MIDD Briefing Paper

BP 122 Existing MIDD Program/Strategy or New Concept Name: Hoarding Disorder Treatment Program

New Concept ☐ (Attach New Concept Form)
Type of category: New Concept

SUMMARY: This concept is to create a Hoarding Disorder Treatment Client (HDTC) that will offer services to help mitigate health and housing issues related to Hoarding. This clinic will be embedded within a behavioral health program and partner with groups such as The Hoarding Project, home care providers, and housing providers, such as Seattle Housing Authority, Plymouth Housing, SHAG and other low-income housing projects.

Collaborators:

Name	**Department**
Chan Saelee, MHCADSD	
Barbara Vannatter, MHCADSD	

Subject Matter Experts and/or Stakeholders consulted for Briefing Paper preparation. List below.

Name	**Role**	**Organization**
Sean Walsh	Operations Manager	Full Life Center
Jennifer Sampson	Executive Director	The Hoarding Project

The following questions are intended to develop and build on information provided in the New Concept Form or gather information about existing MIDD strategies/programs.

A. Description

1. **Please describe the New Concept or Existing MIDD Strategy/Program: Please be concise, clear, and specific. What is being provided to whom, under what circumstances? What are the New Concept Existing MIDD Strategy/Program goals? For New Concepts, does it relate to an existing MIDD strategy? If so, how?**

   This concept is to create a Hoarding Disorder Treatment Client (HDTC) that will offer services to help mitigate health and housing issues related to Hoarding. This clinic will be embedded within a behavioral health program and partner with groups such as The Hoarding Project, home care providers, and housing providers, such as Seattle Housing Authority, Plymouth Housing, SHAG and other low-income housing projects.
   HDTC will offer inpatient visits for Hoarding Treatment, however, the primary focus of this project will be to provide home-based treatment for clients with hoarding disorder based on a model recently developed by The Hoarding Project. This model included six or more visits by a specially trained behavioral health provider paired with a professional organizer or home care professional working alongside housing providers to address the specific behaviors experienced by people suffering from hoarding disorder. The goal of the project is to allow longer lasting

interventions for people suffering from hoarding to allow them to live safely in their communities rather than face eviction, homelessness, or adverse health outcomes as a consequence of hoarding behaviors.

In May 2013, Hoarding Disorder was added as a new psychiatric diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The American Psychiatric Association defines hoarding disorder as:

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 environmental 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).[1]

The proposal also includes a training component on hoarding disorders for behavioral health providers. The Hoarding Project has developed and been providing training (Hoarding Disorder: Diagnosis, Assessment and Effective Treatment Strategies for Mental Health Professionals)[2] around the country for a couple of years.

As will be described again in B.1.a., in partnership with community housing providers, it is proposed to fund a hoarding disorder treatment program to provide ongoing in-home and outpatient hoarding treatment with the goal of decreasing eviction and subsequent homelessness of those who hoard; and reducing the functional consequences of hoarding disorder including health and safety hazards, degraded community living, and poor health outcomes.

As will be described below in item A2, this proposal falls within the New Concept MIDD Strategy/Program goals of prevention and early intervention, and system improvements. Additionally, this concept relates to two existing MIDD strategies:

Strategy #1: Increase Access to Community Mental Health and Substance Abuse Treatment 1a. Increased access to mental health and chemical dependency outpatient services for people not on Medicaid; in that individuals who hoard often are isolated, and unable or unwilling to participate in traditional outpatient behavioral health treatment. High prevalence rates: Up to five percent of the population (1 in 20 individuals) are affected with hoarding disorder- that is a higher prevalence rate than individuals with OCD and schizophrenia *combined*[3]. Older people

[1] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, D.C.

[2] http://thehoardingproject.org/home/trainings

[3] Lervolino et al., 2009; Samuels et al., 2008

hoard more than younger people[4]. People with lower income hoard more than people with higher income[5]. Three-quarters of those with hoarding disorder have a co-morbid mood or anxiety disorder[6] that further exacerbates the individual's perceived inability to access traditional outpatient treatment. Outreach in community living settings may increase access to behavioral health services for individuals not eligible, or not enrolled, in Medicaid. Additionally, outreach to individuals with hoarding behaviors allows for earlier identification and response to delay or reverse eviction proceedings, thus increasing housing stability, another expected outcome for this strategy.

Strategy #3: Increase Access to Housing 3a. Supportive services for housing projects: Partnering with housing providers to address hoarding behaviors may contribute to a reduction of the number of homeless individuals in King County and increase housing stability, which in turn may result in reduced use of the criminal justice and emergency medical systems. Together, this supports the expected outcomes associated with Strategy 3a.

One study found that up to 92 percent of study participants with hoarding disorder also met criteria for another mental health diagnosis[7]. Additionally, there are cognitive deficits that are often linked to hoarding disorder, particularly in the areas of executive functioning, impulse control, and processing of reward value.[8]

2. **Please identify which of the MIDD II Framework's four Strategy Areas best fits this New Concept/Existing MIDD Strategy/Program area** (Select all that apply):

☐ **Crisis Diversion** ☒ **Prevention and Early Intervention**

☐ **Recovery and Re-entry** ☒ **System Improvements**

Please describe the basis for the determination(s).

In the spirit of the MIDD II strategy to "keep people healthy by stopping problems before they start and preventing problems from escalating," a hoarding disorder treatment program fits well in the area of Prevention and Early Intervention. The partnership with housing providers will allow for an earlier identification and response to hoarding behaviors.

Providing both outpatient and in-home treatment will increase access to the behavioral health system. An in-home approach additionally allows for "on-demand" services: that is, the right treatment, at the right time, and in the right amount. Moreover, partnering with housing providers will improve the quality of care coordination. In these ways, a hoarding disorder treatment program supports the strategy to strengthen the behavioral health system to become more accessible and deliver on outcomes

B. Need; Emerging, Promising, Best, or Evidence Based Practices; Outcomes

[4] Samuels, et al. 2008

[5] Samuels, et al. 2008

[6] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, D.C.

[7] R.O. Frost, G. Steketee, D.F. Tolin; Comorbidity in hoarding disorder, Depress Anxiety, *28* (10) (2011), pp. 876–884 http://dx.doi.org/10.1002/da.20861

[8] Grisham, Brown, Savage, Steketee, & Barlow, 2007; Grisham, Norberg, Williams, Certoma, & Kadib, 2010; Hartl, Duffany, Allen, Steketee, & Frost, 2005; Hartl et al., 2004; Lawrence et al., 2006

1. **Please describe the Community Need, Problem, or Opportunity that the New Concept Existing MIDD Strategy/Program addresses: What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program? What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented? Provide specific examples and supporting data if available.**

   B.1.a. "What unmet mental health/substance use related need for what group or what system/service enhancement will be addressed by this New Concept/Existing MIDD Strategy/Program?"

   As described in A.1., the need being addressed is hoarding in public housing, targeting residents of public housing.

   Characterized by "persistent difficulty discarding or parting with possessions, regardless of the value others may attribute to these possessions,"[9] hoarding is a chronic mental health disorder affecting three to five percent of U.S. population. Hoarding follows a worsening course if left untreated, and with an increase of possessions, so increases health and safety issues. When symptoms become severe, hoarding may preclude basic activities, such as cooking, cleaning, hygiene, and even sleeping as living areas fill with clutter, making them unusable. Utilities such as water and electricity may be disconnected, and because of an inability to access and service appliances, those are commonly inoperable. Pest infestation, strong odors, and fire hazard[10] elevate hoarding to a community-level safety issue: in 2014, New York City fire Lieutenant Gordon Ambelas died battling the fire in a hoarder's home;[11] a Portland, Oregon man was killed in a house fire that was fueled by his hoarding clutter in 2012;[12] and in Seattle 2002, firefighters were unable to save a 75 year old woman after she dropped a lit cigarette in her hoarded home.[13]

   Attempted clean-outs—the removal of clutter without the resident having control over which items are discarded—are often the first line of defense to address hoarding, but this is an ineffective strategy.[14] The Hoarding Project's Director of Programs, Janet Yeats, states that forced clean-outs are traumatizing, ineffective, unsustainable, and financially unsound. A Massachusetts Department of Public Health clean-out demonstrated this well: $16,000 was

[9] American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Washington, D.C.

[10] Metropolitan Boston Housing Partnership (2015, January). Rethinking Hoarding Intervention. *MBHP's analysis of the Hoarding Intervention and Tenancy Preservation Project.*

[11] Yee, Vivian, & Baker, Al (2014, July 6). Known for Rescues, a Firefighter Dies in a Brooklyn Blaze. *The New York Times*. Retrieved from http://www.nytimes.com

[12] Fox 12 Webstaff (2012, February 16). Hoarding Conditions Fuel Deadly House Fire in Northeast Portland. *Fox 12 Oregon.* Retrieved from http://www.kptv.com/

[13] Foster, Heath (2002, October 29). Task Force Tries to Save Those Who Save Too Much. *Seattle Post-Intelligencer*. Retrieved from www.seattlepi.com

[14] Yeats, Janet (2015, October 20) The reality of hoarding cleanouts . *Washington Hoarding Conference Keynote.*

needed to clean-out a hoarded home, and store the resident's possessions. Eighteen months later, the home was re-hoarded and in need of a clean-out once again.[15]

Although a majority of evictions result from an inability to pay rent, a 2010 study of non-profit community housing-support organizations in New York City found that 23 percent of residents were seeking eviction intervention because of hoarding, which is a five to 10 times greater prevalence of hoarding behaviors than found in the general population. Of those, another 44 percent had previously been threatened with eviction.[16] This research suggests that such organizations may be fertile ground for identifying and enrolling individuals for hoarding treatment. King County has the opportunity to sidestep expensive and ineffective interventions through the implementation of a hoarding disorder treatment program. A two-prong approach of treating the mental health disorder and the symptoms of hoarding promises a more effective and compassionate strategy, with the potential of eliminating the eviction and subsequent homelessness of individuals with hoarding disorder.

B.1.b. "What service gap/unmet need will be created for whom if this New Concept Existing MIDD Strategy/Program is *not* implemented?"

As the service gap already exists, not implementing this proposal creates no new service gap, but rather leaves the current service gap of no dedicated specialized treatment programming for hoarding disorders.

2. Please describe how the New Concept/Existing MIDD Strategy/Program Addresses the Need outlined above.

Screening, assessment and specialized hoarding treatment will address the need for hoarding treatment by treating hoarding disorder. Hoarding disorder treatment is needed; people suffering from hoarding disorder are falling through the gaps within the behavioral health system. Many of these people are isolated and hoarding is having more than simply an impact on the individual, but on multiple systems hoarding touches, including public health, neighborhoods, law enforcement, clean-up services, etc.

The new concept addresses the need by providing a new innovative approach to treating hoarding disorders that currently doesn't exist in King County; in addition, it fills a needed gap in the behavioral health continuum of care, ensuring that knowledgeable, supportive, compassionate and specially trained services are available.

3. What EVIDENCE exists that the approach of this New Concept/Existing MIDD Strategy/Program will successfully address the identified need? Please cite published research, reports, population feedback, etc. Why would this New Concept/Existing MIDD Strategy/Program be expected to work? If this is an existing MIDD I strategy, please provide

[15] Frost, R. O., Steketee, G., & Williams, L. (2000). Hoarding: a community health problem. *Health & Social Care in the Community*, *8*(4), 229-234.

[16] Rodriguez, C. I., Herman, D., Alcon, J., Chen, S., Tannen, A., Essock, S., & Simpson, H. B. (2012). Prevalence of Hoarding Disorder in Individuals at Potential Risk of Eviction in New York City: A Pilot Study. *The Journal of Nervous and Mental Disease*, *200*(1).

evidence of the results from existing MIDD evaluation reports, including who has/has not benefited from this strategy.

The paucity of hoarding research reflects the hidden nature of this disorder: first, lack of insight, along with mental health issues, is often cited as the greatest barrier for individuals who hoard in their seeking of treatment;[17] [18]and secondly, the most evident expression of hoarding is hidden behind closed doors. Despite its brief history, the hoarding-treatment program-models in current use reduce eviction and homelessness, and increase individual and community safety. Some examples include:

- The Hoarding Intervention and Tenancy Preservation Project (HI/TPP) model merges harm reduction strategies, cognitive-behavioral therapy, intense case management, and collaboration between housing providers, behavioral health service providers, to work with clients. The program reports an astonishing 98 percent success rate, where clients were able to maintain their housing, avoiding eviction or loss of their housing subsidy due to hoarding behavior. For those who left the program early, a substantial reduction of clutter is evident.[19]

- A cognitive-behavioral therapy model which focuses on information processing, maladaptive beliefs about and attachments to possession, and the positive emotions associated with acquiring and saving possessions showed significant reductions in hoarding symptoms. Improvements at post-treatment were sustained at follow-up with ratings by clinicians and patients as "much improved" (62%) or "very much improved," (79%).[20]

- A meta-analysis of seven studies that have assessed the response to a pharmacological approach to hoarding treatment found that more than half of the participants responded positively to pharmaceutical intervention.[21] This further highlights the value of a multi-faceted approach to hoarding, and building onto cognitive-behavioral therapy.

- Research shows that special populations also benefit from hoarding treatment. Results from a study of cognitive behavioral interventions for individuals with intellectual disabilities demonstrate that hoarding significantly reduced following treatment on both self-report and environmental assessment. [22] Individuals participating in a geriatric hoarding study were largely retained and engaged in treatment, much unlike late life

[17] Metropolitan Boston Housing Partnership (2015, January). Rethinking Hoarding Intervention. *MBHP's analysis of the Hoarding Intervention and Tenancy Preservation Project.*

[18] Frost, R. O., Tolin, D. F., & Maltby, N. (2010). Insight-related challenges in the treatment of hoarding. *Cognitive and Behavioral Practice*, *17*(4), 404-413.

[19] Metropolitan Boston Housing Partnership (2015, January). Rethinking Hoarding Intervention. *MBHP's analysis of the Hoarding Intervention and Tenancy Preservation Project.*

[20] Muroff, J., Steketee, G., Frost, R. O., & Tolin, D. F. (2014). Cognitive Behavior Therapy For Hoarding Disorder: Follow-Up Findings And Predictors Of Outcome. *Depression and anxiety*, *31*(12), 964-971.

[21] Brakoulias, V., Eslick, G. D., & Starcevic, V. (2015). A meta-analysis of the response of pathological hoarding to pharmacotherapy. *Psychiatry research*, *229*(1), 272-276.

[22] Kellett, S., Matuozzo, H., & Kotecha, C. (2015). Effectiveness of cognitive-behaviour therapy for hoarding disorder in people with mild intellectual disabilities. *Research in developmental disabilities*, *47*, 385-392.

mood and anxiety disorder treatment research, although they required greater staff support.[23]

- Hoarding and Senior Housing: An Eviction Diversion Program Pilot Project. The purpose of this pilot project is to develop best practices for handling potential hoarding situations in senior housing through the implementation of an Eviction Diversion Program (EDP) developed in collaboration between Senior Housing Assistance Group (SHAG) and The Hoarding Project.[24]

4. Please specify whether this New Concept/Existing MIDD Strategy/Program is a/an: Promising Practice Please detail the basis for this determination. Please include a citation or reference supporting the selection of practice type.

Although a 1966 article "Hamburger Hoarding: A Case of Symbolic Cannibalism Resembling Whitico Psychosis"[25] has the distinction of first labeling these behaviors as *hoarding,* research of the disorder as known today only began emerging in the 1990s. In fact, the first evidence-based mental health model for hoarding treatment was published less than ten years ago.[26] The recent reclassification of hoarding disorder as distinct from obsessive-compulsive disorder in the DSM-5 has treatment implications, encouraging clinicians and researchers to use hoarding-specific tools and measures rather than those designed for obsessive compulsive disorder, as the data shows a high incidence of individuals who hoard are not obsessive compulsive. [27] [28] [29]

This proposal for a hoarding treatment program does not presuppose a specific treatment modality, as there are several approaches. The first evidence-based hoarding treatment practice was rooted in cognitive-behavioral treatment.[30] This model takes place over 26 therapy sessions with the goal or reducing the volume of clutter and rate of acquisition. Harm-reduction mitigates eviction by working with individuals to reduce the amount of clutter while also focusing on improving or maintaining safety, for example clearing exits or reducing risk of fire by moving clutter from heating sources. [31] However, harm reduction models are considered a

[23] Ayers, C. R., Dozier, M., Mayes, T. L., Espejo, E. P., Wilson, A., Iqbal, Y., & Strickland, K. (2015). Treatment Recruitment and Retention of Geriatric Participants With Hoarding Disorder. *Clinical Gerontologist*, (just-accepted).
[24] The Hoarding Project, 2015 http://thehoardingproject.org/home/king-pierce-county-hoarding-task-force
[25] Bolman, William M. and Alan S. Katz. 1966. "Hamburger Hoarding: A Case of Symbolic Cannibalism Resembling Whitico Psychosis." *The Journal of Nervous and Mental Disease* 142: 424-428.
[26] Steketee, G. & Frost, R. (2007). *Treatment for Hoarding Disorder: Therapist Guide (Treatments That Work)*. Oxford University Press: New York.
[27] Bloch, M. H., Bartley, C. A., Zipperer, L., Jakubovski, E., Landeros-Weisenberger, A., Pittenger, C., & Leckman, J. F. (2014). Meta-analysis: hoarding symptoms associated with poor treatment outcome in obsessive–compulsive disorder. *Molecular psychiatry*.
[28] Grisham, J. R., & Norberg, M. M. (2010). Compulsive hoarding: current controversies and new directions. *Dialogues in Clinical Neuroscience*, *12*(2), 233–240.
[29] Rachman, S., Elliott, C. M., Shafran, R., & Radomsky, A. S. (2009). Separating hoarding from OCD. *Behaviour Research and Therapy*, *47*(6), 520-522.
[30] Steketee, G. & Frost, R. (2007). *Treatment for Hoarding Disorder: Therapist Guide (Treatments That Work)*. Oxford University Press: New York.
[31] Tompkins, M. & Hartl, T.L.. (2009) *Digging Out: Helping Your Loved One Manage Clutter, Hoarding, and Compulsive Acquiring.* New Harbringer Publications: Oakland.

beginning and a middle of treatment, but is often only a method to postpone eviction given that hoarding behaviors are not addressed. [32]

A promising program developed by the Metropolitan Boston Housing Partnership (MBHP) working in partnership with the Boston University School of Social Work[33] is currently being replicated in San Francisco; Burlington, Vt.; and Bedford and Burlington, Mass. The Hoarding Intervention and Tenancy Preservation Project (HI/TPP) model merges harm reduction strategies, cognitive-behavioral therapy, intense case management, and collaboration between housing providers, behavioral health service providers, the client, and the MBHP team. The program reports an astonishing 98 percent success rate, where clients were able to maintain their housing, avoiding eviction or loss of their housing subsidy due to hoarding behavior. Even for those who left the program early, a substantial reduction of clutter was evident.

Emerging, best, evidence based, and *promising practices* are shades of gray until King County selects a specific treatment strategy.

5. **What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program? Please be as specific as possible. What indicators and data sources could the County use to measure outcomes?**

B.5.1. What OUTCOMES would the County see as a result of investment in this New Concept/Existing MIDD Strategy/Program?

The goals of a hoarding treatment program are to decrease or delay the eviction and subsequent homelessness of low income individuals who hoard and to reduce the functional consequences of hoarding disorder such as health and safety hazards, degraded community living, and poor health outcomes; it is then reasonable to expect housing stability as a program outcome. The goal for the program is, once the home meets safety standards (applying a critical incident stress management approach to hoarding cleanouts), that transition into longer term mental health care is established during which the client's hoarding disorder symptoms and other co-occurring mental health concerns are addressed, while a long-term maintenance plan is established to sustain the changes made.

B.5.2. What indicators and data sources could the County use to measure outcomes?

Agreements with relevant shareholders (e.g., first responders such as police or fire; housing provider report; behavioral health treatment compliance of enrollees) should provide access to the data that could not be collected directly from enrollees using piloted tools. [34] [35] [36]

C. Populations, Geography, and Collaborations & Partnerships

[32] - Ligatti, C. (2013). Cluttered Apartments and Complicated Tenancies: A Collaborative Intervention Approach to Tenant Hoarding Under the Fair Housing Act. *Suffolk University Law Review*, *46*(1).

[33] Metropolitan Boston Housing Partnership (2015, January). Rethinking Hoarding Intervention. *MBHP's analysis of the Hoarding Intervention and Tenancy Preservation Project.*

[34] Metropolitan Boston Housing Partnership (2015, January). Rethinking Hoarding Intervention. *MBHP's analysis of the Hoarding Intervention and Tenancy Preservation Project.*

[35] Guillard, V., & Pinson, C. (2012). Toward a better understanding and measurement of consumer hoarding. *Recherche et Applications en Marketing (English Edition)*, *27*(3), 57-78.

[36] Morris, S. H., Jaffee, S. R., Goodwin, G. P., & Franklin, M. E. (2015). Hoarding in Children and Adolescents: A Review. *Child Psychiatry & Human Development*, 1-11.

1. **What Populations might directly benefit from this New Concept/Existing MIDD Strategy/Program:** (Select all that apply):

☐ **All children/youth 18 or under**	☐ **Racial-Ethnic minority (any)**
☐ **Children 0-5**	☐ **Black/African-American**
☐ **Children 6-12**	☐ **Hispanic/Latino**
☐ **Teens 13-18**	☐ **Asian/Pacific Islander**
☐ **Transition age youth 18-25**	☐ **First Nations/American Indian/Native American**
☒ **Adults**	☐ **Immigrant/Refugee**
☒ **Older Adults**	☐ **Veteran/US Military**
☐ **Families**	☐ **Homeless**
☐ **Anyone**	☐ **GLBT**
☐ **Offenders/Ex-offenders/Justice-involved**	☐ **Women**
☐ **Other – Please Specify:**	

Please include details about this population such as: individuals transitioning from psychiatric hospital to community; individuals judged incompetent by the court; children of drug users who are in foster care, etc.

The main target population would be individuals residing in subsidized or similar housing, who have been identified as having hoarding-related concerns in their homes; however the program would be made available to anyone needing hoarding treatment.

2. **Location is an important factor in the availability and delivery of services. Please identify whether this New Concept/Existing MIDD Strategy/Program addresses a specific geographic need in the following area. Please provide additional that discusses the basis for the selection**: County-wide

Hoarding crosses the boundaries of rural, suburban, and urban lifestyles.[37] A hoarding treatment clinic could be implemented county-wide, but the likelihood is that the program may be centrally located in Seattle, where there is a concentration of subsidized and public housing.

3. **What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program, and with whom (other jurisdictions & cities, law enforcement, first responders, treatment providers, departments within King County, housing, employers, etc.)? Please be specific.**

C.3.1. What types of COLLABORATIONS and/or PARTNERSHIPS may be necessary to implement this New Concept/Existing MIDD Strategy/Program,
There are several partnerships required for success. First, the assumption is that this program would be administered by a community behavioral health provider. Second, it would be necessary to work with housing providers to more easily identify potential clients, and to

[37] Taylor, D., & Dineen, M. (2015). Working with hoarding and squalor in regional and rural areas. *Parity*, *28*(2), 29.

provide in-home/on-demand treatment. As many individuals with hoarding disorder are identified with first-responders, partnering with police and fire department could provide valuable data, and hopefully with time reduce the need for their services. A fourth partner may be with Public Health inspectors. Together, these partners would assist in the creation of a treatment plan, create referral sources, provide and share tools for intervention, and assist in the creation or improvement upon existing relationships with participants and case managers. Other allies would include Seattle Housing Authority, SHAG, The Hoarding Project, and Aging and Disability Services.

C.3.2. With whom would we collaborate or partner?
Community behavioral health providers, Seattle-King County Public Health, Housing providers, SHAG, Aging and Disability Services, The Hoarding Project and local law enforcement.

D. Drivers, Barriers, Unintended Consequences, and Alternative Approaches

1. **What FACTORS/DRIVERS, such as health care reform, changes in legislation, etc. might impact the need for or feasibility of this New Concept/Existing MIDD Strategy/Program? How?**
   The potential for health care reform, changes in legislation, and similar policy level changes to influence hoarding behaviors is minimal. Treatment does not currently exist, and legislative changes could not alter that—other than to fund treatment. Similarly, the elimination of MIDD funding would also not impact the need for treatment, in that the need would remain unmet.

2. **What potential BARRIERS, if any, might there be to implementation? How might these be overcome? Who would need to be involved in overcoming them?**
   The greatest barrier in hoarding treatment is engaging the client who often lacks insight. This hurdle could be tackled by seasoned therapists, which would require providing, at minimum, a livable wage, but better still, a wage reflective of a therapist's experience, education, and value.

   A larger, systemic challenge related to this is that most therapists (and most other related fields) have not received any training about assessment, diagnosis, or treatment for hoarding disorder because of the recent addition of the diagnosis to the DSM5 in 2013. With the exception of clinicians at The Hoarding Project (Tacoma) and the Evidenced-Based Treatment Centers of Seattle (Seattle), there are almost no other "seasoned clinicians" in the area that have experience working specifically with this population. Requiring education for mental health professionals in the basic area of education on assessment, diagnosis and treatment of hoarding disorder is imperative. This is a challenge, given that one in 20 people in the general population meet criteria for hoarding disorder.

3. **What potential UNINTENDED CONSEQUENCES might exist if this New Concept/Existing MIDD Strategy/Program is implemented? Please be specific---for whom might there be consequences?**
   Most agencies that are not familiar with hoarding disorder and related treatment may feel discomfort with providing hoarding disorder treatment and identifying the need for specialized treatment. In addition, wait times could potentially increase if there is inadequate capacity for the existing need for care (currently there is inadequate capacity for existing need for care).

4. **What potential UNINTENDED CONSEQUENCES might there be if this New Concept/Existing MIDD Strategy/Program is *not* implemented? Please be specific---for whom might there be consequences?**
   Individuals with behavioral health disorders of hoarding will continue to go untreated and will continue to utilize other resources, such as law enforcement/first responders and public health. Evictions will increase and homelessness of individuals with mental illnesses will continue if prevention activities do not occur. There is currently inadequate capacity for the existing need for care.

5. **What ALTERNATIVE APPROACHES currently exist to address this need apart from this New Concept/Existing MIDD Strategy/Program? At a high level, how does this New Concept/Existing MIDD Strategy/Program compare to those other approaches in terms of cost, feasibility, etc. Could this New Concept/Existing MIDD Strategy/Program be merged with one or more of the alternatives? What are the pros/cons of merging?**

   In addition to privately funded treatment and clean-out services, the only resource (beyond ad hoc assistance) is The Hoarding Project. The Hoarding Project is a Tacoma-based non-profit organization that offers education, treatment and consultation, and research in the area of hoarding disorder. Treatment is offered on a sliding scale; services are provided for individuals who hoard, their family members, and professionals in related fields.

   One of the programs of The Hoarding Project is its King/Pierce County Hoarding Task Force. This task force is a multi-disciplinary group of professionals that meets monthly to focus on promoting "an effective, ethical, and sustainable response to hoarding in communities, through research, education and prevention, and collaborative approaches to treatment." It has been noted that the long term stability of task forces is questionable in that many face the challenges of ongoing membership and leadership changes and their subsequent effect on long term goal setting, as well as ever-present funding concerns;[38] additionally, the King/Pierce County Hoarding Task Force, like many others, focuses on community education, research, and case consultation, but not necessarily direct treatment services.

   In 2015, The Hoarding Project partnered with SHAG on a pilot project to address hoarding related concerns in senior housing. The purpose of this pilot project is to develop best practices through the implementation of an Eviction Diversion Program (EDP). SHAG residents who failed inspections of their units for housekeeping-related concerns were referred to the EDP within SHAG. Participants were screened and referred to appropriate resources, which included consultation sessions with a hoarding specialist and/or professional organizer and mental health therapy to support long-term behavioral change in hoarding behaviors. The goal was to develop harm reduction and maintenance plans to help keep the home at basic levels of safety for the resident.

[38] Bratiotis, Christiana (2009). "Task Force Community Response to Compulsive Hoarding Cases." (Unpublished dissertation). Boston University Doctoral Program in Social Work/Sociology.Frost R., Steketee, G. and Williams L. (2000). "Hoarding: a community health problem." *Health and Social Care in the Community* 8(4), 229-234.

The Hoarding Project/SHAG's Eviction Diversion Program concept can be merged with new behavioral health services;the pros of merging would be the integration within the current publicly funded behavioral health treatment system. In addition to a dedicated Hoarding Disorder Treatment Program, all providers could receive specialized training on treating hoarding disorders.

E. Countywide Policies and Priorities

1. How does this New Concept/Existing MIDD Strategy/Program FIT within the CONTINUUM of care, and within other county initiatives such as Behavioral Health Integration, Health and Human Services Transformation, Best Starts for Kids, All Home, the Youth Action Plan, and/or the Vets and Human Services Levy or any other County policy work?

Ideally, a hoarding treatment program would fit within all stages on the continuum of care model: prevention, intervention, treatment and aftercare. Providing a specialized treatment for hoarding disorder could help accurate diagnosis and treatment plans.

Hoarding treatment focuses on wellness, prevention and recovery, supporting the Behavioral Health Integration. Hoarding treatment supports Health and Human Services Transformation in that it shifts from a costly, crisis-oriented response to health and social problems, to one that focuses on prevention and embraces recovery, which similarly supports the goals of All Home, to reduce homelessness.

NOTE: Hoarding is a lifelong mental health issue and most often surfaces for the first time in childhood. Focusing on teaching screening, assessment, and prevention methods for hoarding at a young age will help to prevent severe hoarding from occurring in adulthood.

2. How is this New Concept/Existing MIDD Strategy/Program rooted in principles of recovery, resiliency, and/or trauma-informed care?

Hoarding Treatment is rooted in the principles of recovery and resiliency in that it provides behavioral health treatment, to assist individuals as they work to improve their own health and well-being, live a self-directed life, and strive to achieve their full potential. Addressing hoarding behaviors is traumatic for the individual; taking a trauma informed care approach would lessen this response.[39] The Eviction Diversion plan takes a trauma-informed approach to doing this in helping client's return their home to safety.

3. How does this New Concept/Existing MIDD Strategy/Program enact and further the County's EQUITY and SOCIAL JUSTICE work?

Hoarding treatment supports King County's Equity and Social Justice work in that it recognizes the need to remove barriers, such as access to treatment, so these individuals can contribute, and to live to their fullest potential.

[39] [39] Ligatti, C. (2013). Cluttered Apartments and Complicated Tenancies: A Collaborative Intervention Approach to Tenant Hoarding Under the Fair Housing Act. *Suffolk University Law Review*, *46*(1).

F. Implementation Factors

1. **What types of RESOURCES will be needed to implement this New Concept/Existing MIDD Strategy/Program** (staff, physical space, training, UA kits, etc.)**?**
   Necessary resources include staff, physical space ,presumably within an already existing behavioral health provider's office, and training.

2. **Estimated ANNUAL COST. $100,000 or less Provide unit or other specific costs if known.**

   Full Life Care estimates
   Pilot scale: $10,000 (proposing agency could use existing staff to manage the intervention)
   Medium - Large scale: $25,000 - $50,000 (new staff dedicated to the program, serving 30-60 participants).
   Hoarding Disorder Treatment program: $50,000

   Training estimates:
   8 hour training/6.5 CEU for behavioral health providers, $1,500/day, 2 trainings/annually-$3,000 (backfill/overtime rate for contracted providers @ $400/day/participant)- 30 each session, 60 total. $24,000
   Total training: $27,000

   Proposal total: $77,000

3. **Are there revenue sources other than MIDD that could or currently fund this work? Clarify response, citing revenue sources.**
   None are known.

4. **TIME to implementation: Less than 6 months from award**
   a. **What are the factors in the time to implementation assessment?**
   b. **What are the steps needed for implementation?**
   c. **Does this need an RFP?**

Time to implementation would be dependent on the selection of treatment strategy, program design, length of time spent on the RFP, the total amount of funding which would drive the number of employees that would need to be reassigned or hired. This could take six or 12 months.

A pilot and training could be implemented within six months.

G. Any OTHER INFORMATION that would assist reviewers with making recommendations about this New Concept/Existing MIDD Strategy/Program? (Optional). Do you have suggestions regarding this New Concept/Existing MIDD Strategy/Program?

The concept of hoarding treatment addresses a long-overlooked and difficult to treat disorder that is only recently being conceptualized as an independent diagnosis. Hoarding behaviors may not coincide with other behaviors that are more recognizable to behavioral health providers. Coupled with the hidden nature of the disorder, hoarding is disproportionately untreated. The tendency of community based mental health systems is to operate in a clinical setting which precludes the opportunity to *stumble upon* hoarding behaviors, in the current fashion of discovery by landlords or first-responders. An outreach approach would be most effective in that it could identify the behaviors with more ease, and allow for implementation in the setting in which it occurs.

New Concept Submission Form

122

Working Title of Concept: Hoarding Disorder Treatment Clinic

Name of Person Submitting Concept: Sean Walsh
Organization(s), if any: Full Life Care
Phone: 206-371-2490
Email: seanw@fulllifecare.org
Mailing Address: 800 Jefferson St. #620, Seattle WA, 98104

Please note that county staff may contact the person shown on this form if additional information or clarification is needed.

Please share whatever you know, to the best of your ability.
Concepts must be submitted via email to MIDDconcept@kingcounty.gov by ***October 31, 2015****.*

1. Describe the concept.
Please be specific, and describe new or expanded mental health or substance abuse-related services specifically.

Full Life Care is proposing to create a Hoarding Disorder Treatment Client (HDTC) that will offer services to help mitigate health and housing issues related to Hoarding. This Clinic will be embedded in our RSN-funded Solstice Behavioral Health program (a subcontractor of Navos Behavioral Health) and parter with groups such as the Hoarding Project, Home Care Providers and Housing providers such as Seattle Housing Authority, Plymouth Housing, SHAG and other low-income housing projects. HDTC will offer inpatient visits for Hoarding Treatment, however, the primary focus of this project will be to provide home-based treatment for Hoarding disoders based on a model recently developed by the Hoarding Project. This model included 6 or more visits by a specially trained BH provider paired with a professional organized or Home Care professional working alongside Housing providers to address the specific behaviors experienced by people suffering from Hoarding. The goal of the project is to allow longer lasting interventions for people suffering from Hoarding to allow them to live safely in their communities rather than face eviction, homeless or adverse health outcomes as a consequence of Hoarding behaviors.

2. What community need, problem, or opportunity does your concept address?
Please be specific, and describe how the need relates to mental health or substance abuse.

As many Social Service and Behavioral Health providers are aware, people with Hoarding disorders can present unique and challengeing treatment challenges. Since Hoarding behaviors are most evidently expressed in the homes of people suffering from Hoarding, this issue often goes undiagnoses or unrecognized in traditional site-based Behavioral Health programs. In additions, many people suffering from a primary diagnosis of Hoarding are isolated in their homes and unable or unwilling to participate in typical BH treatments. The consequences of untreated Hoarding behavior include frequent homeless or institutionalization, poor health outcomes, and degraded communities struggling the deal with the

consequences of hoarding—including public health hazards and nuisances such as increased fire hazards, pests, and environmental problems. With the adding of Hoarding as a diagnostic category in the latest version of the DSM-V, and with a coalition of Behavioral Health, Housing and Social Service providers emerging to develop effective interventions, MIDD offers the opportunity to create a resource that can be used throughout King County to mitigate problems related to chronic Hoarding behaviors.

3. How would your concept address the need?
Please be specific.

The key element of this model of treatment is engaging people suffering from Hoarding behaviors both in a Clinical setting and in the participant's own home where Hoarding behaviors are most commonly expressed. Specially trained BH staff will meet 4-6 times in the participant's home accompanied by a professional organizer or Home Care professional. During the course of the intervention, the BH specialists helps reduce the experience of trauma suffered by people with Hoarding behaviors, helping them to contextualize and reduce the activiation of anxiety experienced in the process of making a home or apartment suitable for habitation. This has been found to increase both the short term and long term effectiveness of Hoarding interventions. By involving Housing and other Social Service providers, participants are able to receive support over long periods of time, that may allow more effective and timely interventions if Hoarding behaviors continue.

4. Who would benefit? Please describe potential program participants.

The primary beneficiary of this program is a person whose health and housing status is jeopardized by chronic Hoarding behaviors. Our organization has primarily focused our work on very low-income adults in subsidized or marginal housing situations—these adults tend to have fewer social or family connections providing informal support, and may be more likely to have poor health outcomes as a result of their Hoarding behaviors. However, this disorder may also be found among those who are not low-income or marginally housed in urban areas. In fact, Hoarding behaviors that occur in rural or outlying areas may be even more devastating due to the remoteness and relative lack of contact of people in these areas. It is also true that beneficiaries of this program would be landlords, housing providers, neighbors and public officials such as fire and police who are forced to contend with dangerous or disruptive living conditions due to the public nuiscance that Hoarding behaviors can create.

5. What would be the results of successful implementation of program?
Include outcomes that could be measured and evaluated. Please indicate whether this data is currently collected in some fashion, and in what form.

The primary outcomes of this intervention are: stabilization of housing (i.e. avoiding eviction and homelessness) and stabilization of heatlh (i.e. avoiding medical or long term care institutionalization). While evicition data, and admission data are generally available, it is unlikely that eviction and admission data specific to Hoarding disorders is available at present. One of the goals of this project will be to help develop criteria and processes to capture both the costs and consequences of Hoarding behavior, as well as the savings provided by effective Hoarding interventions.

6. Which of the MIDD II Framework's four strategy areas best fits your concept? (you may identify more than one)

☒ **Prevention and Early Intervention:** Keep people healthy by stopping problems before they start and preventing problems from escalating.

☒ **Crisis Diversion:** Assist people who are in crisis or at risk of crisis to get the help they need.

☐ **Recovery and Reentry:** Empower people to become healthy and safely reintegrate into community after crisis.

☒ **System Improvements:** Strengthen the behavioral health system to become more accessible and deliver on outcomes.

7. How does your concept fit within the MIDD II Objective – to improve health, social, and justice outcomes for people living with, or at risk of, mental illness and substance use disorders?

Our concept address a long-overlooked and difficult to treat disorder that is only recently being conceptualized as an independent disorder. Since Hoarding behaviors may not coincide with other behaviors that have received the attention of Behavioral Health providers, and since Hoarding behaviors are most often exhibited in "private" settings (i.e. a persons home or apartment), it has been disproportionately untreated. Given the strong tendency of community based mental health systems to operate in a clinic (versus outreach) setting, the problem of Hoarding is most often addressed in a non-clinical way by landlords, fire departments, and in-home caregivers. Our project offers the opportunity to change that by creating a resource that can be effectively implemented in the setting where it is most likely to be effective—in the home of the person suffering from Hoarding behaviors.

8. What types of organizations and/or partnerships are necessary for this concept to be successful? Examples: first responders, mental health or substance abuse providers, courts, jails, schools, employers, etc.

There are a number of very important partnerships that will be essential to making this project successful. They included community based mental health providers, housing providers, in-home social service authorizers and providers, police and fire departments, and local departments of health and inspectors. Each of these may provide a key role in a successful intervention by taking steps such as: creating the Hoarding Behavior treatment plan, making referrals, creating or building upon existing relationships with participants, providing tools for carrying out interventions, etc. At Full Life Care, we are already involved with a number of these networks both internally (as a Behavioral Health, case management, and Home Care provider) and externally as a partner with many of the groups are likely to participate in this project: Seattle Housing Authority, SHAG, the Hoarding Project, Aging and Disability Services, and others. This a project we would be very eager to help bring into our community to address a long-overlooked problem.

9. If you are able to provide estimate(s), how much funding per year do you think would be necessary to implement this concept, and how many people would be served?

Pilot/Small-Scale Implementation:	**$ 10,000 per year, serving 15 people per year**
Partial Implementation:	**$ 20,000 per year, serving 30 people per year**
Full Implementation:	**$ 40,000 per year, serving 60 people per year**

Once you have completed whatever information you are able to provide about your concept, please send this form to *MIDDConcept@kingcounty.gov*, no later than 5:00 PM on October 31, 2015.
If at any time you have questions about the MIDD new concept process, please contact MIDD staff at *MIDDConcept@kingcounty.gov*.