type of patient, the knowledge gained into why and how hoarding develops is illuminating and relevant to understanding the problem, whether the hoarder has Diogenes syndrome, or pure OCD, or no obvious disorder at all.

Compulsive hoarding in OCD

4.3 OCD affects 1-3% of the population and hoarding occurs in 20% to 30% of patients with OCD. While some researchers believe there is a biological component to the disorder, there is more agreement that faulty beliefs and thoughts also play a part in the causation of this problem. This psychological model - the cognitive-behavioural theory of OCD - is based on the idea that distorted beliefs, assumptions and thoughts can give rise to feelings of anxiety and distress. If a person responds to these unpleasant feelings with unhelpful behaviours such as avoidance or rituals the problem is maintained and can gradually build up over time.

4.4 A great deal of research now supports this model in accounting for the difficulties that patients experience and people who compulsively hoard have been found to experience the following sorts of thinking errors:

- *Decision-making problems.* People who hoard tend to have difficulty making decisions, especially about the pros and cons of saving something. They may be particularly perfectionist and be concerned that the decision must be exactly right, which is impossible to achieve, and so the object is retained indefinitely. They may have trouble organising and categorising objects and concentrate too much on the possible, although unlikely, negative consequences of throwing something away. They resort to procrastination and avoidance to put off having to decide what to do.
- *Emotional attachment problems.* It used to be assumed that hoarded objects were of no use or value to the person hoarding them, however this is now considered to be erroneous. Most subjects will have strong sentimental attachments to their objects, even if they are objectively of little functional value, as for example with broken objects, out-of-date vouchers, old newspapers and so on. Many hoarders describe throwing away their objects as like losing part of themselves and they experience powerful feelings of loss, grief and emptiness. The objects can hold particular memories for the person, or it may be that having lots of familiar objects around them provides a general feeling of safety and comfort (Frost & Steketee, 1999; Kyrios *et al.*, 2002)
- *Erroneous beliefs about possessions.* People who hoard can show unhelpful distorted beliefs such as feeling responsible for not wasting things and for using objects properly. They can also believe that it is vital to remember everything and not waste any opportunity to hold on to information that might be contained within, for example, a pile of newspapers or books. They can find it intolerable to think they might find a

use tomorrow for something that they have thrown away today.

4.5 People who have a compulsive hoarding problem tend to be older than other OCD patients but most state that their hoarding began with discarding problems in childhood or teens, worsening with the addition of acquisition problems later though, as with other OCD presentations, they may fluctuate with time (Grisham *et al.*, 2005). It affects both men and women. There is no evidence that deprivation in childhood (such as wartime experiences or rationing) is a predisposing factor for hoarding although this may feature in some people's accounts of their problem. Hoarding behaviour does, however, run in families though whether that indicates a genetic influence or simply that it is learned through copying another family member (Winsberg *et al.*, 1999) is unclear.

Treatment of compulsive hoarding

4.6 The most widely accepted psychological treatment for OCD is cognitive-behaviour therapy (CBT). This involves a structured programme of re-education so the sufferer learns how to confront what they fear, deal with any obsessional thoughts and beliefs that are unhelpful, and gradually practices coping with anxiety-provoking situations. At the same time, the sufferer must resist any urge to perform the compulsive behaviours that went along with the fears so, for OCD-related hoarding, a patient must learn to adapt their distorted beliefs and ideas about their possessions, gradually organise and discard objects in a step-by-step programme, and learn ways of coping with the feelings of anxiety, loss and grief as they may arise.

4.7 Medication can also provide relief for sufferers of OCD, particularly the more modern forms of anti-depressants, however, these do not suit everyone and

symptoms can often recur once the medication is stopped. A combination of tailored CBT and medication may be offered for treatment of OCD where the initial response to either alone is poor (NICE, 2005; Saxena et al., 2002).

4.8 All the research to date has indicated that compulsive hoarding is the most difficult form of OCD to treat effectively. Although some small improvement in symptoms may be obtained, even with intensive CBT and medication, gains are usually minimal (Frost & Steketee, 1999; Saxena et al., 2002; Seedat & Stein, 2002). People who compulsively hoard may acknowledge that they have a problem and that their behaviour is abnormal and unlike those with Diogenes syndrome may seek help at some point but in spite of this, still find it extremely difficult to modify their hoarding beliefs and behaviours sufficiently to overcome the problem.

5 Animals

5.1 The hoarding of animate 'objects' is an under-characterised variant of pathological hoarding. More difficult to deal with than non-animal hoarding, it typically involves cats or dogs (though cases of farm animals and birds have been reported) and the numbers of animals kept can be considerable. In the majority of cases, animals are found dead or in poor condition.

5.2 Exhibited predominantly by female subjects, in most cases also satisfying the criteria for adult self-neglect and possibly pointing to a range of medical, social and economic problems, many of their households contain dependents while their homes are often extremely cluttered and fouled. (Patronek G., 1999; Arluke A., 2002)

6 Alternative explanations

Non-medical models

6.1 If most problematic hoarders are, under the foregoing models, not in the best mental health, some authors consider that a Diogenes lifestyle (though not, of course, an obsessive-compulsive one) may be a positive choice by the person concerned rather than a clinical deterioration, perhaps by someone who already had a tendency to self-sufficiency or isolation from their community (Jackson, 1997) and there is a school of thought which prefers to regard many of them as simply 'different' – as choosing to conform to different norms – but certainly not in need of any treatment.

6.2 This model may be reinforced in cases where the subject neglects some aspects of their existence while still displaying more conforming behaviour in others such that, for example, hoarding behaviour is not inevitably combined with poor personal hygiene. Whether their behaviour is longstanding, perhaps learnt, or as in some cases of Diogenes syndrome a reaction to a more recent life event (especially one resulting in later-life social isolation) and though many may be in physically poor condition, this 'socio-psychological' school holds that categorisation of these people by reference to more widely accepted norms should be avoided.

6.3 Though, in common with the more traditional approaches, this school holds that 'care by consent' should be the guiding principle in clinical management, it challenges the predominating medical construction of self-neglect (typified by Clark) and even that such a syndrome exists, suggesting it is largely a product of the professional groups defining it, reinforced by pre-conceptual language in its description and gaining strength from the mere repetition of that (Lauder, 1999). Thus, it is argued, since hygiene and cleanliness are so important to medical

concepts of disease, a lack of hygiene is seen as at least a precursor of disease which itself requires treatment, in some cases forcibly, though empirical evidence for that may be lacking and concentrating on this symptom may overshadow the subject's true problem.

6.4 In this explanation, subjects' life preferences are disregarded as subjective, misguided, or as evidence of underlying personality disorder in favour of the professionals' assumed objectivity which, in the process of seeking common features in the subjects' situations, actually creates a false commonality at the expense of the peculiar features of each case. A more existential approach is recommended to determine when personal choice becomes self-neglect and to identify those cases which irrespective of outward appearance actually cause the greatest distress or genuine risk.

Organic causes

6.5 There may, it has been suggested, also be entirely organic causes for hoarding behaviour. Brain scans of a small number of sufferers have shown different patterns of cerebral glucose metabolism when compared to a group of non-sufferers (*Saxena et al, 2004*) and other recent work has suggested that damage to particular parts of the brain may allow tendencies we all have to acquire and keep belongings to operate unchecked (*Anderson et al., 2005*).

7 Statutory powers

7.1 Problematic hoarders, whether people with Diogenes syndrome or OCD or simply with different norms, present very difficult dilemmas for their families and communities. There are understandable concerns for their mental and physical well-being and often also for their safety if the self-neglect and hoarding appear to compromise hygiene or increase fire risk and though those may not be borne out in

fact, there are significant numbers of complaints made to local authorities regarding individuals who live in domestic squalor or who hoard rubbish. If the person refuses to accede to offers of help there is a growing body of legislation which can be utilised in different circumstances by health agencies and local authorities, nevertheless, in practice, much use of compulsory powers raises tricky ethical issues, in particular where hoarders retain mental capacity and no-one else is being materially harmed.

7.2 They are also difficult to apply and most would agree should be used only where there are compelling reasons to do so and then only to the minimum degree necessary, respecting the subject's autonomy as far as possible. In this respect, however, there is some evidence that different professions may strike the balance in different places, possibly leading to disappointment and even conflict when their respective views on case management diverge.

Mental health powers

7.3 Within the province of health and social services, nevertheless, a person suffering from a mental disorder may be detained under the *Mental Health Act 1983(aa)* if it is necessary for his own health or safety or for the protection of other people and treatment cannot be provided otherwise. An assessment under section 2 may be appropriate if an underlying mental disorder is suspected and section 135 of the Act allows an Approved Mental Health Professional to obtain a warrant to enter and remove a person from their home for this purpose. Of course, the Mental Health Act would not apply at all to the 35% to 50% of people with Diogenes syndrome who have no discernable psychiatric disorder.

7.4 A further power of removal exists under section 47 of the *National Assistance Act 1948* where if, by reason of chronic disease, age, infirmity or physical

incapacity the subject is living in insanitary conditions and is unable to devote proper care and attention to themselves that is deemed to be in their interest. Action under both powers is, however, open to challenge as inconsistent with Articles 5 (Liberty) and 8 (Privacy) of the 1950 European Convention on Human Rights, now directly enforceable under the *Human Rights Act 1998* and repeal of the latter was recommended in a review of adult social care undertaken by the Law Commission in 2010. Whereas their use alone will also do nothing to resolve the manifestation of the problem, some observers advise that they should, therefore, probably be avoided (*Murray & Jacoby, 2002*).

Environmental health powers

7.5 Turning to the treatment of hoarding rather than of the hoarder - and more towards environmental neglect than self-neglect - when hoarding grows to a problem level, possibly spilling over beyond the hoarder's own home, the local environmental health service may be among the first to know. Whether the result is simply a bad smell coming from a flat, an unsightly mess in a garden, or something worse, it will usually be to the local council that neighbours or simply passers-by will turn first. That may in the first instance be to the Housing Department or ALMO if the house is an estate property but even then, the Environmental Health Department is likely to be informed, either to confirm any real risk to physical health (or otherwise) or because of their access to pest control or rubbish removal services.

7.6 Environmental Health services are part of the regulatory arm of local authorities, indeed the principal part of that arm, but while there are more ways than one of fulfilling that role they do have access to a range of enforcement powers which may come into play in hoarding cases. These are divisible, broadly, into two groups: those concerned with some

definition of health, and those concerned more with local amenity.

The health powers

7.7 The oldest available in England and Wales among the first group is the duty under section 83 (aa) of the *Public Health Act 1936* to require the cleansing (by disinfecting and decorating) of any premises which are either in such a 'filthy or unwholesome condition as to be prejudicial to health or are verminous'. By no means all hoarders' homes fit this bill but, in a carry-over from Victorian legislation, 'filth' is a euphemism for excrement, animal or human, and subjects who hoard their own excreta present a singular challenge, including in respect of the duties of care owed to those dealing with it. The meaning of 'unwholesome' is now obscure but 'verminous' includes infestation by insects. While the use of gas to destroy vermin is explicitly mentioned, that technique is now obsolete.

7.8 Unusually there is no appeal as such against a statutory notice given under this section. Though the authority may be required to justify its actions in the course of any summary proceedings brought subsequently for a failure to comply, householders have no other obvious avenue for challenge and EHPs should tread carefully for those reasons if no other. The expenses of carrying out their requirements in default of owners are recoverable by instalments if necessary, secured by a charge on the property or ultimately under a power of sale, and from occupiers as a simple contract debt.

7.9 There is a complementary duty in section 84 to cleanse or, if necessary, destroy filthy or verminous articles (clothing, furnishings etc) found in any premises at the local authority's expense and a power to cleanse verminous persons requesting that or to do so compulsorily pursuant to a Magistrate's Order (section 85). Few, if any, cleansing stations for

this purpose remain and the task usually now falls to a reluctant NHS.

7.10 The mere age of these powers has attracted scrutiny of them recently, with the suggestion that they have been overtaken by amendments made in 2008 to the *Public Health (Control of Disease) Act 1984* introducing co-called 'Part 2A Orders'. Providing powers to require the disinfection (probably including disinfestation) of persons, things and premises, that was not, however (and despite the shortcomings of the 1936 Act powers) their aim and the need to show risk of spread of infection or contamination is likely to be hard to satisfy.

7.11 More modern, and more widely used (at least in other contexts) is another reincarnation of a Victorian concept, that of statutory nuisance. Part 3 of the *Environmental Protection Act 1990* provides powers for local authorities to require the abatement of a range of problems including 'any premises in such a state as to be prejudicial to health or a nuisance' and 'any accumulation or deposit' which meets the same test. 'Premises' includes open land such as a garden.

7.12 Decisions of the courts in recent years have confirmed a quite restrictive construction for the term 'prejudicial to health' here (and which applies equally to the duty described in 7.7 above) which means likely to cause a threat of disease, nevertheless that is probably wide enough to deal with conditions giving rise to infestations or a serious lack of hygiene, for example. 'Nuisance' has its common law meaning of something which materially interferes with the use of another's land (or some right over it) (a private nuisance) or (less likely to apply) which affects the comfort or convenience of the population at large (a public nuisance), and in either event, reflecting the origins of these provisions, is of a public health flavour. Local authorities' power to undertake works in default of

compliance carry with it a power to recover their reasonable costs from the person responsible and, where that person is the owner of any premises, from his successors in title.

7.13 Where the circumstances are right, it is important to note that the use of these powers is mandatory, that is they are statutory duties rather than merely powers though their application involves some discretion in any event. The prevention of injury to the health of, or a serious nuisance to, others are further (and perhaps more justifiable) grounds for seeking the compulsory removal of a person with capacity or, though of unsound mind, not sufficiently so to require hospitalisation for that, from their home under the *National Assistance Act 1948*, mentioned above (7.4) (though, unhelpfully in this context, the local authority is then placed under a duty to safeguard their property).

7.14 Since many subjects will guard their privacy closely, use may have to be made of the powers of entry, if need be under Warrant, contained in section 287 of the 1936 Act or sch. 3 of the 1990 Act. These provide powers to enter premises (in the case of domestic premises after giving notice, except in an emergency) to ascertain whether or not circumstances exist requiring any action by the council, or a statutory nuisance exists respectively, and for the purpose of taking any appropriate action consequently. Powers of entry in general are currently under review by the government and may be restricted in future.

7.15 Thirdly, and with a similar aim to the Public Health Act power above, the *1949 Prevention of Damage by Pests Act* allows local authorities to require steps (such as the removal of materials providing food or harbourage) to be taken by occupiers to keep land clear of rats and mice. Whereas the Public Health Act power tends to be used for internal clearance, the Pests Act power tends to be used for clearing

gardens; arguably, the presence of relevant pests must be shown first.

7.16 The Housing Health and Safety Rating System introduced under the *Housing Act 2004* is concerned with the assessment of deficiencies in the design, construction and maintenance of dwellings but expressly excludes consideration of deficiencies solely attributable to the behaviour of occupiers. Accordingly it provides no mechanism for addressing hoarding or the hazards which often arise as a direct consequence of it. The homes of many, though by no means all, hoarders may nevertheless be in disrepair, sometimes extreme disrepair (and poor electrical wiring may exacerbate fire risk) prompting action by the local housing authority, usually in the forms of Improvement or perhaps Prohibition Notices and where there is an imminent risk of serious harm, their emergency variants. *In extremis*, a house presenting so-called 'Category 1' hazards may be liable to be demolished.

The amenity powers

7.17 Threats to public health and loss of amenity may, but need not necessarily, co-incide, and alone, the latter is, broadly speaking, likely to be regarded as a less serious problem. There may, however, arise situations where the loss of amenity affects neighbours seriously, or where a problem persists for a long period, or gets worse over time. In this respect, the *Refuse Disposal (Amenity) Act 1978* allows a local authority, after giving notice, to remove anything abandoned on land in the open air and to recover their costs but the occupier would first have to disclaim ownership. Alternatively, section 215 of the *Town and Country Planning Act 1990* provides a power to require the owner or occupier of land which is adversely affecting the amenity of an area to return it to an appropriate condition. On similar lines, where land which is open to the air is defaced by litter or refuse so as to be detrimental to the amenity of the locality,

the local authority may serve a Litter Clearing Notice under section 92A of the *Environmental Protection Act 1990* on the occupier.

7.18 These powers deal with situations where the material is visible to neighbours or to other persons living in the community and which is harmful to the amenity or quality of the environment. Though 'amenity' may be as difficult to define as 'nuisance' and the point at which untidiness affects amenity may be unclear, the primary purpose of local authorities in using their powers to deal with amenity problems is to protect the interests of neighbours and the wider community rather than the hoarder, the person seen as the cause of the problem. Many would, nevertheless, use such legislation only reluctantly in the case of a person suffering from a mental illness or disorder.

Enforcement

7.19 All of these powers, both of the health and amenity varieties, follow a traditional enforcement model: in each case, the process begins, the local authority having become aware of the situation by way of complaint or other information or observation, with the service of a statutory notice – a formal, legal instruction – to clean the premises or remove (or at least reduce) the accumulation within a stated time. Subject to rights of appeal against the notices themselves, in each case, to fail to comply is a summary offence. Uniquely, the powers under the Environmental Protection Act bring with them the option of an indefinite prohibition on allowing any recurrence, breaking which gives rise to a further offence of its own. No further complaint need be made first.

7.20 Under the Environmental Protection Act alone, there is a defence to conviction of 'reasonable excuse', however, an excuse of illness or incapacity is unlikely to be accepted as reasonable. Notwithstanding, though therefore likely to

result in conviction, pursuing these cases through the courts is generally inappropriate; from a legal standpoint, they will rarely satisfy the Attorney General's tests (to paraphrase them) of being in the public interest and of being likely to result in an outcome which justifies the input. Prosecutions which do not satisfy these guidelines are at least frowned upon. More practically, the main benefit, indeed the main object of following an enforcement route will be to enable the authority to carry out the steps required in a statutory notice itself, at least in theory, whether or not it subsequently tries to recover its costs. Punishment is not the object.

Effectiveness

7.21 Though there may be both public and political pressure on Environmental Health Officers to use their powers to bring about a swift solution, their effectiveness too will often be in doubt and there may well be a particular disincentive to using them to the full. This is because they will be dealing with people who do not comprehend the inappropriateness of their behaviour, by definition irrational, and who are consequently unlikely to respond to the rationality of the enforcement process, that is to say of an instruction backed by a threat of escalating sanctions. The particular disincentive is that if the person is, as many in this extreme state will be, financially disadvantaged, the authority may have difficulty recovering its costs (though, equally, it should be prepared to write them off).

7.22 While some sufferers will disengage entirely, others may obstruct the process and, often involving some confrontation, it is not without its 'hassle' factor as well. For all these reasons, these formal enforcement tools are probably best seen as palliatives, useful for resolving a crisis and perhaps essential for protecting the interests of close neighbours but nonetheless blunt weapons to be used

sparingly and only when necessary. If longer-term solutions are to be found at all, they will probably be in a multi-agency approach in which EHOs actually play only a minimal, containment, role.

8 The 'Respect Agenda'

8.1 Notwithstanding, there has been a trend over a last few years towards viewing loss of amenity as posing a more serious type of harm where it is associated with behaviours that are socially disapproved-of. The more public effects of hoarders can bring them and EHOs within this paradigm.

8.2 The last government's pursuit of the 'Respect Agenda' led to the enactment of the *Anti-social Behaviour Act 2003* and to related legislation, notably the *Clean Neighbourhoods and Environment Act 2005*. The effect of such legislation has been potentially to illegitimise a wide range of behaviours which cause offence or just simply annoyance to others, reluctant to consider whether the individuals causing the problem may be in need of help or of welfare assistance rather than a good dose of self-discipline. The application of phrases such as 'cracking down' on anti-social behaviours and 'galvanising' action by the community, is, however clearly inappropriate in the context of hoarders and others with mental illness whom it has the potential to make the subjects of criminal penalties when prosecutions are resorted-to.

8.3 Section 85 of the Anti-social Behaviour Act extended the range of authorities able to seek anti-social behaviour orders (ASBOs). Relevant authorities now include social housing providers as well as local authorities and applications have been made to the courts to grant ASBOs in order to control a wide variety of situations, including dealing with hoarders' behaviour. While, the application of ASBOs and their

elaborations has proved wider than was probably envisaged by the government when the legislation was drafted many might nonetheless think them misused in relation to hoarders. Some enforcement authorities, however, do see the ASBO as a simpler route to control, preferable to other measures requiring an order of the court.

8.4 The rationalisation of ASB tools promised in a White Paper ('Putting Victims First') by the current government, incorporating more environmentally- than person-oriented criteria for proposed 'Community Protection Notices', may encourage use of that route (particularly where the subjects are young) but at the risk of the same, generally inappropriate consequences.

9 Local authorities as landlords

9.1 Though the powers described above will in general still apply, local authorities may also have a private interest, in addition to a public interest, in resolving cases of problematic hoarding, that is where the local authority is itself the landlord. Landlords generally reserve a power to enforce 'no-nuisance' terms in tenancy agreements; private sector landlords are often reluctant to do so as long as the rent is paid but many public sector landlords – councils (including ALMOs) and registered social landlords (RSLs) – have more sophisticated covenants covering anti-social behaviour in its various forms. Included will be the acts or behaviour of other members of the tenant's household, even those who may be beyond their control.

9.2 Ultimately, their sanction is to seek possession of the dwelling and according to statistics collated by the Department of Communities and Local Government, social landlords took possession proceedings leading to eviction in some 2,000 cases of anti-social behavior during 2010-11. Under the *Housing Act 1988*, the court may make

a possession order against a secure tenant in breach of a covenant or where he or she is responsible for a nuisance. To that end, section 9A requires the court to take into account not only the past but the continuing and future effects of the nuisance on others. The provision of social housing being a public function, providers' actions have always been challengeable on grounds of reasonableness, but since the decision of the Supreme Court in *Hounslow LBC v Powell* [2011] UKSC 8, the grant of a possession order will (at least if raised by the tenant) now require in addition a wider review by the Court of its proportionality. That will be so even where apparently mandatory, nevertheless such a defence must be 'seriously arguable' and reviews will be allowed only in 'highly exceptional circumstances' - *Riverside Group v Thomas* [2012] EWHC 169 (QB).

9.3 Taking into consideration the consequences of continuing the tenancy as well as ending it, this approach encompasses the possibility that social landlords may be under a duty to third parties to take appropriate measures against a 'nuisance tenant' as an older decision from Northern Ireland illustrates. In the case of *Donnelly* [2003] NICA 55, the Northern Ireland Court of Appeal held in 2003 that a refusal by the Housing Executive to evict a tenant guilty of repeated and serious anti-social behaviour breached his neighbour's right to respect for private and family life and home laid down by the 1950 European Convention on Human Rights. At least, it now appears public landlords are expected to undertake an appropriate balancing exercise, weighing the rights of neighbours against those of the person responsible for the nuisance. The local Ombudsman is also likely to expect no less.

9.4 Other potentially conflicting considerations may nevertheless, apply: in an English decision in 2003 (*N Devon Homes v Brazier* (2003) EWHC 574), the

High Court found that a RSL's attempt to seek possession against a nuisance tenant whose behaviour arose from her mental illness amounted to discrimination contrary to the *Disability Discrimination Act 1995*. That Act held that it was unlawful to discriminate against a disabled occupier by, *inter alia*, evicting him and that discrimination occurred if, for a reason which relates to a person's disability, he was treated less favourably than others to whom that reason did not apply and that treatment could not be justified by, for example, a need to protect the health or safety of the occupier or some other person. That decision suggested that eviction was no longer an option where only amenity was damaged.

9.5 Though that decision was overturned by another of the House of Lords (*LB Lewisham v Malcolm* (2008) UKHL 43) in June 2008, the effect of that seemingly limiting the reach of the 1995 Act to direct discrimination, the 1995 Act has since been repealed by the *Equality Act 2010*, s.15(1)(a) of which now provides that a person discriminates against a disabled person if he treats him unfavourably because of something arising in consequence of his disability. Though that treatment may, nevertheless, be justified where it is a 'proportionate means of achieving a legitimate aim', mirroring the overriding Human Rights obligation, if that does not take things quite back to *N Devon Homes*, most workers in the field would welcome it.

A case study

There is probably no such thing as a typical case of hoarding, such are the number of possible variables, but if it is not a contradiction, the following case from Northern Ireland, is probably not untypical. In any event, it illustrates the intractable nature of many of these cases or, at least, how statutory approaches often fail to resolve them.

The saga began when the Environmental Health Department of a district council on the fringe of Belfast received a complaint of a foul smell coming from the rear of a privately-owned semi-detached house in its area. On next day inspection, the cause was found to be a quantity of rotting vegetables in bags and trays. In addition, the rear garden hid an accumulation of more inert objects including several derelict cars and a number of plastic containers, some of which apparently had been used to carry fish.

Deciding that a statutory nuisance existed, the council, as it was obliged to, served an abatement notice under the *Public Health (Ireland) Act 1878* on the occupier. The law being slightly different in N Ireland to England and Wales, when the notice was not complied with it had no choice but to apply for a summons to enforce it and seven months after the council's first inspection, the Magistrates made a nuisance order requiring the occupier, Mr B, to remove the accumulation within 10 days. When he failed to do that, he was again reported for summons and, five months later, a fine was imposed. Mr B then made some attempt to tidy up.

Two-and-a-half years later, the council received a further similar complaint. As before, following an inspection, another notice was served. As with the first, Mr B did not respond and he was summonsed back to court where the case was adjourned. It did, however, catch the

attention of the press and following the publication of an article in a Sunday newspaper, a well-known drain-clearing company offered to clear the rubbish.

Within weeks, nevertheless, a complaint was received from Mr B's neighbour of mice. Suspecting a connection with Mr B, EHOs sought entry to his house for the first time but were refused. After threatening to force entry, Mr B eventually let them in to discover an infestation, encouraged by accumulations of rotting food, piles of old clothing and other objects. Another statutory notice resulted.

Predictably by now, Mr B did not respond and a further court appearance followed when Mr B was given a conditional discharge and ordered to pay £350 in costs. The council then enforced its notice to clear the house, filling 11 skips at a cost to Mr B of a further £3,775.

Subsequently, the problem recurred to the extent that at a further court hearing four years later, the Magistrates declared that Mr B's home was unfit for habitation and he was ordered no longer to live there. Though offered emergency accommodation by the NI Housing Executive, the council believes Mr B never took that up and does not know where he lives now. Under continuing pressure from neighbours, at the last contact the council was preparing to clear the house and garden once again and to place a charge against the title for their expenses.

Despite the involvement of seven EHOs, social services, the probation service, 19 court appearances and some £14,000 of work, this problem recurred over a nine year period without satisfactory resolution.

10 Survey

10.1 To get a better idea of the number and variety of hoarding cases coming to their attention, the CIEH undertook a

postal survey of every local authority environmental health department in England, Wales and N Ireland. The questionnaire asked a total of 34 questions aimed at characterising the subjects, the nature of the hoarding problems, the responses of the authorities and others and the effectiveness of those. Seventy-seven (of 402) representing all kinds of districts responded before the deadline, reporting a total of 209 cases (mode=4) in hand at some time during the specified timeframe of the preceding calendar year.

The subjects

10.2 Male and female subjects were represented almost equally with a slight majority estimated to be over 60 years of age. A mere 8% were judged to be below 40 though hoarding does, of course, occur in younger people but may be masked or differently labelled. Ten percent lived with dependants other than a partner but overwhelmingly, the subjects lived alone, some 60% in their own homes (slightly less than the 69% in the population as a whole) and 28% in homes owned by social landlords (slightly more than the 21% in the population as a whole). Only 18 cases lived in the private rented sector. Probably partly reflecting their age structure, 86% were not working.

10.3 Asked whether the subjects suffered from any condition which might have contributed to their hoarding behaviour, respondents highlighted 27% with clear problems of substance abuse and physical illnesses, mainly age-related and affecting mobility, in 16% of cases. Asked about knowledge of any events which seemed to have triggered the hoarding behaviour, respondents cited some sort of family separation in 21% of cases, the majority bereavements. Only 37% overall, 77 cases, were known to be receiving any treatment, assistance or supervision however, predominantly from community social or health services.

The nature of their problems

10.4 Turning to the nature of the hoarding, many seemed to collect a wide variety of materials which were nevertheless distinct; where more than three kinds were described, we classified them as collecting 'anything and everything' and 50% of subjects fell into this group. The others, though, were more discerning; most frequently collected was ordinary household refuse, much of it food-related (11% of cases), supported by the finding that in 72% of cases, the items collected originated from normal household activity rather than being brought in from outside. Whether these subjects might be regarded as 'reluctant/negligent discarders' rather than 'active' (or even true) hoarders and benefit from a different approach might be a topic for future enquiry.

10.5 This general rubbish was followed in third place by newspapers and magazines which, though they predominated in only 8% of cases, were listed in 27% in total. Clothing similarly predominated in only 4% of cases yet contributed to 14%. Excessive numbers of animals, in one case 70 cats in a two-bedroom house, likewise were the main problem in 4% of cases but featured in 10% where they were accompanied by inanimate collections.

10.6 Among the more curious cases were several of mail-order goods, bought but never even unwrapped, another of toys bought for grandchildren but never sent, one of buckets of human faeces and another of bottles, cartons and old beer cans filled with urine. But for the food containers, food debris and papers, the owner of over 200 antique clocks and spare parts might have been looked on very differently.

10.7 While undifferentiated materials were the most common collection by both sexes, there did appear to be some differences in the patterns of collection in male and female subjects, mechanical and

electrical goods appearing in 9% of male cases but in only 2% of female cases while animals and clothes were, at c.6% each, more common among females subjects (c.3% and 2% respectively among males). Whether particular attractions are related to former employment might be another subject for future work.

10.8 Perhaps reflecting differences in the materials collected, male subjects were more likely to let their collections spill outside the dwelling. Thirty-three percent of cases involved external accumulations, though only 5% were exclusively of this form. Arguably, these latter case would not fit the clinical definition of hoarding.

The effects

10.9 While in 67% of all cases, the accumulations were confined to the dwelling, 55% of all cases were nevertheless judged to affect persons outside the subjects' homes. It is this in particular which is likely to bring cases to the attention of local authorities. Eighty-six percent were judged significantly to affect the habitability of the home, 70% were judged to present a significant fire hazard and 59% presented some other serious risk of personal harm. Sixty-five percent contributed to infestations, typically of rodents but of insects too, in or around the dwelling.

The response

10.10 Not surprisingly, social services were involved in almost half of all cases. A handful of cases were noted, nevertheless, in which social services had apparently declined to become involved though the reasons were not known. Community health services – GPs in particular – were involved in just under one-third but there was no known health service in-put in 65% of cases. Landlord involvement was particularly high at 71% of cases renting their homes, reflecting no doubt the preponderance of social landlords. Family or friends of the subject

were involved in almost one case in five (though we do not know how many subjects had surviving family or friends) and the Police in 11%. In 10% of cases, however, nobody other than the Environmental Health Officer was involved.

10.11 Perhaps because of their statutory duties or, because when they did get involved there was acknowledged to be a wider public interest, strikingly, in two-thirds of all cases it was the EHO who took the leading role. One corollary was that some sort of formal enforcement action was taken by them in 56% of all cases. There was little overlap in the use of formal powers and the most commonly used was that under the 1936 Act to require the cleansing of filthy or verminous premises which was applied in 27% of cases. In 15% of cases, a statutory nuisance was deemed to exist and an abatement notice was served. Action to remove rats or mice was taken in a further 11% of cases, actually surprisingly few in the light of the number of infestations found.

10.12 Not all of the cases were concluded within the year but among those which were, few seemed to have brought a positive response from the subjects and in 23% of all cases, works were required by the councils to enforce their notices. Typically, these included rubbish removal, in one case over four tons of it, and pest treatments though these services were provided informally, and presumably free, in 12%. Prosecutions were brought in only two cases.

10.13 Complementing these steps, some form of social support was also offered in 20% of cases and rehousing, including into residential care, in another 12%. Possession proceedings were commenced in nine cases. Animals were removed in nine cases. Further informal assistance came from friends and family in 21% of cases and from various voluntary and animal welfare bodies (especially the RSPCA) in another 11%. Several

responses noted the continuing nature of this kind of help.

The outcome

10.14 Underlining the subjects' resistance to intervention, responding councils reported having to take formal steps, including obtaining warrants, to gain entry in 13 cases. That done, however, most subjects became compliant, only 28% remaining resistant. Though many cases remained on-going, overall, through a combination of means, the problem was claimed to have been resolved in 52% of cases handled during the year. In 9%, however, it had recurred already.

10.15 Perhaps not surprisingly, those short-term interventions judged most effective were the statutory ones – the statutory notices, often followed by works in default, providing some degree of 'clean start'. Among the formal actions of agencies other than Environmental Health Departments, those judged most effective were rehousing and the removal of animals – again of a 'clean start' nature – though these and in particular formal interventions by both mental health and social services were ranked very lowly.

10.16 The EHOs' assessments of longer-term interventions produced a markedly different picture, however; while 7% thought, pessimistically, there was no long-term solution to their cases, 42% thought it lay with mental health and social services while only 9% thought they still held the only key. Twelve percent emphasised the role of informal support and only 8% thought a combination of inputs would be most effective.

10.17 Asked which interventions they thought were least effective long-term, only 9% cited their own powers with twice as many mentioning informal steps and 10% formal steps by other agencies. Most believe, then, that enforcement has some role in most cases though that is not an on-going one and it rarely provides the

whole answer. Overall, however, what seems most important is the co-operation of the subject, 37% of respondents citing a lack of acceptance as the greatest obstacle to resolution, followed by 20% who listed poor inter-agency communication and co-ordination.

10.18 If that suggests that 'where there is a will there is a way', answers to the final question, unfortunately, gave little cause for long-term optimism; 44% of the subjects reported had come to the attention of the EHOs in similar circumstances before and in 60% of cases, they expected to be called in again, suggesting, if their prediction turned out to be correct, a substantial likelihood of at least short-term recurrence.

Discussion

10.19 Overall, the results of our survey supported the established literature. The numbers reported by a small sample of local authorities in just one year tend to support the proposition that hoarding behaviour is not at all uncommon and though the cases reported will necessarily reflect the most problematic, they nevertheless show considerable diversity. No two cases are quite the same. Though the survey sought some information on co-morbidity, that was for several reasons limited but there were suggestions both that many cases are associated with self-neglect in the elderly – Diogenes syndrome – and, not least in the multiple collectors, with obsessive-compulsive traits. Separating the two requires more than a simple age-correlation, however, and was beyond the present analysis. Similarly beyond this inquiry was attributing the other cases to any cause though the idea that hoarding tendencies might be encouraged by particular stressors, especially bereavement, is supported, perhaps with implications for its avoidance.

10.20 Nearly half of all the cases reported were recurrent yet in only 77 cases were

other agencies – social services or health services – currently involved. It is not, however, clear whether the earlier occurrence had come to their notice or whether their assistance had since ceased or been rejected though there is evidence in a substantial proportion of cases of resistance to help.

10.21 If outside intervention in hoarding cases is not easy, there can nevertheless be compelling reasons for it (which may override ethical worries) and there is good evidence that EHOs' use of their statutory powers can provide temporary relief, if perhaps at the cost of some distress to the subject. Equally, the survey provides evidence that that relief may be short-lived and that longer-term, less formal approaches by social and mental health services are likely to show better success rates. These nonetheless are more dependent on the co-operation of the subject and the permanent resolution of hoarding problems may remain elusive in a significant minority of cases.

11 Guidelines for working with people with hoarding problems

11.1 As the preceding review and the results of the survey illustrate, people who exhibit problematic hoarding have complex problems and needs. The hoarding problem itself is notoriously difficult to treat, assuming the person is even willing to accept help but the fact that many sufferers steadfastly refuse that makes the management of these situations particularly difficult. There will be times nevertheless when statutory services, including EHOs, are required to investigate and intervene, in which case there are some general points to bear in mind when attempting to relate to and work supportively (and successfully) with someone who hoards.

- Handling a problem of hoarding requires a careful assessment of each case for both practical and legal

- reasons. Though some cases may be distressing, and even shocking, for those dealing with them it is important to remain objective.
- Gather as much information as possible from families, neighbours, friends *et al*, that there is time for, bearing in mind any risks to the subject and others, any special needs and that there may be a duty to take (some) action. Confidentiality (including data protection) is an issue but should not be a barrier.
 - If possible, enlist family and friends not just for information but as a way to offer support and give advice through a less threatening intermediary. In some case studies, a family member or friend has been able to persuade the subject to accept help where no one else has been successful. Be aware too of relevant voluntary organisations, self-help and support groups in the area which might offer assistance.
 - It is extremely important not to make any assumptions or judgements about the causes of the hoarding or the motivation of the person concerned. Unless a full psychiatric assessment has taken place it is not possible to deduce that a hoarder is mentally ill and such assumptions are likely to be irrelevant to the use of environmental health powers anyway. Keeping an open mind and a non-judgemental attitude is more likely to foster a good relationship with the sufferer and allow some dialogue, which may be enough in itself to prompt some improvement, if only temporarily.
 - Subjects are likely to consider that their hoarding is not problematic or irrational at all, so it is usually counter-productive to argue the case with them on the basis of what is normal, rational or acceptable nevertheless a subject may sometimes be led to understand the detrimental effect of their hoarding on others. If statutory action is necessary, a clear explanation of the basis and consequences of that should always be offered.
 - Conversely, a subject's denial may in fact be masking a high level of distress, anxiety or depression and if this is acknowledged, they may feel supported and understood. This will only become evident, however, through getting to know them over time.
 - Subjects may know at one level that they have a problem but feel so ashamed or guilty that they cannot accept help. The approach and use of language is particularly important here. Avoid using terms like 'squalor', 'self-neglect', 'dirty' or medico-legal terms which may exacerbate feelings of shame even though these are used in the literature. Try to use neutral descriptions of the problem that all can agree on, even if they are not exact or commonly used terms. Above all, avoid referring to the subject's possessions as 'rubbish'; most hoarders' possessions have powerful sentimental value and personal meaning to them and their behaviour is involuntary.
 - Be clear about the goal and that it is justified both at law and ethically; adopt a 'solution-focused' approach so that, rather than referring to the problem in every interaction, talk about finding a shared solution that will meet the subject's needs as well as the needs of the statutory services. For example, their perceived need might be to be left alone and interventions might be framed as a positive way to get other services to back off and leave them in peace but only promise what it is certain can be delivered. Even faced with a statutory duty, it is seldom too late for negotiated solutions.
 - If the subject does indicate that they are distressed by their problem and wants help, they should be reassured that the problem is common (that is, 'normalise' the problem) and that help is available. Be prepared: before the

next case arises, contact should be made with the local NHS and Older Adults Services so that there is some agreement (and, ideally, a formal protocol identifying people, funding streams etc) about how these services (which in some areas are integrated) will respond to EHOs' concerns or requests for information and help, eg with a case conference.

- In situations in which it is appropriate to involve mental health services, that should be done without delay. If it is suspected that the hoarder has a mental health problem which puts them or others at serious risk of harm, a request can be made for a Mental Health Act assessment by an Approved Mental Health Professional and a Consultant Psychiatrist. Again, be familiar with emergency numbers and who to contact in this situation.
- If other people are affected by the hoarding there may be additional responsibilities to inform other agencies concerned for their safety and welfare. If, for example, children reside in a house severely affected by hoarding the local children's services must be consulted for advice. Other adults can also be affected by hoarding; though the term may be strictly incorrect (implying satisfaction gained by the 'abuser'), Diogenes syndrome 'by proxy' has been reported when one person's hoarding has led to the neglect of another elderly person sharing the house. This is an example of (unintentional) elder abuse which requires statutory intervention.
- Less well understood than other forms of the phenomenon, people who 'hoard' animals as part of their problem tend to place great value on their pets and may consider them as extensions of themselves. They may have difficulty conceding that the animals are suffering because of their own distorted beliefs and may well be suffering a serious mental health problem. Great sensitivity is needed

in approaching this situation but in the light of probable offences under the *Animal Welfare Act 2006*, this will require prompt additional statutory involvement from animal services.

- The problem is very unlikely to go away completely even if the subject has accepted some help. If services are withdrawn after a time, for example after the person has been rehoused or the dwelling cleaned, the hoarding is more likely than not to recur. Continuity of support can be important and it needs to be offered long-term to reduce the need for statutory input again at a later date.

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