

Making Space Practice Guide:

Compulsive Acquiring and/or
Compulsive Saving with/without
Associated Domestic Neglect
(previously referred to as Hoarding and Squalor)

Making Space Practice Guide

Purpose of this Guide

Working with people experiencing Compulsive Acquiring and/or Compulsive Saving, with or without Associated Domestic Neglect (CA/CS/ADN), requires a thoughtful and adaptable approach. This work is often complex, and many workers encounter it without feeling fully confident or prepared.

This guide is for anyone working with people experiencing Compulsive Acquiring and Compulsive Saving to build confidence, reduce apprehension, and strengthen everyday practice across services, including mental health, housing, aged care, and homelessness support.

CA/CS/ADN is not simply about the environment. It is often linked to underlying factors such as trauma, mental health, and life experiences. People may also experience significant shame, fear, or stigma, which can impact engagement. Effective responses must therefore focus on the person, not just the presentation.

This guide promotes a person-centred, recovery-oriented, and trauma-informed approach. It supports workers to balance risk and responsibility with respect for autonomy, and to work alongside people in a way that is practical, respectful, and sustainable.

**This guide is not intended to be a comprehensive resource. Rather, it provides a practical starting point to support confidence, reflection, and skill development. Learning in this area is ongoing and is enhanced through supervision, training, lived experience perspectives, reflective practice, and direct experience working alongside people in their recovery journeys.*

1. Introduction and Context	4
Welcome.....	4
Purpose and Scope of the Practice Guide.....	4
Guiding Principle – ‘Humans Before Homes’	5
Definitions and Terminology	5
Hoarding Diagnosis is a Recently Recognised Condition.....	5
Prevalence	6
Power of Language	7
2. Understanding Compulsive Acquiring, Compulsive Saving, Associated Domestic Neglect.....	8
Challenging Assumptions and Stigma	8
Compulsive Acquiring, Saving and Associated Domestic Neglect.....	8
Associated Domestic Neglect	8
What is Squalor? (Clinical Understanding).....	9
Why it occurs.....	9
Comorbidities, Trauma and Life Experiences	10
Physical Health, Capacity and Functional Impact.....	10
3. Home Assessment and Risk identification.....	11
Home Assessment Tools.....	11
Clutter Image Rating (CIR) Scale.....	11
Home Environment Assessment Tool for Hoarding (HEATH).....	11
Risk identification	12
Home and Personal Safety.....	12
Practice Considerations for Workers.....	13
Client Risk Assessment Tools	15
4. Foundations of Good Practice.....	16
Humans Before Homes.....	16
Valuing Lived Experience and Peer Support.....	16
Why Forensic or Deep Cleans Don't Work.....	17
Supporting Change, Motivation and Meaningful Outcomes.....	18
Working with Values – What matters the most to people	19
Measuring Progress Beyond the Environment.....	19
5. Communication and Engagement.....	21
Observing and Understanding the Human Through Their Environment	21

Listening for Meaning.....	21
Trust and Rapport	23
Observing and Understanding the Human Through Their Attachment and Emotion....	23
Conversation Starters and Curious Questions	24
6. Understanding Acquiring Behaviour.....	25
Why People Compulsively Acquire.....	25
Responding to Compulsive Acquiring Behaviour.....	25
7. Recovery Approaches and Therapeutic Foundations.....	27
Person-Centred Practice.....	27
Trauma-Informed Practice	27
Culturally Responsive Practice	27
8. Therapeutic Practices to Support Sustainable Long-Term Change	28
An Overview.....	28
Motivational Interviewing (MI).....	28
Cognitive Behavioural Therapy (CBT).....	28
Dialectical Behaviour Therapy (DBT)	28
Acceptance and Commitment Therapy (ACT).....	28
Interpersonal Psychotherapy (IPT).....	28
Attachment Styles and Their Influence	29
Positive Psychotherapy	30
Narrative Therapy	30
Solution-Focused Brief Therapy (SFBT).....	30
Compassion-Focused Therapy (CFT).....	30
Exposure Therapy.....	30
Family Therapy.....	30
Mindfulness	30
Life Skills and Independent Living Skills Training.....	30
Peer Support Groups.....	31
Reflective Practice	32
9. In Practice.....	33
Practical In-Home Support (Working With, Not Doing For).....	33
Knowing When to Refer.....	35
Case Management, Collaboration and Coordinated Support.....	36
Psychoeducation; Formal and Informal	36

Common Barriers and Ethical Dilemmas.....	37
Supporting Families and Significant Others	38
10. Animal Hoarding.....	39
Understanding Animal Hoarding.....	39
The Human-Animal Connection.....	39
Impacts and Risks.....	39
11. Collectors' vs Compulsive Acquiring.....	41
12. Maintaining Progress and Supporting Ongoing Recovery.....	42
13. Final Reflection.....	43
14. Appendix.....	45
Diagnostic Frameworks – Hoarding Disorder	46
Clutter Image Rating Scale (CRS).....	47
Home Environment Assessment Tool for Hoarding (HEATH).....	50
15. References	52
Frameworks.....	52
Useful Websites.....	52

1. Introduction and Context

Welcome

Supporting people experiencing Compulsive Acquiring and/or Compulsive Saving, with or without Associated Domestic Neglect (CA/CS/ADN), can be challenging, but it is also highly rewarding. This guide has been developed to build confidence, strengthen practice, and support workers to respond in a way that focuses on the person behind the environment, promoting safe, respectful, and sustainable outcomes.

Purpose and Scope of the Practice Guide

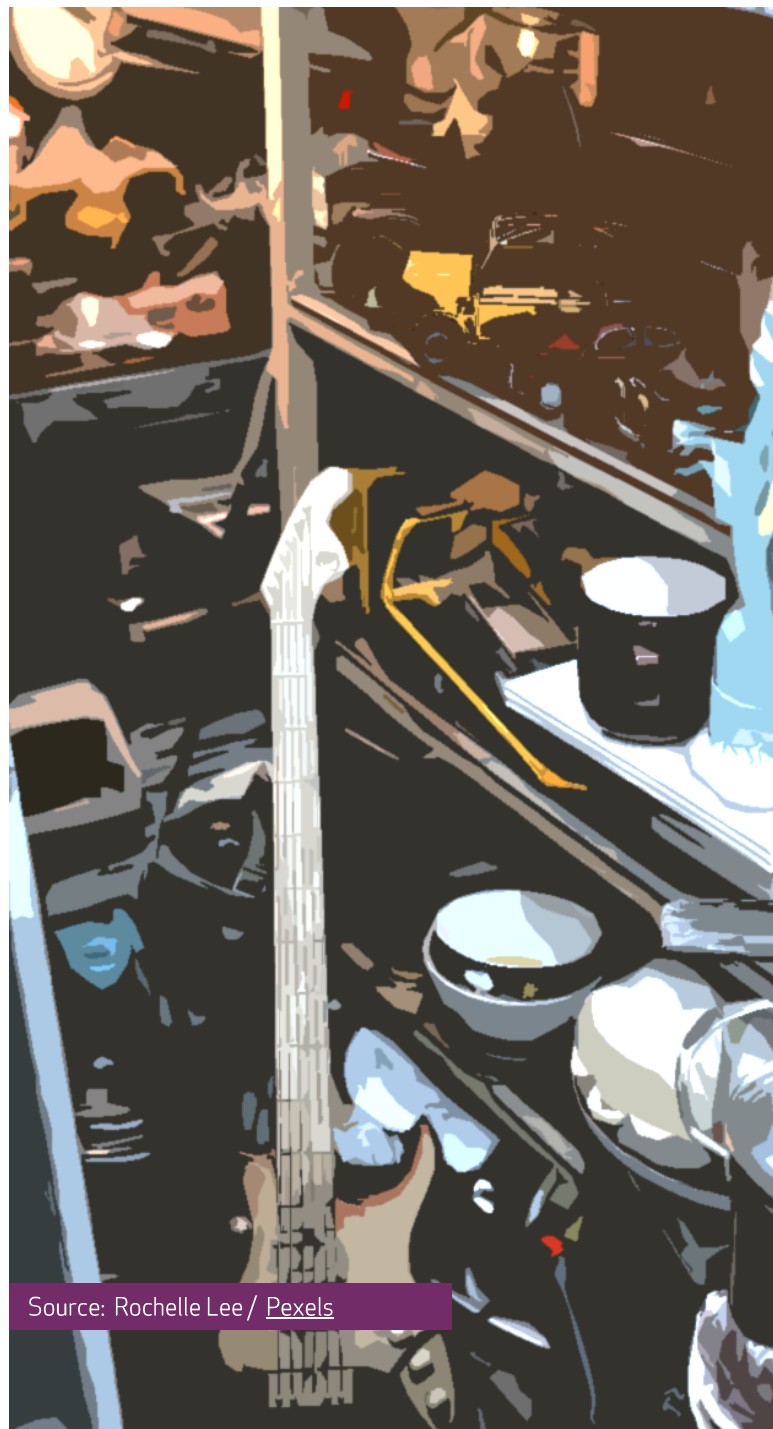
This guide is designed to build confidence, reduce apprehension, and strengthen everyday practice across services. It draws together key frameworks and practical approaches to support workers in partnering with individuals on their recovery journey and achieving meaningful, sustainable change.

It provides practical guidance on how to:

- Respond safely, respectfully and engage effectively
- Balance risk, responsibility, and autonomy
- Support sustainable, person-centred change
- Provide psychoeducation to bring awareness and self-empowerment

This guide is intended for workers who may encounter CA/CS/ADN as part of their broader role, including:

- Mental health and recovery workers
- Tenancy and housing staff
- Homelessness support workers
- Aged care and community support staff



Source: Rochelle Lee / Pexels

Guiding Principle – ‘Humans Before Homes’

At the centre of good practice in CA/CS/ADN is the principle of ‘Humans Before Homes’. This recognises that while the physical environment may present visible risks or concerns, the primary focus of support must always remain on the person. The home reflects the person’s journey, not a measure of their value as a human being.

In practice, ‘Humans Before Homes’ means:

- Valuing the person’s experience, autonomy, and perspective above external expectations

- Working at the person’s pace, not imposing urgency based solely on environmental concerns
- Recognising behaviour as meaningful, rather than something to be “fixed”
- Focusing on long-term, sustainable change rather than short-term visual outcomes
- Working with the person as a whole being, in a journey of recovery to improved mental health and wellbeing.

Ultimately, this principle underpins all trauma-informed, person-centred, and recovery-oriented practice. It reminds workers that **lasting change is achieved by supporting the person first—because when the person changes, the home will follow.**

Definitions and Terminology

For the purpose of this guide:

Compulsive Acquiring (CA): The persistent need to obtain items, including purchasing, collecting, or accepting free items, regardless of need or available space.

Compulsive Saving (CS): Difficulty discarding items due to a perceived need to keep them, often regardless of their actual value.

Associated Domestic Neglect (ADN): A decline in the upkeep of the living environment that may occur when the accumulation of belongings, reduced capacity, health factors, cognitive changes, or difficulties with daily living tasks affect a person's ability to maintain their home. This may impact health, safety, and wellbeing.

The term **CA/CS/ADN** is used to move away from stigmatising language such as “hoarding” or “squalor,” and to better reflect the behaviours and underlying experiences involved.

Hoarding Diagnosis is a Recently Recognised Condition

Hoarding has been the focus of dedicated research only since the mid-1990s and, as understanding of the condition grew, evidence demonstrated that it was distinct from Obsessive-Compulsive Disorder (OCD), under which it had previously been classified. This led to Hoarding Disorder being formally recognised as a separate diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) in 2013. While it remains included within the chapter on Obsessive-Compulsive and Related Disorders, it is no longer considered a subtype of OCD. Hoarding Disorder was later recognised in the International Classification of Diseases (ICD-11), published by the World Health Organisation.

Prior to its inclusion in these diagnostic frameworks, acquiring and saving behaviours were often misunderstood and attributed to lifestyle choices, poor housekeeping, or a lack of motivation. The recognition of Hoarding Disorder within both the DSM-5 and ICD-11 reflects a growing understanding that acquiring and saving behaviours are often associated with complex psychological, emotional, behavioural, social, and functional factors, rather than simply the condition of a home.

Both diagnostic frameworks recognise that Hoarding Disorder can have a significant impact on daily functioning, wellbeing, relationships, health, and safety. For workers, the key takeaway is that acquiring and saving behaviours should be understood within their broader personal, psychological, social, and environmental context, rather than being viewed as a matter of choice, motivation, or housekeeping alone.

Prevalence

As defined under the DSM5 a 'Hoarding Disorder' is more common than often assumed, with research estimating that approximately **2–6% of the general population** meet diagnostic criteria—equating to roughly **1 in 40 people**. Prevalence tends to increase with age, with significantly higher rates observed in older adults, and similar rates across genders and cultures. Despite this, many individuals remain undiagnosed for long periods, with studies indicating that up to **75% may go undiagnosed for 10 years or more**. [\[ourmental.health\]](https://ourmental.health/), [\[psychologytoday.com\]](https://psychologytoday.com) [\[psychiatry.org\]](https://psychiatry.org) [\[worldmetrics.org\]](https://worldmetrics.org)

At a household and community level, the impacts can include:

- **Health and safety risks**, such as increased likelihood of falls, fire hazards, and restricted access for emergency services [\[pmc.ncbi.nlm.nih.gov\]](https://pmc.ncbi.nlm.nih.gov/)
- **Housing instability**, including eviction, unsafe living conditions, and neighbourhood impacts
- **Social isolation and stigma**, often driven by shame and withdrawal
- **Broader community and service system impacts**, including increased demand on health, housing, and emergency services

Understanding prevalence can help challenge assumptions that these experiences are rare or unusual and reinforces the importance of knowledgeable, compassionate, and evidence-informed responses.



Power of Language

Language used in practice should be respectful, non-judgemental, and aligned with recovery-oriented principles. (See: Recovery-Oriented Language Guide).

When people were asked about their preferred terminology, their responses highlighted the importance of language and meaning. Words commonly used in services can feel clinical, judgemental, or disconnected from the person's experience, whereas individuals often use language that reflects value, purpose, or emotional connection.

Acquiring and Saving →

rather than “hoarding” or “clutter”, people may use terms such as:

Collecting, finding, fossicking, opportunities, treasures, belongings, keepsakes, sentimental items, heirlooms, gifts or simply “*my things*”

Disposing and Discarding →

instead of “throwing out” or “getting rid of”, people may prefer terms like:

Letting go, passing things on, donating, sharing, recycling, clearing space, or making room

This highlights that **language carries meaning**. It shapes how people understand themselves, their environment, and their willingness to engage in change. Using the person's own words can reduce shame, build trust, and support a more respectful and collaborative approach.

Clinical or judgmental terms (e.g. “hoarding” or “get rid of”) can lead to resistance and withdrawal, while respectful, person-aligned language helps reduce shame and build trust. Even small changes in wording—such as “letting go” instead of “throwing out”—can make tasks feel more manageable.



2. Understanding Compulsive Acquiring, Compulsive Saving, Associated Domestic Neglect

Challenging Assumptions and Stigma

CA/CS/ADN is often misunderstood. People may be labelled as *“lazy,” “unmotivated,” “choosing to live this way” or “stupid”*. These assumptions can lead to judgement, frustration, fear, distrust and ineffective responses.

In reality:

- People are often doing the best they can with the resources and capacities they have
- Shame, embarrassment, humiliation and guilt may prevent them from seeking help
- Previous negative experiences with services can impact trust
- Change is difficult, slow and often non-linear

Challenging these assumptions is essential. A respectful, non-judgemental approach improves engagement and supports better outcomes. Peer support can be particularly effective in addressing shame and stigma. Many people report feeling understood for the first time when speaking with someone who has experienced similar challenges and who can offer empathy without judgement.

Compulsive Acquiring, Saving and Associated Domestic Neglect

While they often overlap, these presentations can look different in practice:

- **Compulsive acquiring** may involve excessive purchasing, collecting, or accepting items, even when they are not needed or space is limited.
- **Compulsive saving** is characterised by difficulty discarding items, often due to a strong emotional attachment or a belief that items may be needed in the future.
- **Associated Domestic neglect** relates to the condition of the living environment, where upkeep has declined to a level that may affect health, safety, or wellbeing.

These do not always occur together. Some people may experience one without the others, and the level of impact can vary significantly.

Associated Domestic Neglect

Associated domestic neglect often develops not as a primary issue, but as a consequence of the environment becoming increasingly congested over time. As belongings accumulate and spaces become “busy,” the ability to carry out basic cleaning and household tasks can become progressively more difficult. Surfaces may no longer be accessible, floors become obstructed, and key areas such as kitchens and bathrooms can be difficult to reach or use as intended.

This can lead to a gradual build-up of rubbish, food waste, odours, and, over time, issues such as vermin or infestation. Importantly, these conditions are rarely intentional—they develop as a functional consequence of the physical environment and reduced capacity to manage it.

What is Squalor? (Clinical Understanding)

Squalor is not a formal diagnosis within the DSM-5-TR or ICD-11. It is a descriptive clinical term used to describe severely unhygienic and unsafe living conditions that compromise health, safety, and functioning. While it can co-occur with hoarding disorder, squalor is not inherently linked to compulsive acquiring, saving, or attachment to possessions. Instead, it is more commonly associated with significant cognitive impairment, severe mental illness, self-neglect, functional decline, or reduced capacity to maintain the living environment.

A widely cited clinical description is:

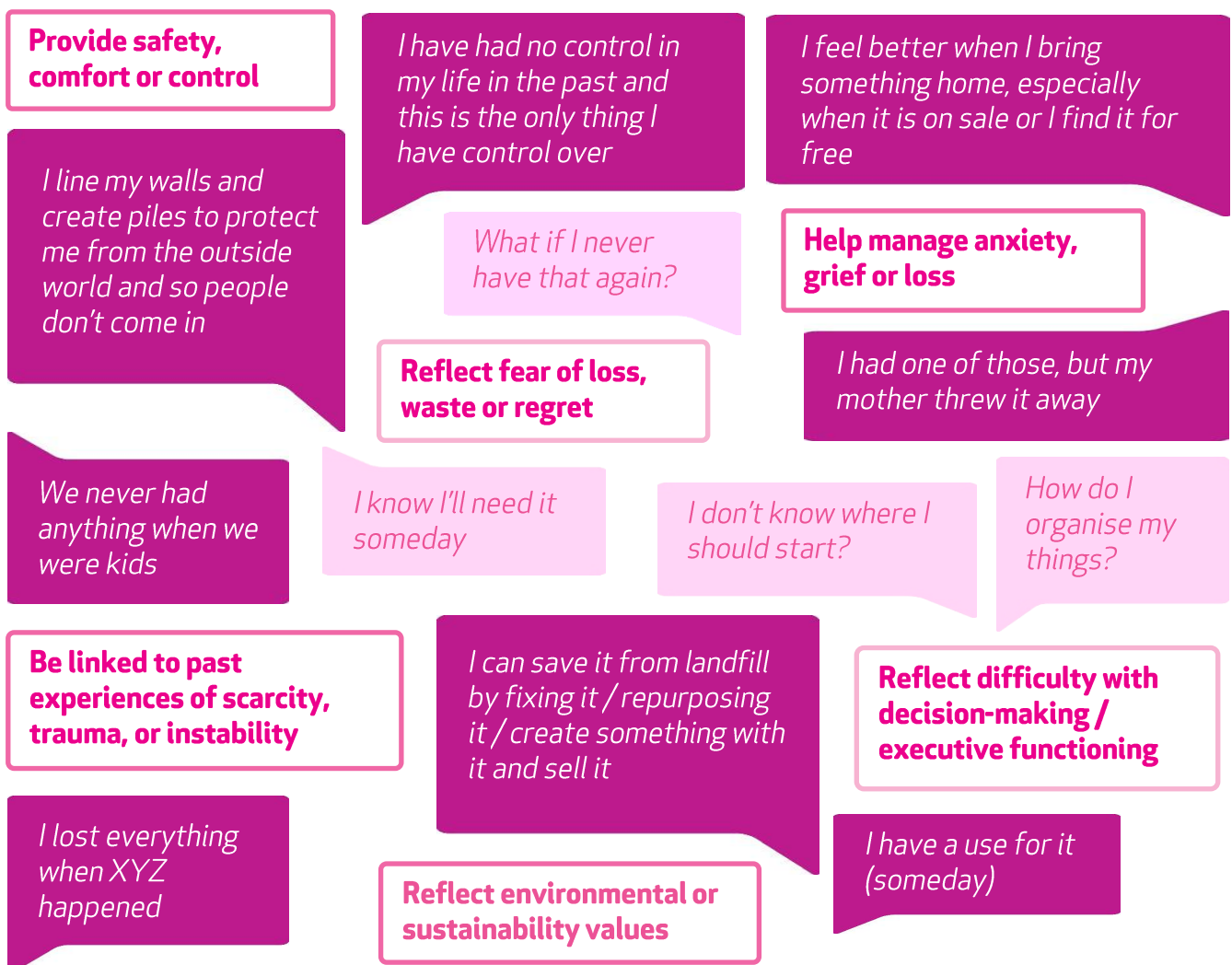
"Severe domestic squalor refers to filthy, unhygienic living conditions that pose a risk to health and safety and require significant cleaning or intervention."

[Diogenes Syndrome: Identification and Distinction from Hoarding Disorder - PMC](#)

Why it occurs

CA/CS/ADN does not occur in isolation. It is usually a response to underlying experiences, needs, or circumstances rather than a deliberate choice.

For many people, these behaviours serve a purpose. They may:



Comorbidities, Trauma and Life Experiences

CA/CS/ADN is often associated with a range of underlying factors that influence how a person functions, copes, and engages with support. These factors rarely occur in isolation and often interact in complex ways.

These can include:

- Significant and traumatic life events, sometimes resulting in complex trauma (cPTSD)
- Mental health challenges such as anxiety, depression, obsessive-compulsive traits, schizophrenia, bipolar disorder, and major depressive disorder
- Attachment patterns and relational difficulties
- Neurodivergence, including ADHD and autism
- Acquired brain injury, cognitive decline, or ageing-related changes
- Physical health issues or reduced mobility

These factors can impact areas such as **decision-making, emotional regulation, memory, organisation, and executive functioning**. For example, difficulties with attention, planning, and task initiation (commonly seen in ADHD or

cognitive decline) can make it harder to organise, discard items, or maintain routines. Similarly, anxiety or trauma can increase avoidance, attachment to items, or fear of making the wrong decision.

These influences are not always visible, but they play a central role in how and why CA/CS/ADN develops and persists. Understanding this helps shift the focus from judging behaviour to recognising it as a response to underlying needs, and reinforces the importance of a holistic, trauma-informed, and person-centred approach to support.

Physical Health, Capacity and Functional Impact

Physical health, mobility, and capacity can play a significant role in the development and progression of CA/CS/ADN. Chronic pain, fatigue, injury, disability, or ageing-related decline can make everyday tasks—such as cleaning, organising, or discarding items—physically difficult or overwhelming. Over time, this can lead to a gradual accumulation of belongings and increasing challenges in maintaining the home.

Understanding these functional impacts helps workers move beyond assumptions about motivation or willingness and instead consider capacity, support needs, and environmental barriers.

Key Message

Compulsive Saving (CS), Compulsive Acquiring (CA), and Associated Domestic Neglect (ADN) are complex experiences that should not be viewed as a matter of choice, laziness, poor housekeeping, or a lack of motivation. These behaviours are often influenced by a range of factors and co-occurring conditions. **Challenging assumptions and recognising the broader psychological, social, environmental, and health-related factors that contribute to these behaviours helps reduce stigma, build trust, and support more compassionate, person-centred practice.**

3. Home Assessment and Risk identification

Home Assessment Tools

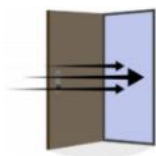
Clutter Image Rating (CIR) Scale

The [Clutter Image Rating \(CIR\) Scale](#) (Appendix, page 47) is an internationally recognised, evidence-based tool that provides an objective way to assess clutter severity. It uses photographs of a living room, kitchen, and bedroom rated from 1 (minimal clutter) to 9 (extreme clutter), allowing the person, worker, or observer to select the image that most closely matches the space. This creates a shared and more objective reference point for assessing clutter, monitoring environmental change over time, and informing decision-making.

Importantly, the CIR is an assessment tool and not a diagnostic tool. It measures visible clutter within the environment but does not explain the underlying causes, the impact and the risks.

Home Environment Assessment Tool for Hoarding (HEATH)

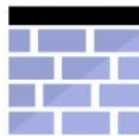
The [Home Environment Assessment Tool for Hoarding \(HEATH\)](#) - (Appendix, page 55) is a structured, evidence-informed tool used to assess environmental health and safety risks in properties impacted by hoarding or clutter. It supports workers to systematically observe, document, and rate risk across five key domains: safe pathways, fire safety, structural integrity, health and wellness, and sanitation.



Safe Pathways



Fire Safety



Structural Integrity



Health and Wellness



Sanitation

Using a simple scoring system, the HEATH assists workers to identify the severity of risks, prioritise responses, and support decision-making. The tool is designed to support consistent assessment while recognising the importance of context, professional judgement, and engagement with the person.

Practice Note

Assessment tools provide valuable information, but they should not replace professional judgement or conversations with the person. Environmental assessments **are most effective when combined with an understanding of the individual's experiences, strengths, goals, support needs, and recovery journey.**

Risk identification

Risk in CA/CS/ADN situations can vary significantly and should be assessed holistically. Risk should be assessed based on **impact rather than appearance**. High clutter does not always indicate high risk, and low clutter does not always indicate low risk.

Key areas to consider include:

- Falls and injury
- Biohazards (human and animal)
- Reduced access to bathroom facilities
- Toxic air quality and respiratory conditions
- Sharps and hazardous materials
- Vermin and infestation
- Structural hazards
- Food contamination and malnutrition
- Heat and ventilation concerns
- Mental health impacts
- Vulnerability and safeguarding concerns

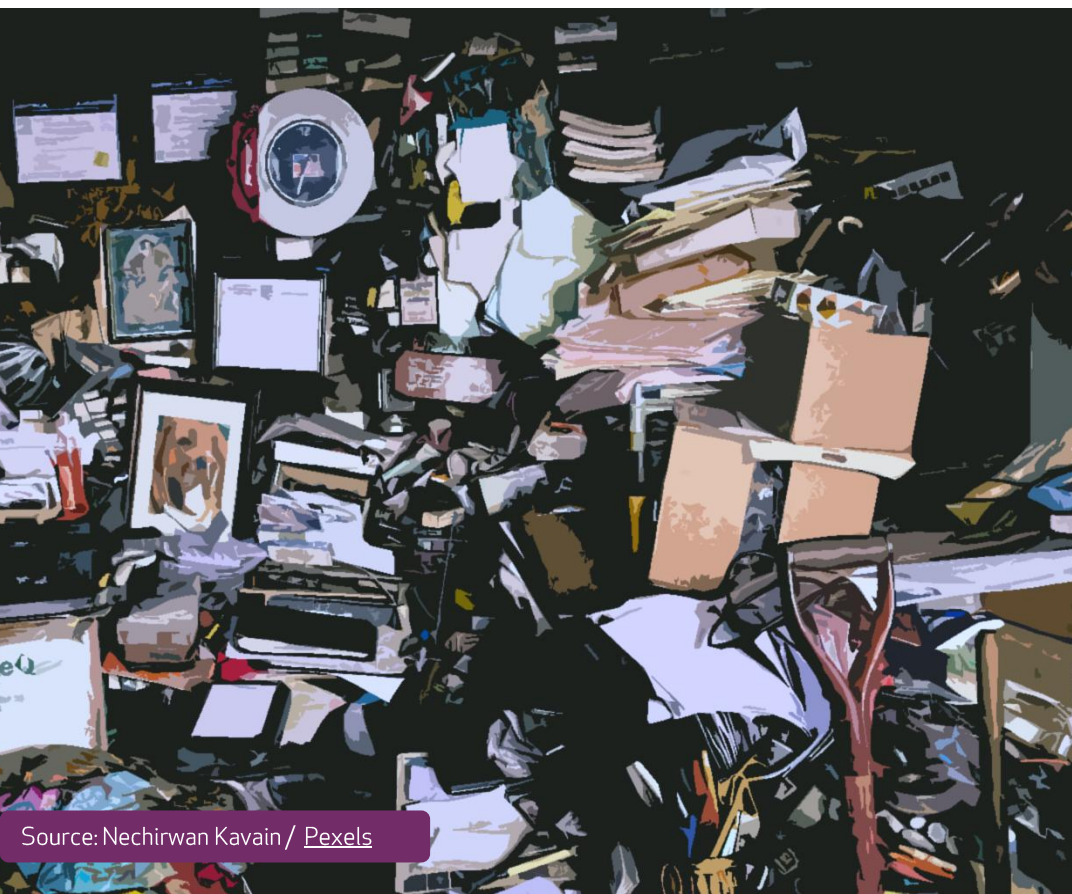
Home and Personal Safety

Fire Safety

Properties impacted by CA/CS/ADN can present significant fire risks due to increased fuel loads, restricted access and egress, and impeded emergency response. These risks may affect occupants, emergency responders, neighbours, and the broader community.

Common Fire Risks

- **Hazards and Ignition Risks** include electrical faults, overloaded power boards, heating sources, cooking incidents, smoking materials, and the unsafe storage or use of hazardous substances.
- Large volumes of belongings and materials that increase **fuel load and enable rapid fire spread**.
- Blocked exits, restricted movement, and limited visibility that may **delay evacuation and emergency response**.



Source: Nechirwan Kavain / [Pexels](#)



Source: Murray Pearce / [Pexels](#)



Source: Josefina / [Pexels](#)

Risks to Emergency Responders

- Restricted access, unstable piles, manual handling hazards, and reduced visibility can increase risks for firefighters and delay rescue efforts.

Available Supports: NSW Fire and Rescue provide free Home Safety Visits to support fire safety education, smoke alarm checks, and risk reduction planning. Go to [Home Safety Visits - Fire and Rescue NSW](#) to request a home visit.

Personal Safety

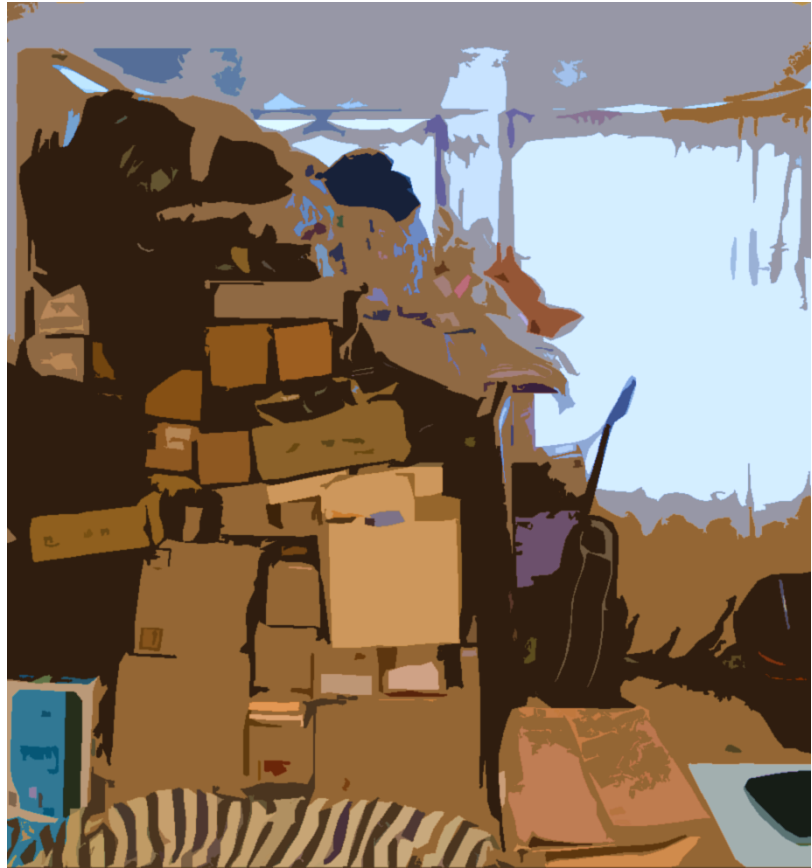
Properties impacted by CA/CS/ADN can present significant challenges for ambulance services and other emergency responders. Environmental barriers may delay access, restrict treatment options, complicate patient extraction, and increase risks for both the individual and attending personnel.

Common Personal Safety Risks

- Restricted entry and movement throughout the property
- Limited space to assess and treat an individual
- Structural instability and trip hazards
- Reduced visibility and contamination concerns
- Delays in emergency access and patient extraction

Risks to Paramedics and Emergency Responders

- Increased risk of manual handling injuries
- Exposure to environmental hazards and contaminants
- Trips, falls, entrapment, and restricted evacuation routes
- Increased psychological stress during complex responses



While safety risks require consideration, they should not become the sole focus of intervention. Effective practice balances risk management with understanding the person, their experiences, strengths, and recovery goals.

Practice Considerations for Workers

Physical Safety

Workers should approach all CA/CS/ADN environments with a focus on safety assessment before entry and intervention.

Consider the following:

- Treat every CA/CS/ADN environment as potentially unsafe until assessed
- Assess entry and exit before entering - and maintain a clear, accessible exit at all times
- Move cautiously and stay within stable, known pathways

- Maintain awareness of trip hazards, unstable piles, and structural risks
- Avoid contact with biohazards, sharps, or contaminated surfaces
- Use appropriate personal protective equipment (PPE) where required
- (e.g. sharps gloves, masks, steel-capped boots, eye protection)
- Monitor air quality, ventilation, odours, and temperature, and leave if unsafe
- Do not attempt to move or clear large items without planning and support
- Stay alert to vermin and pests, animals, or potential aggressive behaviour
- Work within your role and limits — your safety takes priority
- Leave and escalate if you feel unsafe.

Emotional Safety

While the physical conditions of the home can contribute to the challenge of the work, it is often the cumulative emotional and mental impact of hearing and holding these experiences, that can affect workers most. Unlike other recovery and support roles, this work takes place within the person's living environment, where years, and sometimes decades, of life experiences, trauma, loss, adversity, and life experiences exist.

As trust develops, workers may become one of the few people the individual feels safe enough to confide in and share their stories. Conversations can begin with one item and can quickly lead to deeply personal experiences of trauma, grief and loss, abuse, loneliness, or significant life challenges.

Over time, hearing and holding these stories may contribute to:

- Vicarious trauma
- Burnout
- Compassion fatigue
- Emotional exhaustion



It is important to recognise that this is skilled, relational, and emotionally intensive work that requires active and ongoing self-care. Regular supervision, reflective practice, peer consultation, and debriefing are essential components of safe and sustainable practice.

These supports help workers:

- Process experiences and emotional responses
- Maintain professional boundaries
- Reflect on decision-making and practice
- Reduce the risk of burnout and vicarious trauma
- Remain aligned with person-centred and trauma-informed approaches

Workers should actively prioritise their own wellbeing and seek support early. In addition to regular supervision, confidential services such as an Employee Assistance Program (EAP) can provide valuable support in processing challenging experiences, maintaining perspective, and sustaining capacity in this demanding work. Importantly, these supports are not only about maintaining professional effectiveness, but also about protecting personal wellbeing and recognising that the emotional impact of this work can extend beyond the workplace.



Source: Alejandro Quinonez / [Pexels](#)

Client Risk Assessment Tools

In addition to the considerations outlined in this guide, workers should utilise relevant organisational policies, procedures, and program-specific risk assessment tools to support decision-making, documentation, and risk management.

Key Message

The environment may be what workers first see, but the person must remain the primary focus - *Humans Before Homes*. **Lasting change is built through understanding, trust, collaboration, and hope**, not through judgement, urgency, or a sole focus on the condition of the home.

4. Foundations of Good Practice

Humans Before Homes

The principle of *Humans Before Homes* introduced earlier underpins all work in CA/CS/ADN.

Effective support prioritises:

- Understanding the person's situation, needs, and perspectives
- Building trust and working collaboratively
- Supporting change at a pace that is comfortable, realistic, and sustainable

Valuing Lived Experience and Peer Support

People with lived and living experience of compulsive acquiring, compulsive saving, and associated domestic neglect bring unique expertise and insight that cannot be learned through training alone. Their perspectives provide valuable understanding of the emotional, practical, and social realities of these experiences, helping to challenge assumptions, reduce stigma, and strengthen person-centred practice.

Peer support is grounded in shared understanding, mutuality, and hope. For many people, connecting with someone who has navigated similar challenges can reduce isolation, foster trust, and enhance engagement, while reinforcing the belief that meaningful recovery and change are possible.

Peer support complements, rather than replaces, clinical and psychosocial support.

It can promote:

- Hope and optimism
- Self-determination
- Social connection and belonging
- Increased confidence and self-efficacy
- Practical strategies informed by lived experience
- Recovery and meaningful participation in community life



Source: Ron Lach / Pexels

IN PRACTICE: Where available, consider opportunities to connect individuals with peer workers, lived experience services, or peer support groups as part of a holistic approach to recovery.

Why Forensic or Deep Cleans Don't Work

Rapid or forceful “forensic” or deep cleans may create a short-term visual outcome, but they are not effective interventions for CA/CS/ADN and can cause significant emotional and psychological harm.

These approaches focus on removing items rather than understanding why the behaviour exists. They do not address underlying drivers such as trauma, mental health, attachment, emotional regulation, coping strategies, or the function that acquiring and saving behaviours serve. As a result, they rarely lead to sustained change.

Research indicates that forced or non-consensual clean-outs are associated with extremely high rates of recurrence following intervention - estimated to be as high as 97%. More importantly, these interventions can be deeply distressing and experienced as a profound violation.

One individual described a forced clean-out as one of the most violating and distressing experiences of their life, feeling powerless, unheard, and disconnected from decisions affecting their possessions and personal space.

“It was like being raped. I felt completely violated. People I didn't know came into my space without my permission, touched everything, made decisions without me, and took things that mattered to me. It didn't matter that others saw them as worthless—those things were part of my life. It felt like something was taken from me that I could never get back.”

Rapid removal of items can:

- Reinforce fear, shame, and mistrust of services
- Re-traumatise individuals, particularly where trauma is already present
- Damage or completely break the therapeutic relationship
- Increase resistance to future support
- Lead to disengagement and avoidance

For many people, acquiring and saving behaviours have developed over years or decades. Belongings may provide safety, comfort, identity, control, purpose, or relief from emotional distress. Change therefore cannot be imposed through a single intervention. Like all behavioural change, recovery is a process rather than an event.

Forcing change before a person is ready may produce a short-term environmental outcome, but it rarely creates lasting behavioural change. Sustainable change is far more likely when the person feels safe, respected, involved in decision-making, and supported at their own pace.

In effect, these approaches remove the symptom without addressing the cause, often resulting in the behaviour returning. For these reasons, clean-outs should never be considered a first-line—or even second-line—response. They should only be used as a last resort where there is significant and immediate risk.

Supporting Change, Motivation and Meaningful Outcomes

Change is rarely linear. People often move between awareness, ambivalence, readiness, action, and relapse before change is sustained. The emotional attachment associated with saving behaviours and the comfort, reward, or relief gained through acquiring can make change particularly challenging.

What may appear as resistance is often:

- Fear of loss or change
- Feeling overwhelmed
- Lack of trust in services
- Previous negative experiences
- Uncertainty about coping without the behaviour

Workers can support change by:

- Meeting the person where they are at
- Focusing on what matters to them
- Working at a pace that feels safe and achievable
- Breaking change into small, manageable steps
- Recognising and reinforcing progress.

Motivation is built through feeling heard and respected, experiencing small successes, and having control over decisions. Lasting change is more likely when it is self-directed and meaningful to the person.

Goals should be guided by the person's values, strengths, and priorities rather than service expectations. Early goals are often best kept broad and non-overwhelming, then refined over time as insight, confidence, and engagement develop. Goals should be regularly reviewed, adapted, and used to guide support, recognising that recovery is dynamic and person-led.

Meaningful progress is not always visible in the environment. Increased trust, greater insight, improved routines, stronger decision-making skills, better emotional regulation, and a willingness to explore change are all important indicators of progress. These often occur before any noticeable changes in the home and should be recognised as significant milestones in the person's recovery journey.

Sustainable change is most likely when it is driven by the person, aligned with their values, and supported through trust, patience, and collaboration.



Source: PH Galtri / [Pexels](#)

Working with Values – What matters the most to people

Values provide a powerful foundation for recovery and behaviour change. They represent what is most important to a person and give meaning, purpose, and direction to their life.

Common values may include family, health, independence, connection, creativity, security, spirituality, learning, contribution, or personal growth.

People experiencing CA/CS/DN are often attempting to meet these values through their acquiring and saving behaviours, even when the outcome is no longer helpful. For example, a person who values connection may retain items linked to important relationships and memories, while someone who values security may save items “just in case” they are needed in the future.

Values can be identified through observation of the person, their environment, what they acquire, and the items to which they are most strongly attached. They can also be explored through structured values exercises and questionnaires (available online). Understanding a person's top 6 core values helps workers make sense of behaviours without judgement and provides a foundation for meaningful change.

When goals, decisions, and interventions are linked to what matters most to the individual, motivation becomes more personal, relevant, and sustainable. Values can be used to guide difficult decisions about acquiring, saving, or letting go by helping the person consider whether a behaviour aligns with the life they want to build.

People are more likely to engage in change when it is connected to what matters most to them, rather than what others think they should do.

Measuring Progress Beyond the Environment

One of the most common misunderstandings in CA/CS/ADN work is that progress is measured solely by visible changes within the home. While environmental change is important, it is often one of the last indicators of recovery rather than the first.

Workers may become discouraged when significant effort results in little visible change to the environment. However, meaningful recovery often begins with changes that are less obvious and occur long before noticeable reductions in clutter or improvements in the home.

Progress may include:

- Increased trust and engagement with support
- Greater insight into acquiring and saving behaviours
- Increased willingness to discuss challenges openly
- Improved emotional regulation
- Reduced shame and self-stigma
- Increased confidence in decision-making
- Greater awareness of acquiring triggers
- Development of routines and organisational skills
- Improved health and wellbeing
- Reconnection with family, friends, and community
- Increased participation in meaningful activities
- Greater confidence in asking for help
- Improved safety within the home
- Increased hope and belief in the possibility of change

For some people, progress may be as simple as allowing a worker into their home, discussing difficult experiences for the first time, or identifying one small goal they feel ready to work towards.

These milestones should not be overlooked simply because they do not immediately change the physical environment.



PRACTICE TIP:

When reviewing progress, the first question to ask is **what has changed for the person?** then **what has changed in the environment?**

Source: Filiz Yildiz / [Pexels](#)

Recovery is about more than creating space within a home. It's about putting humans before homes through creating a space for safety, wellbeing, connection, hope, and a meaningful life.

Key Message

Sustainable change is most likely when support focuses on the person rather than the environment. Progress is measured not only by changes within the home, but also by growth in trust, insight, confidence, wellbeing, autonomy, and hope. When workers prioritise relationships, strengths, values, lived experience, and readiness for change, meaningful and lasting outcomes become possible.

5. Communication and Engagement

Observing and Understanding the Human Through Their Environment

Assessment and information gathering often begins with careful observation. The physical environment can provide valuable insight into a person's circumstances, values, experiences, strengths, and potential support needs. However, it should always be interpreted in context, recognising that what is visible does not tell the full story, and that meaning is best understood through conversations with the person.

For example, a person who:

Behaviour	Possible interpretation
Acquires excessive clothing, shoes, or personal items	Self-expression and creativity Seeking confidence / self-esteem, Hiding behind a desired image, creating a façade
Holds onto family belongings	Grief, loss, guilt, connection, or unresolved attachment Provides a sense of safety, comfort, or positive memories
Collects broken items	Demonstrates creativity and resourcefulness Reflects own feeling of being “broken” or needing/wanting to be “fixed”
Books, newspapers – reading material	A desire for knowledge Doesn't feel intelligent or feels inferior Needs to be up to date to feel safe
Accepts unwanted gifts	Connection, belonging, or feeling valued because that person thought of them May be feeling vulnerable and influenced/pressured by others

Listening for Meaning

While the environment provides valuable insight, just as much can be understood through a person's words, body language, reactions, and overall communication style. What a person says, and how they say it, can offer important clues about their beliefs, emotional state, values, and the role their environment and belongings play in their life. Verbal and non-verbal communication often reflect identity, coping strategies, and underlying experiences that may not yet be fully expressed.

Workers should listen carefully for:

- The meaning the person assigns to their belongings
- How they describe their space and situation and the language **THEY** use
- Expressions of fear, control, safety, attachment, or responsibility
- Themes of loss, obligation, or missed opportunity
- The reasons they acquire items and what they gain from obtaining them

Workers should remain attentive to the meaning people attach to acquiring, saving, organising, and living within their environment. Listening for underlying emotions, needs, and values often provides more useful information than focusing solely on the behaviour itself.

Verbal and Non-Verbal Communication	Possible Interpretation
"It's important"	Fear of missing out or not having enough
"It's useful"	Fear of regret
"It's a part of me"	Strong emotional or identity-based attachment
"I will need it later"	Anxiety, uncertainty, or previous experiences of lack
"It's not that bad"	Protection from shame, fear, or feeling overwhelmed
"I don't want it to go to landfill"	Feelings about waste, value, or responsibility
"It was too good to pass up"	Fear of missing an opportunity
"It might come in handy"	Need for security or preparedness
"I got a bargain"	Sense of achievement, reward, or success
"It deserves a good home"	Emotional attachment, empathy, or rescuing behaviour
Visible excitement when discussing purchases	Acquiring may be meeting an emotional need or providing a "feel good" response
Avoidance when discussing items	Feeling triggered

Trust and Rapport

Many people experiencing CA/CS/ADN have lived with shame, judgement, intrusion, or loss of control. As a result, they may initially be cautious, guarded, or reluctant to engage. Building trust requires patience, consistency, honesty, and respect for the person's space, belongings, and pace of change. Being invited into someone's home is often a significant sign of trust and should not be underestimated.

Some individuals may find it easier to begin engaging with support through connection with a peer worker who has lived experience of mental health challenges, recovery, or experiences relating to acquiring and saving behaviours. Peer relationships can complement professional relationships and help bridge early engagement barriers.



Small, consistent interactions are often more effective than large, one-off interventions. Over time, a person's language may become more open, reflective, and willing to explore change. This shift is often an early indicator of progress, even before any visible change in the environment occurs.

Observing and Understanding the Human Through Their Attachments and Emotions

At the centre of CA/CS/ADN are not just behaviours, but the emotions, attachments, experiences, and needs that sit beneath them. For many people, possessions are far more than physical objects. They may represent safety, identity, comfort, memories, opportunity, control, or connection to people and important life experiences. Understanding the meaning of items is essential to understanding the person.

While the environment provides important information, understanding the emotions, needs, and attachments behind what is observed is equally important. Attachment influences both compulsive saving and compulsive acquiring behaviours. People may struggle to let go of items because of fear of loss, uncertainty, guilt, regret, or a perceived future need. At the same time, acquiring can provide a sense of excitement, comfort, hope, or achievement.



Source: Cottonbro / Pexels

Workers should remain curious about the emotional significance of belongings and pay attention to emotional responses when items are discussed, acquired, moved, or considered for removal. Anxiety, distress, avoidance, indecision, defensiveness, excitement, or strong attachment can provide valuable insight into the needs the behaviour is meeting.

These emotional responses should not be viewed simply as resistance. They often reveal what the person is trying to gain, protect, avoid, or cope with. A trauma-informed approach is therefore essential, as both acquiring and letting go can be deeply connected to a person's sense of safety, identity, and wellbeing.

Conversation Starters and Curious Questions

The quality of conversations often determines the quality of engagement. Questions that are curious, respectful, and open-ended can help workers better understand the person, their experiences, and the meaning behind behaviours.

The aim is not to interrogate or challenge the person, but to create opportunities for reflection, insight, and shared understanding.

Curiosity creates understanding. Understanding creates trust. Trust creates the conditions for meaningful and sustainable change.

Understanding attachment helps workers move from asking "Why won't they let this go?" or "Why do they keep bringing more in?" to:

"What need is this meeting for the person?"

Key Message

Effective communication is about more than gathering information. It is an opportunity to build trust, understand meaning, strengthen engagement, and support hope. By listening with curiosity, recognising the significance of belongings, and seeking to understand the person behind the environment, workers create the conditions for meaningful and sustainable change. The goal is not to convince, persuade, or direct, but to understand, collaborate, and support the person's own recovery journey.

6. Understanding Acquiring Behaviour

Why People Compulsively Acquire

While much of the focus in CA/CS/ADN is placed on decluttering and discarding, understanding acquiring behaviour is equally important, as lasting change is unlikely if items continue to enter the environment faster than they leave it

Compulsive acquiring and compulsive saving are related but distinct behaviours. Some people primarily struggle with acquiring, others with discarding, and many experience both.

Acquiring often serves a purpose beyond obtaining an item. It may provide:

- Comfort, excitement, or a sense of reward
- Relief from stress, loneliness, boredom, anxiety, or low mood
- A sense of security, preparedness, or control
- Identity, meaning, or self-expression
- Fear of missing out on an opportunity, bargain, or future need
- Feelings of scarcity, deprivation, or "never having enough"
- A temporary boost to confidence, self-worth, or self-esteem
- Difficulties with impulse control, attention, or executive functioning
- Anxiety, intrusive thoughts, anxiety, or fear of loss and regret



Source: esranuralay / Pexels

For some people, the process of finding, purchasing, collecting, rescuing, or receiving an item creates a short-term sense of enjoyment, accomplishment, or emotional relief. The anticipation and search for an item can become rewarding in itself, reinforcing the behaviour and increasing the likelihood that it will be repeated.

Others may acquire items because they fear missing an opportunity, wasting something useful, or repeating past experiences of loss, deprivation, or scarcity.

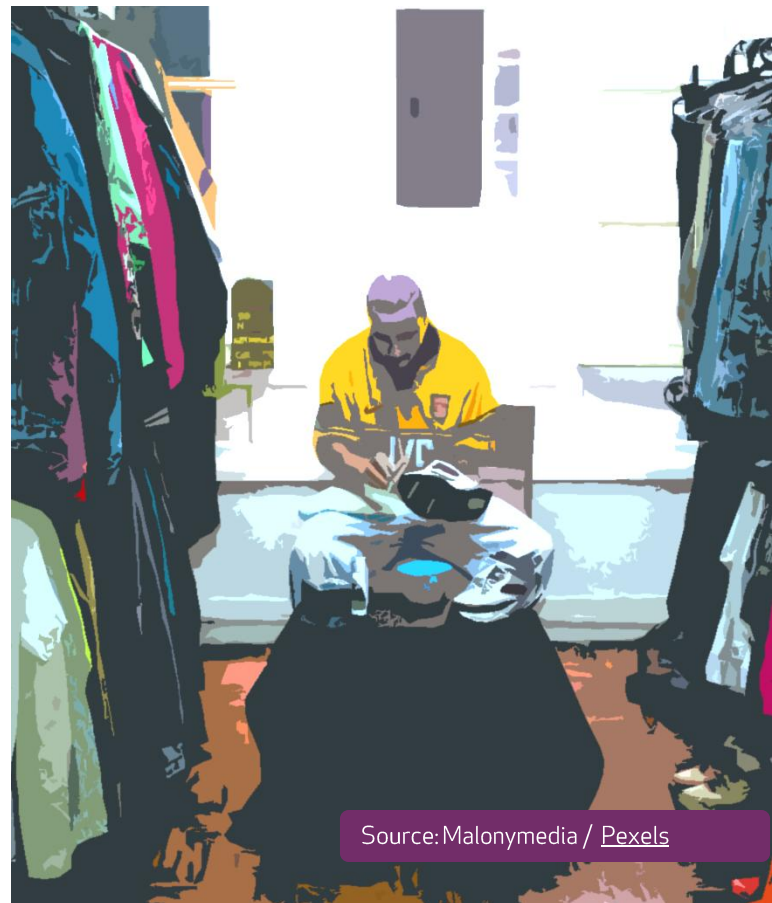
Responding to Compulsive Acquiring Behaviour

Rather than focusing solely on stopping acquiring, workers should remain curious about what the behaviour provides for the person. Understanding the purpose of the behaviour can help identify alternative ways of meeting the same underlying needs.

Support strategies may include:

- Identifying patterns, triggers, and high-risk situations
- Exploring the thoughts, feelings, and needs associated with acquiring
- Linking decisions to the person's values and goals
- Introducing pauses between urge and action
- Supporting budgeting, planning, and decision-making skills
- Exploring alternative ways to meet emotional, social, or practical needs
- Celebrating small successes and progress

As with compulsive saving, lasting change is more likely when the person feels understood, involved in decision-making, and supported to develop their own strategies over time. To reduce accumulation, it is important to understand not only why items stay, but also why they come into the environment in the first place.



Source: Malonymedia / Pexels

Key Message

Compulsive acquiring is often about more than obtaining possessions. The behaviour may provide comfort, connection, relief, security, identity, or a sense of reward. Understanding the needs that acquiring is meeting, helps workers move beyond simply addressing the behaviour and towards supporting meaningful, sustainable change.

7. Recovery Approaches and Therapeutic Foundations

All effective work in CA/CS/DN is grounded in a combination of person-centred, trauma-informed, culturally responsive, recovery-oriented, strengths-based, and evidence-informed practice. These approaches ensure that support is guided by the person's experiences, strengths, needs, values, and goals, rather than focusing solely on the condition of the environment.

Person-Centred Practice

A person-centred approach recognises that the individual is the expert in their own life. It involves working with the person, respecting their autonomy, and supporting change at a pace that reflects their capacity, readiness, and priorities. Rather than imposing outcomes, the focus is on understanding what matters to the person and building on their strengths, skills, and resilience.

IN PRACTICE: Involve the person in all decisions, work towards their goals, and support informed choice even when those choices differ from service expectations.

Trauma-Informed Practice

Many people experiencing CA/CS/ADN have experienced trauma, loss, adversity, or significant life disruption. These experiences can influence how they relate to possessions, safety, control, and relationships. Trauma-informed practice prioritises emotional and physical safety, trust, choice, collaboration, and the avoidance of re-traumatisation.

IN PRACTICE: Move at the person's pace, avoid coercive approaches, seek permission before making changes, and recognise that acquiring or saving behaviours may have developed as coping strategies.

Culturally Responsive Practice

People's beliefs about possessions, home, safety, and support are influenced by their culture, background, and lived experiences. Experiences such as poverty, war, displacement, homelessness, natural disasters, or intergenerational patterns may shape attitudes towards saving, acquiring, and resource use.

IN PRACTICE: Remain curious about the person's experiences and avoid assumptions about what is "normal." Adapt approaches to reflect the person's values, identity, culture, and life history.

Key Message

No single approach provides all the answers. Effective support draws on a range of complementary approaches that prioritise safety, respect, collaboration, strengths, and recovery. Regardless of the approach used, the focus should remain on understanding the person, supporting self-determination, and working towards meaningful and sustainable change.

8. Therapeutic Practices to Support Sustainable Long-Term Change

An Overview

The approaches outlined below may be used by clinicians or inform broader practice. Workers are not expected to deliver formal therapy; however, understanding these approaches can support more informed, consistent, and effective engagement. Many of their principles are already used in everyday conversations and support work, often without workers realising it.

While each approach has its own focus, many share common principles such as collaboration, compassion, strengths-based practice, and behaviour change. The descriptions provided are intended as a brief overview only and do not replace formal training, supervision, or professional qualifications. Rather, they are intended to support recovery-oriented practice, strengthen engagement during support sessions, and help workers recognise when referral to specialist services may be beneficial.

Motivational Interviewing (MI)

A collaborative approach that helps people explore ambivalence and strengthen their own motivation for change. It focuses on drawing out a person's own reasons for change rather than persuading or directing them.

IN PRACTICE: Use open questions, reflective listening, and affirmations to explore what matters to the person and support them to identify their own motivations, goals, and next steps.

Cognitive Behavioural Therapy (CBT)

Focuses on the relationship between thoughts, feelings, and behaviours. In CA/CS/DN, it can

help people understand and challenge unhelpful beliefs about possessions, responsibility, decision-making, and perceived future need.

IN PRACTICE: Explore beliefs such as "I might need this one day" or "I'll regret getting rid of it" and support the person to consider alternative perspectives.

Dialectical Behaviour Therapy (DBT)

Focuses on emotional regulation, distress tolerance, and managing strong emotions. It is particularly useful where overwhelm, anxiety, shame, or frustration interfere with decision-making.

IN PRACTICE: Support the person to use grounding, paced breathing, breaks, or other regulation strategies when sorting, making decisions, or resisting urges to acquire.

Acceptance and Commitment Therapy (ACT)

Supports people to accept difficult thoughts and feelings while taking action aligned with their values. The focus is not on eliminating discomfort, but on moving towards what matters.

IN PRACTICE: Connect tasks and decisions back to the person's values, goals, and the life they want to build.

Interpersonal Psychotherapy (IPT)

Explores how relationships, loss, grief, social isolation, and interpersonal experiences influence wellbeing and behaviour. For some individuals, possessions may provide comfort, connection, or stability that has been difficult to find elsewhere.

IN PRACTICE: Explore how relationships, life experiences, grief or social isolation, or relationship experiences may influence acquiring, saving, or engagement with support.

Attachment Styles and Their Influence

While attachment theory overlaps with Interpersonal Psychotherapy (IPT), it provides a broader framework for understanding why acquiring, saving, and engagement behaviours can become closely linked to emotional needs.

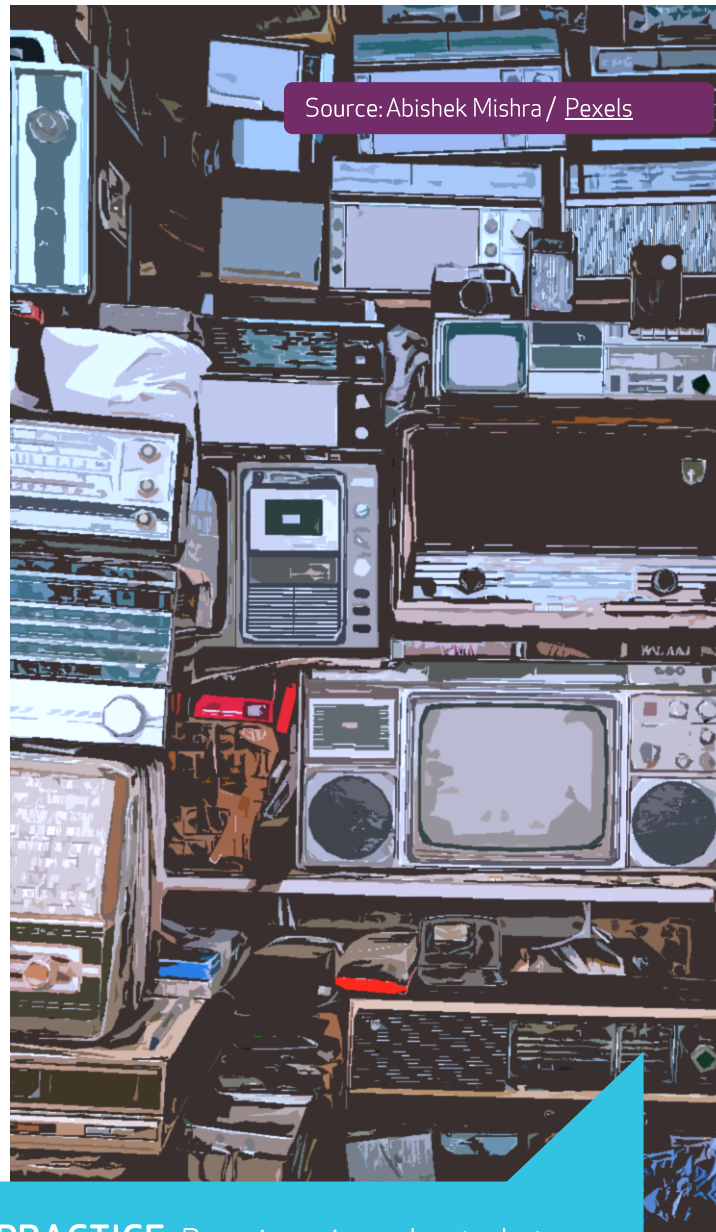
Attachment refers to the ways people develop a sense of safety, trust, and connection through early relationships and life experiences. These patterns often continue into adulthood, influencing how people relate not only to others, but also to their environment and belongings.

In CA/CS/ADN, possessions can sometimes serve the same purpose as relationships, providing comfort, security, predictability, identity, or a sense of control. This helps explain why it can be difficult to let go of items, why some people continue to acquire despite negative consequences, and why change can feel threatening.

Common attachment patterns may include:

- **Anxious attachment** – a strong need for security and fear of loss, often contributing to saving items "just in case" or distress when discarding.
- **Avoidant attachment** – discomfort relying on others, leading some people to depend more on possessions than relationships for stability or comfort.
- **Disorganised attachment** – often associated with trauma and conflicting needs for safety and control, contributing to both acquiring and difficulty letting go.

These patterns are not always obvious, but they can strongly influence behaviour, decision-making, and engagement with support. Understanding attachment helps workers look beyond behaviour and consider the needs for safety, stability, connection, and control that may sit beneath it.



IN PRACTICE: Remain curious about what belongings represent for the person and the role they play in meeting emotional needs. Rather than asking "Why won't they let this go?", consider:

"What does this provide for them?"

Building safe, consistent, and trusting relationships can help reduce fear and support meaningful change over time.

Positive Psychotherapy

Focuses on values and strengths, resilience, wellbeing, and what is working well. Rather than concentrating solely on problems, it identifies and builds upon a person's existing capabilities and successes.

IN PRACTICE: Regularly highlight values, strengths, achievements, and progress, no matter how small, to build confidence, hope and self-efficacy.

Narrative Therapy

Helps people examine the stories they hold about themselves and separate their identity from the problem. This can reduce shame and create opportunities for a more empowering narrative.

IN PRACTICE: Help people separate their identity from the behaviour, for example shifting from "This is who I am" to "This is something I am experiencing and working through."

Solution-Focused Brief Therapy (SFBT)

Focuses on identifying what is working and building practical solutions. Rather than analysing problems in depth, it looks for strengths, exceptions, and achievable next steps.

IN PRACTICE: Ask questions such as "What's already working?" or "What would be one small step forward?" and build on successes.

Compassion-Focused Therapy (CFT)

Focuses on reducing shame and self-criticism while building self-compassion and emotional safety. This is particularly relevant given the stigma often experienced by people living with CA/CS/ADN.

IN PRACTICE: Model compassionate language and encourage the person to view themselves with understanding rather than blame or judgement.

Exposure Therapy

Involves gradual exposure to difficult situations or decisions to reduce anxiety and build confidence over time.

IN PRACTICE: Start with small, manageable tasks such as delaying a purchase, donating one item, sitting with the discomfort of uncertainty, or visiting a shop without purchasing anything.

Family Therapy

Supports family members and significant others to better understand CA/CS/ADN and improve communication, boundaries, and support.

IN PRACTICE: Help family members move from pressure and urgency toward empathy, consistency, and respectful engagement. It may also reveal historical connections and patterns.

Mindfulness

Develops awareness of presence, thoughts, emotions, and urges without immediately acting on them. This helps reduce automatic or impulsive responses.

IN PRACTICE: Encourage pausing before acquiring, saving, or discarding, and noticing thoughts, feelings, and urges before making a decision.

Life Skills and Independent Living Skills Training

Focuses on building practical skills that support independence, organisation, household management, and daily routines in the home.

IN PRACTICE: Work alongside the person to develop simple systems, routines, and organisational skills that improve THEIR functioning and reduce overwhelm.

Peer Support Groups

Peer Support Groups provide connection with others who have lived experience, helping to reduce isolation, shame, and stigma while offering encouragement, understanding, and practical strategies. Through sharing experiences, challenges, successes, and setbacks, people can develop greater confidence, self-compassion, and belief in their own capacity for change.

Hearing others speak openly about challenges, setbacks, and successes can build resilience, persistence, and self-compassion while reducing self-blame. Over time, peer support can provide an ongoing sense of connection, accountability, and belonging that extends beyond formal services and helps sustain progress.

Peer support groups may help individuals:

- Reduce self-stigma and shame
- Develop supportive social networks
- Learn practical coping and organisational strategies
- Increase confidence in managing setbacks
- Build motivation through shared recovery stories
- Strengthen community connection and belonging
- Increase hope and belief that change is possible

IN PRACTICE: Where a Peer Support Group is available, encourage participation and consider attending alongside the person until they feel comfortable. Where no group exists and there is sufficient interest, consider opportunities to establish or support a peer-led group, recovery community, or mutual support network.

Reflective Practice

When considering therapeutic approaches, it is important to remember that every person, situation, and recovery journey is unique. No single approach will suit everyone, and effective support often involves drawing on a range of principles and adapting them over time to reflect the person's strengths, needs, goals, and circumstances. Rather than focusing on a specific therapeutic model, workers can use these approaches to inform engagement, strengthen recovery-oriented practice, and support meaningful change.

The following reflective questions may help guide your work alongside the person throughout their recovery journey:

- What will help me better understand the person's experiences, perspectives, and needs?
- What strengths, interests, and existing supports can I build upon?
- What is most important to the person right now?
- How does this align with their goals, values, and priorities?
- What immediate risks or challenges need to be addressed?
- What would a trauma-informed and recovery-oriented response look like in this situation?
- How can successes and progress be recognised and celebrated in ways that are meaningful to the person?
- What is within my role and scope of practice, and what may require referral or specialist support?

Key Message

No single therapeutic approach is effective for every person or situation. The approaches outlined above offer different ways of understanding behaviours, emotions, relationships, values, and change. While workers are not expected to provide therapy, an understanding of these principles can strengthen engagement, inform practice, and support recovery-oriented care.

Regardless of the approach used, the focus should remain on understanding the person, building on strengths, fostering hope, and supporting meaningful and sustainable change. As with all aspects of CA/CS/ADN practice, the goal is not simply to change the environment, but to support the person behind it.

9. In Practice

Supporting change in CA/CS/ADN is a recovery journey, not a time-limited intervention. Effective support is relational, gradual, and focused on building the person's capacity, skills, and confidence over time rather than "fixing" the environment. Progress is unique to each individual and rarely linear, often involving setbacks and re-engagement, patience, consistency.

Practical In-Home Support (Working With, Not Doing For)

Building Trust Before Entering the Home

Some people may not allow workers into their home for weeks, months, or even longer. This is often not about being uncooperative, but about needing to feel safe, respected, and confident they will not be judged. Many people experiencing compulsive acquiring, compulsive saving, and/or associated domestic neglect have lived with years of shame, stigma, criticism, and misunderstanding, often from people whose opinions matter deeply to them. Building enough trust for someone to open their door can therefore be a significant step in the recovery journey.

While workers can use therapeutic and engagement approaches to encourage access, trust cannot be rushed. Pushing too quickly may reinforce fears of judgement and damage the relationship. Instead, workers should focus on patience, consistency, empathy, and genuine curiosity, taking time to build rapport and trust. Often, it is the strength of the relationship, rather than any specific intervention, that helps a person feel safe enough to eventually invite someone into their home.

The Purpose of In-Home Support

Support in the home should be collaborative and capacity-building, not task-focused. Workers are not cleaners, de-clutterers, or professional organisers brought in to "fix" or clean the home or do things for the person.

In-home support creates the opportunity to work alongside the person and support them to:

- Increase insight and awareness of their compulsive acquiring and/or compulsive saving behaviours
- Develop the skills, confidence, routines, and decision-making abilities needed to manage their environment
- Build independence, self-efficacy, and ownership of the recovery process
- Strengthen daily living skills and establish sustainable habits
- Develop practical strategies to support long-term change and maintain progress
- Improve emotional awareness, emotional regulation, and the ability to tolerate discomfort associated with acquiring, saving, sorting, or letting go

Working with the person means focusing on engagement, learning, capacity-building, and shared decision-making rather than task completion. The goal is support and empower the person to develop the confidence, skills, insight, and strategies needed to manage their environment independently over time.

Consistency and Structure

Consistency is important. Meeting on a regular day and time provides structure, predictability, and routine, which can support engagement and build momentum for change. Over time, people often begin to develop their own systems, look forward to sessions, and increasingly take ownership of the process.

Sessions should remain flexible and may involve planning, psychoeducation, problem-solving, practical support, or simply strengthening the therapeutic relationship.

Session Length and Measuring Progress

It is often helpful to start with shorter sessions of around one hour. As trust, engagement, and capacity develop, sessions can gradually extend to two to three hours where appropriate. The ideal duration will vary depending on the person's needs, emotional wellbeing, stage of change, and ability to remain engaged without becoming overwhelmed.

It is also important to recognise that progress is not measured solely by the amount of decluttering or practical work completed. A person may spend an hour with a worker but only be able to tolerate a few minutes of sorting, decision-making, or letting go of items. This does not mean the session has been unsuccessful. Building trust, strengthening motivation, processing emotions, and increasing a person's capacity to tolerate discomfort, uncertainty, and change are often just as important as the practical tasks themselves and can create the foundation for sustainable progress over time.

What may appear to be a small achievement to a worker can represent a significant milestone for the person. Five minutes of sorting, making a difficult decision, or letting go of a single item may be the most progress they have made in months or even years. These achievements should be recognised and celebrated, no matter how small they may seem. When viewed in the context of the person's experiences, fears, and challenges, what appears to be a minor step can in fact be a monumental act of courage, resilience, and change.



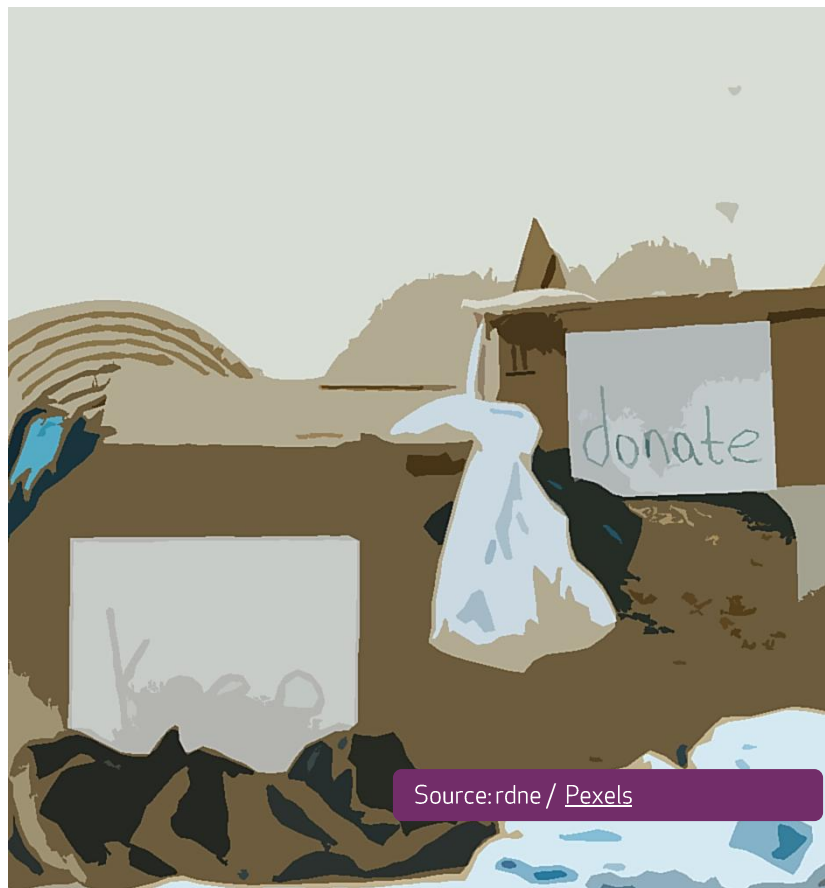
The Four-Box Method

When a person is ready to begin sorting, many workers find it helpful to use the Four-Box Method. This approach can help structure decision-making and reduce the overwhelm often associated with sorting possessions.

The four boxes are:

1. **Keep** – Items the person has decided to keep.
2. **I Don't Know Yet** – Items the person is not ready to make a decision about.
3. **Donate** – Items the person is willing to give to others.
4. **Discard** – Items that are no longer wanted and can be safely disposed of.

The "I Don't Know Yet" box is often one of the most important. It removes the pressure of making immediate decisions and acknowledges that some decisions require time. This can help reduce anxiety, build confidence, and increase a person's willingness to engage in the sorting process. Workers should avoid pressuring people to make rapid decisions and instead, focus on supporting decision-making at a pace that feels manageable and safe and then celebrated.



Source: rdne / Pexels

Knowing When to Refer

An important part of working in CA/CS/ADN is recognising the scope and limits of the role. While workers play a vital and often transformative part in supporting engagement, building trust, and developing practical skills, they are not clinicians and are not responsible for providing therapeutic intervention or addressing complex underlying trauma.

Many individuals with CA/CS/AND experience significant trauma, mental and/or physical health challenges, or complex comorbidities that require specialist support. While workers play an important role in building engagement, insight, and practical skills, exploring these issues in depth without appropriate training may be unsafe and risk causing harm or re-traumatisation. Knowing when to refer to counsellors, psychologists, psychiatrists, or other specialist services is therefore essential. Sustainable outcomes are often achieved through a shared approach, where therapeutic support is provided alongside practical, in-home, and case management interventions.

Recognising the need for additional support is not a limitation of the role, but a reflection of good practice. Effective support occurs when each professional works within their area of expertise, contributing to a coordinated, person-centred approach that promotes safe, holistic, and sustainable recovery.

Case Management, Collaboration and Coordinated Support

Case management is often a critical component of supporting people experiencing CA/CS/ADN. The complexity of these situations frequently extends beyond the scope of a single worker or service, requiring a coordinated approach that addresses practical, social, health, housing, and mental health needs.

Effective case management involves working collaboratively with the person to identify priorities, establish meaningful goals, coordinate supports that assist their recovery. It may include advocacy, referrals, service coordination, and ensuring communication between services remains clear, consistent, and focused on shared outcomes.

Depending on the individual's circumstances, workers may liaise with a range of agencies and professionals, including but not limited to:

- Housing providers (e.g. Homes NSW and Community Housing providers)
- NSW Health and mental health services
- General Practitioners, psychologists, psychiatrists, and allied health professionals
- Hospital social workers and discharge planners
- DCJ and child protection services
- My Aged Care and Carefinders
- Psychosocial support programs
- Community services, NDIS providers, and support coordinators
- Local councils, emergency services, and specialist CA/CS/ADN services
- Peer workers and lived experience services
- Peer-led support groups and community recovery groups

Wherever available, lived experience and peer support services should be considered an important component of a holistic support plan rather than an optional add-on as it can strengthen engagement, hope, and connection throughout the recovery journey.

The goal of case management is not to create dependence on services, but to build capacity, strengthen natural and community supports, and increase the person's ability to direct their own recovery with growing independence over time. Effective case management helps ensure that the right supports, relationships, skills, and systems are in place to promote sustainable change and support long-term wellbeing beyond formal service involvement.

Psychoeducation; Formal and Informal

Psychoeducation helps individuals, families, and services better understand CA/CS/ADN, reducing shame, increasing insight, and supporting engagement in change. It helps people recognise patterns in their behaviour, understand underlying drivers, and develop practical strategies for managing acquiring, saving, and related challenges.

Structured resources can be particularly helpful. For example, **Buried in Treasures** (Tolin, Frost & Steketee) is a widely used, evidence-based CBT workbook designed specifically for people experiencing hoarding behaviours. It provides practical, step-by-step guidance to build insight, strengthen decision-making skills, and support gradual behavioural change. The workbook can be used individually or in groups and is often revisited throughout the recovery journey. Many people also find it useful for helping family members, friends, and other supports better understand their experiences.

Psychoeducation may include:

- Understanding the role of trauma, attachment, and coping
- Normalising ambivalence, setbacks, and non-linear progress
- Exploring the connection between thoughts, emotions, and behaviours
- Developing practical strategies to support decision-making and change

The aim is not to overwhelm people with information, but to build awareness gradually in a way that is relevant and meaningful to them. When linked to a person's experiences, values, and goals, psychoeducation can strengthen engagement, reduce stigma, and support long-term recovery.

Common Barriers and Ethical Dilemmas

Working in CA/CS/ADN involves navigating a range of personal, environmental, service, and ethical challenges that can impact engagement and progress. Maintaining a person-centred, recovery-oriented approach while balancing safety, autonomy, and service expectations is often complex.

When faced with challenging situations or uncertainty, workers should seek guidance through supervision, consultation, and reflective practice to support ethical and informed decision-making.

Common challenges include:

Person-Related Barriers

- Differences in awareness, readiness, or perceptions of risk
- Physical health limitations and reduced capacity
- Cognitive decline
- Severity of domestic neglect or environmental conditions
- Limited financial resources

System and Service Barriers

- Pressure and competing priorities from external stakeholders for rapid outcomes (e.g. *tenancy breach notices requiring immediate action*)
- Program and service constraints
- Limited access to practical resources, brokerage, and community supports

Practice and Ethical Challenges

- Balancing risk with the person's right to autonomy
- Maintaining professional boundaries (e.g. the person begins viewing the worker as a friend or primary source of support)
- Exposure to drug paraphernalia, sharps, biohazards, or hazardous substances such as animal or human faeces
- Pets and animal welfare concerns

In addition to the challenges above, one of the most significant ethical considerations in CA/CS/ADN work is managing the worker-person relationship. Workers are often invited into highly personal spaces and entrusted with experiences, stories, and circumstances that may have been hidden from others for many years.

As trust develops, individuals may offer gifts, seek contact outside agreed boundaries, or begin to view the worker as a friend rather than a professional. While these responses are understandable, maintaining clear, compassionate boundaries is essential to protecting both the individual and the worker, and ensuring the relationship remains focused on the person's recovery, wellbeing, and goals.

Supporting Families and Significant Others

Children and Family Safety: Where children are living in, regularly visiting, or otherwise exposed to environments affected by CA/CS/ADN, their health, safety, wellbeing, development, and access to essential living spaces must be carefully considered.

These situations can present complex practice and ethical challenges, requiring workers to balance a person-centred and recovery-oriented approach with safeguarding responsibilities, risk management, and any child protection obligations.

Workers should be familiar with their organisation's policies, mandatory reporting requirements, and legal responsibilities, while continuing to engage the person with compassion, dignity, and respect.

Family Experience: Family members, carers, neighbours, and other significant people are often impacted by CA/CS/ADN. They may experience concern, frustration, guilt, grief, exhaustion, fear for the person's wellbeing, and uncertainty about how best to help.

Understanding the Behaviours: Families and significant others often benefit from understanding that CA/CS/ADN is rarely about laziness, choice, or a lack of care. These behaviours are influenced by a range of emotional, psychological, social, health, and practical factors. Family members may also have their own experiences, triggers, losses, or family history of acquiring, saving, or domestic neglect, which can influence how they respond to the situation.

Support and Role Boundaries: Families may benefit from psychoeducation, counselling, peer support, family support, or carer support services. Where appropriate, workers may provide information, facilitate conversations, or support family members to better understand CA/CS/ADN. However, the level of involvement should be guided by the person's wishes, the worker's role, organisational policies, and any identified risks. Workers are not expected to provide family therapy or specialist interventions unless appropriately qualified and authorised to do so. Where additional support is needed, referral to appropriate services may be beneficial.

Key Message

Families and significant others are often affected by CA/CS/ADN and may need support in their own right. Building understanding, maintaining relationships, and promoting collaboration can be just as important as addressing the practical impacts of acquiring, saving, and domestic neglect. Positive outcomes are more likely when support focuses on understanding, safety, and partnership rather than blame, judgement, or pressure to change.

10. Animal Hoarding

Understanding Animal Hoarding

Animal hoarding involves the accumulation of animals beyond a person's ability to adequately provide for their health, welfare, and living needs. Unlike responsible pet ownership or animal rescue activities, the number of animals eventually exceeds the person's available resources and capacity to provide appropriate care, resulting in impacts on both the animals and the individual.

The Human-Animal Connection

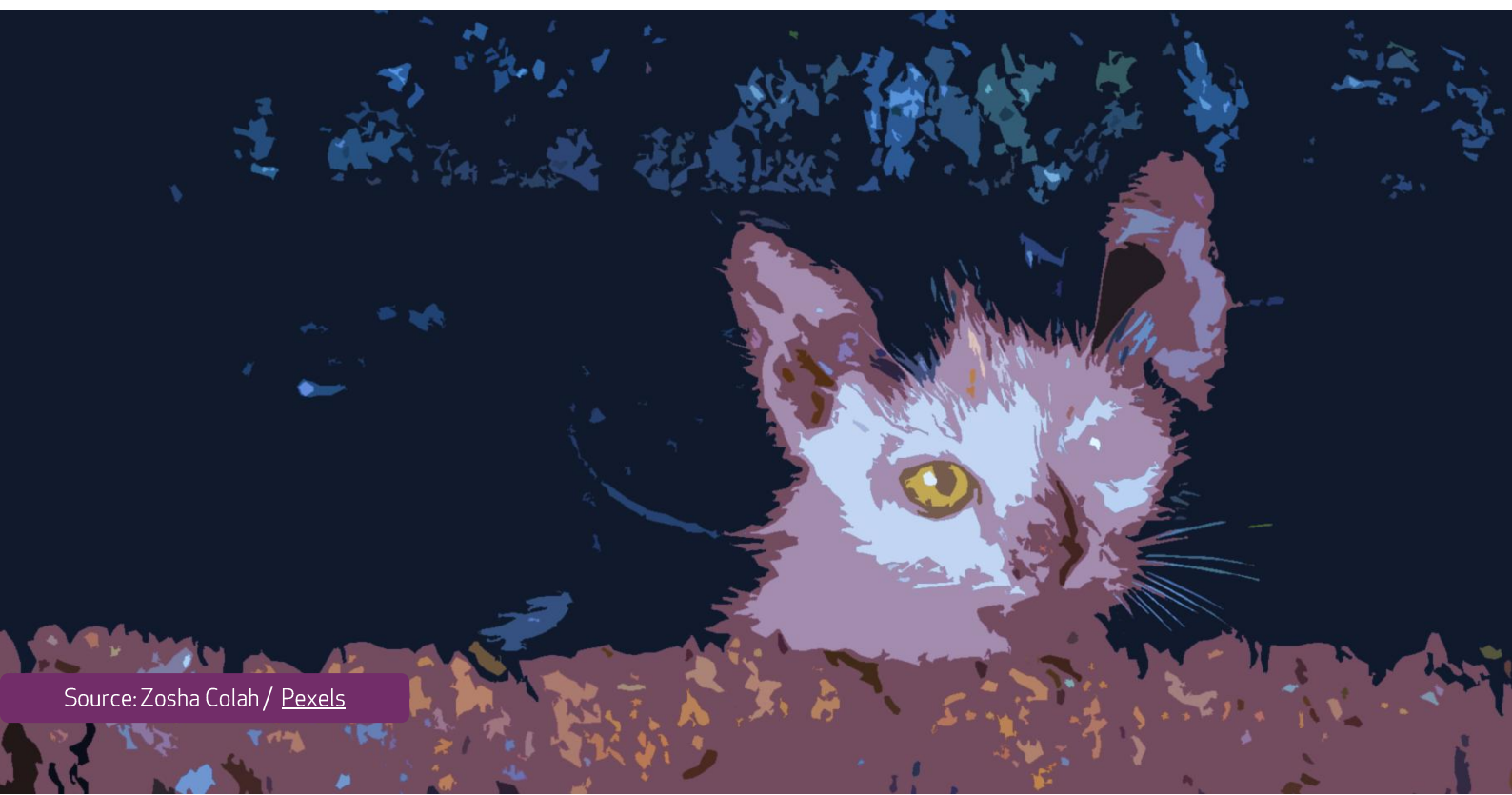
For many people, animals provide companionship, purpose, comfort, identity, and emotional connection. Some may feel a strong sense of responsibility to rescue, protect, or care for animals, making it extremely difficult to refuse additional animals or consider rehoming existing ones. As numbers increase, a person's capacity to provide adequate care may become progressively overwhelmed, even when their intentions remain positive.

Impacts and Risks

Animal hoarding can be associated with trauma, grief, loneliness, attachment difficulties, mental health challenges, and compulsive acquiring behaviours. Similar to other forms of CA/CS/ADN, there can be a significant gap between the person's intentions and the impact of the situation. Concerns about animal welfare or discussions about reducing animal numbers may be experienced as threatening, distressing, or equivalent to losing important human relationships.

The consequences can affect both people and animals, including:

- Reduced animal welfare and unmet veterinary needs
- Health and hygiene concerns within the home environment
- Property damage and environmental decline
- Financial strain
- Social isolation and stigma
- Increased involvement of animal welfare organisations, local councils, and other services





Source: Ali Yaghoubi / Pexels

Workers should approach animal hoarding with empathy, curiosity, and a focus on both human and animal welfare. Building trust and understanding of the meaning that animals hold for the person, are essential.

Support may involve collaboration with:

- Animal welfare organisations
- Veterinary services
- Local councils
- Housing providers
- Mental health and community support services

Where animal numbers need to be reduced, changes should be carefully planned wherever possible and accompanied by appropriate emotional and practical support. Abrupt or unsupported removal of animals may lead to significant grief and loss, emotional distress, disengagement from support, and recurrence of acquiring behaviours.

Key Message

Animal hoarding is often not a problem of caring too little, but a situation where caring has exceeded a person's capacity to provide safe and appropriate care. Effective responses balance compassion for the person with responsibility to protect the welfare of the animals.

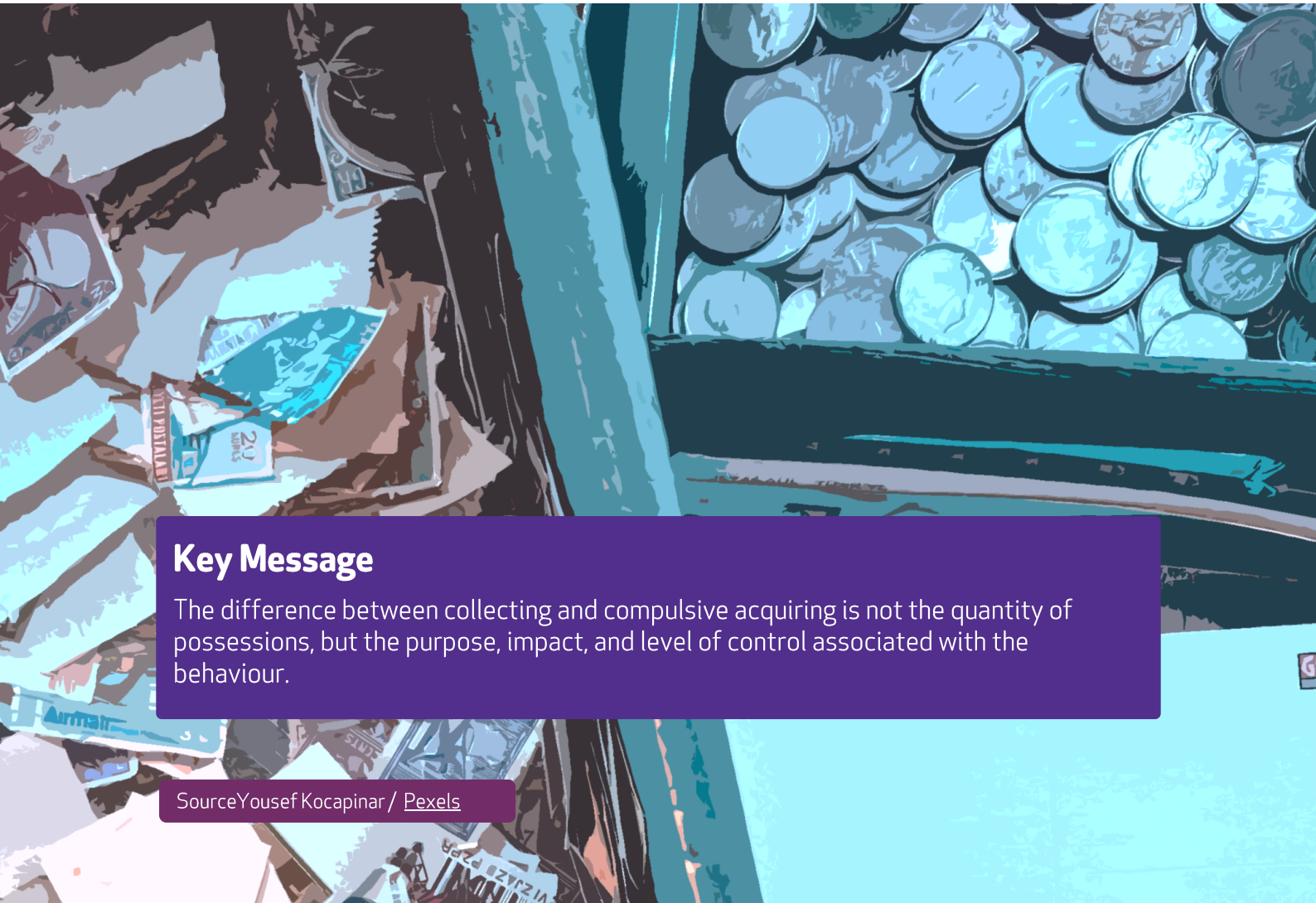
11.Collectors' vs Compulsive Acquiring

It is important to distinguish between collecting and compulsive acquiring, as the two are often confused at first glance due to the quantity of items involved, despite representing very different behaviours.

Collecting is generally characterised by a focused interest in specific types of items, such as stamps, coins, books, model cars, toys, or memorabilia. Items are intentionally acquired, organised, and maintained, often reflecting enjoyment, knowledge, preservation, or appreciation of something with personal, historical, cultural, artistic, or financial significance. Collections are typically a source of interest and pride and do not significantly impact the functional use of the home, safety, relationships, wellbeing, or daily functioning.

The key distinction is not the number of items a person owns, **but the impact and function of the behaviour**. Collecting generally enhances a person's life without causing significant impairment. In contrast, compulsive acquiring continues despite negative consequences and often contributes to ongoing accumulation, distress, financial difficulties, or reduced ability to manage the home environment.

Simply explained, a collector acquires items to build or maintain a collection. A person experiencing compulsive acquiring acquires items because the behaviour is meeting an emotional, psychological, or functional need.



Key Message

The difference between collecting and compulsive acquiring is not the quantity of possessions, but the purpose, impact, and level of control associated with the behaviour.

12. Maintaining Progress and Supporting Ongoing Recovery

Recovery and change in CA/CS/ADN are highly individual. Progress is rarely linear, and periods of increased acquiring, difficulty discarding, reduced engagement, or other setbacks can occur as part of the recovery journey.

Sustaining progress often involves:

- Reinforcing strengths and celebrating successes, no matter how small
- Supporting ongoing routines, structure, and healthy habits
- Building confidence in decision-making and problem-solving
- Preparing for and normalising setbacks; viewing them as opportunities for learning
- Remaining flexible and responsive to the individual's changing circumstances and mental health
- Incorporating self-care, wellbeing, and meaningful activities into daily life
- Maintaining connection with peer supports, community groups, and recovery networks
- Learning and understanding the warning signs early and seeking support when they emerge

Peer connections often remain valuable after formal service involvement ends and can provide ongoing encouragement, accountability, and social connection that supports ongoing recovery.

The focus is on **progress, not perfection**. For some people, milestones may include maintaining routines, reaching out for support, making difficult decisions, reducing social isolation, or continuing to engage despite challenges. These achievements deserve recognition, even when environmental change is slow.

IN PRACTICE: Workers should remember that hope is often transferred through relationships. Sometimes the most powerful intervention is not providing answers, but helping someone feel understood, accepted, and less alone.

Key Message

Recovery is not defined by the condition of a home. Meaningful progress often occurs through small, consistent steps that build confidence, insight, connection, and hope over time.

By remaining person-centred, compassionate, and focused on what matters most to the individual, workers can support lasting change and improved wellbeing.

Ultimately, effective practice begins and ends with the principle of **Humans Before Homes**.

13. Final Reflection

People experiencing CA/CS/ADN are often defined by what others see rather than what they have lived through. Behind every home is a person with their own story, strengths, challenges, hopes, and aspirations.

The guiding principle throughout this guide is **Humans Before Homes**. While acquiring, saving, and associated domestic neglect may be the most visible aspects of the situation, they should not become the sole focus of support. Lasting change begins with understanding the person behind the environment, recognising their experiences, and working alongside them with dignity, compassion, and respect.

This guide aims to encourage workers to remain curious, compassionate, creative as well as trauma informed and person-centred. Although environmental risks may require immediate attention, sustainable change is achieved through relationships, trust, collaboration, and hope. When we put humans before homes and focus on the person's strengths, goals, and wellbeing, meaningful and lasting recovery becomes possible.

A woman with short brown hair, wearing a grey patterned sweater, is sitting on a wooden bench in a park. She is smiling and looking down at her hands, which are resting on her lap. The background shows a grassy area, a path, and some trees. A speech bubble with a pink background and a white border is positioned in the upper left corner of the image, containing a quote.

"For years I thought I was the only person who struggled with these behaviours. Meeting someone who understood what it felt like reduced my shame and helped me realise I wasn't broken. Recovery didn't happen overnight, but it helped me believe change was possible."

14. Appendix

Diagnostic Frameworks

Clutter Image Rating Scale

Home Environment Assessment Tool for Hoarding (HEATH)

Diagnostic Frameworks – Hoarding Disorder

DSM-5-TR – Hoarding Disorder (Extract) (American Psychiatric Association, 2022)

Criterion A:

Persistent difficulty discarding or parting with possessions, regardless of their actual value.

Criterion B:

This difficulty is due to a perceived need to save the items and to the distress associated with discarding them.

Criterion C:

The difficulty discarding possessions results in the accumulation of possessions that congest and clutter active living areas and substantially compromise their intended use.

Criterion D:

If living areas are uncluttered, it is only because of the interventions of third parties (e.g. family members, cleaners, authorities).

Criterion E:

The hoarding causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specifiers:

- With excessive acquisition
- Insight specifiers:
 - Good or fair insight
 - Poor insight
 - Absent insight / delusional beliefs

Reference:

American Psychiatric Association. (2022). Diagnostic and Statistical Manual of Mental Disorders (5th ed., text rev.; DSM-5-TR).

ICD-11 – Hoarding Disorder (6B24) (Extract)

(World Health Organisation)

Hoarding disorder is characterised by **accumulation of possessions** due to both repetitive urges or behaviours related to acquiring items and difficulty discarding possessions due to a **perceived need to save items** and **distress associated with discarding them**.

The accumulation results in living spaces becoming cluttered to the point that **their use or safety is compromised**.

If living areas are uncluttered, this is only because of the **intervention of third parties** (e.g. family members, services, or authorities).

The symptoms result in **significant impairment** in personal, family, social, educational, occupational or other important areas of functioning.

Code:

6B24 – Hoarding Disorder

Specifiers:

- Hoarding disorder with fair to good insight
- Hoarding disorder with poor to absent insight

Reference:

World Health Organisation. International Classification of Diseases 11th Revision (ICD-11), Code 6B24: Hoarding Disorder.

Clutter Image Rating Scale (CRS)

The purpose of this tool is to gauge the impact of hoarding on the person with the hoarding behaviour.

Clutter Image Rating Scale: Part 1 of 3 – Kitchen

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating Scale: Part 2 of 3 – Bedroom

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



1



2



3



4



5



6



7



8



9

Clutter Image Rating Scale: Part 3 of 3 – Living room

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



1



2



3



4



5



6



7



8



9

Source: Frost RO, Steketee G 2006a, *Compulsive Hoarding and Acquiring: Therapist Guide*. New York. Oxford University Press. The Clutter Image Rating (CIR) Tool, p. 188. Used with permission of Oxford University Press, USA.

Home Environment Assessment Tool for Hoarding (HEATH)



hoarding.psych.ubc.ca

Date: _____

Client: _____

Assessor: _____

Home Environment Assessment Tool for Hoarding (HEATH)

Assessment Instructions: Use this tool to assess the home for risky conditions related to hoarding. The HEATH will guide you to assess the level of risk in five categories.

Follow these three steps:

1. Visually assess items on the checklist.

- Check the “**ok**” box if the item does *not* present risk related to hoarding, including if the item is not relevant (e.g., no stairs or interior hallways in the home).
- Check the “**⊗**” box if there is *any* risk related to hoarding. Make a comment about the risks you observe in the Areas of Concern space.
- Use the “*Other*” line within each category to add inspection items that are unique to a specific home or to your professional training.
- If you cannot see some areas for any reason, including due to conditions in the home, then do not check any box. Make note of this in the **Areas of Concern**.
- Talk to the resident to get more information if needed.

2. Make ratings for each category.

Based on your training and experience, rate the *overall* seriousness of the risks you observed in each category. Using the rating scale below, circle the number that reflects your overall rating of risk in the category.

0 = low or no risk: meets common minimum standards for environmental health and safety

1 = moderate risk: health or safety concerns that are important to address

2 = high risk: urgent health or safety concerns

X = not enough information to make an overall rating of this category

Assessment Tips:

- Context matters. The details of the situation in the home (e.g., building type, whether there are vulnerable occupants, how the home is used) may increase or lower risk compared to the same conditions in a different home.
- A category may be high risk even if only one item is marked “**⊗**” if it represents an *urgent* health or safety concern. On the other hand, a category may be only moderate risk even if it has multiple items checked as “**⊗**” if the areas of concern are not *urgent* health or safety concerns.
- Use “**Not assessed**” if you did not observe enough items to make a judgment about degree of risk in that category. In some cases, you may rate a category as high risk even if you were able to observe only one item.

3. After completing the overall ratings for each category, write these ratings in the summary table below.

Sum the ratings from the five risk categories to calculate the total score.

Scoring Summary

Category	Rating
Safe Pathways	
Fire Safety	
Structural Integrity	
Health and Wellness	
Sanitation	
TOTAL	

Safe Pathways	Areas of Concern			
ok ☐				
Exterior doors accessible (can open at least 90°)				
Windows in sleeping room(s) clear for emergency exit				
Emergency responders can enter (with equipment)				
Main paths through daily living space clear for safe passage				
Hallways clear for safe passage and emergency exit				
Stacks or piles lower than 4-feet (120 cm)				
Stairs clear for safe passage and emergency exit				
Other:				
Rate Safe Pathways:	0 Low risk	1 Moderate risk	2 High risk	X Not assessed
Fire Safety	Areas of Concern			
ok ☐				
Stove/oven has 1-foot (30 cm) clearance from combustibles				
Furnace/hot water tank has 3-feet (1 m) clearance				
Space heater has 3-feet (1 m) clearance				
Fireplace has 3.9-feet (1.2 m) clearance				
Radiators have 1-foot (30 cm) clearance from combustibles				
Smoke alarms work and entire ceiling has 3-feet (1 m) clearance				
Carbon monoxide (CO) alarms work				
Sprinkler heads have 1.5-feet (45 cm) clearance				
Electrical cords are intact (e.g., no exposed wires)				
No electrical problems (e.g., overloaded circuit)				
No extension cords coiled or under combustibles (e.g., clothing)				
No hazardous materials (e.g., fireworks) stored in the home				
No open flame (e.g., kerosene lantern) used as a heat source				
Other:				
Rate Fire Safety:	0 Low risk	1 Moderate risk	2 High risk	X Not assessed
Structural Integrity	Areas of Concern			
ok ☐				
Floor boards, stairs, porch are stable				
No visible signs of water leaks				
No obvious leak in the roof				
Other:				
Rate Structural Integrity:	0 Low risk	1 Moderate risk	2 High risk	X Not assessed
Health and Wellness <small>(circle each item of concern on a line)</small>	Areas of Concern			
ok ☐				
In-home health care or support services can be provided				
Electricity, heating, and hot water are usable				
Toilet, bathtub/shower, sinks are usable				
Refrigerator/freezer is usable				
Medical equipment/medication is accessible				
Other:				
Rate Health and Wellness:	0 Low risk	1 Moderate risk	2 High risk	X Not assessed
Sanitation <small>(circle each item of concern on a line)</small>	Areas of Concern			
ok ☐				
No spoiled or rotting food				
No contaminated items (e.g., used toilet paper/tampons)				
No detectable urine or feces				
No insect or rodent infestation				
No widespread mold, mildew, or chronic dampness				
Other:				
Rate Sanitation:	0 Low risk	1 Moderate risk	2 High risk	X Not assessed

15. References

Frameworks

The guide complements existing organisational frameworks:

- Recovery Oriented Practice Framework
- Trauma Informed Framework
- Recovery Oriented Language Guide 3rd edition (MHCC)
- Safe Work Practice - Compulsive Acquiring & Domestic Neglect

Useful Websites

[Assessment of Critical Health and Safety Risks in Homes where Hoarding is Prevalent - PMC](#)

[Buried in Treasures: Help for Compulsive Acquiring, Saving, and Hoarding \(Treatments That Work\) eBook : Tolin, David, Frost, Randy O., Steketee, Gail: Amazon.com.au: Books](#)

[Clutter Image Rating Scale \(CIRS\) | The Deck](#)

[Diogenes Syndrome: Identification and Distinction from Hoarding Disorder - PMC](#)

[HEATH | Centre for Collaborative Research on Hoarding](#)

[Hoarding Disorder Prevalence: A Scientific Assessment | Psychology Today \[psychologytoday.com\]](#)

[Hoarding Disorder Statistics | Verified 2026 Data \[worldmetrics.org\]](#)

[Home Safety Visits - Fire and Rescue NSW](#)

[Psychiatry.org - Hoarding Disorder \[psychiatry.org\]](#)

[Statistics of Hoarding Disorder: Understanding Prevalence and Trends \[ourmental.health\]](#)