UNDERSTANDING HOARDING CLEAN-OUTS: A PUBLIC SCHOLAR APPROACH

by

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The following individuals certify that they have read, and recommend to the Faculty of Graduate and Postdoctoral Studies for acceptance, the dissertation entitled:

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Abstract

Hoarded homes can pose a public safety threat. To mitigate health and safety risks, many communities across North America turn to clean-outs as an intervention. Despite the apparent utility of clean-outs to clear away problematic clutter, anecdotal stories in the academic literature tend to depict clean-outs as a costly, ineffective, and traumatizing intervention. However, no formal studies have been conducted specifically on clean-out interventions, and no formalized guidelines or practice recommendations exist for how and when to conduct such interventions.

Using a scoping review that synthesized the academic and grey literature on clean-outs and an interview-based survey of frontline professionals, this dissertation examined the factors precipitating clean-outs, characterized the range of clean-out practices (including client-centered practices), and provided an overview of possible intervention outcomes. This dissertation followed a public scholarship approach, which involved collaborations with frontline workers, in order to provide a knowledge base from which to promote evidence-based practice.

Findings from the two studies were largely consistent. For most clients, the decision to have a clean-out was not voluntary. Rather, clean-outs were conducted due to a complex set of risks (e.g., unsafe conditions, eviction threat, poor sanitation) and often were used as a last-resort intervention. Clean-outs were fast-paced and required a multidisciplinary team for different aspects of the process, including logistics and planning, case management, emotional support, enforcement, clutter removal, and cleaning. Clean-outs were distressing for most clients. Many providers responded to client distress with client-centered approaches: providing emotional support, involving the client in sorting and discarding decisions, and listening to their concerns and fears. Providers were largely in agreement that clean-outs helped to resolve health and safety issues in the home in the short-term. Clean-outs were moderately successful at preventing
evictions and ensuring a safe discharge home from hospital, however, they did not address the psychological problems that led to the high clutter volume.

Based on the results of both studies, a research report and best practice toolkit were created for dissemination among community providers. In line with the public scholar approach, these materials will offer practical guidance to community organizations and frontline professionals who conduct clean-out interventions.
Lay Summary

Reality television shows have dramatized clean-outs as fast and effective interventions for hoarding. The shows portray a certain kind of clean-out, but almost no research has examined clean-outs that occur off-camera in other settings. This study aimed to document how clean-outs are conducted and to discover the implications of conducting more client-centered clean-outs. Results found most clients did not voluntarily decide to have a clean-out. Clean-outs were conducted due to a complex set of risks (e.g., unsafe conditions, eviction threat, poor sanitation). Clean-outs were distressing for most clients. Many providers responded by using a more client-centered approach: providing emotional support, involving the client in sorting and discarding decisions, and listening to their concerns and fears. Overall, clean-outs helped to resolve health and safety issues in the home in the short-term, but the long-term outcomes were unknown. This dissertation offers guidance to community providers who conduct clean-outs.
Preface

I am the primary contributor of the work presented in this dissertation, under the guidance of Dr. Sheila Woody, my supervisor and the principal investigator of the Centre for Collaborative Research on Hoarding.

The data collected in Chapter 2 were drawn from a larger scoping review conducted by our research team. I led the team in conducting the review by setting up the methodological framework and initiating the search process as well as participating in and managing the team that completed the searching, screening, and extraction stages. Chapter 2 presents my analysis of a subset of the material collected, specifically the data on clean-outs and eviction. I formulated the research questions, analyzed the data, and wrote up the findings. My supervisory committee member, Dr. Christiana Bratiotis, reviewed and provided guidance on the thematic analysis and qualitative writing process, and served as a mentor with expertise in qualitative research methods.

I designed the study presented in Chapter 3 and collected the data. I conducted all data analysis and was responsible for writing the results. The study was approved by the UBC Behavioural Research Ethics Board (H21-00586).

I developed the written content presented in Chapter 5. The graphic design and illustrations were created by UBC Studios.
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List of Abbreviations

CBT: Cognitive behavioural therapy
CIR: Clutter Image Rating
DSM: Diagnostic and Statistical Manual of Mental Disorders
SDM: Shared decision making
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Dedication

To Mom, you are kind, fearless, and honest. You are the person I look to for who I want to be in this world. I am forever thankful for your support in getting this degree. Your belief in me has always meant the most.
Chapter 1: Introduction

Hoarding disorder affects 2.5% of the population (Postlethwaite et al., 2019). As a result of excessive acquisition and difficulty discarding, clutter accumulates in the home. Hoarded homes pose a public safety threat as the risk of fire, pest infestations and health hazards are heightened in both the home and neighbouring dwellings. Due to the health and safety risks, hoarded homes require attention.

Although the psychological symptoms are most important in a therapeutic context, the amassed volume of clutter is the predominant concern when evaluating the health and safety risks relevant to this disorder. In order to mitigate these risks, a clean-out can appear to be the most straightforward intervention: hire a truck and some workers, and clear the clutter out. Many reality television shows depict clean-outs as the primary solution for extreme hoarding behaviours – one that can be achieved relatively quickly with enough person power (Lepselter, 2011).

Despite the apparent utility of clean-outs to clear away problematic clutter and to reduce safety risks, clean-outs are not typically recommended by mental health professionals. Clean-outs have been referred to as a “forced” intervention (Bratiotis & Woody, 2014; Fleury et al., 2012), one that clients may feel coerced into accepting as a way to remain housed or avoid fines. In addition, clinicians caution that rapidly hauling the clutter away does little to treat the actual symptoms of the disorder, and relapse may be expected (Muroff et al., 2014).

Clearly, there are reasons why a clean-out may not be an ideal option for clients who hoard, however communities across North America continue to turn to clean-outs as an intervention. If attempts at voluntary compliance are unsuccessful, clean-outs may be necessary to mitigate public health and safety risks. Community agencies may also be limited by the
interventions and staff available to them; clean-outs may not be their preferred option, but they may seem to be the only feasible way to reduce the overall clutter volume and thereby mitigate the health and safety concerns.

There have been no formal studies conducted specifically on clean-out interventions. In addition there are no formalized guidelines or practice recommendations for how and when to conduct such interventions. This dissertation seeks to address the lack of published research in this area. Using a scoping review that synthesizes the academic and grey literature on clean-outs and an interview-based survey of frontline professionals, the current research examines the factors precipitating clean-outs, characterizes the range of clean-out practices, including those of a client-centered nature, and provides an overview of possible intervention outcomes. This dissertation follows a public scholarship approach which relies on the mutual transfer of knowledge between academia and community settings. The first step in conducting this research begins with providing a definition for a hoarding clean-out.

The phrase “clean-out” might seem easy to define, however its ambiguity is evident when searching for a consistent definition in the literature. Some sources offer a description consistent with an involuntary approach, “when someone who hoards is forced to remove, or someone else forcibly removes, the majority or all of their possessions from their home without their consent” (Gibson, 2015). Others focus on the objective of the intervention, “municipal authorities step in and remove possessions from a home in order to protect the health and safety of those who live there” (Tompkins & Hartl, 2009), while others illustrate the fast-paced and multidisciplinary nature of the intervention, “cleanups involve a massive daylong undertaking involving multiple agencies” (Chapin et al., 2010). Having a clear definition incorporating the amount of clutter removed, duration of the intervention, and roles of the client and stakeholders is critical to
studying clean-outs. For this dissertation, I have operationalized a definition of clean-outs based on my preliminary reading of academic and community-driven literature on the subject and my experience working with professionals who conduct hoarding clean-outs. A clean-out is a fast-paced intervention in which a large amount of clutter is removed from the living spaces of a client’s home. A clean-out may last several days and is usually completed in a condensed time frame (e.g., under a month). The client may not be involved in every decision about which items are kept or discarded.

This dissertation will examine the following five research questions:

1. **Why are clean-outs necessary?** Although some cases of hoarding come to professional attention because clients voluntarily ask for help, most public cases of hoarding attract attention because a complaint or a referral has been made to social services or city officials (Woody et al., 2020). Due to the nature of the disorder, many clients have limited insight into the harms their clutter could cause to themselves or the public and therefore are unlikely to discard their possessions voluntarily (Frost et al., 2010). In the same way as involuntary hospitalizations may be warranted when a client is a danger to themselves or others (Simonovic et al., 2011), in the case of hoarding, clean-outs may be necessary to protect the resident and others from health and safety risks, particularly if the client has not responded to previously-suggested interventions. Clean-outs may also be used to satisfy external pressures (e.g., housing providers, family members) or to preserve tenancy. No previous research has systematically examined the range, frequency, or importance of varying factors in the decision to have a clean-out. This dissertation seeks to address this research gap.

2. **How are clean-outs conducted?** Reality television shows have dramatized hoarding clean-outs as fast and effective interventions for hoarding. The shows portray a certain kind of
clean-out, but almost no research has examined clean-outs that occur off-camera in other settings. It is unclear which procedures community professionals typically follow in a clean-out intervention. This dissertation will examine the amount of clutter removed, the duration of the intervention, and the involvement of stakeholders and the client.

3. Which client-centered strategies are being used? The stereotypical description of a rapid and intense clean-out reflects a process that is coerced and emotionally distressing for the client. In contrast, field knowledge suggests clean-outs can be conducted in a less involuntary and more gradual way that incorporates client-centered strategies. For instance, the majority of clean-outs that occurred within Vancouver’s Hoarding Action Response Team involved client consent and were used in combination with other strategies such as decluttering assistance and biweekly home visits (Kysow et al., 2020). Outside of hoarding, other interventions that are involuntary or considered to be potentially “traumatic” have established best practices often involving shared decision making (e.g., collaborative care for anorexia nervosa; Geller & Srikameswaran, 2006, discussing pros and cons of medication options in schizophrenia; Hamann et al., 2017, incorporating both patient and provider preferences in bipolar disorder treatment; Fisher et al., 2016). The concept of shared decision making is widely regarded as an important clinical practice and has been associated with higher treatment satisfaction, client autonomy, and reduced symptoms (Fisher et al., 2016; Shay & Lafata, 2015). The current dissertation will search for evidence of shared decision making and other client-centered practices in clean-outs, with a view to developing a toolkit of best practices for use in the field.

4. What is the client’s emotional response? The literature suggests that the emotional impact of a rapid nonconsensual clean-out can be extremely distressing; books written for family members of individuals who hoard explain that a clean-out may turn into an anxiety-provoking,
confrontational, and emotionally painful situation for the client, especially if the client is not consulted or does not consent to this drastic approach (Tompkins & Hartl, 2009). From a mental health perspective, it is evidently important to identify and summarize client emotional responses to clean-out interventions in order to develop recommendations to reduce or address distress. This dissertation seeks to address these objectives.

5. What are the health and safety outcomes? Desired intervention objectives related to clean-outs involve tenancy preservation, reduction in clutter volume, and mitigation of health and safety risks. Although clean-outs continue to be used in communities across North America, the effectiveness of such interventions is largely unknown. Outcome evaluation, as evidenced in this dissertation, is critical to measure how well intervention objectives are being achieved.

In order to provide an overall context for the dissertation, this introductory chapter will proceed with an overview of hoarding disorder, including the health and safety risks, functional capacity concerns, and external pressures, followed by a detailed review of the range of interventions available to communities. The introduction will conclude by considering the possible benefits of incorporating client-centered practices into clean-out interventions and the consequences of involuntary or coercive practices.

1.1 Hoarding Disorder

The word “hoarding” often evokes an image of floor-to-ceiling piles of boxes, newspapers, and trinkets. Narrow pathways, drawn blinds and countertops overflowing with items might also come to mind. Interestingly, the clutter in hoarding is only the physical manifestation of the problem. The heart of the disorder lies in clients’ inability to discard items regardless of their value and the urge to acquire items for which they have no room (Frost & Hartl, 1996). Individuals with hoarding disorder are motivated to save for several reasons,
including fear of waste, emotional attachment, intrinsic value, and instrumental purposes (Frost et al., 2015). The accumulation of items interferes with the use of rooms as intended and often leads to impairments in daily life activities, such as bathing, preparing food, or sleeping in one’s bed (Frost et al., 2013).

Originally, hoarding was considered a compulsive behaviour under the category of obsessive compulsive disorder (OCD), but hoarding differs from OCD in important ways. Clients are not distressed by their thoughts related to hoarding (unless they are forced to remove items), do not display other OCD symptoms, and do not respond well to psychotherapy or medication that is efficacious for OCD (Mataix-Cols et al., 2010). In fact, with large samples of OCD patients, factor-analytic studies consistently identified a separate hoarding factor (Mataix-Cols et al., 2005). Hoarding disorder was not codified in the Diagnostic and Statistical Manual of Mental Disorders as a discrete disorder until the publication of DSM-5 in 2013. The diagnostic criteria were largely based on those developed by Frost and Hartl in 1996.

Frost and Hartl (1996) conceptualized hoarding as a complex problem stemming from information processing deficits, problems in forming emotional attachments, behavioural avoidance, and beliefs about possessions. Over the past 28 years, their cognitive behavioural model of hoarding has offered a theoretical framework for hypothesis development and testing. In the model, information-processing deficits are characterized as difficulties with decision making (e.g., procrastination and indecisiveness), deficits in categorization or organization (e.g., piles of clutter with valuable and worthless items mixed together), and difficulties with memory (e.g., a lack of confidence in memory). Problems in forming emotional attachments to possessions are explained in two ways; possessions are seen as both a source of comfort and security and as an extension of the self. Behavioural avoidance is manifested as procrastination
and chronic indecisiveness. Clients save possessions to avoid making the wrong discard decision and to avoid experiencing negative emotions. Important beliefs about the nature of possessions and reasons for saving include the need to be prepared for the future, to make sure the object is used for its intended purpose, and to protect the object from potential harm. In addition to their theoretical model, Frost and Hartl (1996) also proposed the following criteria for a diagnosis of hoarding: 1) the acquisition of, and failure to discard, a large number of possessions that appear to be useless or of limited value; (2) living spaces sufficiently cluttered so as to preclude activities for which those spaces were designed; and (3) significant distress or impairment in functioning caused by the hoarding. As mentioned earlier, these criteria (with slight modifications) were adopted as the diagnostic criteria for hoarding disorder in DSM-5.

The most recent meta-analysis of prevalence studies from Europe, Asia, and Australia indicates approximately 2.5% of the general population meets criteria for hoarding disorder (Postlethwaite et al., 2019). The disorder onsets in adolescence and then follows a chronic and worsening course into older adulthood, with average age of treatment around 50 years old (Tolin, Meunier, et al., 2010). Individuals with hoarding disorder tend to live alone and have a lower marriage rate and higher divorce rate compared to the general population (Tolin, Frost, Steketee, Grey, et al., 2008). A systematic review of studies suggests possible causal factors including genetic factors, emotional traits such as high anxiety sensitivity, abnormal neural activity in areas of the brain related to decision making, and traumatic life events (Hombali et al., 2019).

1.1.1 Health and Safety Risks

Risks relating to hoarding largely implicate the health and safety of the individual client, however the safety of the nearby community is also at risk (Frost et al., 2000). The incidence of preventable fire fatalities is dramatically higher in hoarded homes, and hoarding fires are far
more likely to spread beyond the room of origin (Lucini et al., 2009). Large amounts of clutter and possessions blocking passageways in and around the home can cause delays in receiving emergency care from medical personnel or fire fighters, leading to an increased risk of injury or death (Gonzalez et al., 2016). Client risk is heightened for those who use a mobility aid in their home, are prone to falls, or are neglecting personal hygiene due to lack of clear access to their shower or sink (Kim et al., 2001). Finally, housing problems may be left unresolved (e.g., leaky pipes, circuit overloads) due to the clutter or the shame involved in having a repair person come into the home. These impairments can lead to substandard living conditions and poorer quality of life for the resident (Steketee & Bratiotis, 2020).

Poor sanitation (also referred to as squalor) is also relatively common in hoarded homes. A study of three diverse samples of community clients found 35-72% of hoarded homes also had conditions of poor sanitation (e.g., rotting food, pests infestation, accumulation of dirt, human or animal feces) and that higher clutter volume and impaired access to bathrooms or kitchen facilities predicted the presence of poor sanitary conditions (Luu et al., 2018). The development of mold or the presence of pests, characteristic of poor sanitary conditions, can increase the risk of health problems (Gonzalez et al., 2016).

1.1.2 External Pressures

Enforcement professionals, such as fire prevention officers or code enforcement officials, may intervene in hoarding cases by informing tenants of fire code violations during routine inspections (Kysow et al., 2020; McGuire et al., 2013). The consequences of hoarding create problems for neighbours and landlords and can put tenancy at risk (Gonzalez et al., 2016). For precariously-housed individuals, hoarding behaviour can raise the risk of homelessness. In a study of formerly homeless individuals living in supportive housing, 18.5% of residents had
hoarding behaviour (Greig et al., 2020). Among individuals seeking eviction prevention advocacy services, 22% were estimated to meet criteria for hoarding disorder (Rodriguez et al., 2012). The risk of eviction is of grave importance for low-income tenants, but can also be a risk for homeowners (who can be ordered to vacate their home if it is deemed unsafe or hazardous).

Close family may also become involved if they fear for the safety of their loved ones. Family frustration is associated with both the client’s hoarding severity and degree of insight into their hoarding behaviour (Tolin, Fitch, et al., 2010). Relatives of individuals who hoard report significant caregiver burden and high levels of family accommodation, often with greater impairment for those who cohabit with an individual who hoards (Drury et al., 2014).

1.1.3 Client Functional Capacity

Comorbidity is often the rule rather than the exception in hoarding, with a large proportion of clients meeting criteria for major depressive disorder (51%), attention deficit disorder (28%), or an anxiety disorder (14-24%; Frost et al., 2011). Additionally, medical complexity is correlated with the level of hoarding severity in community settings (Ayers et al., 2014). Hoarding clients are more likely than the general population to report a broad range of chronic and severe medical concerns (e.g., arthritis, hypertension, chronic stomach problems; Tolin, Frost, Steketee, Grey, et al., 2008). Older adults who hoard (Dozier et al., 2016), as well as individuals living in conditions of poor sanitation (Lee et al., 2017), may struggle with co-occurring cognitive deficits with regard to executive functioning (e.g., mental flexibility).

1.2 Hoarding Interventions

As the problem of hoarding is of concern for the individual, neighbours, and society, many disciplines have a stake in responding to hoarding cases (Bratiotis et al., 2011). A diversity of professional input and resources is needed to successfully address problems related to
hoarding (Gonzalez et al., 2016; Raeburn et al., 2015). Various communities across North America are responding to hoarding cases that come to public attention by developing multidisciplinary teams and task forces (Bratiotis et al., 2011). At their best, these teams aim to provide a coordinated intervention response for individuals, families, and communities affected by hoarding behaviour (Bratiotis, 2013). Often, these teams deal with the most severe cases of hoarding – those who have not voluntarily sought help (Bratiotis, 2013).

There are several interventions available to communities to address hoarding. See Figure 1.1 for a schematic representing three intervention pathways: harm reduction, legal enforcement or protection, and treatment. The level of health and safety risks in the home, the presence of vulnerable occupants, and a client’s willingness and capacity to participate in an intervention set the stage for the initial approach. For instance, when there is a high degree of risk and clients are willing to work on improving safety targets, harm reduction strategies, such as decluttering assistance or case management may be used. On the other hand, if there is a high degree of risk and clients are unwilling to consider making changes or accepting assistance, a legal enforcement intervention, such as eviction, may be the response. When the degree of risk is low and clients want help, treatment options such as cognitive behavioural therapy (CBT) or medication may be appropriate. Finally, if the degree of risk is low and a client does not consent to treatment, no intervention is recommended as a competent adult has the right to choose their own living conditions. In this situation, professionals may still offer educational materials or contact information for hoarding services in the local area, in case clients want help in the future.
Figure 1.1

Hoardin Intervention Pathways

Are there major health and safety risks or vulnerable occupants in the home?

No

Does the client want treatment?

No

Do not proceed with an intervention

Yes

1: Mental health treatment

Specialized CBT for hoarding

Medication

Buried in Treasures group

Eviction

Move to care home

Clean-out intervention

Yes

Does the client have the capacity and willingness to reduce the risks?

No

2. Legal enforcement/protection actions

Eviction

Move to care home

Yes

3. Harm reduction strategies

Case management

Decluttering assistance
Hoarding clients may follow different intervention pathways at different times in their lives. For example, a client may receive a harm reduction intervention first and subsequently be referred for CBT.

1.2.1 Mental Health Treatment

The goal of treatment is to reduce hoarding symptoms (e.g., acquisition and difficulty discarding) by targeting the underlying psychological mechanisms (e.g., behavioural avoidance). Treatment is more commonly indicated when the risk to public health is low (e.g., there is no immediate fire risk) and clients are voluntarily presenting for treatment. As seen in Figure 1.1, options available for hoarding treatment include specialized CBT for hoarding, medication, and Buried in Treasures groups (a peer-led structured support group that implements CBT strategies). If a local practitioner who treats hoarding is available, community professionals may refer hoarding clients for individual or group CBT. Specific techniques include practice in decision making and organizing, exposure to emotionally distressing non-acquisition and discarding activities, and cognitive restructuring to target the major symptoms of hoarding: disorganization, compulsive acquisition, and difficulty discarding (Steketee et al., 2000). Therapists assist in the development of decision-making skills, provide feedback regarding saving behaviours, and help identify and challenge distorted thinking. Mental health services are provided by outpatient clinicians as there are no inpatient or residential programs available. Therapists may provide at-home sessions (in addition to in-office sessions) to assess the hoarding environment and to assist clients working through the decision-making process and practicing sorting and discarding in their home environment (Steketee & Frost, 2007).

Although medication to reduce hoarding behaviour is not widely prescribed, somewhat promising improvements have been found in trials of paroxetine and venlafaxine (Saxena et al.,
2007; Saxena & Sumner, 2014). Finally, peer-facilitated bibliotherapy, using the self-help book “Buried in Treasures”, is also a common treatment used by communities who have the capacity to host and run a therapy group (Frost et al., 2012). This non-professionally run group demonstrated clinically significant reductions in hoarding disorder symptoms on a variety of measures compared to a waitlist control (Frost et al., 2012) and showed similar improvements in functional impairment and hoarding severity as a psychologist-led CBT group (Mathews et al., 2016).

1.2.2 Legal Enforcement and Protection Actions

Communities may be forced to take more of an enforcement-focused intervention approach if their attempts at voluntary compliance are fruitless or the public health risks resulting from the hoarding situation are too great (see Figure 1.1). Community teams find low insight to be a challenge because they are unable to convince the client of the urgency of fire or building code violations. Coercive measures, such as fines or threats of eviction, may be used to communicate the seriousness of the problem and to encourage hoarding clients to comply with fire code or property bylaws (Glover & Moss, 2010). If clients do not comply with the demands (usually to reduce the volume of clutter in their home in order to satisfy fire codes), they may risk eviction. Eviction is a serious concern due to its negative downstream effects, including difficulty finding new housing due to an eviction history (Polk, 2020) and significant physical and mental health associated outcomes (e.g., depression, anxiety, high blood pressure; Acharya et al., 2022; Desmond & Kimbro, 2015; Vásquez-Vera, 2017). In some cases, legal action may be taken to ensure clients comply with notices of violation (Ligatti, 2013).

In certain situations, if the conditions of the home are unsanitary or dangerous, interventions may be undertaken to protect vulnerable occupants. Frail elderly clients or those
experiencing cognitive decline may be moved from their home into a care home or assisted living environment. Child welfare organizations are required to investigate and intervene if the health and safety of children are at risk due to the hoarded environment (Bratiotis, 2020). Relatedly, if the well-being of pets in a hoarded home is of concern, animal protection services may also need to be involved.

Hoarding is not the only disorder that involves legal enforcement or protection actions. Any mental health intervention can become compulsory when a client’s life is at risk, their decisional capacity is in question, or public safety is of concern (Dawson & Mullen, 2008; Katsakou et al., 2012). Even patients view involuntary intervention (i.e., a treatment that proceeds without consent) as acceptable if it is necessary to protect themselves or others, or if aspects of their condition prevent them from making decisions in their own best interest (Katsakou et al., 2012; Sjöstrand et al., 2015; Tan et al., 2010). A lack of insight into one’s mental health and poor treatment compliance are consistent predictors of compulsory intervention (Dawson & Mullen, 2008). Professionals commonly face these treatment barriers when working with clients who hoard (Frost et al., 2010; Tolin, Fitch, et al., 2010). Clients remain convinced their behaviour is not problematic, for instance, continuing to spend inordinate amounts of money on storage or a spare property to retain items, despite financial strain or even the risk of homelessness.

Healthcare professionals are trained to consider coercive practices and involuntary interventions as a last resort, as they interfere with a patient’s autonomy. A coercive practice encapsulates any strategy used to forcefully persuade someone to accept a treatment (e.g., medication) or to stop harming themselves or others (Beames & Onwumere, 2022). For example, the use of seclusion or physical restraint within inpatient mental health services is only
permissible when staff are confronted with aggression or violence and alternative strategies (e.g., de-escalation) have not been successful (De Cuyper et al., 2023). Further, practice recommendations clarifying age limits, safe techniques, time limits, and expectations for record-keeping related to seclusion or restraint episodes are widely available (De Cuyper et al., 2023; Kumble & McSherry, 2010). Regarding involuntary interventions, such as involuntary hospitalization, doctors can only certify patients who meet legal criteria, and patients have the right to legal representation (Hoge et al., 1997). Although these concepts are highly relevant to hoarding interventions, currently no formal protocols or procedures exist to safeguard hoarding clients’ rights or to demarcate when an involuntary intervention, such as a clean-out, is necessary.

1.2.3 Harm Reduction Strategies

Harm reduction for hoarding aims to be a non-coercive approach that maximizes client autonomy while ensuring the client remains safe and housed. Such an approach does not use threats or force to achieve compliance. The goal of harm reduction is to minimize the harms associated with hoarding (i.e., to improve the health and safety of the tenant and community), without necessarily asking the person to reduce their hoarding behaviours (Tompkins, 2015).

Harm reduction originates from the field of public health as an approach to address problematic substance use. The International Harm Reduction Association (2010) defined harm reduction as, “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.” Although forms of harm reduction have been around for centuries (e.g., taxation of gin in the 1700s to control the sale of spirits and to reduce alcohol-related harms), harm reduction policies gained popularity in the 1980s (Riley et al.,
In efforts to reduce the spread of AIDS among injection-drug users, harm reduction policies were implemented in the UK, the Netherlands, and North America (Foy, 2017). Cities established safe injection sites and needle exchange programs. Advocates of harm reduction believe an individual’s choice to engage in drug use behaviours should be respected; the individual’s autonomy to make a choice, even one that may lead to harm, is prioritized (Kleinig, 2008).

Research has shown that drug prohibition or abstinence-only policies result in high costs to society and few benefits with regard to health and social outcomes (Cavaliere & Riley, 2012), whereas harm-reduction strategies for drug use are cost-effective and have reliable efficacy and effectiveness data to support their implementation (Ritter & Cameron, 2006). For example, needle exchange programs are associated with reduced rates of HIV infection, outreach programs decrease the re-use of needles, and supervised injection facilities reduce overdoses (Ritter & Cameron, 2006). Importantly, although harm reduction is not aimed at treatment, a person’s engagement in a harm reduction intervention increases the likelihood of future engagement in treatment (Maremmani et al., 2015). There are many examples of harm reduction approaches that have been well-integrated into our society outside of drug use, including nutritional labels on food products to help consumers make more informed choices, low-alcohol beers to minimize violence at sporting events, and mandated seatbelt use in cars to reduce accident-related injuries (Foy, 2017; Kleinig, 2008).

Harm reduction for hoarding can be used by frontline professionals when intervening in cases of hoarding and by family members when attempting to help a loved one who hoards (Tompkins, 2015; Tompkins & Hartl, 2009). The harm reduction approach begins by engaging the client in a trusting relationship, assessing harm potential, and creating a plan to use harm
reduction strategies to minimize harm (Tompkins, 2015). Tompkins (2015) describes harm potential as an interaction between environmental risk in the home and the functional capacity of a client. Environmental risk refers to safety and health hazards in the hoarded home (e.g., unstable piles of clutter, poor sanitation) and functional capacity refers to how well a client functions physically in the home, their motivation and openness to receive help, and their capacity to engage a support system. The harm potential of a hoarding client is high if environmental risk is high (e.g., presence of poor sanitation and degradation in the home) and their functional capacity is low (e.g., they are experiencing cognitive decline). Tompkins (2015) harm potential model was informed by the capacity-risk model for assessing and intervening with vulnerable older adults (Soniat & Micklos, 2010).

A risk reduction or harm minimization approach balances the rights of the individual with the safety of the community. Clients may be more willing to engage in a harm reduction intervention because of its emphasis on managing harm potential instead of a reduction in overall hoarding behaviours (Tompkins, 2015). The approach of harm reduction aims to move items out of high-risk areas (e.g., entrances, exits, heat sources) to keep the client safe and housed. There are a variety of harm reduction strategies available to community professionals dealing with hoarding, including case management and in-home decluttering assistance (see Figure 1.1).

Case management is an intervention to facilitate a client’s needs through assessment, problem identification, care coordination, and advocacy (Tahan, 2017). Although there are many models of case management (e.g., assertive community treatment, intensive case management; Vanderplasschen et al., 2007), the general premise is that case managers support clients in their daily lives and link them to relevant services. Various disciplines provide case management for
hoarding clients including nurses, occupational therapists, and social workers (Bratiotis et al., 2018).

Decluttering assistance as a harm reduction strategy involves slowly and methodically sorting items into categories of: donate, keep, or discard/recycle. Professionals, family members, or peers can take a coach-type role by keeping the client focused on the item up for discussion and encouraging them to talk aloud about their decision process. Coaches limit their physical contact with the objects so that clients are learning to make decisions and implement them.

1.2.4 Clean-Out Intervention

As seen in Figure 1.1, clean-outs result from either legal enforcement/protection or a harm reduction approach. If clients are unwilling to comply with other suggestions to reduce the volume of clutter and have poor insight into the potential for safety risks, professionals may need to enforce a clean-out. Clean-outs may also be considered a protective intervention, if the clutter volume needs to be reduced rapidly to ensure safer home conditions for a vulnerable occupant. A clean-out based on an enforcement or protective approach may provide clients with little choice.

Alternatively, if the client is engaged and consents to the intervention, a clean-out may fit under the rubric of harm reduction. During a harm reduction clean-out, a client may have some choice over which items to keep or discard. In addition, the client might choose whether to be on-site during the clean-out and who they would like to provide emotional support. Tompkins (2015) describes how a clean-out can be completed as part of a comprehensive harm reduction program. At the end of the clean-out, the client will retain some proportion of their possessions and the harm reduction approach will continue in a less intensive manner, usually with decluttering assistance. The degree to which clients are involved in the process, and therefore retain some degree of autonomy, can range depending on the clean-out.
1.3 A Client-Centered Approach

At the core of a client-centered approach, one that prioritizes client involvement, is the working alliance consisting of three core elements: 1) the collaborative nature of the relationship, 2) the bond between client and provider, and 3) the agreement on intervention goals and tasks (Gaston, 1990; Martin et al., 2000). The working alliance has been shown to be a consistent predictor of treatment outcomes and is seen as a common factor explaining much of the effectiveness of a variety of psychotherapy approaches (e.g., CBT, psychoanalytic; Gaston, 1990; Martin et al., 2000). Although research on the alliance originated from psychotherapy literature, the working alliance is associated with symptom improvements in a wide range of contexts, including intensive case management (Neale & Rosenheck, 1995), assertive community treatment (Klinkenberg et al., 1998), and pharmacological interventions (by means of medication adherence; McCabe et al., 2012).

Although there have been no quantitative studies within hoarding research on the alliance, two qualitative studies have found the therapeutic relationship to be one of the most helpful aspects of treatment from the client’s perspective (Ayers et al., 2012; Ryninks et al., 2019). With clean-out interventions, the importance of the alliance is critical to achieving any desirable short- or long-term outcomes. However, certain elements of the alliance may be more difficult to achieve, such as client-provider agreement on treatment goals and tasks. Most clients would not agree that a clean-out is a suitable intervention to meet their intervention goals, therefore frontline professionals involved in such cases likely have to devote significant energy to establishing a relationship and prioritizing collaborative decision making where possible.
1.4 Client Involvement

Client involvement in healthcare decisions and treatment plans has been extensively studied in primary care, inpatient settings, and compulsory treatment orders and is widely regarded as an important practice for preserving client autonomy, respect, and dignity (Priebe et al., 2020). In 2011, the National Institute for Health and Care Excellence (NICE) included shared decision making in its clinical practice guidelines for healthcare professionals. In a shared decision-making model, the expertise of both the provider and patient are recognized, and the dyad joins in a collaborative process to steer the intervention planning (Slade, 2017). Medical practitioners have made a practice change from a clinician-led model, where the clinician made decisions for the patient, to a shared decision-making model (Slade, 2017). This focus on a collaborative relationship has shifted away from a focus on patient’s compliance with medical recommendations and is far less paternalistic (De las Cuevas et al., 2013; Deegan & Drake, 2006).

The standards for shared decision making include (1) explanation of the health issue, (2) elicitation of patient preferences, and (3) integration of patient preferences (Barr et al., 2014; Elwyn, 2003). These standards could be applied to a clean-out intervention, for instance explaining the health and safety risks necessitating such an intervention (e.g., risk of fire), eliciting client preferences for the clean-out (e.g., “Would you like to be at your home during the clean-out or with a family member?”), and following the clean-out plan the client chooses. Shared decision making could also be enacted during the sorting and removal process (e.g., ensuring clients have some control over which possessions are removed from their home).

The importance of client autonomy within a harm reduction model has been discussed in the substance use and medical management literature. If a healthcare professional decides to
pursue a harm reduction intervention, rather than a compliance intervention, they are acknowledging it is the patient’s choice to pursue the behaviour (Szott, 2015). For instance, in addressing non-adherence to antipsychotic medication, professionals may decide between enforcing a community treatment order that requires patients to accept medication or to pursue more of a harm reduction approach and support and inform patients about the consequences that would follow from their decision to withdraw from medication (Aldridge, 2012). In a harm reduction model, the practitioner’s role is to advocate for the patient’s autonomy while informing them about the consequences of their choice and focusing on reducing harms (Vearrier, 2019).

The research literature offers several suggestions as to how to improve client involvement or to enact shared decision making. In medicine, decision aids have been used to support patient’s decision making. For example, Perestelo-Perez (2017) developed a web-based decision aid to help patients with depression learn about available treatments and to read narratives of patient experiences with the various options. Similarly, LeBlanc (2015) used a series of cards highlighting the effects of various antidepressant medications. Geller (2019) created guidelines for the use of non-negotiables (mandatory treatment components) in a collaborative care model. Non-negotiables need to have a sound rationale, be consistently implemented, discussed at the beginning of treatment, and maximize client choice. Frontline professionals may be able to incorporate the use of non-negotiables into clean-out interventions (e.g., by communicating the specific health and safety targets that need to be remediated).

Shared decision making increases client autonomy and is in line with ethical guidelines. Conceptual frameworks suggest shared decision making may lead to improved health and behavioural outcomes, such as adherence with treatment recommendations or symptom reduction, either directly or indirectly based on the client’s affective response (Shay & Lafata,
For example, the use of shared decision making could improve satisfaction with care which could then affect adherence to treatment and result in better health outcomes.

Recent research efforts have turned to collecting empirical support for the effectiveness of shared decision making to improve affective, health, and behavioural outcomes. A meta-analysis of 39 studies published between 1989 and 2012 found that shared decision making was primarily associated with affective outcomes, such as treatment satisfaction and reduced decisional conflict (Shay & Lafata, 2015). Other, more distal behavioural and health outcomes, including medication adherence, quality of life, and symptom reduction, were not consistently associated with shared decision making (i.e., only 37% of the behavioural outcomes and 25% of the health outcomes evaluated were associated with shared decision making, Shay & Lafata, 2015). Two other systematic reviews, the first on patients with psychosis, the second on patients with bipolar disorder, found similar findings. Across 11 randomized control trials concerning the use of shared decision making for individuals with psychosis, shared decision making was associated with increases in patients’ subjective sense of involvement in treatment, self-efficacy, and autonomy (Stovell et al., 2016). In terms of more distal outcomes, there was a trend towards shared decision making reducing the likelihood of future compulsory in-patient treatment over the subsequent 15-18 months (Stovell et al., 2016). Relatedly, a systematic review of studies on patients with bipolar disorder found evidence across five studies that involvement in treatment decisions was related to greater patient satisfaction, better adherence with medication, and lower suicidal ideation (Fisher et al., 2016).
1.4.1 Client Experience of Involuntary Interventions and Coercive Practices

Evidently, shared decision making or client involvement is associated with certain benefits. There is also a body of literature on the consequences of a lack of client involvement in treatment decisions. The majority of this research has been done on involuntary or compulsory interventions, where collaborative care is more difficult to achieve. It appears the perception of reduced autonomy or perceived coercion is a key factor in predicting treatment satisfaction and experience.

A qualitative study on the experience of involuntary hospital patients found themes centered around a strong negative evaluation of care (Nyttingnes et al., 2016). Patients described their experience as a violation of autonomy; they experienced pressure and coercion to take medication and felt staff disregarded their complaints (Nyttingnes et al., 2016). In another qualitative study, themes that patients described as contributing to their perception of coercion, included perceiving hospital treatment as not effective, not participating in the admission and treatment process, and not being treated with respect (Katsakou et al., 2011). Patients with anorexia nervosa expressed a belief that recovery from anorexia requires consent and cooperation from the patient, which is not possible with compulsory treatment (Tan et al., 2010).

These involuntary patient experiences may be similar to a hoarding client who experiences a clean-out intervention and has minimal involvement in the process. One qualitative study on the acceptability of hoarding interventions found that lack of control over the process was an important factor in treatments that clients viewed to be unacceptable (Rodriguez et al., 2016). As such, the use of cleaning and removal services was rated among the three most unacceptable services, alongside serotonin-reuptake inhibitors and a court-appointed guardian (Rodriguez et al., 2016).
A key determinant of dissatisfaction among involuntary patients is their perception of coercion during admission and treatment. In several studies, perceived coercion, rather than documented use of coercive measures, has been negatively associated with treatment satisfaction (Iversen et al., 2007; Katsakou et al., 2010). It is the patient’s experience or view of events that is most predictive of their satisfaction (Hoge et al., 1997). Interestingly, perceived coercion may not be directly related to involuntary admission status. In one study, 10% of legally voluntary patients felt coerced, and 35% of involuntary participants did not feel coerced (Hoge et al., 1997). Similarly, Kallert (2011) found that voluntary patients who felt coerced had poorer symptom improvement outcomes at follow-up compared to involuntary patients who did not report feeling coerced. Further, this perception of coercion and patients’ ratings of treatment satisfaction are predictive of symptom improvement post-hospitalization (Kallert et al., 2011; Wallsten et al., 2006). The degree to which hoarding clients perceive coercion during clean-out interventions is largely unknown.

In addition to perceived coercion, involuntary or restrictive interventions often have adverse emotional consequences. A 2019 systematic review of 56 qualitative studies on patient experiences of involuntary hospitalizations found the emotional impact of these interventions was most commonly negative (Akther et al., 2019). Patients across studies identified experiencing anger, confusion, distress, fear, resentment, and defensiveness in response to involuntary interventions. Relatedly, Chieze et al. (2019) systematically reviewed 35 quantitative studies on the effects of seclusion and restraint in adult psychiatry; they found the use of these measures was also consistently associated with negative emotions, particularly feelings of punishment and distress. There is also evidence that involuntary interventions achieve undesirable patient outcomes. For instance, patients who were restrained have a lower likelihood
of voluntarily engaging in outpatient services (Im et al., 2024), and short-term hospitalizations to manage acute suicidality have been associated with increased suicide risk during and immediately following hospitalization (Large et al., 2014; Ward-Ciesielski & Rizvi, 2021).

Although clean-out interventions likely achieve positive health and safety outcomes from the perspective of enforcement professionals or neighbours, it would be important to document outcomes more relevant to the client perspective (e.g., their emotional response, difficulty discarding, tenancy preservation).

1.5 Current Research

As stated previously, the current research will examine factors precipitating clean-outs, characterize the range of practices used to conduct clean-outs, including the degree to which client-centered practices are employed, and examine the immediate affective, health, and safety outcomes. As this is the first comprehensive study on hoarding clean-outs, I will initially look to the existing academic and community practice literature to identify the extent and breadth of research activity relating to my research questions. I will subsequently survey frontline professionals to corroborate what I have learned and follow up with more in-depth questions related to my research aims.

Clean-out Rationales. This dissertation will examine the range of antecedent conditions that prompt clean-outs and will identify which are the most important in the decision to have a clean-out. Based on the concept of harm potential described by Tompkins (2015), the current research will also examine factors relevant to the functional capacity of the client and the health and safety risks in the home environment. These factors are hypothesized to predict whether or not a clean-out is necessary, in the same way as involuntary hospitalizations or compulsory treatment orders are warranted when a client has limited decision-making capacity, low insight,
or a risk of harm to self or others (Dawson & Mullen, 2008; Katsakou et al., 2012). This dissertation will also examine external pressures that may influence the necessity of a clean-out for compliance purposes (e.g., risk of eviction).

**Clean-Out Practices.** This dissertation will explore if there are existing procedures or protocols with regard to the process of conducting clean-out interventions. Additionally, I will explore the ways clean-outs differ or coincide with regard to the duration of the intervention, the amount of clutter removed, and the number of individuals involved. Based on these elements, I will be able to determine if a prototypical clean-out exists.

**Client-Centered Approach.** The current research will search for evidence of client-centered strategies in clean-outs (e.g., shared decision making, client involvement, collaboration on clean-out goals). The existing literature portrays clean-outs as the opposite of client-centered (e.g., forced, non-consenting, and traumatic). This dissertation will search for any evidence of client-centered practices being used in clean-outs. Based on associations described earlier in this chapter (Fisher et al., 2016; Shay & Lafata, 2015; Stovell et al., 2016), Chapter 3 will also examine if the use of these strategies relates to the client’s emotional response and health and safety outcomes.

**Affective Response.** Published articles on hoarding often warn practitioners about the potentially negative psychological effect clean-outs can have on clients. As described earlier, there are also clear relationships between the client’s perception of coercion and involuntariness and their emotional response. Therefore, I will document the range of clients’ emotional responses to a clean-out. Although the literature has previously only described negative emotional responses, I will also include questions about positive emotional responses (e.g.,
relief) as this has never been examined. Data collected from these questions may either support or refute the descriptions that are currently in the literature.

*Health and Safety Outcomes.* Similar to case descriptions of the client’s emotional response following a clean-out, the expected long-term outcomes are also typically negative. As clean-outs do not target the underlying psychological mechanisms (e.g., difficulty discarding, intentional saving), a re-accumulation of the clutter is likely (Frost, 2000). The current research will examine immediate outcomes, such as the client’s housing status and if health and safety risks have been remediated. Due to the negative consequences of eviction, the scoping review will take a more in-depth look at eviction and how it relates to clean-outs. The interview-based survey will then examine whether eviction threats are alleviated following a clean-out. By assessing short-term outcomes, this dissertation will characterize why clean-outs continue to be used as a strategy, despite the negative descriptions in the literature.

### 1.5.1 Conceptual Framework of Clean-Out Interventions

This dissertation relies upon the conceptual framework presented in Figure 1.2. Each of the five research objectives are included within the model. As the model shows, antecedent conditions form the *Clean-Out Rationale.* These antecedent conditions (i.e., health and safety risks, functional capacity, external pressures) give rise to a clean-out intervention. With respect to the intervention, clean-outs may range in the intensity of *Clean-Out Practices* (i.e., volume removed, duration, individuals involved) and in the use of *Client-Centered Strategies* (i.e., emotional support, shared decision making). Finally, given the antecedent conditions and clean-out practices, certain *Affective Response* and *Health And Safety Outcomes* may be observed (i.e., resolution of risk, tenancy preservation).
Figure 1.2

Conceptual Framework of Clean-Out Interventions

1. What makes a clean-out necessary?
   - Clean-out rationales
     - Client functional capacity
     - Health and safety risks
     - External pressures

2. How are clean-outs conducted?
   - Clean-out practices
     - Volume removed
     - Duration
     - Number of participants

3. Which client-centered strategies are being used?
   - Client-centered strategies
     - An active client role
     - Emotional support
     - Shared decision making

4. What is the client’s emotional response?
   - Affective response
     - Client distress

5. What are the health and safety outcomes?
   - Health and safety outcomes
     - Risks diminished
     - Housing status
     - Hoarding symptoms
The framework was developed based upon the harm reduction for hoarding approach and models of shared decision making. For example, the relation between the antecedent conditions and the intensity and client-centeredness of practices reflects Tompkins’ harm reduction for hoarding approach, which suggests that a harm reduction intervention should be responsive to a client’s functional capacity, health and safety risks, and external pressures. To illustrate his point, a complex case involving multiple clean-out rationales (e.g., eviction risk, pest infestation, poor physical health) may involve a greater intensity of practices (e.g., more clutter removed, more staff on-site) and fewer client-centered strategies.

The relations between client-centered strategies, a client’s affective response, and outcomes draw upon the shared decision-making models of Shay (2014) and Street (2008). Their conceptual frameworks suggest client-centered strategies can lead to improved health and behavioural outcomes either directly or indirectly based on the client’s affective response (Shay, 2014; Street, 2008). To put it in the context of hoarding, a voluntary clean-out with a high degree of client involvement may be associated with less distress and improvements in hoarding symptoms. Ultimately, future research can test the proposed associations among constructs, however this dissertation will prioritize describing the constructs.

1.5.2 Overview of Methods

The role of descriptive research is to collect information that allows researchers to observe and describe phenomena (Dulock, 1993; Grobbee, 2003). The current dissertation will address the descriptive research objectives in Figure 1.2 with a scoping review and a survey of frontline professionals with direct experience conducting clean-out interventions. The scoping review will provide an overview of the current literature that exists on clean-outs in both the published and grey literature, in addition to identifying knowledge gaps. Using the scoping
review as a foundation, the provider interview will use a quantitative approach to investigate clean-out interventions among frontline professionals from various sectors (e.g., housing, nursing, social work).

1.5.3 Public Scholarship

Through public scholarship, this dissertation will ensure research questions are relevant to community practitioners from a wide array of service sectors who conduct clean-out interventions (e.g., mental health, nursing, housing, fire prevention, protective services). Public scholarship aims to connect academics with community organizations to pursue research for the public good. My primary goal in the dissertation is to engage in meaningful community-based research through collaborations with frontline workers, in order to promote evidence-based practice.

Data collection will rely partly on community partnerships with the Hoarding Action Response Team, Toronto Hoarding Support Services Network, Fraser Health Authority, Wellington Guelph Hoarding Response, and the Hoarding Disorder Foundation of Alberta. Staff members at these organizations helped to identify grey literature (e.g., program reports, intervention protocols, training materials) for inclusion in the scoping review, assisted with recruitment efforts and participated in the provider interview-based survey. These organizations were selected for their interest in the dissertation topic (and willingness to help with recruitment), however numerous other organizations across North America, Australia, and the UK were also invited to participate.

The results of this research will benefit members of the public by providing hoarding providers, related professionals and family members with information that will guide them in conducting clean-out interventions; to this end, a research report that summarizes the research
findings and a best practice toolkit can be found in Chapter 5. These materials will be disseminated to providers with support from the UBC Public Scholars Initiative. As communities continue to turn to clean-outs to mitigate health and safety risks, this project will offer practice recommendations to partner organizations and broadly to their counterparts across North America.

I am motivated to do this work based on my clinical experience using a cognitive behavioural approach to treat individuals who hoard, as well as my nine years of research experience in community interventions for hoarding. During my master’s program, I conducted and published community-engaged research with the Hoarding Action Response Team in Vancouver. I developed a deep understanding of the challenges in community-based interventions for hoarding, including the lack of resources, organizational support, and training available for professionals who work with clients who hoard. With this knowledge and continued mentorship from my supervisors throughout my doctoral program, I regularly consulted with community organizations and provided educational seminars and workshops to a variety of community audiences (e.g., housing professionals, nurses, social workers) on how to assess and intervene in cases of hoarding. Throughout these nine years, I have been amazed by the dedication and heart that community professionals put into working with hoarding clients. In turn, I have been motivated to research clean-outs with a view to offering guidance to practitioners and support to the clients involved.
Chapter 2: Hoarding Clean-Out Interventions and Evictions: A Scoping Review

Scoping reviews differ from other scholarly reviews because they incorporate documents that have been created by community professionals outside of academia, such as program reports, intervention protocols, health and safety assessment checklists, and training materials (Arksey & O’Malley, 2005; Peters et al., 2015). As hoarding disorder has a relatively short history within the psychiatric and academic community, information disseminated by community providers has not yet been integrated into the academic literature. Meta-analyses and reviews have been conducted on various aspects of hoarding disorder, such as the age of onset (Zaboski et al., 2019), treatment outcomes (Tolin et al., 2015), cognitive performance (Woody et al., 2014), and prevalence (Postlethwaite et al., 2019), but there are no extant review articles on community interventions for hoarding.

The scoping review described in this chapter focuses on the most extreme – and often coerced – interventions related to problems associated with hoarding: clean-outs and eviction. These interventions are considered to be severe and intensive interventions, relative to more client-centered approaches such as gradual decluttering sessions or cognitive behavioural therapy for hoarding. Clean-outs and eviction are often described as the community-based interventions providers should avoid using. Usually the focus, when discussed in published or practice documents, is on the potential negative effects. For example, “Forced clean-up without the consent of the individual with hoarding behaviours worsens symptoms and contributes to recidivism” (Chapin et al., 2010). Relatedly, eviction is frequently described as a crisis intervention or a marker of a failed intervention. For example, “eviction resulted for four cases following an unsuccessful harm reduction approach” (Kysow et al., 2020). Despite these
interventions having large impacts on the clients and communities involved, no research has systematically examined their practices or outcomes. A scoping review that combines grey literature from community practitioners with the work published in academia will shed light on the use of these interventions.

2.1 Objectives for the Scoping Review

This scoping review aims to provide an overview of what is known about hoarding-related clean-outs and eviction. Specifically, the research aims guiding the scoping review are to:

1) Understand the factors precipitating clean-outs and eviction.
2) Outline the planning and logistics required to conduct these interventions.
3) Examine the immediate affective, health, and safety outcomes.
4) Summarize perspectives on clean-outs.

2.2 Method

The clean-out and eviction scoping review data were drawn from a larger scoping review conducted by our research team in 2020. The objectives of this broad scoping review on community interventions for hoarding were to: 1) identify the targets or aims of community-based interventions, 2) characterize the strategies community agencies use to address hoarding, and 3) summarize the available literature on clean-out interventions and eviction. I led the team in conducting the review by setting up the methodological framework and initiating the search process as well as participating in and managing the team that completed the searching, screening, and extraction stages. This chapter presents my analysis of a subset of the material collected, specifically the data on clean-outs and eviction.

The scoping review followed the Joanna Briggs Institute methodological framework for the searching, screening, and extracting phases of a scoping review (Peters et al., 2015) as well
as additional recommendations by Levac et al. (2010). I adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Extension for Scoping Reviews (PRISMA-SCR) checklist (Tricco et al., 2018).

The following sections detail the eligibility criteria, as well as the four stages of the scoping review (Stage 1: Search Strategies and Initial Screening, Stage 2: Full-Text Eligibility, Stage 3: Data Extraction, and Stage 4: Data Analysis). Stage 1 to Stage 3 were a team process, whereas Stage 4 was conducted solely by me.

2.2.1 Eligibility Criteria

The complete eligibility criteria are shown in Table 2.1. Documents had to meet all 10 criteria for inclusion. English language materials published in 1993 or later were included. This date reflects the earliest peer-reviewed publications on hoarding that came to inform the development of the DSM-5 diagnostic criteria for hoarding disorder. There were no restrictions on research design or study type. The larger scoping review included documents with a primary focus on targets or strategies used in community interventions for hoarding. Targets were defined as any serious risks in the home (e.g., fire safety, degradation, sanitation) or concern regarding the client’s functional capacity (e.g., their physical, social, or psychological capacity). Strategies were defined as specific procedures to address the risks or improve the hoarding situation; these included a broad range of strategies relevant for use by community agencies, such as case management, capacity building, decluttering assistance, clean-outs, eviction, and condemnation. As will be described below, for my subset of the review, I had an additional inclusion criterion: documents were required to contain material relevant to clean-outs, eviction, or condemnation. Condemnation, a situation in which a home is deemed uninhabitable and its residents are forced to leave, was also included, as it is functionally equivalent to eviction.
## Table 2.1

*Eligibility Criteria for the Scoping Review*

<table>
<thead>
<tr>
<th>Document characteristics:</th>
<th>Inclusion criteria</th>
<th>Exclusion criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-Identifiable author or organization responsible for the content</td>
<td>1-Non-identifiable author or organization responsible for the content</td>
<td></td>
</tr>
<tr>
<td>2-Published in 1993 or later</td>
<td>2-Published prior to 1993</td>
<td></td>
</tr>
<tr>
<td>3-Available in English</td>
<td>3-Not available in English</td>
<td></td>
</tr>
<tr>
<td>Document type:</td>
<td>4-Formal documents such as journal articles, books, program reports, policies and procedures, practice guidelines, health &amp; safety assessment checklists, toolkits, newsletters, and training materials (including PowerPoints)</td>
<td>4a-Informal communications such as personal correspondence, emails, blogs, social media postings, and wiki articles (e.g., personal opinion pieces)</td>
</tr>
<tr>
<td>5-Material produced by academic researchers, hoarding task forces, community agencies, or public service providers who work with hoarding</td>
<td>5-Material produced by for-profit organizations or individuals (e.g., cleaning companies)</td>
<td></td>
</tr>
<tr>
<td>6-Content is original to the source (i.e., drawn from the author’s professional experiences, research, or training)</td>
<td>6-Content is not original to the source (i.e., pulled from another article or document)</td>
<td></td>
</tr>
<tr>
<td>Content focuses on:</td>
<td>7-Hoarding is the primary topic of the article/document</td>
<td>7-Hoarding is one topic mentioned in the article/document</td>
</tr>
<tr>
<td>8-Content goes beyond general information on the risks of hoarding</td>
<td>8-Content is only about the general topic of hoarding (e.g., public interest or news article on hoarding)</td>
<td></td>
</tr>
<tr>
<td>9-Content focuses on hoarding risks that fall within the mandate of community agencies or interventions used by such agencies to address those risks</td>
<td>9a-University-based studies of the psychological phenomenon of hoarding without intervention</td>
<td></td>
</tr>
<tr>
<td>9b-Content focuses on animal hoarding</td>
<td>10-Material includes targets and/or strategies within the scope of community-based interventions for hoarding. Targets may represent risks in the home or concern regarding the client’s functional capacity (e.g., safety risks, health risks, housing security). Strategies may aim to reduce environmental risk or improve functional capacity (e.g., case management, clean-out, eviction).</td>
<td>10a-Psychological targets such as beliefs about possessions or strategies primarily used by specialized mental health providers (e.g., components of CBT)</td>
</tr>
<tr>
<td>10b-Descriptions of codes for enforcement (e.g., fire codes) or strategies for fire suppression rather than prevention</td>
<td>10c-Strategies presented as self-help materials</td>
<td></td>
</tr>
<tr>
<td>11-Material mentions the strategy cleanout, eviction, or condemnation</td>
<td>11-Material does not mention the strategy clean-out, eviction, or condemnation</td>
<td></td>
</tr>
</tbody>
</table>

**Clean-out and eviction subset of the review:**
2.2.2 **Stage 1: Search Strategies and Initial Screening**

The research team searched both the academic and grey literature (literature not subject to the academic peer-review process, including dissertations, PowerPoint presentations, or program evaluation reports; Adams et al., 2017). Three strategies were used to identify academic and grey literature: 1) a reference database search, 2) a website search, and 3) consultation with content experts. The following sections detail these search strategies. Figure 2.1 includes a synopsis of the entire search and selection process, from the number of documents identified to the number of documents selected for inclusion in the scoping review.

2.2.2.1 **Reference Databases**

Based on the eligibility criteria, the team conducted a systematic search of the scholarly literature in July 2020 across six electronic databases: PsycInfo, CINAHL, MEDLINE, EMBASE, Social Services Abstracts, and Web of Science Core Collection. In collaboration with a research librarian, a search strategy for each database was devised, and search terms related to community-based interventions for hoarding were used across all six databases. (See Appendix A.) One grey literature database was also identified as having documents pertaining to community hoarding interventions: the National Emergency Training Center’s online library operated by the U.S. Fire Administration. I searched this database by using the search term “hoarding.”

During the initial search of scholarly and grey literature reference databases, 558 documents were identified (512 published articles and 46 grey literature papers), of which 61 were duplicates, leaving 497 articles to be screened. Reviewing the titles and abstracts of the documents screened out 348 published articles and 29 grey literature papers that did not appear to meet the eligibility criteria. An additional 18 duplicate documents were excluded at this stage.
Search And Selection Process

Identification

Reference database searches
(n = 558; n = 497 after 61 duplicates removed)

Website searches
(n = 101)

Consultation with content experts
(n = 216)

Documents screened by title, headings, summary, or abstract (n = 814)

Documents excluded (n = 461)
Initially identified from:
Reference database searches (n = 377)
Consultation with content experts (n = 84)

Duplicates excluded (n = 61)
Initially identified from:
Reference database searches (n = 18)
Website searches (n = 19)
Consultation with content experts (n = 24)

Full-text of documents screened for eligibility (n = 292)

Full-text documents excluded, with reasons (n = 149)
No targets/strategies (n = 79)
Not aimed for community provider (n = 43)
Too general (n = 17)
Content not original to source (n = 10)

Documents included in broader study (n = 143)

Documents excluded (n = 64)
Did not mention clean-out or eviction

Documents included in the subset of the review on Clean-out Interventions and Eviction (n = 79)
The remaining 102 documents (89 published articles and 13 grey literature) were screened for eligibility based on the full text.

2.2.2.2 Website Search

Two search strategies were used to identify grey literature: a website search and consultation with knowledge experts. These search strategies aimed to identify hoarding intervention targets and strategies from a broad array of service sectors, including mental health, nursing, housing, occupational therapy, aging, fire prevention, public health and safety, code and law enforcement, protective services, and pest management. Documents such as program reports, policies and procedures, practice guidelines, intervention protocols, health and safety assessment checklists, toolkits, newsletters, and training materials were eligible for inclusion.

The website search strategy involved browsing relevant websites of hoarding task forces, teams, or networks as well as health services or housing advocacy websites. The research team’s long history of research on community-based interventions for hoarding guided the identification and selection of the 44 websites. Appendix B presents the complete list of websites searched and their URLs. All available summary information was screened; if no summary information was available, the entire document was screened. For websites that were particularly difficult to navigate, the website’s search bar or Google Programmable Search were used to locate relevant information. Documents that appeared to be likely to meet eligibility criteria were identified and saved. Twenty-four of the 44 searched websites had information relevant to our review. All 101 documents identified in the initial screening were retained for full-text eligibility screening (as abstracts are generally not available for grey literature); 19 were identified as duplicates, leaving 82 documents for full-text eligibility screening.
2.2.2.3 Consultation with Content Experts

The third search technique involved contacting knowledge experts to identify other documents for possible inclusion in the review (e.g., authors of relevant books; community experts who provide international hoarding training and consultation). Including two senior members of the research team, 33 knowledge experts were contacted; 10 experts submitted 216 documents for possible inclusion. This included published and unpublished documents. An initial screening of titles and available abstracts identified 84 documents that did not meet the eligibility criteria and an additional 24 duplicates, leaving 108 for full-text eligibility review.

2.2.3 Stage 2: Full-Text Eligibility

Four members of the research team conducted a full-text eligibility screening of the 292 remaining documents. Two members were assigned to judge the full text of all the published literature documents against eligibility criteria and two took responsibility for the grey literature documents. Reviewers determined if potentially eligible documents met the 10 inclusion criteria listed in Table 2.1. Pairs of reviewers initially reviewed the same documents, until an 85% agreement rate was achieved. A fifth and senior member of our team facilitated discussion and provided methodological consultation. During later stages of eligibility screening, verification strategies were used to ensure consistency among research team decisions (Morse et al., 2002); team members consulted on documents about which they were uncertain and regularly reviewed the eligibility criteria to check and confirm decisions were both reliable among team members and valid.

Of 292 full-text documents, 174 were reviewed in pairs with a 76% agreement rate; 149 documents were excluded as not meeting eligibility criteria. The remaining 143 documents met criteria for the broader study.
2.2.4 Stage 3: Data Extraction

The 143 eligible documents were imported into NVivo (Release 1.6.1), a qualitative data analysis software. An initial codebook was developed (Roberts et al., 2019; Skjott Linneberg & Korsgaard, 2019) based on the research team’s extensive knowledge of community interventions for hoarding, relevant community hoarding manuscripts (Bratiotis et al., 2018), and widely used assessment tools (e.g., Bratiotis et al., 2011). The codebook was organized into two themes, “Targets” for hoarding intervention and “Strategies” used in intervention (see Appendix C). More specific sub-themes and codes were also included. The specific sub-themes relevant to the subset of data on clean-outs and eviction included Clean-out Rationale, Clean-out Practices, Clean-out Outcomes, Clean-out Perspectives, and Eviction Rationale. In addition to coding the text, full-text files were classified based on type (e.g., book, newsletter, web page) and attributes were assigned (e.g., author, organization, country).

Seven members of the research team participated in the extraction of key content. The research team started by coding the same two documents independently to trial the codebook and ensure consistency of judgment across coders (Levac et al., 2010; Peters et al., 2015; Richards & Hemphill, 2018; Roberts et al., 2019). The team met regularly during this training phase to resolve discrepancies and to refine code definitions in the codebook. As the team developed greater consensus, we gradually progressed to each person being responsible for their own coding assignment, although 15% of documents were coded through consensus coding to ensure the extraction process remained reliable and valid (Morse et al., 2002; Richards & Hemphill, 2018). Team members were encouraged to memo (i.e., to write down their reflections) regarding their code choices, emergent patterns, or any problems with the codebook (Saldaña, 2014).
Throughout the data extraction process, the team met weekly to discuss challenging pieces of text and discrepancies from documents that were consensus coded.

2.2.5 Stage 4: Data Analysis

The next stage focused on analyzing the text extracted from the subset of documents coded for the presence of the strategy “clean-out” or “eviction”. I completed this data analysis stage independently (without the other six members of the research team). Of the 143 documents included in the full-text eligibility phase, the research team had coded 77 documents for “clean-out” or “eviction”. In preparation for data analysis, I first revisited the initial round of coding completed by the research team to ensure that I included all documents relevant to clean-outs or eviction. Upon review, 79 documents were retained for final analysis: 68 of the original 77 and another 11 that the larger team had not initially coded for “clean-out” or “eviction”.

Thematic analysis, a qualitative methodological approach that involves identifying, analyzing, and reporting repeated themes in a data set, was followed to answer the research questions relating to eviction and clean-outs (Braun & Clarke, 2006). A deductive (top-down) approach was primarily used (Braun & Clarke, 2006; Roberts et al., 2019). This deductive thematic analysis approach has been used in several other scoping reviews with comparable research aims and scopes (Chandna et al., 2019; Kennedy et al., 2018; Ravenna & Cleaver, 2016). Figure 2.2 demonstrates how the research questions mapped onto the conceptual framework, guiding this phase of analysis and the larger dissertation (as discussed in Chapter 1).
Figure 2.2

Conceptual Framework Including Eviction

RQ1
Why are more severe interventions, such as eviction and clean-outs, necessary?

Rationale for clean-outs
Rationale for eviction

RQ2
What are the practices used to conduct a clean-out or complete an eviction?

Clean-out Practices
Eviction Practices

RQ3
What are the outcomes of clean-outs or evictions?

Clean-out Outcomes
Eviction Outcomes

RQ4
What are the perspectives surrounding clean-out as interventions for community hoarding clients?

Clean-out Perspectives
Data from the different document types (e.g., journal articles, protocols, presentations) were coded through the following process. As described above, data had been categorized by the team into the following sub-themes generated from the broader codebook: *Clean-out Rationale, Clean-out Practices, Clean-out Outcomes, Clean-Out Perspectives, and Eviction Rationale*. I added two additional deductive sub-themes, *Eviction Practices* and *Eviction Outcomes*, to better represent my theoretical model and to mirror the clean-out codes. However, I did not add an *Eviction Perspectives* sub-theme as there is less debate surrounding the use of eviction (compared to clean-outs) as an intervention for community hoarding clients. Housing is a social determinant of health (World Health Organization, 2018); therefore, eviction (including hoarding-related eviction) is widely seen as an intervention to avoid.

I carefully reviewed data within each of the themes and sub-themes, which resulted in emerging codes to add to the codebook. This blended approach of starting with deductive coding, then using an inductive approach in a secondary coding cycle enabled me to capture unexpected themes (Roberts et al., 2019; Skjott Linneberg & Korsgaard, 2019). When all the data were initially coded, I followed an iterative process of reviewing and refining the coded data extracts until all the themes and sub-themes were clearly defined and labelled (Braun & Clarke, 2006).

As described earlier, I completed this data analysis stage independently. Due to the entirely qualitative nature of thematic analysis, inter-rater reliability is not required (Vaismoradi et al., 2013). Interpretative flexibility is not only acceptable, but expected for qualitative research at the analysis stage (O’Connor & Joffe, 2020). Qualitative research is subjective; findings are informed by the researcher’s circumstances, theoretical expertise, and approach to interpretation (Tuval-Mashiach, 2021). Other qualitative methods are used to ensure methodological integrity (Levitt et al., 2018). To establish trustworthiness, my work on the data analysis was reviewed.
frequently by a mentor with expertise in qualitative research methods and in community interventions for hoarding. The research mentor reviewed the evolving codebook, highlighted errors or inconsistent code definitions, and recommended changes during the analysis process (Richards & Hemphill, 2018; Shenton, 2004). Through frequent debriefing sessions, we discussed my developing reflections and interpretations, reviewed the memos I wrote in reference to the coding process, and resolved any challenges with coding particular documents or pieces of extracted text (Richards & Hemphill, 2018; Shenton, 2004). My final codebook including the overarching themes and subthemes is included in Table 2.2 (narrower themes are discussed narratively in the Results section).

Table 2.2

Scoping Review Codebook

<table>
<thead>
<tr>
<th>Unit</th>
<th>Unit Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme</td>
<td>Clean-out</td>
<td>rapid removal of a large volume of materials from the home; may be consensual or coerced; client’s decision-making power is low or none.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Examples: housing provider forced removal, family cleaned</em></td>
</tr>
<tr>
<td>Sub-theme</td>
<td>Clean Out Rationale</td>
<td>conditions that necessitate a clean-out intervention; may include imminent risks in the home, external pressures, or client characteristics.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Examples: extreme level of risk that cannot be ameliorated without a clean out, imminent hospital discharge delayed due to conditions in the home, client unable to participate in consensual decluttering due to cognitive decline, housing provider ultimatum of clean out or eviction</em></td>
</tr>
<tr>
<td>Sub-theme</td>
<td>Clean Out Practices</td>
<td>procedures used for a clean-out; includes preparation for clean-out and follow-up with client; includes policies that guide practices.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Examples: official notice is given, outsourced to clean-out company, family</em></td>
</tr>
</tbody>
</table>
| Sub-theme | Clean Out Outcomes | results or consequences of a clean-out; can include changes in level of risk, client reactions, long- or short-term follow-up  
Examples: lower clutter volume, tenancy preservation, client stopped the clean-out, client distress, clutter rebuilt quickly |
| --- | --- | --- |
| Sub-theme | Clean Out Perspective | statement that reflects a perspective about clean-outs
Examples: “A clean-out does not address the resident’s underlying attachments to clutter”, “Clean-outs are a tool that we use under some conditions”, “Client previously had a clean-out and it was a negative experience” |
| Theme | Eviction | interventions that involve removing the client from the home  
Examples: forced move to another unit, eviction, condemnation |
| Sub-theme | Rationale for eviction | conditions that necessitate removal; may include imminent risks in the home, external pressures, or client characteristics  
Examples: noncompliance with city orders, housing court ruled in favour of removal |
| Sub-theme | Eviction Practices | procedures used for eviction  
Examples: lease violation warnings, eviction notice, clean-outs to prevent eviction, court involvement |
| Sub-theme | Eviction Outcomes | results or consequences of an eviction  
Examples: homelessness, emotional responses, re-accumulation of clutter, loss of belongings |
2.3 Results

The goal of the scoping review was to present a comprehensive summary of the grey and published literature regarding clean-outs and eviction and the impact of these interventions on people with lived experience of hoarding. Documents included in the scoping review were from writers in North America and around the world (see Table 2.3 for document attributes). Published and grey literature were represented. Interestingly, in some instances the published and grey literature included the same authors. For example, the first author of a piece of scholarly literature may have also authored research reports and presentations published in the grey literature. This may be in part because the field of research on community-based interventions for hoarding is relatively new (~10 years).

For the majority of documents, clean-outs and eviction were not the sole focus; rather these interventions were discussed alongside other topics (e.g., the overall topic was older adults who hoard, with clean-outs discussed as a possible intervention). There were only six documents dedicated to eviction (Boston Housing Court, 2007; Cobb et al., 2007; Crimmins, 2016; Gibson, 2015; Rodriguez et al., 2010, 2016), and only one document, a presentation, focused solely on clean-outs (Shapiro, 2019). The remaining documents addressed clean-outs or eviction in a few sentences to a couple of paragraphs.

Table 2.3

<table>
<thead>
<tr>
<th>Scoping Review Document Attributes (N = 79)</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of Author</td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>50 (63%)</td>
</tr>
<tr>
<td>Canada</td>
<td>16 (20%)</td>
</tr>
<tr>
<td>Australia</td>
<td>6 (8%)</td>
</tr>
<tr>
<td>UK</td>
<td>6 (8%)</td>
</tr>
</tbody>
</table>
Table 2.4 presents the three primary data categories (i.e., descriptions, case examples, protocols) that emerged from the analysis and were coded. Table 2.4 also provides corresponding clean-out and eviction examples for each primary theme (i.e., rationale, practices, outcomes, perspective). Descriptive codes were the most common, representing slightly more than half of the codes.

A summary of included published and grey documents is provided in Appendix D. Specific information includes: file classification, country of origin, year of publication, and themes addressed in the document. The following section synthesizes findings across documents and links key concepts to the conceptual framework. Results were organized according to the codebook shown in Table 2.2.
Table 2.4

Data Categories and Corresponding Clean-Out and Eviction Themes

<table>
<thead>
<tr>
<th>Data Categories</th>
<th>Rationale</th>
<th>Practice</th>
<th>Outcome</th>
<th>Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptions</td>
<td>A description of a rationale</td>
<td>A description of a clean-out or eviction practice or what should be done in someone’s professional opinion (e.g., a housing provider)</td>
<td>A description of possible outcomes</td>
<td>Perspectives held by public, a group of individuals, or an individual</td>
</tr>
<tr>
<td>Statement</td>
<td>“Often a clean-out with a bio-hazard cleaning company will be required in order to bring the home to safety and protect the homeowner as well as those in proximity.” (Shapiro, 2019)</td>
<td>“The individual should always be involved in the clean-out process.” (Owen, 2019)</td>
<td>“Home clean-outs require intensive fiscal and human resources and commonly lead to re-accumulation of clutter.” (Bratiotis, 2011)</td>
<td>“Clear outs will resolve an immediate health and safety crisis, but won’t stop the condition from recurring.” (Dinning, 2006)</td>
</tr>
<tr>
<td>May include</td>
<td>“In the case of pest infestation, damage to property, or disturbance to the neighbors caused by hoarding, a landlord can issue a written warning for the situation to be rectified within 30 days. If the problem is not resolved to the landlord’s satisfaction, they can seek to end the lease agreement through eviction, a lengthy and expensive legal process.” (Baker, 2014)</td>
<td>“At the point where the courts get involved, the eviction process itself puts pressures on the family to proceed with actions, such as a clean-out or a move.” (Davis, 2013)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>individual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>perspectives on</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>clean-outs and</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>evictions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Examples</td>
<td>An example of why a clean-out or eviction occurred or could occur</td>
<td>An example of a practice used in a clean-out or eviction that occurred</td>
<td>An actual outcome of a clean-out or eviction</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Statement referencing a hoarding case or cases.</td>
<td>“Because of the insect infestation that was causing problems for her neighbors and structural concerns for her home, the police and other agencies conducted a one-day clean up that involved clearing out the entire house of trash and other things that appeared to be useless.” (Koenig, 2010)</td>
<td>“The court ordered the house to be secured and the property to be cleaned. The occupants could not live in the house, however they could enter the property during the day to clean the interior of the house.” (Patterson, 2014)</td>
<td>“S. had experienced multiple forced clean-ups over the years. Code enforcement had the paperwork for another clean-up. They arrived at the house to drop off a dumpster, and S. became very upset. He argued with one of the workers, shoved him, and received a court summons.” (Chapin, 2010)</td>
<td></td>
</tr>
<tr>
<td>Some of these statements were hypothetical examples or case vignettes.</td>
<td>“Alice continued to live in the apartment but resumed her hoarding behavior, once again bringing trash home and hoarding rotting and decomposing food. The manager of the building complained about the smell and threatened to evict Alice if her apartment was not cleaned up.” (Franks, 2004)</td>
<td>“Warnings of eviction and eviction notices were used as tools by building operators in publicly and privately operated buildings to engage tenants with hoarding problems and to indicate the severity of the situation.” (Glover, 2010)</td>
<td>“The landlord served her with an eviction notice to which she reacted so violently that commitment to a psychiatric facility for evaluation was necessary.” (Thomas, 1998)</td>
<td></td>
</tr>
<tr>
<td>Protocols</td>
<td>Why a specific organization does clean-outs or uses eviction</td>
<td>What practices organizations aim to follow</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------------------------</td>
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</tr>
<tr>
<td>Practices and procedures community organizations planned to follow for clean-out and eviction interventions.</td>
<td>“The by-law official interviewed for this research explained, ‘Generally we would give a couple of weeks in order to remove the items, otherwise we would come in and do a clean up’.” (Gibson, 2015)</td>
<td>“During such a clean-up, two staff from a human service team, as well as an animal welfare team, when appropriate, should be on site, in addition to the cleaners, to troubleshoot unexpected events and provide support and assistance to the person if required.” (State of Victoria Dept of Health, 2013)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Formal protocol: statement included in formalized intervention protocol</td>
<td>“We will only consider possession proceedings as a last resort and are committed to preventing unnecessary evictions.” (Circle Housing, 2014)</td>
<td>“As always, NRH will need to continue to review each case where there is a risk of eviction for its programmatic and legal obligations to support and accommodate individuals who have significant social and health needs, balanced against its obligations to provide safe housing for all of its tenants.” (Beckwith, 2013)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Informal protocol: Statement referencing an organization’s protocol (what they do)</td>
<td>Protocols differed depending on organizational regulations and city bylaws.</td>
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</tr>
</tbody>
</table>
2.3.1 Thematic Analysis Clean-out Findings

2.3.1.1 Terminology

Although the term “clean-out” was primarily used, synonyms and qualifiers were also used when describing clean-out interventions. (See Table 2.5). The inconsistent language speaks to the confusion and ambiguity surrounding clean-out interventions. This variability likely contributes to misunderstandings between clients and providers as to what intervention is actually taking place. Such a large range of synonyms also potentially conveys a hesitancy on behalf of providers to discuss clean-outs openly, perhaps for fear of stigma (from other providers) or to soften the severity of intervention for clients.

Table 2.5

Terminology Related to “Clean-Out”

<table>
<thead>
<tr>
<th>Synonyms</th>
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</tr>
</thead>
<tbody>
<tr>
<td>clean-up</td>
<td></td>
</tr>
<tr>
<td>clearance</td>
<td></td>
</tr>
<tr>
<td>blitz clean</td>
<td></td>
</tr>
<tr>
<td>special cleanse of property</td>
<td></td>
</tr>
<tr>
<td>extreme cleaning</td>
<td></td>
</tr>
<tr>
<td>heavy chore</td>
<td></td>
</tr>
<tr>
<td>removal of biohazard waste</td>
<td></td>
</tr>
<tr>
<td>forced abatement of the exterior</td>
<td></td>
</tr>
<tr>
<td>safety day</td>
<td></td>
</tr>
<tr>
<td>intervention following a notice to clean or a 30-day cleaning order</td>
<td></td>
</tr>
<tr>
<td>intervention conducted by cleaning services</td>
<td></td>
</tr>
</tbody>
</table>

| Qualifiers                                                              |      |
| forced clear-out                                                       |      |
| one-off clean-up                                                        |      |
| large-scale clean                                                       |      |
total clean-out
clean sweep type clean-outs
one room clean-out
modified cleanout

2.3.1.2 Clean-out Rationale

In order to better understand why clean-outs continue to be a possible course of action, in spite of their intrusiveness and perceived severity, I examined the various factors and conditions triggering such an intervention.

Across grey and published literature, clean-outs were not voluntarily requested by the client responsible for the hoarding behaviours. Rather, they occurred as a result of external pressures from housing providers, public health officers, and fire services. The most commonly reported reason for a clean-out was health and safety risks to the residents in the home and their surrounding neighbours; risks included fire hazards, poor sanitation, and structural concerns. Clean-outs were often conducted to mitigate imminent risks, to safeguard the client and neighbours, or to satisfy maintenance standards and fire codes. For some, clean-outs were enforced through a “notice to comply”; in these cases, clients were pressured to have a clean-out as they were in violation of their lease conditions or local laws (e.g., excessive combustibles in the home). On the surface, clients appeared to consent to the clean-out, but they had been coerced into agreeing as they faced the constrained choice between a clean-out or eviction. Forced clean-outs occurred when there was no consent and possessions were forcibly removed from a client’s home (Gibson, 2015).

A clean-out was frequently described as an intervention of last resort; previous attempts had been made to reduce health and safety risk in the home using other approaches, but they
were unsuccessful as the client refused to cooperate or did not want to engage. In one case, adult protective services became aware of an 80-year-old client’s hoarding behaviours. Over the span of three years, various interventions were attempted to decrease health and safety risk in her home, including hospitalization, condemnation, several moves, and ultimately two clean-outs. The clean-outs were motivated by eviction pressure, ongoing concerns about unsanitary living conditions, and a re-accumulation of possessions (Franks et al., 2004). When less severe and intense interventions fail, a clean-out becomes the only remaining solution.

Clean-outs were also presented as a preventative solution intended to avoid detrimental housing outcomes, such as eviction, loss of housing subsidy, or condemnation of an owned property. Occasionally, clean-outs were mentioned in the context of a home that was heavily pest infested, and pest control workers could not perform their services until a large volume of clutter was removed (Saltz et al., 2010; Whitfield et al., 2012). A clean-out may also have been used to clear space so that professionals could repair non-functioning plumbing or heating (Bratiotis et al., 2011; Tompkins, 2015).

A small number of cases in the sourced material stated that clean-outs occur to ensure the safety of staff who provide in-home care, for example home-health aides (Baker et al., 2014; Kysow et al., 2020; Saltz et al., 2010; State of Victoria, Department of Health, 2013). Clean-outs were also recommended by hospital staff to ensure a safe discharge home for clients receiving medical care (Frigulietti, 2014; Kysow et al., 2020; Slatter, 2012). There was one mention of a clean-out being necessary to prevent removal of a child from a home that was unsafe due to excessive clutter (Baker et al., 2014).
A Practice Guide on How to Conduct a Clean-Out

*Items with an asterisk may not be required for every clean-out.
2.3.1.1 **Clean-out Practices**

Clean-outs require a great deal of planning and coordination. The following section outlines the stages of a clean-out, the personnel involved, and the required finances or funding.

2.3.1.1.1 **Planning/Logistics**

Many different activities and tasks are needed to successfully organize and execute a clean-out. In order to best represent all of the tasks mentioned across the sourced material, I created a visual graphic amalgamating the tasks into a clean-out timeline. Figure 2.3 shows the steps involved in a clean-out, arranged in chronological order, from the initial to end phase. Recommendations for how to involve the client in each phase were largely drawn from Tompkins (2015), one of the only resources to describe how to improve a client’s experience of such an intrusive and intense intervention. Overall, the graphic can be used as a guide for how to conduct a clean-out following the practices curated in this scoping review. Each practice included in the figure was mentioned by at least one document in the review. Future research to validate this model and the use of these practices consecutively would be beneficial.

2.3.1.1.2 **Personnel**

As implied in Figure 2.3, a diverse team of professionals was often required to conduct a clean-out. Table 2.6 provides a taxonomy of clean-out personnel mentioned in the scoping review documents. A client may have been overwhelmed when confronted by such a large number of individuals, but, due to the inherent complexity of hoarding, assembling such a large multidisciplinary team was often necessary to address the variety of risk factors, in addition to client-specific needs and housing implications.
Table 2.6

*Personnel Involved in Clean-Outs*

<table>
<thead>
<tr>
<th>Categories of Personnel</th>
<th>Examples of Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoarding specialists</td>
<td>hoarding task force members, clean-out company staff, pest control, animal control,</td>
</tr>
<tr>
<td></td>
<td>professional organizers, and storage facility owners</td>
</tr>
<tr>
<td>Housing providers</td>
<td>landlords, building owners, social housing staff, and resident service coordinators</td>
</tr>
<tr>
<td>Health and social services</td>
<td>public health, social services, protective services</td>
</tr>
<tr>
<td>Safety and bylaw officers</td>
<td>fire prevention, first responders, police, public work crews, City Council</td>
</tr>
<tr>
<td>Mental health professionals</td>
<td>therapist, case manager</td>
</tr>
<tr>
<td>Medical team members</td>
<td>family physician, nurses, occupational therapists</td>
</tr>
<tr>
<td>Social network</td>
<td>family, friends, neighbours, volunteers (e.g., from faith community, youth organizations)</td>
</tr>
</tbody>
</table>

2.3.1.1.3  Finances/Funding

Owing in part to the multiple phases and personnel involved, clean-outs were portrayed as expensive interventions. The importance of ascertaining in advance who was responsible for funding the clean-out was an important element of the process. Community practitioners cautioned that some clients may not have adequate savings to pay for such a costly intervention, whereas others may (understandably) refuse to contribute their own finances to an intervention they do not want.

The cost of a clean-out varied, likely depending on the home’s size and what specific services were used. More costly items included fees for dumpster rental, rubbish removal, storage fees, cleaning services, and labour costs. Additional costs included a loss of rent to
landlords and the cost of legal proceedings. After a clean-out, there were often additional costs to remediate the home’s condition, such as pest control and repairs.

Clean-outs were often funded through grants and social programs, such as adult protective services, Veteran’s Administration, or disability services. In some instances, cleaning companies partnered with social service programs to provide discounted rates for clean-out assistance or to offer reduced-fee services, such as dumpster rentals or garbage pick-up. These partnerships were recommended for health or social service agencies who typically served a low-income client population. If costs were not covered through these programs, clean-out fees were the responsibility of the homeowner or client, housing provider, family members, or the city. In certain cases, the local government or courts may have placed a lien on the client’s property or charged the client through property tax to recoup the costs. In one emotionally charged case example, a client was sued for the cost of the clean-out after six months of unsuccessful negotiations and inspections had ended with environmental health officers arranging a clean-out. The client had been living in conditions of poor sanitation (i.e., mice and rat infestation, presence of spoiled food), but he repeatedly denied that his home conditions were unsanitary and assaulted the police during their inspection (Slatter, 2012).

2.3.1.2 Clean-out Outcomes

As evidenced by the previous case example, clean-outs tended to have a large impact on the clients and providers involved. The following section describes the immediate and long-term emotional, behavioural, and safety outcomes resulting from clean-outs.

2.3.1.2.1 Emotional Response

Clean-outs evoked a strong negative emotional response from the clients involved. Clean-outs were described as an intrusive and intense intervention, and clients reported feelings of
helplessness, anxiety, grief, humiliation, guilt, and anger. This affective response was comparable to a trauma response; clients experienced a clean-out as a life-altering and psychologically damaging event. In a few papers, some clients even described the experience as similar to rape (Gibson, 2015; Lee & LoGiudice, 2012; State of Victoria, Department of Health, 2013). This language highlights how clean-outs can be experienced as a non-consensual, oppressive, and deeply traumatic intervention. Clients felt violated due to their treasured possessions being forcibly removed without their consent. A client’s risk of suicidal or non-suicidal self-injury was also sometimes elevated during the course and aftermath of a clean-out intervention (Baker et al., 2014; Gillespie, 2015; Glassheim, 2016; Koenig et al., 2010, 2013; State of Victoria, Department of Health, 2013). One client threatened suicide when an animal control officer and city code inspector arrived at their home for a clean-out. The inspector called the police, and the client was connected to mental health services (Koenig et al., 2013).

2.3.1.2.2 Behavioural Response

Unsurprisingly, this strong negative emotional response led some clients to revoke their consent during the clean-out, turn against the clean-out team, or refuse to engage with service providers in the future. Some clients expressed their anger and betrayal with the clean-out by reporting their complaints to police, blaming family members, or, in efforts to re-gain control, climbing into dumpsters to re-acquire possessions that were discarded. It was not uncommon for clients to also accuse their providers of stealing their possessions during the clean-out.

2.3.1.2.3 Re-Accumulation

Clean-outs were frequently described as a cyclical intervention characterized by initial compliance, followed by rapid re-accumulation of belongings. Providers identified that clean-outs do not address the underlying hoarding problem and if mental health services are not
integrated into the intervention, clients do not have the tools to maintain the level of clutter reduction, thereby perpetuating the costly, traumatizing, and ineffective cycle.

2.3.1.2.4 Short-Term Benefits

Despite these undesirable outcomes, some clean-outs realized short-term benefits: clutter volume was reduced, fire hazards and welfare concerns were mitigated, tenancy was preserved, and clients were permitted to return to their home from hospital or a short-term relocation. In contrast to the previously-described negative emotional response, a small number of clients experienced a positive emotional response following the clean-out (Bratiotis et al., 2011; Gibson, 2015; MassHousing, 2017; Shapiro, 2019). Due to a reduction of health and safety risks, clients felt pleased with the results in their home, grateful for the opportunity to “start from scratch” while all of their possessions were moved to storage (Gibson, 2015), and eager to use their new space.

2.3.1.3 Clean-out Perspectives

The dominant perspective, documented by researchers and community professionals alike, was that clean-outs led to harmful outcomes. This viewpoint seems to have created a large degree of bias and stigma associated with the use and execution of hoarding clean-outs. The following section outlines the common perspectives about clean-outs and their use as an intervention.

2.3.1.3.1 Clean-Outs Lead to Harmful Outcomes

Many reasons were given for avoiding a clean-out: 1) clean-outs did not address the underlying problem and were seen as a temporary public safety fix; 2) clean-outs were financially unwise due to the likelihood of re-accumulation necessitating another clean-out in the future; and 3) clean-outs undermined future interventions as clients refused further help. The idea
that “clean-outs worsen symptoms and lead to recidivism” was often paraphrased by researchers and community-based practitioners, underscoring the common perspective: clean-outs are not a recommended intervention. This perspective seemed to originate from a 2000 paper by Frost, Steketee, and Williams in which one Massachusetts health department spent $16,000 on one clean-out. Following this intervention, the client re-accumulated, leaving the health department to face the same situation 18 months later. Interestingly, this one case story continues to be routinely cited, presumably because there is a dearth of research on this topic. In the past 20 years, no work has systematically been done to document the outcomes of clean-outs. The intention of this scoping review is to shed light on this under-examined aspect of community interventions for hoarding.

2.3.1.3.2 Clean-Outs May Be Necessary in Certain Circumstances

In certain instances, a clean-out was described as being necessary to address imminent health and safety risks to the person(s) in spite of the potential negative long-term outcomes. Situations in which a clean-out was justified included a sudden hospitalization of an elderly client, extremely poor sanitation, or repeated failures to reach any other resolution with a client. Some municipalities’ funding permitted clean-outs, but no funding was available to implement alternative interventions or mental health services. Recognizing that clean-outs should not be a default solution, authors described some recommendations for how to improve a clean-out when deemed necessary, these included: clients should be involved; clean-outs should focus on harm reduction, and clean-outs should occur over a longer timeline in conjunction with other interventions (e.g., discarding sessions, family support).
2.3.1.3.3 There Are Alternatives to Clean-Outs.

There were some perspectives provided in the literature that encouraged a radical shift in hoarding interventions. A coordinator of a hoarding intervention and tenancy preservation program suggested that resources were being wasted on failed clean-outs and should instead be used for case management approaches that incorporate harm reduction and cognitive behavioural techniques (Davis & Edsell-Vetter, 2015). An Assistant Fire Chief observed that there is an overfocus in hoarding interventions on the remediation of code violations instead of addressing mental health needs (Patterson, 2014). Finally, a psychologist and author of several seminal publications on hoarding argued that clean-outs are comparable to abstinence-only substance use interventions in that both advocate complete removal of the problem, a lofty and unrealistic goal for many (Tompkins, 2015).

Perspectives encouraging the use of clean-outs were entirely absent from the literature, reinforcing the impression that clean-outs are viewed negatively. The most positive viewpoint was that clean-outs can be conducted through a client-centered lens and that staff working in clean-out companies are often kind and willing to accommodate clients.

2.3.2 Thematic Analysis Eviction Findings

Clean-outs and eviction were often discussed in tandem. Both interventions were portrayed as outcomes to avoid, due to their harmful impact on clients. The following section outlines the rationale, practices, and outcomes relevant to hoarding evictions and condemnation.

2.3.2.1 Eviction Rationale

Eviction is one of the most severe interventions a client with hoarding can experience. The presence of “hoarding” in and of itself was not typically a valid reason for eviction. Legally, a landlord needed to specify the precise consequences of the hoarding behaviour that threatened
a person’s tenancy (through a lease violation). The most common reasons hoarding was in
violation of a lease agreement included failure to keep the home clean and safe (e.g., fire
hazards, excessive possessions), damage to the property, refusal of access for the landlord to
complete repairs, disturbance to neighbours, and pest infestations. If the infractions cited in the
lease violation were not rectified in a timely manner, eviction would proceed.

Across the documents, eviction seemed to be understood as an intervention of last resort,
used after the failure of a long list of interventions to mitigate risks associated with hoarded
conditions. For example, one client rejected an offer of homemaking services because he wanted
to go through each of his items piece-by-piece. He also was unwilling to accept mental health
services because he “did not have a very good view of psychologists or of mental health
professionals”. However, he agreed to work toward decluttering on his own terms. When the
client did not follow through on his agreement, he was evicted (Koenig et al., 2014). Eviction
was also used as a tool for responding to emergent situations. For example, if a landlord was
unaware of the hoarding situation and an emergency occurred in the home (e.g., water pipe burst,
fire), eviction might occur reactively. A less frequently discussed, but still important, rationale
for eviction was a client’s aggressive response following a warning about their hoarding
behaviour. For instance, one client became violent after receiving an eviction notice and was
subsequently evicted due to their physical reaction, rather than the hoarding itself (Glover &
Moss, 2010).

2.3.2.1.1 Rationale for Condemnation Due to Hoarding

A special case of eviction primarily relevant for privately-owned detached homes was
condemnation. A home was condemned if it was deemed uninhabitable or unsafe for occupation
by the local Fire Department or Board of Health (also known as a Do Not Occupy order within
the field of fire prevention; Kysow et al., 2020). Examples of unsafe conditions that led to condemnation included unstable floors that sagged under the weight of excessive clutter, walls at risk of collapsing, and a home that was so dilapidated that conditions could not be remedied with cleaning or fumigation. One provider shared that they had worked in two to three homes that were at risk of condemnation because of “body waste in buckets around the home” and because the “back half of [the] house was actually sagging and falling” (Gibson, 2015).

Although condemnation primarily relates to owner-occupied homes, if a rental property were deemed uninhabitable, the tenant would be evicted and the property condemned. Whereas eviction relates to the person, condemnation relates to the state of the building.

2.3.2.2 Eviction Process

The source material outlined various steps in the hoarding eviction process. I developed a linear description of the three main phases: 1) warning stage, 2) posting of an eviction notice, and 3) enforcement of the notice. Key stakeholders in the eviction process included the client and housing officials (e.g., landlord, property manager). In certain situations, legal aid services and lawyers were also involved.

2.3.2.2.1 1) Warning Stage

The warning stage of eviction due to hoarding begins when the housing provider issues the resident a verbal warning or written complaint regarding the home’s conditions. This warning indicates the lease violations that need to be rectified (e.g., inability to exit the apartment through windows or doors in an emergency). These unsafe conditions may have first been noticed during a fire or health department inspection.

This phase of the eviction process typically involved repeated reminders, verbal warnings, or conversations between the resident and housing provider about specific hoarding
concerns. Housing providers might schedule a conference with the resident to outline an action plan for remediation (Frigulietti, 2014).

2.3.2.2.2 2) Eviction Notice Issued

If lease violations due to hoarding were not addressed during the warning stage, a housing provider could issue an eviction notice for the situation to be rectified by a certain date (usually a 30 day notice). If conditions were not met, the resident would be evicted (and would lose their housing subsidy, if they had one). Legal professionals often became involved at this stage because housing providers wanted to ensure the seriousness of their notice or because the resident requested a reasonable accommodation for disability (on the grounds of hoarding disorder as a mental illness). A commonly requested reasonable accommodation for hoarding-related evictions was to request an extension of the time to make the required changes (i.e., beyond 30 days; Ligatti, 2013). Court involvement at this stage could extend the eviction process, for example, if the judge set deadlines for smaller goals to be achieved in future months.

The threat of eviction, enacted by an eviction notice, often provoked action because clients were pressured into addressing the hoarding within a very short time period. For example, to save their housing, some clients decided to accept help from social services (e.g., adult protective services, social work), consent to a clean-out intervention, or engage in decluttering when previously they had refused. These interventions were all short-term and focused on the home’s conditions, as longer, more client-centered interventions, such as psychotherapy, were far too time-consuming to fit within the eviction process. Changes to the state of the home at this stage were likely due to the external pressures and some degree of coercion, rather than the client’s internal motivation to change. With eviction on the line, a clear power differential emerged between the housing provider, who held the position of authority, and the resident, who
felt coerced into complying with their demands (Gibson, 2015). In certain cases, an eviction notice might be issued without the real possibility of eviction, if the housing provider was trying to underscore the seriousness of the hoarding problem, without causing the resident to lose their housing.

Although an eviction notice was intended to provoke action, it could also have the opposite effect. Several clients said they felt overwhelmed, unable to cope, or ashamed when threatened with eviction. Some clients were paralyzed by the overwhelming fear of losing their housing: “I found having that date, that final date, felt like that’s the day you’ll be hung at noon on, from the scaffold, until you die” (Gibson, 2015). Others reported that receiving an eviction notice was like having a “gun put to her head…you can’t get anything done until the guy puts the gun down” (Gibson, 2015). In these cases, the eviction deadline did not elicit the desired response. The fear of a hoarding eviction also had other consequences for the client, including increased isolation and withdrawal.

2.3.2.2.3  3) Eviction Notice Enforced

If the lease violations were not resolved to the housing provider’s satisfaction by the deadline, the eviction notice was enforced. If the process was unfolding in court, the judge would issue an order to evict the resident.

2.3.2.2.4  Process of Condemnation Due to Hoarding

Similar to eviction, the condemnation process was triggered when an official from code enforcement, the fire department, or the board of health (or a judge) raised concerns about the conditions of a hoarded home. As described above, condemnation primarily refers to owner-occupied homes, however condemnation and eviction could co-occur in a detached rental building. A notice of condemnation was posted at the residence if officials deemed conditions in
the home to be uninhabitable. The notice clarified the conditions that justified condemnation and provided a timeline within which residents could attempt to bring the hoarded home into compliance. The home would be padlocked and a sign placed on the entrance indicating that the building was unfit for human habitation. During this remediation period, some courts ordered the house to be secured at night and only allowed residents to enter during the day to clean and discard items. In order to remediate conditions, various interventions were taken including clean-outs, involvement of family and friends, and repair work.

2.3.2.3 Eviction Outcomes

The life-changing effects of an eviction due to hoarding extended beyond a client’s housing status; losing one’s home led to psychological consequences and detrimental financial costs.

2.3.2.3.1 Extreme Emotional Response

Eviction has devastating emotional impacts. Strong feelings of powerlessness, grief, and anger were often experienced by clients as a result of eviction. One woman was outraged by her eviction and blamed her daughter for alerting the landlord of her hoarding behaviour. The mother’s final communication to her daughter was written on a postcard stating, “My daughter is dead” (Tompkins & Hartl, 2009). The eviction resulted in the woman losing both her home and her connection to her daughter. Another resident, who was evicted after a multi-year court process, was believed to have set his home on fire following the judge’s ruling (Michaels, 2012). Despite the emotional toll of eviction, mental health services were not typically available to help individuals navigate the intense emotional consequences of eviction (Ligatti, 2013).
2.3.2.3.2 Re-Accumulation

Similar to the outcomes of a clean-out, re-accumulation of possessions in their new residence often followed an eviction because the hoarding behaviour was not addressed in the response. Without time to properly sort and pack (during an eviction), residents simply moved their possessions, in a disorganized fashion, to their new accommodations. Residents subsequently re-entered the eviction cycle: lease violations were issued in the new housing and eviction notices were posted again.

2.3.2.3.3 Cost of Eviction

Eviction was expensive for all parties involved—resident and housing providers alike. Residents were responsible to pay relocation costs, and sometimes storage fees for their belongings if their new residence did not have space or if they were currently without a home. Housing providers had often missed out on rent payments and were responsible for the costs of a clean-out and preparing the unit for a new resident. Costs for everyone rose substantially if the court system became involved (e.g., if a resident tried to dispute the eviction). One legal service attorney interviewed for a 2009 report of the San Francisco Task Force on Compulsive Hoarding said he could defend 20 non-hoarding eviction cases in the same time it took to resolve one hoarding case, indicating the complexity and expense. Local governments also had a price to pay for hoarding-related eviction, in the form of homelessness services (e.g., increased demand on shelters) and increased costs related to emergency medical services and police. In the long-term, interventions designed to keep individuals housed were likely less expensive compared to the cost of homelessness services (Nixon et al., 2020). As a crisis intervention, eviction was particularly costly. If mental health interventions had occurred in the early stages of hoarding,
costs could have been mitigated and eviction avoided (Montgomery County Task Force on Hoarding Behavior, 2011).

2.3.2.3.4 Housing

The outcomes of eviction due to hoarding were understandably grave, particularly the potential for homelessness. This outcome was realized if residents could not find alternative housing (e.g., if their landlord would not provide a positive reference) or if they could not afford alternative housing (e.g., if they lost their housing subsidy). In many cases, the hoarding residents who were at risk of eviction were living in “last resort” housing, therefore the risk of homelessness was heightened. Although shelters are designed to be a safety net for individuals who are precariously housed, hoarding behaviour often would jeopardize a client’s ability to benefit from these social supports. Nothing could prepare a hoarding client for the experience of homelessness, especially when they were dealing with co-occurring mental health challenges.

If residents found alternative housing following an eviction, they moved into new accommodations. If this was not possible, residents may have temporarily relocated to shelter accommodation to wait for a social housing unit to become available. For an individual living in a supported housing complex, a housing provider might have relocated the tenant to a different unit within the property rather than evicting them entirely. An elderly resident might have been forced to move to a long-term-care facility, following an eviction, if they required additional supports to maintain a safe home environment.

Although the rehousing of clients was discussed in the sourced materials, there was almost no reference to the relocation of possessions following an eviction. It was unclear from the literature if people who were evicted were forced to abandon their possessions or if they attempted to relocate with their belongings.
2.3.2.3.5 Outcomes of Condemnation Due to Hoarding

If a homeowner was unable to remediate conditions to satisfy inspection (by the board of health, fire department, or property use), their home would be condemned. At this time the resident would be asked to leave the premises permanently. However, there were several reports of individuals continuing to live in their homes past the condemnation date illegally (Koenig et al., 2014; Patterson, 2014). One older adult refused to leave her home, even though a flood had submerged the first level of her property; she was later rescued, against her will, by a sheriff in a boat. The multidisciplinary team involved in her care highlighted the need to first establish trust with the resident, prior to offering assistance (Koenig et al., 2014). Unsalvageable properties, in certain cases, were bulldozed or destroyed in a controlled burn. Two residents in this situation were placed under guardianship due to their significant physical or cognitive impairments (Franks et al., 2004).

2.4 Discussion

This scoping review examined the existing academic and community literature written on clean-outs and eviction from 1996-2020 in the USA, Canada, Australia, the UK, and Singapore. A wide variety of document types were reviewed, including journal articles, research reports, protocols, books, and online material. This scoping review is the first synthesis of academic and grey literature on clean-outs and eviction.

2.4.1 Summary of Findings

2.4.1.1 Factors Precipitating Clean-Outs And Eviction

Findings revealed many similarities between clean-outs and eviction. Both interventions were most commonly triggered by health and safety hazards identified by housing professionals, neighbours, or social service agencies. Clients were rarely the driving forces behind such
interventions. Although severe and intrusive, these interventions appeared to be necessary when public safety was at risk due to fire hazards, poor sanitation, or structural concerns. The case stories of condemned homes portrayed a striking picture of dilapidated conditions beyond repair. There were no case stories depicting clean-out or eviction for a mild to moderate hoarding situation, perhaps indicating that these interventions are only used for severe conditions.

From the viewpoint of a landlord or a service provider, the rationale for using a clean-out or eviction as a last resort was to protect their property, other residents of the building, and ensure compliance with the fire code. From the viewpoint of a client, it is understandably more challenging to reconcile why such an intervention would be necessary due to the negative psychological and financial consequences associated with a clean-out or eviction. One client faced with eviction stated, “apparently I was living in a squalid death trap and I needed to be saved from myself and they were gonna go to the tribunal if necessary” (Gibson, 2015). Clients may be perceived as having poor insight into the potential risks of hoarding behaviours to themselves or their neighbours (Kysow, 2018; Woody et al., 2020). On the other hand, housing providers may be overly critical of the conditions in which their residents choose to live. These opposing viewpoints illustrate the debate regarding whether intrusive interventions, such as clean-outs and eviction, are necessary.

### 2.4.1.2 Clean-out and Eviction Practices

Clean-outs and eviction required a lengthy planning process, substantial financial resources, and a team of multidisciplinary professionals to fulfill all the required roles (e.g., safety inspections, physical labour, emotional support). Clean-outs and eviction were often precipitated by a notice to comply, the provision of a lease violation, or legal action enforced through a court proceeding. It appeared clients were often given a warning and granted a period
of time to remediate the situation prior to a clean-out or eviction being enacted. Although this warning stage seemed compassionate from the service provider perspective, clients typically viewed it as insufficient as hoarded conditions and poor sanitation could not be resolved quickly due to strong emotional attachments to the clutter. Clients at risk of eviction often requested a disability accommodation to increase the amount of time given by housing providers to satisfy their lease violations.

The frequent involvement of the legal system in hoarding situations to assess whether a clean-out or eviction is justified and to arbitrate between the client and service providers shows how challenging and contentious these interventions could be. Once a clean-out or eviction was underway, it was understood these interventions could take multiple days or weeks to finish. Financial considerations were also apparent; designating who was responsible for payment needed to be determined as soon as possible to avoid even more conflict between the various stakeholders. The financial costs to society and property managers for conducting a clean-out or eviction were intertwined with an emotional tone and involved complex decision-making, as one hoarding clean-out or eviction could jeopardize an organization’s entire yearly budget and may not have the desired long-term outcome. One town administrator stated that funds should only be allocated to clean-outs in the “most urgent of cases”; otherwise, it “seems that every time you take a step forward you then have to take two steps back” (Patterson, 2014). Another hoarding task force member stated, "we're no longer spending funds to do cleanouts because we know now that this isn't a solution, just money wasted" (Bratiotis, 2009).

2.4.1.3 Emotional, Health, And Safety Outcomes

Once enacted, the outcomes of eviction and clean-outs tended to be quite severe. The psychological costs of a clean-out or eviction were significant when considering the multiple and
layered losses associated with losing one’s belongings and/or one’s home. As hoarding behaviour is largely driven by an intense emotional attachment to possessions within the home, clients who experienced these interventions felt wounded as their belongings and homes were ripped away. There were no data speaking to the duration of the emotional consequences, but some clients ended family relationships, withdrew engagement from services, and required psychiatric hospitalization, or experienced other long-lasting consequences. In addition to the emotional consequences being devastating, the health and safety benefits of such an intervention tended to be short-lived due to the likelihood of re-accumulation.

Related to eviction and condemnation, homelessness was a very real potential outcome. Hoarding clients facing the possibility of losing their housing were incredibly vulnerable, especially as the shelter system is typically unable to accommodate storage of many possessions.

Few positive outcomes for the client were described. Primarily, the positive outcomes from a clean-out or eviction were experienced by the housing provider or code enforcement official who improved public safety, avoided a fire or infestation, or ended the interpersonal conflict with the client who was hoarding.

2.4.1.4 Perspectives Surrounding Clean-Outs

On the whole, perspectives surrounding clean-outs were negative. The most compelling argument against the use of these interventions focused on the devastating emotional consequences. There were some perspectives that were more nuanced and described the tension between protecting the public while trying to avoid causing irreparable emotional damage to an individual hoarding client. It was evident some professionals would have preferred to engage in less intrusive and severe interventions, but these were not feasible nor available within the constraints of each unique situation.
2.4.2 Practice Implications

For interventions of such intensity, one would hope that numerous guidelines would have been available to support practitioners in how to conduct these interventions in a client-centered and trauma-informed way. However, only a handful of recommendations were available. In terms of clean-outs, these were largely derived from one book on harm reduction for hoarding specifically targeted to mental health clinicians (Tompkins, 2015). Regarding eviction, client-centered strategies were highlighted primarily in a thesis on hoarding clients at risk of eviction (e.g., clients benefit from a nonjudgmental and supportive provider stance, as well as clear expectations and deadlines regarding their possible eviction timeline; Gibson, 2015). A large literature base exists on tenancy preservation (and would benefit from its own scoping review), but there is little to guide property management on how to best support a client through an eviction.

The long list of synonyms and qualifiers in Table 2.5 demonstrates practitioners’ evident desire to use euphemisms when discussing clean-outs. This likely contributes to client confusion as to what intervention is about to happen. For example, a social worker might say, “We have been granted funds for a one-off heavy chore service. The cleaners can visit your apartment Friday. Is that okay with you?” In this situation, the client may not realize that what is actually being presented is a clean-out. An important practice implication for informed consent would be to use standardized language and to eliminate the use of clean-out synonyms to ensure clients are aware of and understand what intervention is being offered to them.

One noteworthy challenge in articulating practice implications based on this review, is that the practices described in the literature often appeared to be aspirational, rather than representative of practices currently used by multidisciplinary professionals. For instance, most
protocols outlined communication strategies and the importance of establishing rapport, however it was impossible to deduce if these strategies were in fact common practice. Additionally, there likely is a discrepancy between what should ideally be done and what is feasible. Although client-centered practices, such as maximizing a client’s decision-making power, appear obvious and perhaps easy to implement from a researcher’s perspective, they are far more challenging to implement in the field. Making a client-centered approach feasible would require more partnerships between social service and enforcement professions, more funding for hoarding initiatives, and increased allocation of service time per hoarding client.

In hoarding-related training for service providers, clean-outs and eviction should be re-categorized alongside other crisis interventions, such as hospitalization for individuals at serious risk of harming themselves or others. Mental health practitioners are aware that overnight stays in the emergency unit are wholly inadequate interventions when psychotherapy is indicated, however the emergency room is a vital component of the mental health intervention continuum; clean-outs and eviction should explicitly be considered in a similar light. Providers should be encouraged to reserve the use of these interventions for situations of imminent risk and those that demand an immediate solution, while acknowledging the need to follow-up with another intervention capable of treating the underlying mental health symptoms (e.g., specialized CBT for hoarding; Steketee & Frost, 2006).

2.4.3 Policy Implications

Results suggest several implications for policy. Hoarding interventions receive very little funding. Policy makers could allocate increased governmental funds to harm reduction for hoarding, low-cost decluttering services, and specialized mental health services for hoarding. Clean-outs and eviction will continue to be part of the hoarding intervention spectrum, until
changes are made at the city, provincial, and national level to intervene in cases of hoarding earlier. Without widespread prevention and maintenance strategies in place, clients with hoarding disorder will continue to fly under the radar until serious problems arise that demand immediate attention. As a society we are unable to rewind a traumatic crisis that has damaged a client’s psychological wellbeing, but neither can we manage situations of imminent risk without effective tools. Eviction and clean-outs can be effective in situations that have spiraled out of control because they bring results immediately.

If clean-outs and evictions are viewed as analogous to involuntary psychiatric hospitalization, specific policies and guidelines would need to be in place to ensure such interventions are not unjustly used. For example, regular monitoring and recording of each time a clean-out or eviction is conducted (within an agency) alongside the contextual factors for why such an intervention was chosen over a less-intrusive option. Similar processes are in place for Ontario service agencies responsible for persons with developmental disabilities. These agencies must complete a behaviour support plan to protect clients from intrusive interventions, such as physical restraints or prescribed medications. Intrusive interventions are permitted only when an individual is at immediate risk of harming themself or others and behaviour support plans must be reviewed by a qualified mental health professional (Ministry of Community and Social Services, 2017). Similar safeguards could be in place for hoarding clients to ensure intrusive interventions are not used unnecessarily.

2.4.4 Limitations

The majority of work was conducted in North America, therefore findings may not be applicable for countries that are culturally dissimilar. Although clean-outs and eviction were mentioned frequently in the documents surveyed, the amount of text elaborating upon each
intervention was limited. The quantity of extracted text also varied by document. Certain document types were more heavily represented, such as books, because they were able to go into greater detail and cover topics more deeply.

Further, what was available tended to narrate similar perspectives. Scoping reviews can only summarize what is made publicly available, therefore certain viewpoints were underrepresented or absent from this review. For example, there were no available documents from the perspective of a client who experienced a clean-out. Relatedly, although two studies included in this review interviewed clients at risk of eviction (Gibson, 2015; Whitfield et al., 2012), no studies have specifically focused on those who have been evicted.

This review has exposed the limited, practically nonexistent, quantitative evidence base available to community practitioners regarding clean-outs and eviction. Descriptions of each intervention were largely based on anecdotes or case examples, so it was not possible to include an assessment of the methodological quality of documents included in the scoping review. Of the included journal articles, most were qualitative papers, with only a handful of descriptive or correlational papers. This is likely related to the numerous challenges involved in conducting research in community settings, for example, the limited staffing available in community organizations to devote time to research projects, the organizational and scheduling challenges inherent in community work, and the fluidity (and lack of standardization) of interventions required to adapt to crises and imminent safety and health risks (Kue et al., 2015; Kysow et al., 2020; Racine et al., 2022).

2.4.5 Future Research

As clean-out and eviction-related discussions currently in the literature rarely span more than a few sentences, future research reports and papers should exclusively focus on these severe
interventions. A more fulsome study is warranted to properly examine the usefulness and success, or failure, of these interventions. There are likely many reasons why the most-cited paper discussing clean-outs was published in 2000 and only describes one case example of a clean-out in less than three sentences. Presumably there is a great degree of stigma limiting open discussion (in a written format) of the use of these interventions. Undoubtedly some professionals advocate for the use of hoarding-related clean-outs and eviction, but their voices were not available via the search strategies in this study. On an organizational level, cities or public health departments may have ignored the reality that these interventions occur because they do not have the resources to provide the necessary oversight to help protect the clients and neighbouring residents involved.

As mentioned earlier, future studies should document practices that are currently in use, rather than those that are aspirational. Research methods that could be used to explore these practices include surveys, case studies, or participatory action research. Additionally, research is needed to track the outcomes of large samples, and to collect systematic descriptive data alongside qualitative data, to enhance the current state of the literature. It would be beneficial to collect, a) demographic data (e.g., gender, age, housing type) on the clients who have had a clean-out or eviction, b) precipitants for the intervention, c) program data on resources allocated to these clients (e.g., staff time, clean-out costs, missed payment of rent), and d) pre-post data to evaluate the effectiveness of these interventions (e.g., changes in clutter volume, length of housing, rate of re-accumulation of clutter, client’s psychological experience, client satisfaction).

Until more systematic research is conducted on these interventions, questions surrounding the client’s psychological experience and longer-term outcomes, such as the re-accumulation of clutter will remain unanswered. Randomised controlled trials of clean-outs and
eviction are neither practical nor ethical, but systematised collection of community data is possible. One possible way to collect such data would be to develop a standardized reporting tool for hoarding-related clean-outs and eviction.

Additionally, research focused on novel perspectives would be important to get a more complete understanding of clean-outs and eviction. For example, it would be feasible and helpful to conduct an interview study of housing providers, specifically landlords, who have recently evicted a tenant due to hoarding. Although anecdotal stories published in the literature have briefly addressed clean-out outcomes, there is a gap in our knowledge regarding the client perspective. A survey of hoarding clients who have experienced an eviction or clean-out would provide a closer examination of the client’s experience. Clean-outs have the potential to be a coercive and traumatizing intervention; taking client experiences into account is not only a requirement of community-engaged scholarship, but an ethical obligation. Shedding light on the client experience may help to shape clean-out best practices and minimize emotional distress for the client.

2.4.6 Conclusion

This scoping review was the first to synthesize academic and grey literature on clean-outs and eviction. Our team completed a thorough search of the literature. Findings demonstrate that clean-outs and eviction are commonly depicted as high-intensity interventions. Although they are a part of the hoarding intervention spectrum, researcher and practitioner perspectives on their use tend to be negative. Clean-outs and eviction are viewed as emotionally toxic, costly, and ineffective in the long-term due to the rates of re-accumulation. Taken together, these findings clearly highlight the importance of preventing the use of clean-outs and eviction for hoarding clients. However, without policy changes and increased governmental funds devoted to harm
reduction for hoarding efforts and low-cost decluttering services, clean-outs and eviction will continue to be a necessary option for situations when all other interventions have failed and the risk of fire, health complications, or serious injury is imminent.
Chapter 3: Clean-Out Interventions: An Interview-Based Survey

Now in its 15th season, the American television show Hoarders chronicles the experiences of people with hoarding behaviour who are having a clean-out. From the viewpoint of Hoarders and other similar reality television shows (often the public’s only viewpoint into how clean-outs are conducted), clean-outs become necessary because individuals are facing a crisis. Often the home has been condemned or an eviction notice is pending. In other cases, close family and friends are at the end of their rope and have given their family member one last opportunity to “fix” the problem before severing familial ties. Clients appear to be given a forced choice; either consent to a televised clean-out or lose their family, their home, or both. Clean-outs in these television shows require a large number of staff (often a crew of over 20 individuals) and unfold over the course of a week. In each episode, a professional organizer and psychologist try to engage the client in sorting their possessions, however most decisions are not made by the client. At the end of the clean-out, a large quantity of clutter has been removed – often the “after” photos appear ready for a magazine shoot. In several episodes, the clean-out is prematurely terminated because the client refuses to continue, or conditions are deemed too dangerous for the crew.

The scoping review provides a different perspective on clean-outs. It suggested that clean-outs were most commonly motivated by health and safety hazards. Clean-outs were often used to protect the resident of the home and neighbouring tenants from potential risks, in spite of the fact that clients often disagreed that such interventions were necessary. Clean-outs carry huge financial costs and require extensive planning. In terms of emotional costs, clean-outs were described as traumatic and emotionally devastating. In addition, clean-outs were not considered to be effective interventions in the long term, as case reports frequently stated clients re-hoarded
following the clean-out. In broad strokes, a clean-out was seen as a temporary public safety fix, as the psychological symptoms (e.g., difficulty discarding) were not targeted or improved during the intervention and therefore public safety and that of the client continued to be at risk.

Although both the scoping review and the reality television series provide an understanding of hoarding clean-outs, most findings from the scoping review are based on anecdotes or single case examples, which may not generalize to other cases. Likewise, it is unclear how representative the cases presented in television episodes are compared to cases that come to attention in local communities, or relatedly, how the presence of a TV crew and a production deadline might impact the process of a clean-out. A naïve television watcher may assume from watching a single episode of A&E’s Hoarders, for example, that a clean-out is a fast and effective remedy for hoarding behaviour. Without more systematic data on clean-outs, this view cannot be supported or refuted. Therefore, the focus of the interview-based study was to establish foundational knowledge on clean-out interventions.

3.1 Study Overview

The study used an interview-based survey of frontline professionals to achieve several research aims, largely paralleling those of the scoping review. The goal was to ensure a detailed and fulsome picture of clean-out interventions, as this is the first quantitative study on the topic. The descriptive variables are outlined in the conceptual framework adapted for this chapter (see Figure 3.1). In addition, targeted exploratory analyses were conducted based on the scoping review, impressions gathered during the provider interviews, and from a desire to begin to identify best practices for clean-out interventions.

The first research aim was to understand the reasons why a clean-out is necessary. As described in Chapter 1, the initial step in a harm reduction approach for hoarding involves
assessing environmental risk (i.e., the safety and health hazards in the home) and a client’s functional capacity (i.e., how well a client physically, psychologically and socially functions in their home). Tompkins (2015) outlined health and safety risks (e.g., pest infestations) and client factors (e.g., cognitive concerns) clinicians need to assess when intervening in hoarding. These factors motivate the need for community hoarding interventions, such as clean-out interventions. Additionally, thematic findings from the scoping review provided a broad overview of possible rationales for conducting a clean-out. In addition to the health and safety and client factors acknowledged by Tompkins (2015), the scoping review illustrated the role that external pressures play in triggering clean-out interventions. Based on these two sources, I was interested in the relevance and importance of health and safety risks, client functional capacity, and external pressures. I wanted to establish contextual factors that lead to a clean-out and to identify some correlates of these factors.

Building on the rationale for clean-outs, the next research question examined how clean-outs are conducted, specifically with regard to the range in intensity of practices used. The television shows portrayed clean-outs as requiring a large number of staff, long and intensive workdays, and a considerable reduction in clutter. The scoping review added the logistical steps involved, the importance of funding, and the multidisciplinary personnel required. I was therefore interested in learning the range of clean-outs community providers would describe – the scale of their operations in terms of number of crew, whether they removed items from the whole house or devised more targeted clutter removal plans, and the time frame required. Additionally, I was interested in the personnel – do clean-outs always involve professional cleaning companies, or are more affordable options sometimes used (e.g., volunteers, family members)?
I also wanted to look for evidence of shared decision making, the voluntariness of the clean-out, and the degree to which clients received emotional support. As described in Chapter 1, a shared decision-making model highlights the importance of collaboration between health professionals and clients (Slade, 2017). In order to make healthcare decisions together, a healthcare practitioner must explain the health issue, elicit the client’s preferences, and integrate the client’s preferences into the final decision (Barr et al., 2014; Elwyn, 2003). As recent research on shared decision making explores barriers and facilitators in the implementation of these practices, correlates of the use of client-centered practices were also examined. Previous researchers have hypothesized numerous client and provider factors that are expected to influence the use of shared decision making in healthcare settings, such as clinicians’ motivation to implement shared decision making and client capacity to participate (Alsulamy et al., 2020). The question in the current study context was to determine if such collaborative practices between providers and hoarding clients were influenced by specific clean-out rationales (e.g., refusal to engage, eviction risk) or circumstances (e.g., provider experience, hospitalization).

Involuntary and coercive interventions, such as involuntary hospitalization, seclusion, or restraint interventions, have a strong negative emotional impact on clients (Akther et al., 2019; Chieze et al., 2019). As described in Chapter 1, these experiences generate feelings of anger, confusion, distress, fear, resentment, and defensiveness. The scoping review illustrated the negative emotional costs of a clean-out, whereas the television series provided a more nuanced perspective, as at times certain positive emotions were portrayed following a clean-out, including relief and appreciation. For example, the client in one episode was relieved that her home passed the fire inspection and was noticeably appreciative that her kitchen appliances and bathroom fixtures were now accessible and operational. To capture the range of emotions, the interview-
based survey included the providers’ perceptions of both negative and positive emotional responses. I also explored correlates of client distress with the intention of beginning to establish best practices for minimizing negative emotional experiences related to having a clean-out.

Finally, the study set out to gain a preliminary understanding of short-term outcomes, including eviction prevention, success in addressing health and safety risks, and improvement in the client’s hoarding symptoms. As described in the scoping review, clean-out interventions have been presented as a preventative solution to avoid eviction or condemnation. However, some clean-outs fail to prevent eviction, and I was interested in the possible explanations (i.e., predictors) for such outcomes. As I outlined in Chapter 1, shared decision-making practices predict clients’ satisfaction with mental health treatment (Fisher et al., 2016; Geller et al., 2019; Shay & Lafata, 2015). I was therefore interested in exploring whether a similar relationship exists between the client’s affective response during the clean-out and the use of client-centered practices.

3.2 Method

3.2.1 Participants

The target population for this study was frontline professionals from a variety of sectors (e.g., housing, mental health, fire prevention) who had actively participated in at least one clean-out in the preceding three years. Initially, participants were recruited from the laboratory’s research registry of providers who had participated in past research or had otherwise contacted the laboratory and given permission to be contacted for future research participation. In addition, I advertised the study through my professional networks, and I asked colleagues to distribute the study advertisement to their professional networks. I also contacted members of hoarding task forces or networks in Canada and the USA. Study advertisements were also posted on relevant
Figure 3.1

Conceptual Framework Including Interview-Based Survey Variables

**Antecedents**

1. What makes a clean-out necessary?

**Clean-out rationale**
- Health and safety risk:
  - Poor sanitation
  - Insects or rodents
  - Unsafe conditions
  - Clutter volume
- Functional capacity:
  - Physical health
  - Cognitive functioning
  - Refusal to engage
- External pressures:
  - Discharge from hospital
  - Eviction risk
  - Neighbour complaints

**Residence outcomes**
- Housing outcomes
- Resolution of hoarding symptoms
- Resolution of health & safety concerns

**Characterizing the Intervention**

2. How are clean-outs conducted?

**Intensity of practices used**
- Individuals involved
- Volume removed
- Duration

3. Which client-centered strategies are being used?

**Client-centered strategies**
- Client decision to have a clean-out
- Emotional support offered
- Client role in sorting
- Shared decision-making
- Post clean-out check-ins/decluttering assistance

**Outcomes**

5. What are the health & safety outcomes?

**Affective response**
- Client distress
Facebook pages, groups, and Reddit forums. A study flyer was distributed to professional organizers, speakers from an international hoarding conference, and authors of journal articles on hoarding and squalor. Finally, snowball sampling was used; study participants were invited to advertise the study to other relevant professionals.

Data were analyzed from 65 providers primarily from Canada (66.2%). The remaining third of participants were from the USA (24.6%), Australia (7.7%), and the UK (1.5%). The mean age of providers was 46.48 years ($SD = 11.82$). Most participants identified as female (72.3%) and reported being from a European cultural background (89.2%). Providers worked in a wide range of organizations, including housing (27.7%), private organizations (e.g., cleaning companies, private practice, financial services; 23.1%), older adult services (18.5%), community health organizations (13.8%), public safety and public health (e.g., fire prevention, environmental health; 9.2%), and hospitals (4.6%). Two participants were family members (3.1%) who had conducted a clean-out for their parents who were hoarding.

Providers reported having previously worked with a median of 25 hoarding cases (range = 1 - 400) and having conducted a median of five clean-outs (range = 1 - 200) over the preceding three years. Of the clean-outs described in the study, 60% had occurred within the previous year of data collection.

### 3.2.2 Procedure

#### 3.2.2.1 Phone Screen

Prospective participants completed a preliminary phone screen. Callers who met inclusion criteria were invited to engage in a one-hour virtual interview-based survey. I emailed an online consent form containing the information necessary for informed consent and encouraged participants to ask questions prior to their scheduled appointment.
At the scheduled time, participants joined a Zoom video conference call. Once participants indicated their verbal consent and confirmed they had signed the online consent form, the interview proceeded. Participants were asked to answer questions about a specific clean-out, rather than their experience with clean-outs in general. If the participant had conducted multiple clean-outs over the past three years, the most recent clean-out that met criteria was selected for the interview. I conducted all the interviews, except one in which I directly supervised a fellow lab member to conduct the interview. Participants received the equivalent of $25 CAD in the form of e-transfer or a gift card as an honorarium.

3.2.2.2 Case Flow

As shown in Figure 3.2, 129 providers were recruited for the study. Of these, 89 completed the phone screen process. Inclusion criteria were that the provider had: a) conducted a hoarding clean-out (see Table 3.1 for definition) within the previous three years, b) actively participated by coordinating the clean-out, supporting the client, or doing hands-on clutter removal, cleaning, or pest control, c) met the client (unless the client was absent because of hospitalization), and d) witnessed the home conditions before and after the clean-out (ideally in-person, however photos were acceptable). Eighty-three participants met these criteria and were interviewed.

After the interviews had been completed, eighteen cases were excluded (reasons shown in Figure 3.2). Although fourteen of these cases had appeared to be clean-outs during the phone screen, discussion during the interview made it clear that the intervention the provider was referencing did not meet my definition of a hoarding clean-out (based on the duration of the intervention, the amount of clutter removed, or the involvement of the client and stakeholders). As such, it was necessary to differentiate hoarding clean-outs from other interventions by
creating definitions for decluttering assistance \((n = 8)\), eviction clean-outs \((n = 4)\), estate clean-outs \((n = 1)\), and condemnation without an accompanying clean-out \((n = 1); \text{see Table 3.1 for definitions}\). These other interventions were identified as exclusion criteria.

In two cases, the provider was not involved enough to report on key topics, such as duration and number of team members, leaving uncertainty as to whether a clean-out did occur. In two other cases, two different providers separately participated in the study but coincidentally reported on the same clean-out. This was only discovered after the interviews were completed. Only data from the interview with the provider who had greater involvement in the cases were retained. The final sample included 65 participants.

**Table 3.1**

*Definitions of Clean-Outs and Related Interventions*

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hoarding clean-out</td>
<td>A fast-paced intervention in which a large amount of clutter is removed from the living spaces of a client’s home. A clean-out may last several days and is usually completed in a condensed time frame (e.g., under a month). The client may or may not be involved in every decision about which items are kept or discarded.</td>
</tr>
<tr>
<td>Decluttering assistance</td>
<td>A gradual intervention where clutter is sorted and then removed or organized within a home. Decluttering often occurs during periodic scheduled visits across several months. Due to the gradual nature of decluttering assistance, a client is typically responsible for – or a full partner in – decisions about which items are kept or discarded.</td>
</tr>
</tbody>
</table>
Decluttering assistance may precede or follow a clean-out, but it is a separate intervention, distinct from a hoarding clean-out.

**Eviction clean-out**

An eviction clean-out takes place after the client has permanently left the home due to an eviction. The clean-out proceeds without the (former) tenant’s involvement and is designed to prepare the property for the next tenant. Possessions are discarded at the property manager or landlord’s discretion. Eviction clean-outs may or may not involve hoarding.

**Estate clean-out**

An estate clean-out takes place after the resident has died. The intervention involves getting the property ready for another occupant. The intervention may include cleaning, packing items, removing trash, and completing repairs to prepare the home for sale. Estate clean-outs may or may not involve hoarding.

**Condemnation**

Condemnation is a situation (primarily relevant for owner-occupied detached homes) in which authorities judge a home to be uninhabitable, and the residents are forced to vacate the premises. A resident may attempt to coordinate a clean-out to claim some of their belongings or to regain access to their home. Condemnation may or may not involve hoarding.
Figure 3.2

Provider Interview-Based Survey Case Flow

- Contacted lab to participate/Recruited to participate (n = 129)
- Completed phone screen (n = 89)
- Completed interview (n = 83)
- Included in data analysis (n = 65)
- Did not complete phone screen (either not able to schedule or not eligible based on email communication) (n = 40)
- 6 participants excluded
  - Not eligible (n = 3)
  - Unable to schedule (n = 3)
- 18 cases excluded
  - Decluttering assistance (n = 8)
  - Client had already permanently left the home due to an eviction (n = 4)
  - Estate clean-out (n = 1)
  - Condemnation without a clean-out (n = 1)
  - Provider not involved enough to determine if clean-out happened (n = 2)
  - Same clean-out described by another provider who had been more involved (n = 2)
3.2.3 Materials

3.2.3.1 Survey Development

Language and concepts from the scoping review, as well as my years of experience as an embedded researcher on a community hoarding team, informed survey questions and response options. As clean-outs are a stigmatized intervention and are typically not recommended by mental health professionals, efforts were made to present the questions and study objectives in a nonjudgmental way. Following the recommendations of Shakir and Rahman (2022), I conducted three pilot interviews prior to launching the study to test the interview questions for clarity and relevance.

To start the interview, providers answered demographic questions about themselves and about their client. Providers also answered questions about the terminology they used to describe the clean-out, the circumstances that necessitated the clean-out, personnel involved, the duration of the intervention, the amount of clutter removed, and the degree to which shared decision-making or client-centered practices were used. Providers also responded to questions about the client’s emotional response and the short-term health and safety outcomes. Survey questions are provided in Appendix E. For questions that required a quantitative answer (e.g., from 1 = not at all important to 5 = extremely important), I shared my screen to show the relevant rating scale. Ratings represented the provider’s best judgment of the situation, rather than an objective truth. I asked follow-up questions, including requests for examples, to make sure the scales were being used appropriately and to better understand the unique case being described. Study data were collected and managed using REDCap electronic data capture tools hosted at the University of British Columbia (Harris et al., 2009).
3.2.4 Measures

3.2.4.1 Clean-Out Rationale

Providers rated the importance of nine different reasons, or rationales, why the clean-out was necessary. These rationales were identified based on thematic findings from the scoping review on the factors precipitating clean-outs and the model of assessing harm potential in hoarding (Tompkins, 2015). Items covered specific health and safety risks (e.g., unsafe conditions in the home, poor sanitation), client functional capacity (e.g., concerns about the client’s physical health, cognitive functioning), and external pressures (e.g., eviction risk, pressure to be discharged from hospital). Using a 5-point scale from 1 (not at all important / not a part of the decision) to 5 (extremely important / one of the most important deciding factors), providers rated the importance of each reason in the decision to have a clean-out. The mean inter-item correlation was $r = .16$, with values ranging from $r = -.26$ to $r = .46$; therefore, items were analyzed individually as nine different circumstances.

3.2.4.2 Clutter Image Rating

The Clutter Image Rating (CIR; Frost et al., 2008) scale assesses clutter volume using three sets of photographs of a kitchen, living room, and bedroom, each showing progressively increasing clutter scaled from 1 (like an empty hotel room) to 9 (clutter nearly to the ceiling). Respondents selected the photograph that most closely depicted the level of clutter in the kitchen, living room, and bedroom before and after the clean-out. The CIR has good internal consistency, test–retest reliability, and convergent validity, as well as excellent inter-rater reliability (Frost et al., 2008). In this study, an average was calculated of the initial kitchen, living room, and bedroom scores, alongside an average final CIR and average CIR change score.
(the difference between initial and final CIR). Internal consistency in this study was acceptable to good, $\alpha = .74 - .83$.

3.2.4.3 **Shared Decision Making During Clean-outs**

The construct of shared decision making in clean-out interventions was assessed with a five-item measure. The items were based on the three core features of shared decision making in primary care settings: (1) explanation of health issue, (2) elicitation of patient preferences, and (3) integration of patient preferences (Barr et al., 2014; Elwyn, 2003). Items were adapted to fit the context of a clean-out intervention and covered provision of a rationale for the clean-out, degree of client involvement in decisions about which items would be removed, and discussion about the client’s role or expectations for the clean-out day, their personal goals (e.g., retaining their housing), and concerns or fears related to the clean-out. For each item, providers rated the level of shared decision making on a 5-point scale from 1 (not at all) to 5 (extremely / a great deal).

Internal consistency was good, $\alpha = .83$. The mean inter-item correlation was $r = .51$, with coefficients ranging from .25 to .67. As evidence of convergent validity, providers reported more frequent shared decision making with clients who were on-site during the clean-out ($M = 4.15$, $SD = 0.82$, $n = 40$) compared to those who were off-site ($M = 3.41$, $SD = 1.15$, $n = 21$), $t(31.05) = -2.61, p = .01, d = -0.78$.

3.2.4.4 **Affective Reaction**

Client distress was assessed with five items adapted from the Affective Reaction subscale of the MacArthur Admission Experience Survey (Gardner, 1993), which was designed to assess the emotional experiences of psychiatric hospital patients and has been used to study involuntary and coercive mental health care experiences (Poreddi et al., 2017; Shozi et al., 2023). Adaptions
to the scale included removing the emotion “confused” and changing the response options from a true/false dichotomy to a 5-point Likert scale ranging from 1 (not at all) to 5 (extremely). On the Affective Reaction scale, providers rated their perception of how angry, frightened, sad, pleased, and relieved the client felt about having a clean-out. Ratings for “pleased” and “relieved” were reverse coded. Internal consistency of this measure was good, $\alpha = .81$. The mean inter-item correlation was $r = .45$, with values ranging from .17 to .86. As evidence of convergent validity, client distress was negatively correlated with a rating of how voluntary the clean-out was, $r = -.56$, $p < .001$, $n = 63$, with more client distress associated with a more involuntary clean-out.

3.2.5 Data Analytic Plan

As this was the first survey on hoarding clean-outs, the data analytic plan was largely descriptive. Analyses were conducted on all available data for each of the 65 clean-outs that met inclusion criteria. Some providers were unable to provide a response for certain variables for which they had no responsibility (e.g., a fire prevention officer did not know if the mental health worker had discussed the client’s role in the clean-out), resulting in some missing data.

The overall purpose of the analysis was to learn and discover as much as possible from the collected data. Measures of central tendency were used to characterize the clean-outs represented in the sample, including the reasons for the clean-out, the amount of clutter removed, the duration of the intervention, the number of individuals involved, the degree to which client-centered practices were used, and short-term outcomes. Provider quotes and examples were integrated alongside the presentation of descriptive statistics to better illuminate findings. Exploratory data analysis using independent samples $t$-tests and correlations were computed to assess relations among specific variables of interest. Decisions about which analyses to conduct were informed by the scoping review, potential relevance to best practice recommendations, and
impressions I formed during the interviews. These hypotheses were examined with statistical tests.

Prior to conducting analyses, assumptions underlying parametric analyses were tested. The number of clean-outs providers had previously conducted and the number of hoarding clients providers had worked with was skewed, so these variables were transformed to a log scale before analysis. Data analysis was conducted using SPSS Statistics for Mac, version 25.

3.3 Results

3.3.1 Terminology

Approximately 50% of providers reported using the term “clean-out” or a variation, such as “clear-out” or “clean-up”. Several others \((n = 5)\) reported adding a qualifier, such as “modified clean-out”, “therapeutic clean-out”, “forced clean-out”, or “trauma-informed clean-out”. Table 3.2 presents other terms providers used to describe the intervention (presented in decreasing order of frequency; several providers reported the use of multiple terms). Euphemisms, such as “downsizing”, “decluttering”, or “sorting”, were commonly used \((n = 19\) providers). Some providers stated that they used more ambiguous terms such as “re-organizing” to avoid upsetting or alarming clients. Some providers reported using the term “clean-out” when talking with other professionals but using a euphemism with clients.

Cleaning-specific language, such as “cleaning order” or “heavy chore”, was used by 13 providers. Providers from Australia uniquely used the term “squalor clean” to refer to a clean-out. Six providers used removal language, such as “junk removal”.

Other providers used enforcement or safety language, such as “adhering to fire safety” or “taking corrective action”, rather than referring to the clean-out itself \((n = 5)\). Similarly, in five cases involving an eviction or re-location, providers used language that emphasized the client’s
changing housing status (e.g., “moving an individual out of a home”). Overall, the uniqueness in
responses suggests terminology related to clean-out interventions is inconsistent across service
providers. The frequent use of euphemisms suggests a reluctance to use the term “clean-out”.

Table 3.2

Provider Clean-Out Terminology

<table>
<thead>
<tr>
<th>Types of terms used</th>
<th>Participant examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Euphemisms</td>
<td>decluttering¹, (substantial) downsizing, minimizing, reorganizing, sorting, tidying, “helping him organize his stuff”, removing excess items, disposing of less-treasured belongings, “the agency is coming to pick stuff up”, The Big Day</td>
</tr>
<tr>
<td>Cleaning-specific</td>
<td>cleaning order, extreme clean, heavy chore, cleaning, a clean, cleaning visit, forensic clean, biohazard clean, squalor clean, squalor hoarding clean, major clean, spring clean</td>
</tr>
<tr>
<td>Removal</td>
<td>junk removal, dig out, clearance</td>
</tr>
<tr>
<td>Enforcement/safety</td>
<td>corrective action, safety infraction, “adhering to fire safety”, creating space for safety purposes, remediation, “action had to be taken or person had to vacate”</td>
</tr>
<tr>
<td>Related to moving</td>
<td>moving an individual out of a home, impromptu forced move, “get it ready to sell”</td>
</tr>
</tbody>
</table>

¹The term “decluttering” was often used incorrectly to describe a clean-out. A definition for decluttering assistance was created to distinguish the two interventions and to discourage the use of decluttering as a euphemism for clean-out. (see Table 3.1).
3.3.2 Case Characteristics

Of the 65 cases providers described, most clients were female (60%) and above the age of 65 years (66%). Most were renters (60%) and lived in multi-family dwellings such as apartment buildings (71%). A total of 26 clients lived in subsidized housing. Most lived alone (77%).

3.3.2.1 Initial CIR

Homes had substantial clutter accumulation prior to the clean-out (CIR $M = 6.07$, $SD = 1.45$) suggesting a high initial CIR is typical in cases of clean-outs. All cases had at least one room with a CIR $\geq 4$, indicating clutter significant enough to warrant clinical attention (Frost, 2004). Sixty-five percent of cases were severely hoarded with an initial CIR $\geq 6$, a level that poses a significant fire risk and has been used as a cut-off for local hoarding teams to intervene (Enfield Council, 2020; Hampshire Safeguarding Adults Board, 2022; Kent Fire and Rescue Service, 2016; Kysow et al., 2020). Providers recounted “goat trails” from the front door through to the living room, non-functional bathrooms, and limited places to sit other than the toilet seat and the client’s bed. A few providers noted that certain rooms were not hoarded because they belonged to or were maintained by cohabitants. As evidence of this, initial CIR was higher for those who lived alone ($M = 6.29$, $SD = 1.40$, $n = 50$) compared to those who lived with cohabitants ($M = 5.34$, $SD = 1.44$, $n = 15$), $t(63) = -2.28$, $p = .03$, $d = -0.67$, suggesting that the presence of cohabitants may help to maintain a safer home.

3.3.3 Clean-Out Context

3.3.3.1 Previous Interventions

Clean-outs are considered one of the more intense and aggressive interventions for hoarding clients, therefore it was important to understand if clients had been offered any other hoarding-specific intervention (i.e., peer support, CBT for hoarding, decluttering assistance)
prior to the clean-out. Across the 65 cases, only a handful of clients had attended a hoarding peer support group (8%) or received therapy targeting their hoarding behaviours (8%). A third of clients (34%) had received decluttering assistance prior to the clean-out, but providers noted that a clean-out was still necessary for reasons such as increased pressure from the fire department or the client’s landlord (i.e., an eviction notice), changed circumstances (e.g., hospitalization and need for discharge), or because the client withdrew or declined engagement. In two cases, the client initiated the transition from decluttering to a clean-out. In almost every decluttering case ($n = 21$), the same provider who assisted with decluttering was also involved in the clean-out, permitting some degree of continuity of care.

Several providers spontaneously reported other non-hoarding interventions that clients received prior to the clean-out, such as case management (e.g., for precariously housed individuals), older adult services, general mental health services, or psychosocial rehabilitation. Other providers noted that family or friends had tried to intervene without success and that some clients had experienced a previous clean-out.

3.3.3.2 Precipitating Event

In the days and weeks preceding the clean-out, there was often an event (or events) that triggered the clean-out. In most cases ($n = 37$), this event was an inspection conducted by housing officials, bylaw officers, a health inspector, the fire department, or animal control. For 21 other cases, a medical event that required hospitalization preceded the clean-out. Less typical precipitating events included a wellness check (whereby a crisis team checked on the client’s wellbeing), family visiting, and building renovations.
3.3.4 Clean-out Rationale

On average, providers rated four reasons as very or extremely important ($M = 4.40$, $SD = 1.89$, range = $0 – 9$ reasons) in the decision to have a clean-out, indicating that a complex interplay of factors is typically involved. In only one case was a single rationale responsible for prompting a clean-out. Two cases had no clean-out rationales rated as very or extremely important; these clean-outs had been initiated by the client (a reason not included in the survey, but that was spontaneously reported by some providers).

As shown in Table 3.3, certain rationales were correlated. Complexities in one factor were often associated with complexities in another. (Significant associations are discussed in each relevant section below.) For example, in a case with nine rationales rated as very or extremely important, an untreated rodent infestation led both to neighbour complaints and an eviction notice. Additionally, the client in this situation refused to engage with the property manager, as the client did not acknowledge there was a problem (possibly due to suspected dementia), which further increased his risk of eviction.

To provide a visual illustration of the frequency of each rationale, Figures 3.3 – 3.5 show bar graphs grouped by concerns representing health and safety risks, client functional capacity, and external pressures.

3.3.4.1 Unsafe Conditions as a Clean-Out Rationale

For almost all cases (97%), providers reported that concerns about unsafe conditions in the home were at least important in the decision to have a clean-out, suggesting this factor is a minimum requirement for most clean-outs to be conducted. Examples of unsafe conditions included blocked entrances and exits, difficulty navigating through the home due to limited pathways, combustibles near the stove and heat sources, concern for fire due to cigarette
smoking combined with clutter in the house, and structural concerns (e.g., cracks in the house necessitating a property inspection to ensure safety of the clean-out crew).

### 3.3.4.2 Poor Sanitation as a Clean-Out Rationale

Providers who rated poor sanitation as *extremely important* (46%) described severe squalor, such as one case that involved rotting food in the sink and on kitchen counters, bottles of urine and feces stored in the home, and surfaces covered with piles of garbage. A couple of cases involved sewage that had backed up into the home. Across multiple cases, providers described clients who were soiled and incontinent living with poorly functioning or broken toilets and showers. They also described rotten food in fridges and freezers, some of which had been turned off for years. In several cases, poor sanitation was due to clients being unable to take care of their pets. For example, one client living with two cats had 22 boxes of used cat litter in her home because they were too heavy for her to lift; as such, the odour in the home was severe. In cases of extremely poor sanitation, workers took safety precautions such as wearing hazmat suits. These illustrations of extremely poor sanitation suggest a clean-out was the only possible intervention to achieve safe conditions. The presence of poor sanitation also limited a client’s decision-making power. For example, one provider stated, “The client was given a measure of control and choice about the actual belongings, but for all the food and unhygienic items, he had no choice.”

As would be expected, poor sanitation and pest infestations were often linked as clean-out rationales, $r = .46, p < .001$. For example, providers who described rotten or inadequately stored food often described fruit flies and cockroach infestations, and providers who reported an infestation of mice often described the presence of mouse droppings in the home.
Table 3.3

*Correlations Among Clean-Out Rationales (N = 65)*

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unsafe conditions</td>
<td>4.52</td>
<td>0.81</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Poor sanitation</td>
<td>3.72</td>
<td>1.43</td>
<td>.44</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Insects or rodents</td>
<td>3.34</td>
<td>1.55</td>
<td>.16</td>
<td>.46</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Physical health concerns</td>
<td>3.57</td>
<td>1.41</td>
<td>.44</td>
<td>.35</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Cognitive functioning</td>
<td>1.82</td>
<td>1.39</td>
<td>.23</td>
<td>.19</td>
<td>.16</td>
<td>.25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Refusal to engage</td>
<td>3.37</td>
<td>1.46</td>
<td>.30</td>
<td>.12</td>
<td>.27</td>
<td>.16</td>
<td>.40</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Neighbour complaints</td>
<td>2.27</td>
<td>1.56</td>
<td>-.11</td>
<td>.08</td>
<td>.28</td>
<td>-.18</td>
<td>-.004</td>
<td>.24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Eviction risk</td>
<td>3.42</td>
<td>1.79</td>
<td>.02</td>
<td>-.003</td>
<td>.31</td>
<td>-.28</td>
<td>.14</td>
<td>.25</td>
<td>.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Discharge from hospital</td>
<td>1.98</td>
<td>1.64</td>
<td>.19</td>
<td>.23</td>
<td>-.01</td>
<td>.31</td>
<td>.14</td>
<td>.02</td>
<td>-.18</td>
<td>-.16</td>
<td></td>
</tr>
</tbody>
</table>

*Note: *$r \geq .25 = $ significant at $\alpha = .05$ (2-tailed)*

1Three providers were unable to make a rating about neighbour complaints, therefore $n = 62$ for this variable.
Figure 3.3

Importance of Health and Safety Rationales in the Decision to Have a Clean-Out (N = 65)

Note: 1 = Not at all important, 2 = Slightly important, 3 = Important, 4 = Very important, 5 = Extremely important
Unsafe conditions and poor sanitation also commonly co-occurred as clean-out rationales, \( r = .44, \ p < .001 \). A total of 37 cases had both unsafe conditions and poor sanitation rated as very or extremely important in the decision to have a clean-out.

### 3.3.4.3 Insects or Rodents as a Clean-Out Rationale

Pests were very or extremely important in the decision to have a clean-out for half of the cases (51%). These included insects (e.g., bedbugs, cockroaches, fleas) and rodents (e.g., mice, rats, squirrels). Infestations could be severe; one provider witnessed “thousands of fruit flies”, and another described, “so many cockroaches, that when you opened the door, they fell on the ground.” In several cases, bedbug (and other pest) infestations had spread to neighbouring units and shared hallways, leading to complaints from neighbours. Accordingly, the importance of insect or rodent infestations in the decision to have a clean-out was associated with the importance of neighbour complaints, \( r = .28, \ p = .03, n = 62 \). Eviction risk and insects or rodents were also associated as clean-out rationales, \( r = .31, p = .01 \). Pest infestations typically violate sanitary or health department codes, which can be grounds for eviction.

### 3.3.4.4 Physical Health Concerns as a Clean-Out Rationale

Physical health concerns were very or extremely important in the decision to have a clean-out for 59% of cases. The providers who rated this concern as extremely important offered examples of life-threatening or medically complex health problems. For example, one client was in hospital for cellulitis (a bacterial skin infection that can be fatal if left untreated). The provider said the condition required a sanitary home environment upon discharge. Another client became ill from the rotten food in her home. She also had asthma and chronic obstructive pulmonary disease (COPD), which were made worse by the mold in her home.
Figure 3.4

*Importance of Functional Capacity Rationales in the Decision to Have a Clean-Out (N = 65)*

Note: 1 = Not at all important, 2 = Slightly important, 3 = Important, 4 = Very important, 5 = Extremely important
Mobility concerns were another common health consideration for a clean-out, for example, one client who had recently had a heart attack was largely immobile in her home. She could not lift anything, was very weak, and was unable to navigate around the house. Another client had repeatedly fallen in her home but was unable to use a walker due to space constraints. These examples illustrate how conditions in the home (e.g., poor sanitation, narrow pathways) could aggravate existing physical health problems to create unsafe conditions and an urgency for a rapid change. The relation between poor housing conditions and co-occurring medical conditions is likely bidirectional. Poor conditions in the home can lead to or worsen existing medical conditions, and medical conditions limit the client’s ability to ensure their home environment is safe and sanitary (Ayers, 2013; Bates, 2021). As evidence of this, poor sanitation and unsafe conditions were both associated with physical health concerns as clean-out rationales, $r = .35, p = .004$ and $r = .44, p < .001$, respectively.

3.3.4.5 Cognitive Functioning as a Clean-Out Rationale

Concerns about cognitive functioning were the least common reason given for a clean-out. Cases in which cognitive functioning was of concern included situations involving dementia, cognitive decline, psychosis, and impaired problem solving (e.g., one client collected bedbugs in a jar and used a microwave to kill them). For cases in which cognitive functioning was extremely important (11%) in the decision to have a clean-out, providers pointed to care decisions around client capacity, adult guardianship, and the need to complete a cognitive assessment. For example, one client who came to attention due to aggressive behaviour refused to be tested for cognitive impairment because she did not want to lose her ability to live independently, but her care team suspected she had dementia. The association between cognitive functioning concerns and refusal to engage as clean-out rationales, $r = .40, p < .001$, suggests some clients may have
been unwilling to accept help in part because they did not have the cognitive capacity to understand the risk in their home.

Cases in which cognitive functioning was a contributing factor sometimes also involved poor sanitation as a reason to conduct a clean-out, $r = .19, p = .12$. For example, one client lacked awareness of the feces on the floor and would unknowingly track feces around the unit. In another case, a client was at risk of losing her housing unless she proved her capacity. This client was throwing garbage on the floor, sharing her food with mice, and keeping food in the toaster oven because the fridge was broken; she was also unable to maintain her personal hygiene.

### 3.3.4.6 Refusal to Engage as a Clean-Out Rationale

Almost half of clients (49%) were unwilling to accept offers of help or reluctant to address the safety concerns in their home, and this became *very or extremely important* in the decision to conduct a clean-out. Providers described cases in which clients were given multiple warnings and an extended time period (e.g., more than a year) to remediate the situation, but no change occurred. Other clients would give verbal agreement to engage and then fail to follow through. For example, a client might accept “heavy chore” services, but not allow workers into the house when they arrived. In approximately half of the cases for whom refusal to engage was *very or extremely important* in the clean-out decision, a previous hoarding-specific intervention, such as decluttering assistance or peer support, had been unsuccessful because clients were unmotivated and resistant to making changes even at a gradual pace.

Stakeholder frustration was a common factor in these cases. From the stakeholder’s perspective, a large amount of resources and effort had been devoted to these clients with little to no result. Providers conjectured that such clients were too anxious, paranoid, or avoidant to
consent to accepting help. Sadly, two clients’ refusal to engage with providers led to them losing their homes and suffering greater limitations to their autonomy.

Refusal to engage was associated with several other clean-out rationales including unsafe conditions, $r = .30, p = .02$, insects or rodents, $r = .27, p = .03$, eviction risk, $r = .25, p = .04$, and cognitive functioning (described above). Clients in these cases had refused prior assistance, but had to allow a clean-out intervention to remediate safety concerns, manage a pest infestation, or to prevent their eviction.

3.3.4.7 Neighbour Complaints as a Clean-Out Rationale

In this sample, only a third of providers rated complaints from neighbours as very or extremely important (31%) in the decision to have a clean-out. These neighbours complained about pest infestations, odours, water leaks, risk of fire, or the condition of the yard. Some neighbour complaints were longstanding and involved multiple complainants. At the other end of the scale, some providers described neighbours as helpful, considerate, and supportive. Three providers were unable to make a rating about neighbour complaints.

3.3.4.8 Eviction Risk as a Clean-Out Rationale

Unlike the other rationales, which had relatively normal distributions, eviction risk had a bimodal distribution. Eviction risk was either a major driver or irrelevant in the decision to have a clean-out. In multiple cases, a threat of eviction was used to motivate change in the home’s conditions; retaining housing was contingent on a successful clean-out. Eviction notices were posted for a variety of reasons such as repairs that could not be completed due to conditions in the unit, a strong odour of decay, untreated pest infestations, or non-compliance with fire department orders.
Figure 3.5

Importance of External Pressure Rationales in the Decision to Have a Clean-Out

Note: 1 = Not at all important, 2 = Slightly important, 3 = Important, 4 = Very important, 5 = Extremely important
As expected, eviction risk was more of an important rationale for renters ($M = 4.44$, $SD = 1.05$, $n = 39$) compared to owners ($M = 1.88$, $SD = 1.58$, $n = 26$), $t(39.48) = -7.23$, $p < .001$, $d = -1.98$. (Results remained the same when examining eviction risk as a continuous or dichotomized variable).

### 3.3.4.9 Discharge from Hospital as a Clean-Out Rationale

Approximately a third of cases ($n = 21$) involved a client who was hospitalized, which in most cases created strong pressure to have a clean-out to facilitate a safe discharge. Medical staff explained to family and other providers that the client would not be discharged from hospital until a clean-out had been completed to ensure a safe and sanitary home environment. (Three cases of hospitalized clients did not involve discharge-related pressure because the clients were not returning home. One client moved to palliative care, another was evicted, and the third’s home was condemned.) One provider expressed the view that hospitalization was a blessing in disguise for a client in a privately-owned home because it created leverage to conduct a clean-out and to connect the client to needed services (e.g., home care).

Clients were hospitalized for medical incidents (e.g., falls in the home, malnourishment, breathing difficulties), cognitive concerns (e.g., self-neglect and suspected dementia), or psychological factors. Psychological factors included a client who was hospitalized due to a suicide attempt triggered by an eviction notice, and two clients were admitted due to psychosis. As would be expected, physical health concerns and discharge from hospital were associated as clean-out rationales, $r = .31$, $p = .01$.

### 3.3.4.10 Additional Reasons

Providers were also asked if there were other reasons for the clean-out that had not yet been mentioned. Fifty-two percent of providers reported at least one additional reason as very or
extremely important in the decision to have a clean-out, the most common being mental health concerns \((n = 8)\), such as depression, anxiety, PTSD, or substance use. For example, one provider described a couple with limited mobility who were “at their breaking point mentally” because of the conditions in their home. A clean-out was necessary to improve their mental health. Another common additional reason was that the client had initiated the intervention \((n = 7)\). In these cases, providers reported that their clients were motivated and ready to make a big change in their environment. In six other cases, the clean-out was necessary because provision of in-home caregiving services (e.g., personal support workers, home care) was contingent on having a safe work environment for staff. Other notable additional reasons included facilitating access for home repairs (e.g., electrical, plumbing; \(n = 5\)), alleviating pressure from family members \((n = 4)\) or improving living conditions for vulnerable co-occupants in the home \((n = 4)\). Reasons relevant to only one or two cases included preventing the loss of a housing subsidy and ensuring the well-being of pets in the home.

### 3.3.5 Clean-out Logistics

This section will describe some of the practices used, specifically with regard to the composition of the clean-out team, the removal process, and the duration of the clean-out.

#### 3.3.5.1 Clean-Out Team

Clean-outs were usually conducted by multidisciplinary teams. Diverse disciplines were required to manage different aspects of the process (e.g., clutter removal, sanitation, pest control) and the client’s psychological or physical needs. Several providers described how clean-outs required “all hands-on deck.” Each worker may have been responsible for several roles, including logistics and planning, case management, emotional support, enforcement, clutter removal, or cleaning. Depending on the clean-out, some team members were present for the
planning stages but not the removal process (or vice versa). Family members or partners were involved in 32% of cases.

On average, each clean-out team consisted of five to six individuals, but there was significant variability across cases ($M = 5.82$, $SD = 4.48$, range $= 1 – 34$, $n = 56$). Smaller clean-out teams included just one or two paid workers to assist with clutter removal in addition to the provider who participated in the study. Mid-size teams (i.e., 4 – 7 workers) involved a few hired workers for clutter removal, and either a family member or another service provider, such as a fire inspector, property manager, or social worker. One case (an extreme outlier) involved 34 workers, including 20 staff from a “junk crew”, five family members, four professional organizers, three auctioneers, one therapist, and the provider who was interviewed for the study. Every room in the home had an initial CIR of 9. This clean-out was conducted and filmed as part of a reality TV show on hoarding; the company used a large crew of individuals to speed the removal process.

**3.3.5.2 Clean-Out Removal**

In most cases (79%), a professional cleaning or removal service removed the items. Encouragingly, several providers described the workers’ compassion and respect while handling clients’ possessions. Although hiring such a company made practical sense (to remove clutter more efficiently), many providers emphasized that they were unable to hire such a company as there was limited or no funding available to pay for the service. When a professional company was not involved, the removal work was completed by social service providers (e.g., social workers, housing staff, nurses), professional organizers, or family and friends.

Eleven providers spontaneously reported the cost of hiring a clean-out company ($M = $5,599, $SD = $3,522 CAD). The lowest cost estimate was $600 CAD; this covered two hours of
clutter removal by two contractors, as well as five hours of cleaning by two other contractors. In the mid-range, $5,000 CAD covered three individuals from a “professional decluttering company” working a total of 24 hours over three days. The highest cost estimate was for an outdoor clean-out that cost $11,000 CAD. This covered 10 city crew workers working for 20 hours over 3 days. Clean-out costs were paid by the client, another individual (e.g., property manager), or grants or crisis stabilization funds. In one case, money that was found in the unit was allocated towards the cost of removal.

Providers described several different organizing strategies. For example, one provider described bringing everything outside to be organized on the lawn. In this case, the family were given strict guidance (by a nurse and hospital administrator) as to what could be kept and moved into their new home. Due to poor sanitation in the home, only hard objects that could be bleached were saved in this case. Another provider described using black garbage bags for garbage and clear garbage bags for items that would be kept. The black bags were taken outside for removal. With larger clean-out crews, removal team members would each take control of a separate room. Several providers described arranging an extra trash pick-up, hiring a bin removal service, or renting a dumpster to remove the items from the property.

3.3.5.3 Clutter Reduction

On average, clean-outs reduced clutter volume by more than 50% (ΔCIR $M = 3.45$, $SD = 1.81$). Figure 3.6 presents histograms comparing initial and final CIR. As described earlier, the average initial CIR was 6.07 ($SD = 1.45$). The average final CIR was 2.62 ($SD = 1.26$).

Most clean-outs focused on reducing clutter in areas of concern. If a room did not present a safety risk, it may not have been targeted during the clean-out. As such, in 11 cases, the CIR rating for one or more rooms did not change during the clean-out. Several providers articulated
specific harm reduction targets for the clean-outs they engaged in. These targets included: creating room for egress in entryways, staircases, and hallways; providing clearance from heat or ignition sources; improving sanitation to enable home care services; and ensuring bathroom plumbing fixtures were useable.

Unsurprisingly, clutter reduction (as measured by change in CIR) was more drastic in cases where clients were evicted or relocated ($M = 4.52$, $SD = 2.06$, $n = 16$) compared to clients who retained their homes ($M = 3.06$, $SD = 1.63$, $n = 47$), $t(61) = 2.89$, $p = .01$, $d = 0.84$.

**Figure 3.6**

*Comparison of Initial and Final Clutter Image Ratings (N = 65)*

<table>
<thead>
<tr>
<th>Clutter Image Rating</th>
<th>Frequency</th>
<th>Initial CIR</th>
<th>Final CIR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>5</td>
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<td>8</td>
<td>9</td>
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<tr>
<td>9</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note:* Initial and Final CIR values are an average of kitchen, living room, and bedroom CIRs

### 3.3.5.4 Number of Possessions Removed

A stereotype of clean-outs is that clients lose the majority of their belongings. As detailed in Table 3.4, most clean-outs did involve removing either “everything” or “a lot” from every room in the home. Most of the cases where “everything was removed” occurred in the context of
an eviction \((n = 5)\) or a move \((n = 3)\). There was one case that included a full clean-out and was not an eviction or move, although the provider (a fire prevention officer) did not advocate a full-clean-out and believed that the amount ordered to be removed by the client’s family member was “not necessary”. Even when many possessions were removed during the clean-out, most clients still retained a portion of their belongings. For example, after a clean-out in which “a lot was removed from every room”, one client retained their furniture and “100 bags of clothing, five totes of jewelry, and five totes of makeup/products.”

**Table 3.4**  
*Number of Possessions Removed \((N = 64)\)*  

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some possessions were removed from 1 or 2 rooms, but the rest of the home stayed the same.</td>
<td>5 (8%)</td>
</tr>
<tr>
<td>Some possessions were removed from every room.</td>
<td>6 (9%)</td>
</tr>
<tr>
<td>A lot of possessions were removed from 1 or 2 rooms, but the rest of the home stayed pretty much the same.</td>
<td>11 (17%)</td>
</tr>
<tr>
<td>A lot of possessions were removed from every room.</td>
<td>33 (52%)</td>
</tr>
<tr>
<td>Everything was removed from the home.</td>
<td>9 (14%)</td>
</tr>
</tbody>
</table>

### 3.3.5.5 Practices Following Clutter Removal

The removal of clutter often facilitated the completion of other work in the home, including maintenance, renovations and repairs, and the purchase of new furniture. With the help of grant money, one client received new flooring, updated plumbing, a new kitchen, and new furniture, including a bed, couch, and entertainment centre. Following the clean-out and these renovations, this client was described as “so happy and so committed to keeping it clean”. In some cases, a clean-out permitted the engagement of pest control services.
Thirty-four (52%) cases ended with a re-inspection by the property manager or fire inspector to ensure that the home was in compliance, thereby permitting the client to remain in the home, or to ensure the home was empty following the client’s eviction or relocation. One client who retained his housing was proud to show his progress during the final housing inspection. His provider said he was, “excited and dressed up, showered, and shaved” specifically for the inspection.

3.3.5.6 Clean-Out Duration

As shown in Table 3.5, the median duration of clutter removal took 16 hours across three days. This duration does not include time spent in pre-sorting, sanitation, or supporting the client prior to the clean-out. In terms of the total labour and volume of work completed, a median of 41 person-hours were required per clean-out for clutter removal.

Table 3.5

<table>
<thead>
<tr>
<th>Clean-Out Duration</th>
<th>n</th>
<th>M</th>
<th>SD</th>
<th>Median</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours for removal</td>
<td>55</td>
<td>23</td>
<td>25</td>
<td>16</td>
<td>3 – 160</td>
</tr>
<tr>
<td>Days clean-out team on-site</td>
<td>57</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>0.5 – 24</td>
</tr>
<tr>
<td>Estimated person-hours</td>
<td>52</td>
<td>92</td>
<td>185</td>
<td>41</td>
<td>8 - 1,260</td>
</tr>
</tbody>
</table>

A few clean-outs (n = 5) were prematurely terminated, which affected the reduction in clutter volume. Three clients withdrew consent to the clean-out midway through the intervention. Two other clean-outs were prematurely terminated because of COVID-19 and because a client’s public guardian ordered it to end (without explanation) before the home achieved compliance with fire safety standards.
As expected, clean-outs of detached homes took longer to complete ($M = 6$ days, $SD = 6$, $n = 17$) than apartment clean-outs ($M = 3$ days, $SD = 2$, $n = 40$). $t(17.70) = 2.41$, $p = .03$, $d = 0.98$, likely due to the difference in size of the home.

### 3.3.6 Client-Centered Strategies

Another stereotype about clean-outs is that they are involuntary and forced; this study examined how often both the client and service provider contributed to the decision-making process. This section examines the degree to which collaborative practices are used in clean-out interventions, as well as barriers and facilitators to their use.

#### 3.3.6.1 Voluntariness of Clean-Out Decision

Most providers (61.5%) reported that having a clean-out was not (or mostly not) the client’s decision. Instead, stakeholders, such as the fire department, property management, family members, or hospital staff made this decision. A clean-out was orchestrated to satisfy these external pressures (e.g., to reduce eviction risk, to mitigate fire risk).

Nearly a third of providers (28%) reported the clean-out was “mostly” or “completely” the client’s decision. However, several providers explained that the choice was constrained, bordering on coerced. For example, a social worker stated, “The client did consent, but it was an ultimatum,” as caregiving services would not agree to enter the home unless a clean-out and pest removal were conducted. Relatedly, another client agreed only because preserving his tenancy was contingent on having a clean-out. Other clients were motivated to agree to the clean-out due to the severity of their physical health conditions (e.g., mobility issues, breathing difficulties).

The remaining seven providers said the decision to have a clean-out was neither voluntary nor involuntary (i.e., it was a “neutral” decision). Two of these providers stated their clients consented to the clean-out, but it was not their idea (i.e., “the client completely
understood that it had to happen, but he wouldn't have engaged in it had it not been a crisis” or “it wasn’t her decision, but she was in agreement”).

3.3.6.1.1 Barriers to a Voluntary Clean-Out

As the 65 clients described in this study did not always make a voluntary decision to accept or decline a clean-out, I examined which clean-out rationales were associated with decreased voluntariness. Specifically, I was interested in rationales that may have given stakeholders (e.g., property manager, fire inspector, hospital staff, family) leverage to pursue a clean-out even though it was not the client’s preference. As such, I explored correlations between the voluntariness of the clean-out decision and the clean-out rationales of cognitive functioning, refusal to engage, eviction risk, and discharge from hospital. Voluntariness was negatively associated with both refusal to engage, \( r = -.43, p < .001 \), and eviction risk, \( r = -.41, p < .001 \). However, there was no evidence that voluntariness was associated with either cognitive functioning, \( r = -.16, p = .22 \), or discharge from hospital, \( r = -.06, p = .63 \), as reasons for the clean-out.

3.3.6.2 Emotional Support

In almost all cases (91%) with available data \( n = 63 \), some type of emotional support was offered to the client during the clean-out by service providers involved in the clean-out or by family and friends. One provider explained how they offered emotional support: "I get involved and keep an eye on the client. I decide if we need to pause for a bit." Another stated, “My role was to calm down the client, while my supervisor was in the front hall trying to get as much out as she could.” In only 13 cases was the emotional support offered by a mental health clinician, although four providers spontaneously stated this would have been helpful.
Of the six cases where no emotional support was offered, two providers stated that the family was unable or unwilling to provide emotional support to the client. Two other providers expressed dissatisfaction with the fact that no emotional support was provided. For example, in one case, support staff were scheduled to attend the clean-out, but did not show up on the day for unknown reasons. The provider interviewed said it seemed like the client’s housing organization had “written them off” and provided “zero support”.

3.3.6.3  Client Location During the Clean-Out

During the clean-out, half of the clients remained at home \( (n = 33) \), so they were able to observe and directly participate in clutter removal. One provider articulated the importance of having the client be present: “Having a client on-site is a big thing, they're working with me, I want the change to last, so they have to learn to work with me.” Nine clients were present for part of the intervention but left at times. One client was evicted between clean-out days.

The remaining 22 clients were not at home for any part of the intervention, suggesting more limited involvement in the clean-out. Most of these clients (73%) were hospitalized at the time of the clean-out. Several providers in these cases voiced that it would have been their preference for the client to be on-site had that been possible, but two providers noted that having the client off-site was positive because the clean-out was faster without “interference”.

3.3.6.4  Client Role During the Clean-Out

Most clients (75%) actively engaged in sorting at least some of their possessions, which gave them a role in deciding what to keep versus discard. In a handful of cases, clients were responsible for every decision about what to discard. For example, two providers stated, “Every decision was their decision 100%” and “Nothing left the apartment without her say and her consent.” Relatedly, several providers described establishing “ground rules” for what the client
wanted to keep versus discard. For example, one client gave the green light to remove all rotten food, but also had a list of possessions that should not be touched. Another client labelled her items to indicate what she wanted to keep. Other providers described a pre-sorting phase during which the provider and client sorted possessions before the clean-out; then during the clean-out, the client was able to direct the clean-out team regarding which items to remove.

Being involved in decisions about what to keep was not always a positive experience for clients. Four providers shared that the clients were distressed or agitated while attempting to participate. Another provider described working to maintain a balance between engaging the client and ensuring the client did not delay or impede the clean-out.

Of the clients who helped to sort their items, nine of them also participated in the physical removal of items. One provider stated, “The client was very hands on. The client had control because we developed a list of rules and tasks. It was very organized, and everyone involved knew what they were supposed to be doing.” In a similar case, another provider stated, “It was amazing- for all three days it was like having four people assisting the entire time. The client showed us she was ready, and she backed up her talk with actions.” Interestingly, clients who assisted in removing items from their home had a smaller reduction in CIR ($\Delta\text{CIR} M = 2.26, SD = 1.33, n = 9$) compared to clients who did not participate in clutter removal ($\Delta\text{CIR} M = 3.64, SD = 1.82, n = 56$), $t(63) = 2.18, p = .03, d = 0.78$. Clients who participated in sorting had a marginally smaller reduction in CIR ($\Delta\text{CIR} M = 3.23, SD = 1.88, n = 49$) compared to clients who did not participate in sorting ($\Delta\text{CIR} M = 4.13, SD = 1.45, n = 16$), $t(63) = 1.74, p = .09, d = 0.50$. This suggests client involvement in sorting and discarding is associated with a smaller reduction in clutter volume.
At the other end of the continuum were 25% of cases in which clients made no decisions and had no role in sorting. In 12 of these cases, the client was in hospital. Family members, friends, or service providers were responsible for making decisions in the client’s absence. Applying for legal guardianship or instituting a power of attorney was instrumental in the removal process for three cases to empower a substitute decision maker.

3.3.6.4.1 Barriers to Client Involvement in Sorting

In mental health interventions for hoarding, standard practice is for clients to be in control regarding which possessions are discarded or retained. Although the speed and urgency of a clean-out understandably would diminish a client’s decision-making power, I wanted to know the types of circumstances in which clients would have no role in sorting. As such, I explored correlations between client involvement in sorting and clean-out rationales that may have diminished a client’s ability to participate, including cognitive functioning concerns, refusal to engage, and eviction risk. There was no evidence that clean-outs motivated by problems with cognitive functioning, refusal to engage, or eviction risk presented barriers to client participation in sorting, $|r| \leq .08$, $p \geq .55$. On the other hand, hospitalization was related to involvement in sorting, $\chi^2(1) = 17.69$, $p < .001$. The odds of a client participating in sorting were 13 times lower if they were in hospital.

3.3.6.5 Shared Decision Making

Most providers reported members of the clean-out team put considerable effort into being collaborative with the client during the clean-out ($M = 3.89$, $SD = 1.00$, range = 1.4 – 5.0, $n = 61$). Sixty-seven percent of providers reported shared decision-making practices were used “quite a bit” or “a great deal”. Ratings represented how much effort providers put into ensuring the clean-out was collaborative, not necessarily how much the client engaged with those efforts or
even whether the client perceived the provider’s efforts. Four providers were unable to answer all five shared decision-making items because they were uncertain whether other members of the clean-out team had used these practices.

Providers who endorsed high levels of shared decision making reported having multiple conversations with their client about the upcoming clean-out, collaboratively developing guidelines about which items should be saved (versus removed), and listening to client concerns, including fears that too many items would be discarded and concern about who was in control of the clean-out. To increase client involvement, one social worker set guidelines around the percentage of items to be removed and allowed the client to decide which particular possessions would be removed. Another provider created an “action plan” with the client that included a list of items the client would like to find during the clean-out and also items that were of value. The provider also asked, "If you had a magic wand, what would [your home] look like?"; the client’s answer became the ultimate goal for the clean-out. Establishing an action plan was important because it created a commitment for the client and allowed clean-out staff to continue working, even when it became too difficult for the client to make decisions.

3.3.6.5.1 Barriers to Shared Decision Making

While reporting on their use of shared decision-making practices, providers spontaneously described various barriers to shared decision making. The most frequently-mentioned barrier to shared decision making was client disengagement. For example, despite provider efforts, some clients did not want to discuss their role during the clean-out or their personal goals or discarding preferences. Additionally, client engagement sometimes changed over the course of the intervention. Several clients started out more willing to converse, but over time, they withdrew and declined to participate. As this study did not assess client engagement
during the decision-making process, I used the extent to which the clean-out was motivated by client refusal to engage as a proxy indicator. Despite client disengagement being a commonly reported barrier, based on the data, refusal to engage was not associated with shared decision making, \( r = .12, p = .34, n = 61 \).

In other cases, providers reported that there was significant pressure to prioritize the goals of external agencies (e.g., the fire department, strata council, or building officials) instead of the client’s goals. For example, “the clean-out was happening because of the strata [council], not really because of [the client’s] personal goals.” Or, “the building manager was not very good at seeing the big picture, he was very intrusive, for example, telling the client what she should have on her coffee table.” In these cases, it was more challenging for providers to advocate and to see a pathway to including the client in goal-setting and shared decision making. In order to assess the impact of one external pressure on shared decision making, I examined the association of shared decision making and the extent to which the clean-out was conducted due to eviction risk. However, there was no evidence that eviction risk as a clean-out rationale was associated with shared decision making, \( r = .18, p = .18, n = 61 \).

In some cases, providers primarily engaged with family members (rather than the client) for logistical reasons. Furthermore, in certain cases family members, rather than the client, made the majority of the decisions. One provider stated this was not their professional preference because “at the end of the day, the family member was not our client. I don’t know if our client was happy with their choices.” Providers reported less frequent shared decision making when a family member was a part of the clean-out team (\( M = 3.46, SD = 1.20, n = 20 \)) compared to when a family member was not involved (\( M = 4.10, SD = 0.82, n = 41 \)), \( t(28.00) = 2.16, p = .04, d = 0.67 \).
Hospitalization presented another barrier to shared decision making because it impeded collaboration and communication between the provider and the client. For example, a fire inspector explained that he never spoke to the client directly about why the clean-out was necessary. Instead, he communicated the clean-out rationale to the client’s family member, who had regular contact with the client during the hospitalization. Hospitalization was also a barrier to shared decision making because clients were unable to be on-site with the clean-out team.

Providers reported less frequent shared decision making with hospitalized clients \((M = 3.20, SD = 1.06, n = 20)\) compared to those who were not hospitalized \((M = 4.23, SD = 0.78, n = 41)\), \(t(59) = 4.29, p < .001, d = 1.17\). Five providers explained the efforts they made to involve their clients even while they were in hospital. These providers visited clients in hospital, showed photos of the client’s items to facilitate decision-making, made lists detailing what clients wanted to keep, prioritized their client’s attention on larger items, rather than decisions about items that were squalid or rotten (e.g., food), and stayed in communication through text messages or phone calls during the clean-out.

### 3.3.6.5.2 Facilitators of Shared Decision Making

I hypothesized that providers who have more experience with hoarding and specifically with clean-out interventions would use more shared decision-making practices. In this study, provider experience with hoarding and with conducting clean-outs (in the past three years) was associated with greater use of shared decision-making practices, \(r = .47, p < .001, n = 61\) and \(r = .28, p = .03, n = 61\), respectively.

Providers reported more shared decision-making practices with clients who they had previously worked with in a decluttering framework \((M = 4.29, SD = 0.73, n = 20)\) compared to those who had not had a previous intervention \((M = 3.70, SD = 1.06, n = 41)\), \(t(52.30) = -2.55, p = .014\).
$p = .01, d = -0.61$, suggesting that an existing provider-client relationship facilitates collaboration. For example, several providers explained that conversations about the client’s goals and concerns about the clean-out began during the decluttering phase, which laid the foundation for client involvement when things progressed to a clean-out. The use of shared decision making during the clean-out was also correlated with the use of post-clean-out interventions, including emotional check-in calls, $r = .28, p = .03, n = 61$, and further decluttering assistance, $r = .26, p = .05, n = 61$.

### 3.3.7 Client Distress

Losing a large number of possessions especially involuntarily would be distressing for most people. In this study, providers reported a range of affective reactions from *not at all* to *extremely* distressed, $M = 3.34, SD = 1.00, n = 63$. Two providers were unable to answer all five affective reaction items because they did not communicate directly with the clients. Almost 50% of the sample was described as *very* or *extremely* distressed about having a clean-out. During the interview, providers were invited to explain their ratings of each emotion. Table 3.6 provides a selection of quotes to illustrate these explanations.
<table>
<thead>
<tr>
<th>Emotion</th>
<th>$M$</th>
<th>$SD$</th>
<th>Low Distress</th>
<th>High Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frightened</td>
<td>3.46</td>
<td>1.26</td>
<td>“I never really saw the client’s fear, but I assumed it was there.”</td>
<td>“Client was afraid of the unknown: ‘what else is [the clean-out team] going to take?’, ‘what will be left?’”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“At the end of the clean-out, the client cried when she walked in her bedroom. She was in a bit of a shock. Not necessarily like upset tears.”</td>
</tr>
<tr>
<td>Sad</td>
<td>3.19</td>
<td>1.33</td>
<td>“She wasn’t sad about having a clean-out…but she was sad things weren’t able to be donated [because of COVID-19].”</td>
<td>“She felt like we were throwing her whole life away.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“The client was sad that [her home] got to that point and that [the clean-out team] had to be there. She was extremely sad and embarrassed.”</td>
</tr>
<tr>
<td>Angry</td>
<td>3.02</td>
<td>1.39</td>
<td>“The client was very laid-back, like an old hippie, he kept saying ‘doesn’t matter’.”</td>
<td>“The client was supposed to help us and agreed to help, but he got angry. He filled a grocery cart and left with his pet.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>“Since the move/clean-out, the client has gone into intense attack mode and is talking about suing the city.”</td>
</tr>
<tr>
<td>Pleased</td>
<td>2.41</td>
<td>1.38</td>
<td>“The client was pleased because she was able to start using her bathroom and kitchen.”</td>
<td>“She was resentful for being evicted.”</td>
</tr>
<tr>
<td>Relieved</td>
<td>2.50</td>
<td>1.31</td>
<td>“It was a very positive clean-out. The team put in new carpets and purchased new furniture for the client, as well as hired a utility company to examine the electrical system.”</td>
<td>“It was a loss of control.”</td>
</tr>
</tbody>
</table>
3.3.7.1 Predictors of Client Distress

To understand predictors of client distress in clean-outs, correlational analyses were first conducted to identify correlates of client distress. These analyses were conducted to begin to develop practices to respond to the specific sources of distress in clean-out interventions. Constructs of interest included clean-out rationales and case characteristics (eviction risk, refusal to engage, initial CIR), client-centered variables (voluntariness of clean-out decision, participation in sorting, shared decision making), clutter reduction variables (CIR change, final CIR), and housing outcomes (retained or not). These constructs were selected based on the conceptual framework, studies of involuntary hospital admission (Akther et al., 2019; Murphy et al., 2017), and thematic findings from the scoping review.

Several clean-out rationales and case characteristics were hypothesized to be associated with greater client distress: eviction risk (because of the dire consequences of losing one’s housing), refusal to engage (because client disengagement is often accompanied by negative emotional arousal, as shown in psychotherapy literature; Stringer et al., 2010), and initial CIR (because more possessions would be at risk for removal). Of these, refusal to engage, $r = .58, p < .001, n = 63$, and initial clutter volume were positively related with apparent client distress, $r = .33, p = .01, n = 63$. Eviction risk (as a rationale for the clean-out) had a weaker relationship with client distress, $r = .23, p = .07, n = 63$.

Client-centered variables of voluntariness of the clean-out decision, shared decision making, and client participation in sorting were also expected to correlate with client distress. Only voluntariness of the clean-out decision was related to distress, $r = -.56, p < .001, n = 63$. Neither frequency of shared decision making, $r = -.04, p = .76, n = 60$, nor client participation in sorting, $r = -.16, p = .23, n = 63$, were related to affective response.
Finally, client distress was hypothesized to be associated with the clean-out outcomes of CIR change, final CIR, and housing retention based on a general understanding that hoarding clients prefer to retain as many possessions as they can during an intervention and to retain their housing. Somewhat surprisingly, final CIR was not related to distress, $r = .07, p = .58, n = 63$. The correlation of change in CIR with client distress was weak, $r = .21, p = .10, n = 63$. As expected, clients who lost their housing due to eviction or a forced relocation showed more distress ($M = 3.96, SD = 0.70, n = 16$) compared to those who retained it ($M = 3.10, SD = 1.01, n = 46$), $t(60) = 3.15, p = .003, d = .91$.

Variables with significant bivariate correlations were included in hierarchical multiple regression analyses to identify unique predictors of client distress. Assumptions of regression analysis were met. Table 3.7 shows the steps and results of this analysis. In the first model, refusal to engage and initial CIR accounted for $35\%$ of the variance in client distress, $F(2, 59) = 17.15, p < .001$. The second model, which added voluntariness of the clean-out decision, explained $43\%$ of the variance in client distress and was a significant improvement from the first model, $\Delta F(1, 58) = 9.87, p = .003$. The third model added housing retention but was not a significant improvement over model 2, $\Delta F(1, 57) = 2.01, p = .16$. In this final model, which accounted for $44\%$ of the variance in client distress, neither housing retention nor initial CIR were uniquely associated with client distress when accounting for refusal to engage and voluntariness of clean-out decision. Clients who refuse to engage appear to be more distressed, and clean-outs that are more involuntary appear to evoke greater client distress.
Table 3.7

*Predicting Client Distress (N = 62)*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>β</th>
<th>95% CI</th>
<th>p</th>
<th>Adj. $R^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td>.35</td>
</tr>
<tr>
<td>Refusal to engage</td>
<td>0.53</td>
<td>[0.32, 0.74]</td>
<td>&lt; .001</td>
<td></td>
</tr>
<tr>
<td>Initial CIR</td>
<td>0.20</td>
<td>[-0.01, 0.41]</td>
<td>.07</td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td></td>
<td></td>
<td>.43</td>
</tr>
<tr>
<td>Refusal to engage</td>
<td>0.38</td>
<td>[0.17, 0.60]</td>
<td>&lt; .001</td>
<td></td>
</tr>
<tr>
<td>Initial CIR</td>
<td>0.16</td>
<td>[-0.04, 0.36]</td>
<td>.12</td>
<td></td>
</tr>
<tr>
<td>Voluntariness</td>
<td>-0.35</td>
<td>[-0.58, -0.13]</td>
<td>.003</td>
<td></td>
</tr>
<tr>
<td>Step 3</td>
<td></td>
<td></td>
<td></td>
<td>.44</td>
</tr>
<tr>
<td>Refusal to engage</td>
<td>0.38</td>
<td>[0.17, 0.60]</td>
<td>&lt; .001</td>
<td></td>
</tr>
<tr>
<td>Initial CIR</td>
<td>0.14</td>
<td>[-0.06, 0.34]</td>
<td>.17</td>
<td></td>
</tr>
<tr>
<td>Voluntariness</td>
<td>-0.29</td>
<td>[-0.53, -0.05]</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>Housing retention</td>
<td>-0.15</td>
<td>[-0.36, 0.06]</td>
<td>.16</td>
<td></td>
</tr>
</tbody>
</table>

Two case examples qualitatively illustrate the two ends of the client distress continuum and how the relevant predictor variables relate. The first client was *not at all* distressed about having a clean-out, which had been the client’s decision because she wanted to have her family members visit. Her average initial CIR across the living room, bedroom, and kitchen was a 7. She had been fully engaged in other hoarding-related interventions before the clean-out, and she participated actively in sorting and removing items, remaining on-site for the entire duration. At the end of the clean-out (final CIR = 3), the client retained her home, and the provider reported that she had maintained the clutter reduction 30-days later.

At the other end of the spectrum, a social worker described a client who was *extremely* distressed about having a fully involuntary clean-out. Having a clean-out was necessary to improve the living conditions for a cohabitating family member. The average initial CIR was a 7.
The client was very resistant to other interventions and was unwilling to participate in the clean-out in any way. As such, no possessions were removed from their bedroom. This client did retain their housing (final CIR = 5), but at a six-month follow-up the provider noticed the clutter “creeping back”. The provider stated it would have been preferable to use a different intervention, such as a decluttering assistance, and to have had the client’s involvement, but urgent intervention had been required.

3.3.8 Post Clean-Out Interventions

What happens after the clutter is removed? In this sample, 77% of clients ($n = 50$) received at least one emotional support phone call or in-person visit from their service provider (or someone else) following the clean-out. Clients in 28 cases (43%) were also provided with in-home decluttering assistance or cleaning services following the clean-out. The purpose of these services was largely to help maintain the home through regular housekeeping services or to teach clients decluttering skills. Some clients discontinued these services prematurely. Four clients completely declined further assistance even though it was offered. For example, a social worker offered to help with decluttering and unpacking her clients’ belongings in her new place (following eviction), but the client would not provide her new address.

Finally, providers referred 18 clients for additional services. These included referrals to mental health ($n = 6$), hoarding-specific supports (e.g., online support group, $n = 4$), medical or related services ($n = 5$), home care ($n = 5$), and other supports (e.g., elder care, public trustee; $n = 2$). Some providers ($n = 4$) also worked towards securing alternative housing for their clients. Not all of these 18 clients engaged or accepted the referrals.
3.3.9 Clean-Out Outcomes

The long-term outcomes of clean-outs are difficult to track because most providers do not follow clients in the months following the intervention. As such, this study focused on short-term outcomes, including whether the clean-out prevented eviction and how well the clean-out addressed health and safety issues or hoarding symptoms (i.e., difficulties with discarding and intentional saving).

3.3.9.1 Housing Outcomes

Tenancy preservation is often a main driver for conducting a clean-out. In this study, 41 clients were at risk of eviction, as shown in Figure 3.7, of whom 27 retained their housing. After the clean-out, the threat of eviction was lifted, although in three cases, continued tenancy was conditional on ongoing progress in clutter reduction and compliance with monthly mandated inspections.

Sadly, the clean-out intervention was not successful in preserving the tenancy of 10 clients. These cases were all extremely complex and involved multiple stakeholders (e.g., the client, property managers, family, aging services, paramedics, police). In two cases, the clean-out was an effort to prevent condemnation, but the homes were ultimately deemed unsalvageable by public health officials.

Following the eviction, most clients found new housing (or remained in hospital until their health was improved). However, two clients experienced homelessness following their clean-out and eviction. In the first case, the provider's organization did have emergency housing prepared for the client and offered multiple times to discuss other housing options, but the client chose to live in a tent. In the second case, the client transitioned to living in a shelter following his eviction.
Most of these cases could be described as forced moves; if circumstances had been different (e.g., if they were in better health) the clients would have preferred to remain in their homes. At the time of the interview, it was unclear whether two clients would ultimately return home from the hospital or move to a care home.

3.3.9.1.1 Predictors of Eviction

Based on my impressions from the interviews, I hypothesized that cases in which clean-outs were unsuccessful in preventing eviction may have involved additional complexities beyond the risk of eviction. To set up the analysis testing this idea, I included only the 37 cases for which the clean-out rationale of eviction risk was coded as very or extremely important. I did not include the 4 cases that were relocated as they represented a different housing outcome.
Independent samples *t*-tests were used to compare clients who were evicted (*n* = 10) and clients who had been at risk for eviction but who retained their housing due to the clean-out (*n* = 27). Specifically, I examined initial CIR and clean-out rationales I thought were relevant to eviction. As can be seen in Table 3.8, clean-outs that did not ultimately prevent eviction were more motivated by insect or rodent infestations and the client’s refusal to engage in previously offered interventions. Poor sanitation was also marginally higher in cases where a clean-out did not successfully prevent eviction.

**Table 3.8**

*Clean-Out Rationales For Cases at Risk of Eviction With Different Outcomes (N = 37)*

<table>
<thead>
<tr>
<th></th>
<th>Evicted</th>
<th>Retained Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>n</em> = 10</td>
<td><em>n</em> = 27</td>
</tr>
<tr>
<td><strong>M</strong> <strong>SD</strong></td>
<td><strong>M</strong> <strong>SD</strong></td>
<td><strong>t</strong> <strong>df</strong> <strong>p</strong> <strong>d</strong></td>
</tr>
<tr>
<td>Poor Sanitation</td>
<td>4.30 0.95</td>
<td>3.48 1.53</td>
</tr>
<tr>
<td>Insects or Rodents</td>
<td>4.40 1.08</td>
<td>3.44 1.50</td>
</tr>
<tr>
<td>Refusal to Engage</td>
<td>4.40 0.84</td>
<td>3.52 1.37</td>
</tr>
<tr>
<td>Neighbour Complaints</td>
<td>3.30 1.64</td>
<td>2.48 1.64</td>
</tr>
<tr>
<td>Initial CIR</td>
<td>6.47 1.01</td>
<td>5.95 1.57</td>
</tr>
</tbody>
</table>

1There were two fewer cases for this test.

3.3.9.2 **Resolution of Health and Safety Issues**

Unsafe and unsanitary conditions were the most frequently cited rationales for a clean-out. Encouragingly, providers were largely in agreement that clean-outs resolved health and safety issues in the short-term (*M* = 4.75, *SD* = 0.47). There was some evidence harm reduction
principles were followed because greater resolution of health and safety issues was related to a lower final CIR, $r = -.35, p = .004$, but not to overall CIR change, $r = .11, p = .38$. This may indicate clutter removal was focused on resolving health and safety issues, not on removing a predetermined volume of clutter. This finding could also indicate providers’ judgment of whether health and safety issues were resolved may have been influenced by the final CIR (and not by how many possessions were removed).

Fifty providers (77%) reported that the clean-out “helped a great deal” with the health and safety issues in the home. For example, “because of the clean-out, the home was a lot safer, the client was able to get [caregiving] services in the home, and the neighbours felt reassured.” The provider in this case said her client, “surprised everyone involved by how well she did end up coping.” Positive outcomes included improved egress in and out of the home, improved mobility throughout the home, and reduction in falls risk. Providers also described a reduction in noxious odours and safer conditions due to maintenance and pest control services that were made possible by the reduction in clutter.

On the other hand, 23% of providers ($n = 15$) reported that unsafe and unsanitary issues were only “somewhat” resolved by the clean-out. Persisting issues included a higher-than-ideal clutter volume, safety risks pertaining to the client (e.g., “there are still falls risks and the client still smokes”), and unfinished renovation work (e.g., “the landlord will have to do a remodel”). Despite these concerns, no providers stated clean-outs “did not really help” to address health and safety issues or “seemed to make things worse”, suggesting that clean-outs do achieve these specific health and safety goals.
3.3.9.3 Resolution of Hoarding Symptoms

In contrast to their views on the success in reducing health and safety risks, providers had less positive views about whether the clean-out helped to resolve the client’s hoarding symptoms, including difficulties with discarding and intentional saving ($M = 2.80$, $SD = 1.17$, $n = 64$). Approximately half of the respondents ($n = 33$) reported that the clean-out “did not really help” in this regard. For example, one provider described the clean-out as a “means to an end”, while another stated that doing the clean-out only helped to “buy us time.”

Four providers (6%) reported that the clean-out worsened the client’s existing hoarding symptoms. In one such case, the client believed workers from the clean-out team had stolen some of her belongings. The team went back to the home and located three of the lost items, but this did not help to improve the situation, as the client said, "No one’s touching my stuff again." Another provider said the clean-out escalated the client’s interpersonal difficulties (related to her excessive acquisition and difficulty discarding) and triggered psychotic symptoms. Following the clean-out in this case, a family member moved in and continued to do decluttering. The client became extremely agitated and felt that she had lost her freedom and that her life was no longer under her control. She was ultimately admitted involuntarily to a mental health facility and then into a long-term care home.

At the other end of the spectrum, 22 providers (34%) said the clean-out helped “somewhat” or “a great deal” with their client’s hoarding. These providers described clients enjoying their new space following the clean-out and feeling motivated to maintain their home with less clutter. A peace officer described the clean-out as “hitting the reset button”. The client had told her that preparing for the clean-out “got him into a different mindset” and “forced him to think about how to get rid of stuff.” Another provider said the clean-out helped build the
client’s motivation to continue working on her clutter problem. Finally, one professional organizer said the clean-out helped to strengthen behaviours her client had been working on for years.

### 3.3.9.4 Evidence to Support the Use of Client-Centered Strategies

In order to understand if there is evidence to support the use of client-centered strategies, I analyzed correlations between the client-centered strategies and the provider report of how well hoarding symptoms were addressed. The voluntariness of the clean-out was positively associated with the resolution of hoarding symptoms, $r = .39, p = .001, n = 64$. As expected, based on the organizational and emotion regulation skills clients develop when learning to make difficult decisions about their possessions, clients who actively participated in sorting during the clean-out had a better resolution of hoarding symptoms ($M = 2.96, SD = 1.17, n = 49$) than clients who did not help to sort ($M = 2.27, SD = 1.03, n = 15$), $t(26.03) = -2.20, p = .04, d = -0.61$. Interestingly, there was little evidence of a meaningful association between resolution of hoarding symptoms and the shared decision-making practices that were examined in this study, $r = .18, p = .17, n = 61$.

As described in Chapter 1, client satisfaction has been one of the primary outcome variables examined in research on shared decision making. Although this study did not assess client satisfaction per se, how pleased the client seemed during the clean-out is a proxy indicator, so I examined the correlation with client-centered practices. Provider report of how pleased the client seemed was positively associated with the voluntariness of the clean-out decision, $r = .60, p < .001, n = 64$, the client’s participation in sorting, $r = .33, p = .01, n = 64$, and the provider’s use of shared decision-making approaches, $r = .26, p = .04, n = 61$. 

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3.3.9.5 Clutter Reduction Maintenance

Although this study primarily focused on short-term outcomes, providers were asked if they had information on maintenance of the clutter reduction. Only 51% of providers \( (n = 33) \) were able to comment on clutter maintenance, and most of those were in regard to the timeframe of the final follow-up inspection. Estimates on how long the clutter reduction was maintained ranged widely (median = 61 days, range = 7 – 730 days). Most providers \( (n = 20) \) reported clutter reduction was maintained up until their final inspection but could not speak to maintenance beyond that follow-up visit. Several providers \( (n = 8) \) reported that their clients slowly re-acquired items following the clean-out, but not to the same level as observed before the clean-out. On the other hand, three providers said the clutter volume returned to the level predating the clean-out and two providers reported that the client required another intervention. Maintenance seemed to be contingent on the availability of ongoing visits to provide accountability. For example, one provider stated, “With COVID-19 there weren't as many visits. His cleaning supports were on hold; it fell apart.” Although limited, these data suggest that clients were able to maintain the clutter reduction for at least two months post clean-out, especially with routine maintenance visits.

3.4 Discussion

Descriptive studies are the “first scientific toe in the water” (Grimes & Schulz, 2002). There is no extant empirical research on clean-outs. The scoping review revealed that the grey and published literature on this topic is sparse and tends to rely on a few fairly anecdotal scholarly papers. To begin to understand clean-outs, this interview-based survey of frontline professionals set out to understand the (1) conditions necessitating a clean-out, (2) range of practices used to conduct a clean-out, (3) degree to which client-centered practices were
employed, (4) client’s emotional response, and (5) short-term health and safety outcomes. As described in the introduction to the chapter, this study aimed to provide a research-based examination of the factors involved in clean-outs, thereby adding a data-driven perspective in contrast to that which is shown on television. Each of the 65 clean-outs in this study represented a unique client story. Descriptive statistics and exploratory analyses were used to characterize the clean-outs represented in this sample, while quotes from interviewees enriched the quantitative data and provided context for the variability among cases. The following sections provide an overview and interpretation of the findings from each research question.

3.4.1 What Makes a Clean-Out Necessary?

The clean-out rationale data showed that the decision to proceed with a clean-out was not made lightly; not only are these interventions labour-intensive and expensive, but also clean-outs are often conducted during a crisis situation. To illustrate this point, eighty percent of clean-outs in this study occurred within the context of impending threats of eviction, hospitalization, or both. Providers emphasized that the decision to have a clean-out was unavoidable due to the factors at play. For example, one provider was tasked with doing whatever was necessary to prevent eviction paperwork from being filed, while another stated their client would not accept help until they were “on death’s door”. Conditions in some homes had deteriorated during the COVID-19 pandemic (due to limited home visits), and the need for intervention had reached a critical point.

Providers described extremely poor living conditions to illustrate why clean-outs were necessary. Concern about unsafe conditions (e.g., blocked entrances and exits, combustibles near the stove and heat sources) was a nearly ubiquitous rationale for a clean-out. Unhygienic conditions of poor sanitation or pest infestations were also a common motivation for a clean-out;
these conditions present a barrier to using less intensive interventions (e.g., decluttering assistance) for occupational safety reasons.

Many clean-outs were motivated by clients’ unwillingness to accept offers of help or reluctance to address safety concerns in their home. Clients who refused to engage seemed to experience more distress and were more likely to be evicted. These less-than-ideal outcomes may have been potentiated by additional complexities, such as increased presence of insects or rodents, unsafe conditions, and the importance of cognitive concerns. These factors may have made it more challenging for a client to retain their housing or address their clutter problems. In addition, clean-outs were less likely to be voluntary for these clients, suggesting they may have felt coerced or forced into a clean-out. Clients likely felt defeated and angry to be experiencing a “last resort” intervention they never wanted and were desperately trying to avoid.

A pair of rationales that were very important in necessitating a clean-out intervention in my sample, but are less frequently discussed in the literature or on television, was hospitalization and physical health concerns. In these cases, clean-outs were necessary due to the need to safely discharge medically complex and physically vulnerable clients from hospital to a home that was safe and hygienic. My thesis work on characterizing community hoarding clients found a similar cluster of clients, which I labelled as “Medically Complex” (Kysow, 2018). These clients were likely to have been hospitalized during their hoarding intervention, had mobility concerns, physical health comorbidities, and were at increased risk of falling. These features became barriers to hoarding intervention because of medical complications and delayed discharge. Such clean-out interventions required a multidisciplinary team, including medical staff, to ensure appropriate care (Ayers, 2013).
3.4.2 How Are Clean-Outs Conducted?

As evident by the range of professionals involved, clean-outs were conducted by multidisciplinary providers and required a team effort – on average, five people. This number was far smaller than the clean-out teams portrayed on television and likely far less intimidating for a client to welcome into their home. Across cases, clutter was reduced by more than 50%, demonstrating a large reduction in clutter volume over an average of three days.

Some clean-outs appeared to follow harm reduction guidelines, such as reducing clutter in targeted areas of concern while retaining as many possessions as possible. Final CIR was significantly associated with resolution of health and safety issues, suggesting that clutter reduction was aimed at reducing harm (or that providers conflate lower clutter volume with satisfactory health and safety issues to some extent). The ultimate goal of most clean-outs appeared to be safer conditions, pest management, and compliance with lease agreements and fire codes, rather than simply clutter reduction. Additionally, among clients who retained their housing \((n = 47)\), 49% of them still had at least one room for which \(\text{CIR} \geq 4\), which is considered to be the threshold for clutter requiring clinical attention (Frost et al., 2008). In addition, the average final CIR was a 3, indicating most clients retained a sizeable number of possessions, unlike most of the clean-outs portrayed on television which frequently end at a CIR \(\leq 2\). However, the harm reduction approach was not followed for all clean-outs, especially those that ended in eviction in which everything was removed from the home. More work needs to be done to understand how to prioritize harm reduction principles in cases where eviction is unavoidable.
3.4.3 Which Client-Centered Strategies Are Being Used?

Although having a clean-out was not the client’s decision for about two-thirds of cases, and clean-outs were distressing for most clients, many providers responded to this distress with client-centered strategies: providing emotional support during (and after) the clean-out, involving the client in sorting and discarding decisions, and listening to clients’ concerns and fears. Even in the context of non-voluntary interventions, shared decision-making practices, such as providing a rationale for the intervention and elicitation of client preferences, were feasible in many cases.

On the other hand, I also identified several barriers to the use of client-centered strategies, including hospitalization, eviction risk, refusal to engage, and family involvement. I will discuss each of these results in turn. Client hospitalization emerged as an under-recognized factor in clean-outs. Client hospitalization was related to less shared decision-making strategies and fewer clients being involved in sorting. Evidently, it is far more challenging to engage clients in shared decision making and sorting when they are not on-site during the intervention. Providers had to act as intermediaries between the client and the clean-out team (e.g., cleaning company, contractors) and to communicate client preferences on their behalf.

In clean-outs motivated by eviction risk or refusal to engage, clients were less likely to voluntarily elect to have a clean-out. Clients at risk of eviction did not have the power to refuse a clean-out while still retaining their (mostly rented) housing, therefore the decision would have been more coerced. However, many providers still found a way to facilitate the client’s participation in sorting and to use shared decision-making practices, suggesting that it is never too late to engage and involve a client in the clean-out process.

The challenges of family conflict within hoarding situations have been well documented (Büscher et al., 2014; Tolin, Frost, Steketee, & Fitch, 2008), and books have been written.
specifically to guide family members to help, not harm, while intervening in hoarding cases (Tompkins & Hartl, 2009). However, this is the first study to provide evidence that family members can hinder a provider’s ability to engage in collaborative care. In emotionally charged situations, such as a clean-out, it is foreseeable that family members may have difficulty refraining from taking charge or making decisions on their family member’s behalf, particularly when the family is frustrated by the client’s refusal of offers of assistance.

Unsurprisingly, I saw evidence that shared decision-making strategies are more likely to occur in the context of an existing provider-client relationship developed during hoarding-related interventions prior to the clean-out. This finding parallels the results of an umbrella review of five systematic reviews and two scoping reviews. In that review, quality of the therapeutic relationship and trust in the clinician were consistently reported as facilitators of shared decision making (Alsulamy et al., 2020). A primary practice implication of the umbrella review was to encourage healthcare professionals to attend to the working alliance because of its importance in facilitating shared decision making. Communication about a client’s preferences is enabled by a high-quality relationship; without a relationship, the ability to partake in shared decision making is limited.

In addition, highly experienced hoarding services providers were better able to implement shared decision-making strategies. Possibly these providers were more knowledgeable about hoarding as a mental health disorder, which may have afforded them a deeper understanding of the client’s perspective – an empathy that may facilitate effort toward shared decision making. More advanced skills may be required to use shared decision-making practices in clean-out interventions, because most clients do not voluntarily seek the intervention.
Interestingly, when providers were able to implement shared decision-making practices, they were also likely to offer post-clean-out interventions, including emotional check-in calls and further decluttering assistance. This suggests that providers who use more shared decision-making practices also prioritize helping the client to process the emotional toll of the clean-out and supporting maintenance of the clutter reduction.

Prior to conducting the interviews, I would have thought the use of client centered strategies would differ with respect to survey participants’ disciplines. However, the interviews suggested that many providers take on multiple roles within the same clean-out (e.g., enforcement, case management, emotional support). If a mental health professional was not involved or onsite, a provider from a different background (e.g., fire prevention, housing) often took on the role of providing emotional support or trying to engage the client in decisions. For example, one pest control technician was the only individual who was willing to provide emotional support to a client undergoing a tense situation involving eviction risk. Across the interviews, there were multiple instances of providers stepping up, outside of their disciplinary training, to do the work that was required.

3.4.4 What Is the Client’s Emotional Response?

On the whole, almost half of the clients seemed very or extremely distressed by the clean-out. In several cases, client distress remained high in the aftermath of the clean-out (and eviction). As expected, most clients were not pleased or relieved to have a clean-out. However, as a whole, the ratings showed a wider range of affective response than I had anticipated based on the scoping review, which had suggested that only extremely negative emotional reactions were likely. The range in emotional responses witnessed by providers was more in line with portrayals on the television series.
What made a clean-out so distressing? Clients who had refused to engage with earlier offers of assistance, and for whom the clean-out was more non-voluntary, appeared to experience a more negative affective reaction. As described in Chapter 1, involuntary or coercive interventions have negative emotional consequences, such as humiliation, isolation, frustration, and defensiveness (Akther et al., 2019; Chieze et al., 2019). The causal direction is likely complicated: although involuntariness can give rise to distress, more distressed clients are also less likely to voluntarily engage in services. If a client is less willing to address the safety concerns in their home because of heightened distress, a provider (especially one who is less experienced with hoarding) might jump to an involuntary intervention instead of providing opportunity for a client to make their own decision.

I was surprised that shared decision making was not related to client distress. I had assumed clients would be less distressed if providers prioritized their wellbeing and autonomy during the intervention and that shared decision-making strategies would be easier to use if clients were less distressed. However, the results showed no association between shared decision making and overall client distress. This may be due to the fact that I was able to measure only the provider’s attempt at shared decision making, not whether they were successful in their implementation. Secondly, I was only able to measure the client’s apparent distress, not their actual feelings from their own perspective. Clients would obviously differ in how much they express their feelings.

Turning to practice implications, the providers suggested that most stakeholders understand that a clean-out has the potential to be emotionally damaging and would like to reduce client distress. The primary implication of the regression results is the potential for distress to be reduced by increasing a client’s degree of control over the decision to have a clean-out.
out. Although the clean-outs described in this sample often seemed unavoidable, there is often a way of providing some degree of choice to a client. One option to increase client decision-making power would be to have at least one conversation laying out possible interventions and the consequences of not engaging in said interventions. For instance, “at this current time, we would be able to offer you decluttering assistance, but if you decline this offer, we will be forced to conduct a clean-out in a few months.” Even in crisis situations in which an involuntary clean-out must occur, the client’s control can be increased by helping them to make choices about which possessions get removed.

3.4.5 What Are the Health and Safety Outcomes?

On the whole, clean-outs appeared to reduce health and safety risks and were moderately successful at preventing evictions and ensuring a safe discharge home from hospital. Clean-outs were successful, for example, in improving egress and ingress, improving mobility throughout the home, and reducing the risk of falling. Each of these outcomes is noteworthy when considering the severity of conditions prior to the clean-out. Not surprisingly, however, clean-outs did not address the psychological problems that led to the high clutter volume.

The most notable achievement was that tenancy was preserved for two-thirds of clients who had been facing eviction prior to the clean-out. Clients who were evicted had more severe conditions, and the cases were complex, often involving multiple stakeholders. Eviction was an outcome of particular consequence for the two clients who experienced homelessness. In both of these cases, providers remarked that increased tenant support could have led to better outcomes (e.g., if the tenant had lived in a 24/7 staffed building to limit acquisition or if the client’s case manager had been a better housing advocate).
In this sample, only 57% of hospitalized clients were successfully discharged home. Most of the remaining clients required a move to assisted living facilities or remained in hospital as they needed ongoing medical care, and the clean-out was not sufficient to protect especially vulnerable clients given their existing physical or cognitive conditions. Providers in these situations had to weigh the pros and cons of a client continuing to age in place versus being removed to another (safer and more sanitary) environment. These clients often presented with a complex interplay of mental health and physical symptoms, requiring individualized solutions.

Based on my impressions from the interviews and the limited data I collected regarding maintenance, clean-outs are not a permanent solution to hoarding behaviour. Aftercare and follow-up interventions are required to address the mental health symptoms that gave rise to the unsafe and unsanitary home conditions and to ensure that healthy and safe conditions are maintained.

3.4.6 Study Limitations

The primary limitation of this study was that the client’s perspective was not taken into consideration as the entire interview took place from the provider’s perspective. As a result, ratings of shared decision making represented how much effort providers believed they put into ensuring the clean-out was collaborative, not necessarily the client’s perceptions. Additionally, ratings of client distress represented the provider’s observations and understanding of their client’s displayed emotion, and therefore may not have reflected the client’s true emotional experience.

For the current study, I attempted to recruit a client sample for an interview-based survey that would mirror the provider survey and include measures of the client’s psychological experience and longer-term outcomes. Unfortunately, I was unable to recruit more than a handful
of participants. One recruitment barrier included the fact that the large majority of clients on our research registry had never had a hoarding clean-out. Furthermore, providers who had conducted clean-outs usually did not have ongoing contact with their client and therefore could not pass along information about the study. Possibly, clients who did see the study advertisement did not want to discuss their experience because it was overly distressing.

The type of clients I was trying to recruit may be especially unlikely to participate in research studies as they are experiencing severe and debilitating symptoms as well as strong societal (and self-) stigma. Based on my sample, clients who have had a clean-out are likely struggling with not just hoarding but also housing instability or health problems. Most are older adults who live alone, perhaps not the typical profile for research volunteers. Our research team had similar challenges recruiting participants for client interviews while partnering with a large affordable housing provider in the US. Despite having the housing provider’s assistance, we were not able to recruit a single resident to agree to be interviewed about their experience receiving assistance for hoarding (not specific to clean-out interventions).

Although recruiting providers who had conducted clean-out interventions was more straightforward, the final sample size of $n = 65$ was modest and may have impacted the generalizability and reliability of the study findings. Findings from certain correlational analyses and $t$-tests may reflect Type II error as I did not have enough statistical power to detect smaller effects. Future research should build upon the current study with a larger sample size to further validate the findings and enhance the generalizability of the results. Increasing sample size in future research may produce significant results that the current study was not sensitive enough to detect.
Finally, as I had no contact with the clients and the majority of providers recruited for this study were not diagnosticians, it was unclear to what extent the sample represented clients who would meet the diagnostic criteria for hoarding disorder. Without conducting a clinical interview, it was uncertain if clients had a high clutter volume due to hoarding disorder or some other reason. For example, in clean-outs conducted due to cognitive functioning concerns, cognitive impairment may have been the primary problem and hoarding only a secondary symptom.

3.4.7 Study Strengths

Prior to this study, the available evidence on clean-out interventions largely consisted of anecdotal reports or single case examples. In comparison, this study offers insight into the clean-out rationales, practices, and outcomes of 65 clean-outs. Foundational knowledge from this study can inform the practices of frontline professionals as well as the policies of public health officials. Further, the initial work to clearly define hoarding clean-outs and other related interventions (e.g., decluttering assistance, eviction clean-out, estate clean-out) can influence the focus and approach of future research into community-based interventions for hoarding.

Another strength of this study included the multidisciplinary sample. As the selection of research participants was critical to ensuring external validity (Siedlecki, 2020), it was important to recruit a wide variety of professionals. The diversity of recruitment strategies, including advertising at community hoarding talks and hoarding task force meetings, led to a range of provider disciplines and organizations, as well as a diverse collection of clean-out cases. As the primary purpose in descriptive research is to describe, it was important that efforts were made to ensure the results would generalize beyond the sample itself.
As I used an interview format, providers were encouraged to elaborate upon their answers and to provide examples which resulted in a more complete picture of each clean-out intervention. As clean-out interventions can be a sensitive topic for providers (due to the stigma associated with such an intervention), it was important to spend time establishing rapport with participants to ensure trust between interviewee and interviewer, especially as I was inquiring about the voluntariness of the intervention and the frequency of client-centered strategies used by the provider. An unexpected benefit of the interview format was having the opportunity to hear how the clean-out intervention impacted the provider (not only their client). Multiple providers recounted how the intervention temporarily affected their own well-being in a negative way. They described both the personal impact of subjecting clients to unwanted, but necessary, interventions and the lack of organizational support and assistance to ensure the best-case outcomes. For example, one provider stated she felt like her organization had “written off the client and [was] effectively dumping them”, another stated the clean-out was hard for her to emotionally process as the intervention hurt the client. As I used an interview format, I was able to provide participants with the opportunity to debrief their experience, which would not have been possible in a survey questionnaire format.

3.4.8 Future Research Directions

Even though I was not able to include the client perspective in my study, this perspective is still of utmost importance. Although several research objectives were likely more accurately answered from the perspective of the provider (e.g., why was the clean-out necessary, how was it conducted), having clients’ perspective on their emotional experience and their experience of shared decision making would have strengthened the study. In future research, interviews should aim to understand the client’s emotional experience, what went well during the intervention, and
what they would have liked the clean-out team to have done differently. Future research with a client sample should also prioritize the measurement of client satisfaction (Attkisson & Greenfield, 2004; Larsen et al., 1979) to understand how shared decision making and collaborative care relate to client perceptions of the quality of services they received. To overcome the recruitment challenges I experienced, one possibility would be to partner with a clean-out company who has a vested interest in assessing client satisfaction.

Previous literature on shared decision making in mental health contexts reported that patients who received involuntary treatment report the lowest levels of shared decision making and show the highest discrepancy between provider and client report (Drivenes et al., 2020). As the current evidence on shared decision making is largely based on primary care or inpatient mental health settings, it would be useful to continue to better understand shared decision-making practices that are transferable to clean-out interventions. Additional research into the barriers and facilitators of shared decision making and other client-centered strategies would be welcome. For instance, among physicians, time pressure is the primary barrier to shared decision making (Alsulamy et al., 2020); perhaps an imminent and inflexible timeline for change influences the use of such practices more broadly. Additionally, provider perceptions have been found to greatly influence the use of shared decision-making practices. Hoarding professionals’ perceptions of the relevance and feasibility of shared decision making could be investigated further.

Future research should also focus on systematically documenting the outcomes of clean-out interventions. In addition to focusing on how quickly clutter re-accumulates, research questions could include discovering the strategies clients use to maintain the changes achieved by the clean-out and what challenges clients encountered with the unfamiliarity and distress
associated with having empty space in their home. Possible solutions to overcoming the recruitment barriers I encountered might be to recruit family members who have participated in clean-outs and continue to maintain a supportive relationship with their loved one. Providers in this study suggested the importance of future research questions including how to increase the likelihood that gains will be maintained, which clients benefit from a clean-out, whether harm reduction approaches have better outcomes, and whether the addition of mental health services improves outcomes and maintenance of clutter reduction.

One clear finding from this chapter was that a client-centered approach to clean-out interventions is possible, however community providers would greatly benefit from understanding how to navigate challenging situations of client refusal, especially how to increase cooperation in crisis situations. As clean-outs are a multidisciplinary intervention, any practice recommendations must be suitable for providers coming from a variety of training backgrounds. Chapter 4 will provide an in-depth look into other macro- and microsystem challenges involved in conducting clean-outs. Chapter 5 consists of my concrete recommendations for a client-centered clean-out based on the evidence acquired through this dissertation.
Chapter 4: Discussion

In Chapters 2 and 3, using a scoping review and an interview-based survey, I examined the factors precipitating clean-outs, characterized the intensity of intervention practices, explored client-centered strategies that were in use, and examined immediate affective, health, and safety outcomes, with a special focus on eviction.

As a PhD student partially funded by the UBC Public Scholars Initiative, I followed a public scholarship approach by drawing from community practitioner knowledge in the scoping review and by engaging in community-based research through collaborations with frontline workers. I contributed to public discourse on the subject of hoarding by producing a research report and toolkit of best practices to be used by providers in the public domain (see Chapter 5).

As defined in the Oxford Handbook of Methods for Public Scholarship, public scholarship “circulates outside of the academy in accessible formats and is useful to relevant stakeholders” (Leavy, 2019). This dissertation shows the results of community-university interactions that go beyond traditional disciplinary boundaries to not only add to the existing research around hoarding but also to directly influence practice in the field.

This discussion chapter will examine challenges related to clean-outs at both the macro- and microsystem levels (Bronfenbrenner, 1979). The person-in-environment conceptual framework highlights the importance of considering an individual within the context of their environment (Bronfenbrenner, 1979). As the psychological symptoms of hoarding disorder (i.e., excessive acquisition and difficulty discarding) manifest in the excessive accumulation of clutter in the home environment as well as health and safety risks affecting the individual and neighbouring tenants, such a perspective is highly relevant to the discussion of clean-out interventions.
Hoarding clients and clean-out professionals are embedded within a macrosystem that includes challenges at the community, management, and policy practice level (Reisch, 2016; Rothman & Mizrahi, 2014). Accordingly, action needs to be taken at both the macro- and microsystem levels to effect lasting change while improving the client experience of one-to-one interventions (Reisch, 2016; Rothman & Mizrahi, 2014). This chapter will offer recommendations to address the wider system challenges, followed by a discussion of the specific intervention challenges experienced by providers at the micro-level. I will conclude with a set of practice recommendations based on my personal reflections, my experience in the field, and provider input from the interview-based survey.

4.1 Macrosystem Challenges and Recommendations

4.1.1 Clean-Outs Occur During Crisis Situations

As evident in both the scoping review and interview-based survey, most clean-outs occur during a crisis. These situations create an urgency to prevent eviction, safely discharge clients from hospital, treat severe pest infestations, or address dangerous safety and sanitation concerns. In many cases, a clean-out is used as a last resort because clients previously have been unwilling or unable to address hazardous health and safety concerns. Once a hoarding situation has reached a crisis point, it is hard to avoid a clean-out intervention. One provider stated, “I wish these situations wouldn’t come to a crisis. I wish the client came to the realization that an intervention needed to be done before it got to this crisis point.”

The high stakes in these situations make it more challenging to use client-centered strategies, as a rapid resolution in the form of a clean-out is needed to protect the health and safety of the client (and neighbouring tenants) and to prevent the escalation of risk. Client-centered strategies, such as shared decision making and client participation in sorting or removal,
take time to implement. Several providers noted more time would have improved the client’s experience, for example, “I would have liked more time to talk to the client to understand their story”, or, “I would have loved the time to address the underlying issue”. In the provider study, most clients did not receive any hoarding-specific intervention (e.g., decluttering assistance, peer-support group, CBT) prior to the clean-out. As the level of risk was high, the urgency of the situation precluded a more gradual or lower-intensity approach.

It can be difficult to provide the best care for clients in these emergency situations. Several providers said they did everything they could to help their clients within the constraints of the situation. In one example, it would have been helpful to have had a family member from out of town join on the day, but the limitations of the situation made this impossible. Even a dedicated and compassionate clean-out team can find it challenging to obtain desirable outcomes in a crisis situation (i.e., a client who is satisfied with the clean-out process and who retains their housing). As described in the interview-based survey, most clients were highly distressed about having a clean-out intervention, and clean-outs were not always successful in preventing eviction.

The urgency of hoarding situations may not be unique to clients undergoing a clean-out intervention, as by the time most community hoarding cases come to attention, clients often present with a complex and severe set of problems. For example, a qualitative study detailing the experience of safeguarding managers who were intervening in cases of hoarding (through adult protective services), found that by the time hoarding behaviour is discovered, a crisis response may be all that is offered (Owen et al., 2022). Relatedly, a study from Spain looked at the prevalence of hoarding behaviour in clients who were suspected to have a mental illness and refused to participate in outpatient follow-up; of the clients diagnosed with hoarding disorder, the
median duration of hoarding behaviour was 15 years (Córcoles et al., 2023). In other words, these clients went an average of 15 years without diagnosis or treatment for their hoarding behaviour. This is concerning as hoarding typically follows a chronic and worsening course over time (Tolin, Meunier, et al., 2010).

Earlier detection and intervention of these cases is likely limited by social stigma. Hoarding is a stigmatized condition, which decreases the likelihood that individuals will reach out for help before their situation is in crisis (e.g., before receiving an eviction notice). The public perception of hoarding is that it is a problem of laziness, one caused by personal failings, and one that often coincides with the presence of unsanitary conditions in the home (Bratiotis & Woody, 2020). Results of a study on the public perception of hoarding found that watching an episode of A&E’s *Hoarders*, compared to watching an episode of a home design show, increased stigmatized perceptions of hoarding (Bates et al., 2020). Specifically, participants who watched *Hoarders* reported increases in the social distance they desire from a person with hoarding disorder, as well as increases in the belief that someone with hoarding disorder is different compared to the general population and is a greater threat to society.

Many individuals with hoarding try to avoid social stigma by preventing friends, family, and building professionals from entering their home. Social stigma triggers powerful feelings of shame which often develop into self-stigma if an individual adopts the negative judgements of others into their self-concept (Allport, 1954; Crocker & Major, 1989; Lucksted & Drapalski, 2015). In turn, social and self-stigma translate to reduced treatment seeking (Akdağ et al., 2018; Livingston & Boyd, 2010; Regan et al., 2017).
4.1.1.1 Recommendation for Change: Screening and Early Intervention

Several clean-out providers wished they could have intervened earlier, stating “it would be better to have more supports earlier to try to make the best of a bad situation”, or “I wish the client had accepted home health support and that we had found ways for treatment earlier and if the client would have cooperated with us earlier.” Clean-out interventions are perceived as a first-line intervention based on their depiction in reality television shows. However, due to the stressful, fast-paced nature of clean-outs and the limited degree of client involvement, it would be preferable if clean-outs were not the first hoarding intervention clients experience. Solutions are needed to prevent hoarding situations from reaching such a critical intervention point, and to preclude the need for clean-out interventions altogether.

One possible way to prevent crisis situations would be to implement regular screening by physicians or nurse practitioners in primary care. Primary care is often the first point of contact within the healthcare system and is accessible by most population subgroups (Starfield et al., 2005). The role of family physicians in the detection and intervention of hoarding has been receiving increasing attention (Frank & Misiaszek, 2012; Morein-Zamir & Ahluwalia, 2023). Although family physicians would not be involved in hoarding intervention directly, they could play an important role in the detection of poor living conditions, including excessive clutter and poor sanitation. If hoarding behaviours were suspected based on the screening tools, a follow up home visit by a community health practitioner could be arranged to assess conditions in the home. As primary care practitioners have a large role in primary prevention (Starfield et al., 2005), they should be well-positioned to assist in the detection of hoarding.

The reality, however, is that hoarding cases in the current system are rarely discovered by primary care staff or indeed by mental health professionals (Córcoles et al., 2023; McGuire et al.,
Frontline professionals who regularly enter homes to offer home-based services or to respond to emergencies are better positioned to detect hoarding cases. Paramedics, fire prevention officers, police officers, home health aides, and personal care assistants inadvertently encounter hoarding in their routine work and would therefore benefit from mental health training on how to assess both hoarding behaviour and functional impairment in the home using standardized tools, such as the Clutter Image Rating scale (Frost et al., 2008) and the Activities of Daily Living-Hoarding scale (Frost et al., 2013). A professional (with appropriate training) who has access to the home could quickly and accurately screen for hoarding.

Improvements in early detection of hoarding behaviour would also need to coincide with improvements in the accessibility and availability of hoarding intervention options as well as trained personnel to provide them. If additional resources were devoted to hoarding at the community level, more clients could be offered lower-intensity interventions, such as decluttering assistance, family coaching, or peer-support, to prevent the need for a clean-out or at least to diminish the intensity of one carried out in a crisis. However, as described in the next section, there is no simple solution with regard to the allocation of additional resources.

4.1.2 Mental Health Treatment for Hoarding is Often Unavailable

As I concluded in the scoping review and interview-based survey, clean-outs do not address the psychological symptoms underlying the accumulation of clutter. As hoarding is a mental health disorder, one would expect clean-outs to be used in the context of a broader range of mental health supports; unfortunately, this is rarely the case. The clean-out teams I studied frequently lacked a mental health professional, and only a handful of clients were offered a mental health intervention before or after the clean-out. Without some degree of mental health support, the psychological symptoms of hoarding disorder remain untreated. Further, without
addressing the psychological symptoms, any changes achieved by the clean-out intervention are
difficult to maintain. Clients need to learn how to challenge unhelpful thoughts (e.g., I can’t get
rid of this cookbook because I may need it in the future) and tolerate emotional distress (e.g., by
learning that the discomfort associated with discarding a possession lessens over time). In
addition, clients need help to develop decision-making and decluttering skills to keep their home
in a condition that allows them to meet their own living goals and also to keep the threat of
eviction at bay.

Several providers expressed a wish that more mental health support had been available
for the client. Providers wished they had connected their client to mental health services earlier,
coordinated mental health assistance for the day of the clean-out, and organized resources to
address mental health needs following the clean-out. One provider said, “It would have been
helpful to have a counsellor join the intervention to do mental health work with both the client
and his wife. It would have been helpful to address the underlying causes and to treat the client’s
anxiety, PTSD, and trauma.”

One social housing provider stated her “biggest frustration is that our mental health
services do not recognize that hoarding is a mental health problem that they can deal with. They
say it ‘requires specialized training’, so they don't get involved. There are no services - and the
services that could address it - don't do it!” She also noted that providers need to “cross the
threshold - you can't treat hoarding without being in the home.” Few professionals are trained
and willing to treat hoarding disorder, and many mental health practitioners consider the
treatment of hoarding outside their general scope. Additionally, mental health professionals may
be unwilling to participate in clean-outs, due to occupational risks such as bringing home
bedbugs.
Hoarding clients do not receive adequate care for their mental health needs, and in the context of the current mental health system, with its insufficient resources and paucity of trained professionals, they are not alone. The percentage of Canadians who meet diagnostic criteria for a major depressive episode, bipolar disorder, or generalized anxiety disorder (GAD) has increased in the past 10 years (e.g., prevalence of GAD in 2012 was 2.5%, compared to 5% in 2022; Stephenson, 2023), but the availability of mental health services has not kept pace. More than one in three Canadians who have been diagnosed with a mental health disorder report unmet mental health care needs (e.g., inadequate provision of medication, information, or counselling; Stephenson, 2023). More specifically, in Canada only 50% of individuals experiencing a major depressive episode received “potentially adequate care” defined as taking an antidepressant or attending six or more visits with a health professional, such as a psychiatrist, psychologist, or social worker (Patten et al., 2016). Any system change for hoarding disorder must be made possible within this already strapped and overburdened mental health care system.

**4.1.2.1 Recommendation for Change: Availability of Hoarding-Specific Supports**

As clean-outs are an emotionally draining and intense intervention, a client would benefit greatly from having a trained clinician on-site, as well as access to mental health services before and after the clean-out. Ideally, clean-outs would be followed by a structured mental health intervention, such as individual or group cognitive behavioural therapy for hoarding, or a peer-led structured support group (such as *Buried in Treasures*). Although these treatments are evidence-based (Tolin et al., 2015) and have demonstrated feasibility in both virtual and in-person formats (Muroff & Steketee, 2018), few mental health providers in Canada are qualified to provide them.
In place of (or in addition to) a formal mental health intervention, a decluttering assistance program could be implemented to ensure the maintenance of health and safety gains achieved during the clean-out. One program like this in the UK is called Clutter Buddies (Crone et al., 2020). This is a volunteer program whereby two students visit the client in their home to do in-home decluttering work as an adjunct to group cognitive behavioural therapy. The program is intended to help hoarding clients feel supported and encouraged to do regular decluttering work. This type of program would be relatively inexpensive and much easier to administer, in comparison to a clean-out. The challenges include finding experts in hoarding interventions who can train volunteers, as well as finding clients who are willing to have volunteers come into their homes. At the very least, ongoing monitoring by a frontline professional in housing, fire prevention, or nursing would still provide significant benefits, including consistent oversight and an opportunity to mitigate risk before the necessity of a clean-out arrived.

4.1.3 Organizational Support is Inadequate

One common factor related to burnout across multiple disciplines (e.g., nurses, hotel employees, police officers) is the level of perceived organizational support (Cheng & O-Yang, 2018; Sheng et al., 2023; Zeng et al., 2020). In clean-out interventions, the lack of organizational support for providers is initially evident in the lack of training they receive in preparation for dealing with hoarding disorder. Despite hoarding being a complex mental health disorder, most providers who encounter hoarding during their day-to-day job duties have not had specific training on the assessment or intervention of hoarding disorder. This lack of training is evident across disciplines (e.g., emergency responders, older adult service providers).

One study reported that providers felt more frustrated, irritated, and hopeless or helpless in their efforts to help clients who hoard compared to non-hoarding clients (Tolin et al., 2012).
During my interview-based survey, several providers mentioned the emotional toll they experienced from conducting such an intervention. Providers would benefit from organizational support to receive appropriate training and to debrief particularly challenging cases.

In addition to the lack of support for professionals, there are limited funds accessible to community members to pay for clean-outs even when they are necessary for imminent health and safety risks. Many providers reported that they devoted significant energy to applying for small grants to ensure clean-outs would be funded. Other providers who traditionally would not have taken a hands-on role, such as property managers and psychiatric nurses, helped to physically remove possessions, sanitize, and organize to avoid additional costs to the client. Further, providers in my study indicated that they wanted to provide clients experiencing clean-outs with more support (e.g., mental health, maintenance services), but they could not do so as their organizations were not willing to devote increased resources to these clients or to hoarding as a problem. Time constraints imposed by organizations on the duration of client interactions, also present as critical barriers in the use of shared decision making (Alsubamy et al., 2020).

4.1.3.1 Recommendation for Change: Training and Resources

Workshops focused on educating professionals about the psychopathology of hoarding, as well as specific practice recommendations around client-centered care and harm reduction, would have a large impact on how clean-out interventions are conducted. As evidence of this, one provider mentioned that following the clean-out she attended a hoarding conference, and, based on the information she learned, she would have conducted the clean-out differently. Specifically, she would have asked which items were very important to the client and reassured her that those items would be set aside. She also would have “acknowledged this was a time of great anxiety” and would have been much more sensitive to how difficult it would be for the
client. As evidenced by the association between shared decision making and provider experience, having more knowledge about hoarding may promote providers’ use of client-centered practices.

In order to better support providers, the practice of debriefing could be implemented at an organizational level. Debriefing following a clean-out can offer providers validation, reassurance, and encouragement, while reducing provider demoralization or burn-out (Aggett & Goldberg, 2005; Dimeff et al., 2000; Smith et al., 2023). Providers could also benefit from developing a community of practice related to conducting clean-outs. In this context, a community of practice is a group of health care workers who share “a common domain of interest in which they collaborate to enhance the practice, promote professional expertise, and augment institutional knowledge” (Seibert, 2015). A clean-out community of practice would enable dialogue among multidisciplinary professionals to provide support and to promote the spread of best practices in clean-out interventions. Organizational support offered through these avenues is critical to help individual providers maintain hope in the face of such a complex and often intractable problem.

4.1.4 Clean-Outs Are Not Regulated

Protocols, regulations, or procedures govern most involuntary interventions or coercive practices, and there is usually a mechanism for oversight or judicial review. In British Columbia, for instance, patients have the legal right to challenge a physician’s certification decision to admit them involuntarily to a designated facility, by attending a hearing with someone from the Mental Health Review Board (Ministry of Health, 2005). Regulations governing involuntary hospitalization in Canada have transformed drastically over the past 70 years. A landmark change occurred in 1967 when involuntary admission was no longer permitted in cases of a “psychiatric disorder which required observation, care, and treatment”; rather, involuntary
hospitalization was only deemed legitimate if the client was at risk of endangering their own safety or the safety of others (Government of Canada, 2023).

This regulatory process is in stark contrast to clean-out interventions which are unregulated, despite often being of an involuntary nature. As demonstrated in both Chapters 2 and 3, clean-outs are frequently not the decision of the client, but are enforced due to external pressures, such as a threat of eviction or the need to be safely discharged from hospital. Clean-outs involve a serious infringement on the autonomy and dignity of clients due to the fast-paced (and at times non-consensual) removal of possessions from their homes.

A lack of regulation means a lack of oversight. Clean-outs may be conducted in situations when they are unwarranted, such as when health and safety risks in the home are neither imminent nor in violation of local fire or property law codes and a lower-intensity intervention such as decluttering assistance would be more appropriate. Hoarding clients are particularly vulnerable as most providers lack hoarding-specific training and are working without any real guidance or procedures to follow.

The lack of guidelines and protocols governing clean-outs may be a reflection of the fact that hoarding disorder has only recently gained legitimacy as a mental health disorder. Hoarding disorder was not codified in the Diagnostic and Statistical Manual of Mental Disorders as a discrete disorder until 2013 (DSM-5). As such, the field of hoarding is relatively new; no single discipline has taken ownership or accountability for hoarding, and the challenge of developing guidelines for such a multidisciplinary group is evident. Further, private for-profit cleaning companies tend to be one of the main players in clean-out interventions; it is not in their business interest to help develop guidelines that would add restrictions to the use of hoarding clean-outs.
4.1.4.1 Recommendation for Change: Regulation of Clean-Out Interventions

Effective guidelines for clean-out interventions would first include clear criteria for when a clean-out intervention is indicated and contraindicated. I have developed a set of questions that providers from any discipline can use to determine the appropriateness of a clean-out intervention (see Chapter 5). Questions focus on the presence of major health and safety risks, the client’s cognitive capacity, and the urgency of the timeline required to remediate risks.

If a clean-out were indicated, a standardized clean-out protocol would include a defined timeline and due process to warn clients of the necessity of a clean-out unless the risks were remediated. The process used to warn a tenant of their eviction risk and to allow time for remediation could be adapted for a clean-out situation, for instance initially giving clients a warning, then posting a clean-out notice, followed by scheduling and enacting the clean-out.

Regulations would also require verbal and written documentation of the specific risks requiring immediate remediation in the home (e.g., blocked egress, pathways less than three feet wide, combustible items stored near or on heat sources, insect or rodent infestation, spoiled or rotting food). Such an approach would involve following the principles of harm reduction for hoarding. A regulated clean-out would involve pre-determined standards for when the clean-out should end. Clean-out professionals would be tasked with identifying and communicating the “non-negotiables” that need to be achieved to satisfy external pressures.

Finally, regulations would include a mechanism for clients to appeal a clean-out decision or seek redress if their items have been removed without due process. Existing processes for judicial review in cases of eviction or involuntary hospitalization could be used as a foundation from which to work, although challenges would exist in terms of establishing a shared mandate among multidisciplinary teams.
4.2 Microsystem Challenges and Practice Recommendations

The final section of this chapter will focus on practice recommendations for hoarding clean-outs. In response to the system limitations described earlier, the ideal clean-out intervention would take place with a trained and respectful clean-out crew, over a sufficient time period, and with adequate funding. The process for the clean-out would be regulated and the client would have voluntarily agreed to the clean-out and would have been informed of the timeline. They would have had prior decluttering support and access to mental health care before, during, and after the clean-out. Unfortunately, such a clean-out is not feasible within the current unregulated, poorly supported system nor within the context of clean-outs that occur in response to a crisis. However, this chapter offers some foundational principles and practical tools that could guide clean-outs in the future.

The current clean-out practices are problematic for the majority of clients. In the interview-based study, for example, a large proportion of clients had poor engagement, were not sufficiently involved in the intervention, and were highly distressed. I offer guidelines based on provider recommendations and literature from similar client populations (e.g., community mental health, severe mental illness) to support practitioners in how to conduct these interventions in a more client-centered way.

4.2.1 Foundational Principles

The principles of harm reduction and client-centered care serve as a foundation for all practice recommendations. Within clean-outs, the principle of harm reduction is applied by removing only as many possessions as required to address the potential harm that is at issue, thereby achieving minimum health and safety standards. Harm reduction often involves advocacy work. For example, a provider may need to gain agreement with the landlord about
what needs to happen to preserve a client’s tenancy – and then do no more than that. The harm reduction goals for a given case may stop short of addressing all the major health and safety risks. The goals in some cases would be simply to do enough to satisfy the external pressure (e.g., pass the fire inspection) while allowing the client to retain decision-making power about their other health and safety risks (e.g., the place may still be extremely unsanitary). Although during my interviews, some providers mentioned harm reduction goals related to clutter removal, this was not a universal consideration. To ensure providers have a full understanding of what harm reduction means in relation to hoarding and how to apply it to clean-out interventions, I created the toolkit (see Chapter 5).

The principle of client-centered care aims to treat clients with respect and to preserve their autonomy and dignity as much as possible. This principle is challenging to uphold when considering the conflicting pressures in clean-out interventions. A provider may need to balance the interests of multiple stakeholders, while protecting the health and safety of the client, neighbouring residents, and first responders who enter the home. In most mental health interventions, the provider’s responsibility and attention is primarily devoted to the client. For instance, in the Canadian Code of Ethics for Psychologists the principle of Respect for the Dignity of Persons and Peoples is given the highest weight. When there is a conflict between the welfare of an individual and the greater good of society, a psychologist’s ethical obligation is to the client (Canadian Psychological Association, 2017). In clean-out interventions, these conflicts may be more pronounced and difficult to navigate.

It may also be challenging for certain professionals to embrace a client-centered clean-out approach because they do not understand their client’s behaviour. The first time a professional enters a hoarded home they may be unaware that hoarding is a mental health disorder and that
the client may willingly choose and prefer to live in conditions that the provider would personally find unacceptable or undesirable. Learning about hoarding as a mental health disorder and developing empathy for a client undergoing a clean-out intervention would facilitate a more client-centered approach. A provider could consider the impact of losing possessions in a natural disaster, such as a flood or fire; the imagined loss would be devastating. Another way to generate empathy would be to consider an involuntary or coerced clean-out as a traumatic and highly distressing event involving a significant loss of control.

Client-centered and harm reduction principles can be applied in tandem to ensure the best possible experience for the client. Informed by these foundational principles, providers may use core clinical strategies including informed consent, development of a working alliance, motivational interviewing, shared decision making, and de-escalation.

4.2.2 Informed Consent

Informed consent is one of the primary principles underlying ethics in healthcare and is a legal right for all Canadian healthcare clients (Health Care and Care Facility Act, 2024). However, in provider interviews and the scoping review, the explicit process of obtaining informed consent for a clean-out was not mentioned. Informed consent may not be a common practice in clean-out interventions, because the procedure is unfamiliar to clean-out professionals who come from a non-healthcare background (e.g., cleaning staff, fire prevention officers, landlords). Even for healthcare professionals, informed consent may not be an automatic procedure in the same way as it is used in other interventions (e.g., pharmacotherapy, psychotherapy, medical procedure).

Most providers in the interview study did offer a rationale for the clean-out intervention to their client, but it was unclear how much they focused on the client’s comprehension of the
rationale and the voluntariness of consent. Some clients may feel coerced into consenting because the consequences of refusing are so dire (e.g., eviction). The power dynamic in these situations cannot be ignored. Similar conflicts occur in other mental health settings, for instance patients in forensic mental health services are given the opportunity to provide informed consent to engage with psychologists on staff; however, the consequences of not consenting include appearing “less engaged”, which may negatively influence their progress through the forensic system (Simms-Sawyers et al., 2020). The challenges of navigating voluntariness within the constraints of a clean-out situation are evident. To obtain informed consent, providers may choose to follow the protocol I offer in the Best Practice toolkit (see Chapter 5).

4.2.3 Development of a Working Alliance

The working alliance or therapeutic relationship is the foundation of all practice recommendations suggested in this chapter. Therapeutic relationships are important in all forms of psychotherapy for all mental health problems and the alliance is the strongest and most consistent predictor of treatment outcome (Horvath et al., 2011). In a meta-analysis of over 200 research reports on the alliance from a variety of theoretical orientations (e.g., CBT, IPT, psychodynamic), the overall relation between the alliance and treatment outcome was $r = .28$ (Horvath et al., 2011). The concept of the working alliance can apply directly to the broad range of professionals who work with hoarding, even those from a non-mental health discipline. Investing time into the development of a strong relationship has positive outcomes beyond those in psychotherapy.

The importance of the working alliance has been documented in non-clinical settings as well. In a longitudinal study, Sturm et al. (2022) examined the influence of the working alliance within the judicial system. They found the working alliance between probation officers and
individuals convicted of a crime was a significant predictor of recidivism over a 4-year follow-up period, even when controlling for criminal history, age, gender, ethnicity, family status, employment, and addiction problems. Similarly, in police investigative interviewing, the rapport between police officer and interviewee (suspect or witness) is recognized as a key feature in the “success or failure” of an investigative interview (Holmberg, 2013). In a study on 126 police interviews, the working alliance was positively correlated with the investigator’s self-reported empathy for the interviewee and the use of a humanitarian interviewing style (an investigation style that prioritizes personal interest and positive attitude compared to aggression or a condemning attitude; Vanderhallen et al., 2011). Study findings illuminate the challenges of establishing a working alliance when police officers may not empathize with their interviewee. This is especially important, as other studies have found the level of rapport correlates with interviewees providing greater amounts of information, more accurate information, and more admissions of crime (Collins et al., 2002; Holmberg & Christianson, 2002).

Establishing a strong alliance can be difficult with hoarding clients. Not only is poor insight a clinical feature of the disorder, but it can be very challenging for clients to establish trust due to past experiences of criticism and social stigma. In a study on healthcare and social service professionals’ views of working with hoarding, a poorer working alliance was reported for hoarding clients compared to non-hoarding clients (Tolin et al., 2012). In this study, working alliance was positively related to the client’s understanding of the treatment rationale, insight into the nature of their problem and its impact on others, and active participation in treatment (Tolin et al., 2012). The clean-out context has challenges in all of these areas.

Although a strong relationship may be difficult to foster, multiple interview participants described the importance of the relationship. For example, one provider noted their client only
agreed to the clean-out after she had spent significant time building a trusting relationship. Another stated that the client felt respected during the process because the team did not use stigmatizing language and seemed trustworthy. Some providers made in-roads with engagement by taking interest in the client. For example, one client was not willing to accept help until their provider asked to meet their cat. That was the “in” to establishing rapport and later conducting a clean-out intervention that greatly improved the client’s health and safety.

For a clean-out team, spending time getting to know the client, embracing a warm, open, and respectful communication style, and being willing to address client needs can be useful in establishing a working alliance. The professional characteristics of flexibility and responsivity can be crucially important to building such an alliance. Additionally, a strong rapport may be developed by communicating safety concerns openly while providing clear information (verbally and in a written format) about the clean-out process.

In clean-out interventions, difficulty with engagement and the establishment of a bond between client and provider can manifest in many forms. A client may demonstrate a lack of engagement by avoiding contact (e.g., not answering their phone or answering the door), refusing to consent to a clean-out despite imminent consequences (e.g., eviction), declining to discuss their role in the clean-out or their goals, being unwilling to identify anything they want to keep, refusing to interact with the clean-out team during the clean-out, or deciding to prematurely stop the clean-out before it is complete. Client engagement may also change over the course of the intervention. Clients might start out more willing to converse, but may shut down over time.

Challenges with client engagement are a common experience for all hoarding providers, not only those who conduct clean-outs. In my time as an embedded researcher on the Vancouver
Hoarding Action and Response Team, 21% of clients who had initially consented to intervention later withdrew their engagement before meeting harm reduction goals (Kysow et al., 2020). Team members labelled this concept as “reached impasse”. These clients tended to avoid phone contact and would cancel or not show up for home inspections. Similarly, in cognitive behavioural trials, challenges with session attendance and homework completion have led to substantial attrition (Tolin et al., 2019).

Although it would be easy to assume from the provider’s perspective that “these clients were just being difficult”, we need to understand why hoarding clients refuse to engage. To begin, hoarding clients experience high levels of functional impairment and are often managing multiple comorbidities (e.g., depression, anxiety, medical complexities) and psychosocial challenges (e.g., housing insecurity). Additionally, there are several possible psychological explanations for refusal to engage. Poor insight may hamper engagement because hoarding clients do not appreciate the severity of health and safety concerns in their home (Frost et al., 2010; Tolin, Fitch, et al., 2010). If they believe their home is safe, they will likely be resistant to engaging in any interventions, especially a clean-out. One provider described a client who was unwilling to meet the landlord’s requests for a year because he did not agree there was a problem. He was eventually evicted. The severity of hoarding symptoms is also associated with more self-criticism and shame (Chou et al., 2018), which may hinder the development of a therapeutic relationship because clients may feel embarrassed about their poor living conditions. Furthermore, if clients feel incapable of change, they may refuse to engage with professionals because from their outlook the situation is hopeless.
The following strategies to address client reluctance to engage are borrowed from other hard-to-reach populations, including clients with severe mental illness and clients with substance use who have episodic engagement in therapy. Primary recommendations include:

1) Increasing the amount of contact providers have with hard to reach hoarding clients, for example, by making home visits on a regular and predictable basis, scheduling check-in phone calls, or having contact via email leading up to the clean-out (Aggett & Goldberg, 2005; Dimeff et al., 2000; George et al., 2016).

2) Continuing to be persistent, even if initial engagement strategies are not successful. It is impossible for practitioners to accurately predict when a hoarding client will or will not engage. An exception to this strategy is if the client has clearly communicated a definitive refusal of services (Aggett & Goldberg, 2005; George et al., 2016; Smith et al., 2023).

3) Maintaining realistic expectations of client engagement by acknowledging that clients are dealing with complex challenges and may not be able to engage at a high level (George et al., 2016).

4) Demonstrating sensitivity to client boundaries and respecting the client’s rights to decline services. Following the principle of harm reduction, providers must respect their client’s autonomy to make a choice, even one that may lead to undesirable consequences (George et al., 2016; Kleinig, 2008).

4.2.4 Motivational Interviewing

Client’s poor insight into health and safety risks, as well as persistent ambivalence about changing their home conditions, are challenging barriers for hoarding professionals to overcome (Frost et al., 2010; Tolin et al., 2012). Many clinicians reflect on the transtheoretical model of
change when motivational challenges arise (Prochaska et al., 1992). Alongside the stages of change model, Miller and Rollnick (1991) developed the counselling style of motivational interviewing which “emphasizes using empathic listening to minimize resistance and increase motivation for change”. Motivational interviewing is designed to help clients acknowledge and address their own ambivalence about the situation they are in and the possibility of changing it.

Such an approach has proven successful in other disorders involving resistance to change, including anorexia nervosa (Geller & Drab, 1999) and substance use (Killeen et al., 2014). The ego-syntonic beliefs of clients with anorexia nervosa (e.g., that their disorder helps them achieve stability and safety) are a key component in symptom maintenance and treatment ambivalence (Gregertsen et al., 2017). Correspondingly, in substance use disorder, individuals with lower insight into their problems had more difficulty maintaining motivation once treatment began (Castine et al., 2019). Motivation in clean-out cases and other disorders affected by low motivation to change, such as substance use and eating disorders, is often extrinsic, for example to reduce family conflict, eviction risk, or neighbour complaints.

Newer treatment approaches for hoarding are incorporating motivational interviewing to reduce treatment attrition. For example, in one group cognitive behavioural treatment protocol, session time is dedicated to weighing the pros and cons of behavioural change, exploring goals and values, and highlighting the discrepancy between the client’s current behaviours and their desired goals or values (Tolin et al., 2019). Hoarding providers are interested in implementing motivational interviewing strategies, for instance, one provider stated that the client’s experience would have been better, if she had had the time to talk to the client about their clean-out with a view to increasing their motivation.
Motivational interviewing has been used in hoarding interventions by non-mental health professionals, indicating its relevance for clean-outs. For example, Williams et al. (2022) used a five-day training on motivational interviewing to train 26 equine welfare officers on how to intervene in cases of equine hoarding. The training prioritized active listening skills, psychoeducation relevant to mental health and animal hoarding, discussion about behaviour change, and skills practice. Participants were encouraged to develop empathy for the animal owners by considering the underlying reasons driving animal hoarding (e.g., dysfunctional belief systems, childhood trauma, attachment problems). Participants provided follow-up qualitative feedback several months later during a review of how participants put the training into practice. Using a motivational interviewing approach, officers stated engagement with owners was easier and more collaborative (Williams et al., 2022). Several of their clients (who would meet criteria for animal hoarding) were willing to relinquish their horses following the opportunity to openly discuss their situation and discuss the consequences of their behaviour with a curious and non-judgmental officer. A comparable workshop on motivational interviewing for clean-out professionals would assist practitioners in addressing their client’s ambivalence and may be useful for providers who are feeling frustrated and overwhelmed by the lack of change in their client’s homes. However, the investment in a five-day training course would require substantial resources.

4.2.5 Shared Decision Making

Shared decision making is a key strategy for community practitioners during clean-out interventions and follows the principle of client-centered care. As described in Chapter 1, the National Institute for Health and Care Excellence (NICE) includes shared decision making in its clinical practice guidelines for healthcare professionals. The benefits of shared decision making
on an individual’s experience of the health care system are clear; the practice ensures clients understand the risks, benefits, and possible consequences of different intervention options. It also empowers clients to ask questions of health care experts and to tailor treatment options for their individual needs. To incorporate shared decision making into their routine client interactions, a professional must respect the client’s concerns or opinions and recognize clients’ rights to be involved (Alsulamy et al., 2020). Although these professional beliefs may be second nature to healthcare professionals, those in enforcement disciplines (e.g., police, fire protection, property use, bylaw enforcement) may struggle to perceive the utility of shared decision making if their training supported a more authoritarian style. Especially when public health and safety is a risk, it may be understandably challenging for enforcement professionals to uphold their duty to public safety while collaboratively engaging with the individual client in front of them.

In terms of applying shared decision making to a greater extent in clean-out interventions, providers in Chapter 3 suggested involving the client in more decisions about which possessions were removed and spending more time connecting with the client and listening to their concerns. Multiple providers stated the wish that their client could have been on-site for the intervention. For example, one provider stated it would have been better for the client’s ongoing hoarding behaviour if they had been on-site and if she could have made more of the discard or keep decisions. Similarly, another provider stated having the client on-site would have given her “more piece of mind and more ownership over what was happening”. Several providers also indicated that having a smaller clean-out team and extending the removal process over a longer duration would have afforded the client more opportunities to be involved in the process.
4.2.6 De-escalation

When hoarding clients experience fear around a lack of control, sadness at being in a crisis situation, or anger due to the loss of their possessions, emotional dysregulation is a likely result. For example, in one case a client had agreed to help with the removal process, but became angry during the clean-out and left. Staff in this case were worried he would become violent and considered calling the police. In another case, the client started yelling at the clean-out team and threatening to “sue the city”. Despite being evicted, this client refused to leave their home until a sheriff arrived to change the locks. Clearly, professionals need strategies to work with clients experiencing extreme distress during clean-out interventions.

Although de-escalation strategies are commonly associated with reducing or averting violence (an unlikely consequence in most of the clean-outs I studied), they can also be used to reduce heightened negative emotions (Spielfogel & McMillen, 2017). The National Institute for Health and Care Excellence (NICE) defines de-escalation as “the use of techniques (including verbal and non-verbal communication skills) aimed at defusing anger and averting aggression” (NICE, 2015). Two important goals of de-escalation are to reduce the use of coercive or harsh responses to perceived conflict, and to reduce the intensity of negative emotions present in the situation (Spielfogel & McMillen, 2017).

Several components of de-escalation, often used in inpatient settings, may be relevant in high-distress clean-out situations; these include assessment (e.g., observing and recognizing early warning signs of aggression), communication (e.g., using an appropriate tone of voice; exploring opportunities for agreement, especially on shared goals), validation (e.g., acknowledging the client’s feelings related to the situation and demonstrating empathy in verbal and non-verbal modes of communication), actions (e.g., redirecting the client’s attention), self-
regulation (e.g., remaining calm and avoiding making judgments about the client or taking the
client’s distress personally), and safety maintenance (e.g., debriefing following an incident; Del Bel, 2003; Hallett & Dickens, 2017, 2017; Maunder, 1997; National Institute for Health and Care Excellence, 2015). A power imbalance between provider and client—specifically if clients are excluded from decisions about their care—is a barrier to de-escalation (Johnston et al., 2022). Specific de-escalation strategies corresponding to client vignettes are provided in the toolkit (Chapter 5).

Additionally, preventative measures can be taken to avoid the risk of violence, aggression, or emotional dysregulation in clean-out interventions by following the principles of harm reduction and client-centered care. A client’s negative emotional arousal may be warranted if these principles are not followed, for instance, if more possessions are removed than agreed upon or if a clean-out team member decides to make discard decisions without the client’s consent. With the understanding that certain clean-out practices may violate a client’s autonomy, providers can move towards practices that emphasize collaborativeness and compassion.

4.3 Conclusion

Reality television shows have been portraying clean-out interventions for over 20 years. Although they have helped to promote awareness that hoarding is a mental health problem, they also depict a sensationalized and possibly harmful image of hoarding and clean-out interventions. This dissertation provides a more balanced perspective by synthesizing the existing literature on clean-outs published in the grey and academic literature, as well as by interviewing community providers about their direct experience conducting these interventions.

Clean-outs are a challenging intervention. They often require a multidisciplinary team for a successful execution, are resource intensive, and carry a significant financial cost. The problem
clean-outs are trying to solve (the remediation of health and safety risks) is complicated by untreated mental health symptoms, housing instability and medical complexity. In addition, hoarding interventions are clearly under-resourced. Unmistakably, clean-outs are a useful tool to address health and safety concerns, as psychological interventions are limited in their ability to mitigate functional impairment in the home (Tolin et al., 2015). However, hoarding as a mental health problem is not solved by clean-outs, and clean-outs are often extremely distressing.

The practice needs of community hoarding professionals helped guide this dissertation throughout the research process, from the choice of research questions to the communication of research findings. With the help of frontline professionals, I have expanded the academic literature, in addition to providing needed resources for agencies involved in clean-out interventions. Specifically, the next chapter presents the research report and best practice toolkit that I developed for dissemination among community providers (Chapter 5). The research report provides a detailed summary of the study rationale, findings, and directions for future research accompanied by illustrative infographics. My aim was to go beyond the typical preparation of a lay summary by producing an accessible report that would enhance communication with community practitioners and be used as a reference in their pursuit of funding to support hoarding clients. The best practice toolkit was designed to promote best practices for a clean-out in situations where a more gradual and voluntary approach is not possible. The toolkit was designed to be even more accessible than the research report and consists of key terms, practice recommendations, and suggestions on how to navigate challenging clean-out situations.

This dissertation’s public scholarship approach is in line with a changing attitude with regard to scholarly traditions and the increasing prioritization of community-engaged research (Leavy, 2019; Wang et al., 2023). University researchers dedicate substantial efforts to
publishing and promoting their work within traditional academic circles because the current academic system incentivizes the publication of peer-reviewed journal articles (Leavy, 2019). In response to the current challenges facing our society (Wang et al., 2023), a public scholarship approach calls on academics to democratize research. Such a process encourages researchers to consider the accessibility and inclusivity of their research portfolios from the outset of their work, rather than as a final stage (as typically seen in knowledge translation work). The academic tradition can adapt by facilitating, embracing, and legitimizing applied scholarly products that prioritize contributions to the public good (Porter & Phelps, 2014). As evident in this dissertation, understanding the complexity of hoarding cases, while improving the existing community interventions available to these clients, is best achieved with research collaborations that blend together the expertise of researchers with the frontline expertise of community providers.
5.1 Best Practice Toolkit: A Client-Centered Approach to Hoarding Clean-Outs
Included in this **Best Practice Toolkit**

1. Key Terms
2. How to Decide if a Clean-Out is the Right Intervention
3. Guiding Principles for a Client-Centered Clean-out
4. Who Should be Involved
5. Steps to Consider When Conducting a Client-Centered Clean-Out
6. Overcoming Barriers to a Client-Centered Clean-Out

**How was this best practice toolkit developed?**

This best practice toolkit was developed by researchers at the Centre for Collaborative Research on Hoarding in consultation with hoarding service providers in various jurisdictions in North America (primarily Canada). The recommended strategies were informed by our research related to hoarding clean-outs, including interviews with service providers who use harm reduction approaches, careful review of the academic and nonpublished literature on clean-outs, and a recent interview-based survey about hoarding clean-outs.

Although we do not recommend clean-outs as a preferred or first-line approach in responding to hoarding, our research shows they are often an intervention of last-resort to prevent dire outcomes such as eviction, incidents of fire, relocation to a care home, or worsening physical and mental health. We offer this toolkit to draw upon our research to promote best practices for a clean-out intervention, still in the hopes that other, more gradual and voluntary, interventions will be prioritized and offered to clients in need.
1. Key Terms

**HOARDING**
Hoarding is characterized by difficulty discarding and intentional saving of items that most people would clear from their home. Accordingly, clutter accumulates in the home and prevents the person from using some or all parts of their home.

Hoarding can violate the terms of a tenant’s lease and can be a public safety threat due to the risk of fire, pest infestations and health hazards.

**CLIENT-CENTERED**
Interventions that generally focus on client engagement and prioritizing the client’s individual needs and concerns are called client-centered. Related to hoarding clean-outs, this approach aims to maximize client involvement in the clean-out process. The client, rather than external stakeholders (e.g., the landlord, family members, fire department), is considered to be at the “center” of the intervention.

**CLEAN-OUT**
A fast-paced intervention in which a large amount of clutter is removed from the living spaces of a client’s home. A clean-out may last several days and is usually completed in a condensed time frame (e.g., under a month). The client may not be involved in every decision about which items are kept or discarded.

**HARM REDUCTION**
This approach involves first identifying the specific health and safety risks posed by the hoarding behaviour and then taking action to reduce those risks (e.g., removing items that block exit paths). Harm reduction does not require the individual to stop acquiring or to discard all of their possessions. This approach targets the potential harms rather than the hoarding itself.

**DECLUTTERING ASSISTANCE**
A gradual intervention where clutter is sorted and then removed or organized within a home. Decluttering often occurs during periodic scheduled visits across several months. Due to the gradual nature of decluttering assistance, a client is typically responsible for — or a full partner in — decisions about which items are kept or discarded. Decluttering assistance may precede or follow a clean-out, but it is a separate intervention, distinct from a hoarding clean-out.

**TRAUMA-INFORMED PRACTICES**
Trauma-informed approaches aim to provide services that prioritize safety, trustworthiness, collaboration, and personal choice. As many people with hoarding have a history of aversive or traumatic experiences, trauma-informed practices involve being mindful of these personal histories.
2. How to Decide if a Clean-Out is the Right Intervention

Are there major health and safety risks in the home and is there significant pressure from an external agency to reduce those risks in order to:

1. Satisfy the fire/health code
2. Avoid eviction/condemnation
3. Ensure a safe discharge from hospital
4. Improve living conditions for vulnerable co-occupants
5. Receive in-home caregiving services, or
6. Facilitate access for critical home maintenance

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NO

Does the client consent to services?

NO

Educate the client about possible safety and health risks, but do not proceed with an intervention. A competent adult has the right to choose their own living conditions. Ensure the client is aware of what hoarding-specific services are available in their area (or online), if they want help in the future.

YES

Consider a lower intensity intervention such as decluttering assistance, hiring a professional organizer, or mental health treatment (e.g., a hoarding peer support group, cognitive behavioral therapy for hoarding). After such an intervention has occurred, follow the client’s lead if they want (or do not want) to proceed with a clean-out.

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YES

Does the client appear to have adequate cognitive capacity to understand the risk of harm in their current home?

NO

A cognitive assessment by a trained health professional and a protective intervention (e.g., hospitalization, relocation) may be necessary. These steps may be taken in combination with a clean-out.

YES

Is the timeline imminent and inflexible?

NO

Focus on a more gradual intervention first (e.g., setting harm reduction goals, monthly inspections, decluttering assistance, case management, family involvement). These interventions may be used in combination with specialized mental health treatment.

YES

Consider proceeding with a targeted clean-out intervention that focuses on reducing major health and safety risks.
3. Guiding Principles for a Client-Centered Clean-Out

A client-centered clean-out starts with obtaining the client’s informed consent and follows the principles of harm reduction and trauma-informed practices. The primary aim of a client-centered clean-out is to ensure the best possible experience for the client while acknowledging that a clean-out is most likely not the client’s first choice for how to proceed.

Basic ethical principles of treating clients with respect and preserving their autonomy and dignity as much as possible are at the core of client-centered approaches. Although much more research needs to be done on this topic, our research so far suggests that prioritizing the client’s decision-making in a clean-out intervention may lead to less client distress and may improve their ability to maintain changes after the clean-out. Forced or involuntary clean-outs can result in negative outcomes, such as strong negative emotional responses, risk of suicidal or non-suicidal self-injury, client refusal to engage with service providers in the future, or rapid clutter re-accumulation. The strategies suggested in this toolkit are designed to minimize the likelihood of such outcomes.

How to obtain informed consent for a clean-out:

1. Start by explaining the health and safety risks present in the home. Explain why certain conditions present a risk. Provide this information in a written format for the client.

2. Outline how a clean-out can reduce the health and safety risks.

3. Communicate your proposed plan to conduct a clean-out. Be open to collaborating and adjusting this proposed plan, if possible.

4. Acknowledge that a clean-out can be distressing, and discuss the client's preferences for emotional support.

5. Explain the likely consequences of not consenting to the clean-out. In certain situations, consequences may be quite severe, such as eviction, forced relocation to a care home, or condemnation of the home.

6. Address the client’s questions and concerns.

7. Provide the opportunity for the client to consent or to refuse consent.

8. If the client consents, explain that they may withdraw their consent later in the process, although there may be consequences to such a decision.
Incorporating harm reduction and trauma-informed practices into the clean-out:

1. Spend time establishing rapport and providing clear information (verbally and in a written format) about the clean-out process. You can build trust by being empathetic and communicating safety concerns openly.

2. Educate yourself on the mental health aspects of hoarding behaviour and be aware of the potential harm a clean-out may cause. Your client may be hesitant to engage based on their past experience with hoarding interventions that were forced, involuntary, and emotionally devastating.

3. Understand that most clients who are at the center of a clean-out are facing a complex array of problems, including housing instability, health issues, other mental health conditions, and/or a trauma history.

4. Building on the relationship you developed, collaborate with your client to plan the clean-out. The clean-out should proceed with them not without them. They are an essential member of the clean-out team.

5. Maximize the amount of control and choice the client has over clean-out decisions.

6. Establish very specific harm reduction goals to address the major imminent health and safety risks in the home. Examples of goals that would reduce these risks include: removing items from entryways, staircases, and hallways to allow rapid exit and permit emergency responders to enter; clearing items away from heat sources, such as the stove, furnace or heater, and other appliances that pose a fire risk; taking steps to ensure basic sanitation so home care staff can safely visit; ensuring bathroom (e.g., tub, sink, toilet) and kitchen appliances (e.g., fridge, oven) are accessible and useable.

7. **Aim to retain as many of the client’s possessions as possible** while still addressing major health and safety risks. Once the harm reduction goals are met, follow the client’s lead. They may want to continue removing items, or they may want to stop.

8. If the clean-out has taken place under collaborative conditions involving a trusting relationship with the provider, then the client may be interested in engaging in more gradual decluttering work following the clean-out.

Although community providers and family members may be tempted to avoid using the term “clean-out” in favor of a euphemism (e.g., “spring clean”), it is important to openly communicate your proposed intervention. Consent is not “informed” if the client does not know what intervention you are proposing. We recommend using one of the following terms:

- Harm reduction clean-out
- Supported clean-out
- Safety clean-out
- Client-centered clean-out
- Trauma-informed clean-out
- Targeted clean-out

These terms indicate an attempt on behalf of the provider to conduct a clean-out that prioritizes harm reduction and client involvement, rather than a clean-out that focuses on removing most or all possessions from the home and one that limits the client’s involvement.
### 4. Who Should be Involved

Clean-outs often require an “all hands on deck” approach. A variety of professionals may be required to manage different aspects of the process (e.g., clutter removal, sanitation, pest control) and the client’s psychological and/or physical needs. Each clean-out team member may be responsible for several roles: logistics and planning, case management, emotional support, enforcement, clutter removal, cleaning, or organizing. It is often helpful for one professional to take on a leadership role with regard to planning and coordination. Additionally, it may be necessary for one (or several) providers to take on an advocacy role with regard to supporting the client and protecting their best interests in response to external pressures (e.g., a landlord who has posted an eviction notice).

<table>
<thead>
<tr>
<th><strong>Cleaning, Organizing, and Removal</strong>*</th>
<th><strong>Public Safety</strong></th>
<th><strong>Housing</strong></th>
<th><strong>Public Health</strong></th>
<th><strong>Social Services</strong></th>
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<tbody>
<tr>
<td>Cleaning/removal company</td>
<td>Fire inspector</td>
<td>Property manager</td>
<td>Environmental health officer</td>
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<td>Hauling service</td>
<td>Peace officer</td>
<td>Landlord</td>
<td>Public health inspector</td>
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<td>Moving company</td>
<td>Police officer</td>
<td>Resident services coordinator</td>
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<td>Professional organizer</td>
<td>Bylaw officer</td>
<td>Tenant support worker</td>
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<td>Auctioneer</td>
<td>Property use inspector</td>
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<tr>
<th><strong>Mental Health</strong></th>
<th><strong>Support Workers</strong></th>
<th><strong>Medical Professionals</strong></th>
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<tr>
<td>Social worker</td>
<td>Outreach worker</td>
<td>Physician</td>
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<tr>
<td>Counsellor</td>
<td>Community support worker</td>
<td>Nurse practitioner</td>
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<td>Psychologist</td>
<td>Personal caregiver</td>
<td>Home care nurse</td>
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<td>Psychiatrist</td>
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<td>Psychiatric nurse</td>
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<td>Occupational therapist</td>
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<td>Paramedic</td>
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<tr>
<th><strong>Case Manager</strong></th>
<th><strong>Client</strong></th>
<th><strong>Utilities/Maintenance</strong></th>
<th><strong>Social Network</strong></th>
<th><strong>Faith-based Organizations</strong></th>
<th><strong>Animal Control</strong></th>
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<td></td>
<td>Electrical</td>
<td>Family</td>
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<td>Plumbing</td>
<td>Friends</td>
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<td>Handy person/Carpenter</td>
<td>Neighbours</td>
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<td>HVAC technician</td>
<td>Volunteers</td>
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<td>(heating, ventilation, and air conditioning systems)</td>
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*If you are hiring a cleaning/removal company, ensure they are experienced in hoarding situations and have credible references.
5. **Steps to Consider When Conducting a Client-Centered Clean-Out**

Each clean-out has four stages: 1) **rapport building and planning**, 2) **pre-sorting**, 3) **the clean-out**, and 4) **post clean-out**. The steps outlined here are suggestions for how to complete each stage from a client-centered approach. Depending on the clean-out situation, not all steps may be required or possible due to limited funds, client engagement, or situational factors.

As can be observed from the number of steps below, clean-outs require a great deal of time and energy. They are often a challenging intervention for all stakeholders involved, including the client, family members, professionals, and volunteers.

---

**Funding the costs of a clean-out**

**CLEAN-OUT COSTS VARY BY:**
- Number of days or hours the cleaning/removal company is onsite
- Number of paid staff involved
- Size of the home
- Amount of clutter removed
- Resources required (e.g., dumpster rental)
- Additional services involved (e.g., pest control, professional organizing, housekeeping)
- Use of a cleaning/removal company

The costs of a clean-out are usually paid by: the client, family members, housing officials (e.g., landlord, condominium board), or grants or crisis stabilization funds through seniors’ agencies, social services, faith-based organizations, eviction prevention initiatives, or hoarding advocacy groups.
### 1. Before the Clean-Out: Rapport Building and Planning

*Please ensure that the clean-out is an intervention of last resort and all other options are exhausted.*

#### Meet with Client
- Establish rapport.
- Discuss the client’s personal goals (e.g., eviction prevention) as well as their concerns and fears related to the clean-out.
- Ensure the client knows why the clean-out is necessary.
- Provide accurate information (verbally and in a written format) and obtain the client’s informed consent.
- Determine the client’s preferences for the clean-out (e.g., Do they want to be present? Who would they like as a support person?).
- Review coping strategies to use on the clean-out day(s).
- If the client consents, refer for mental health services.

#### Health and Safety Risk Assessment
- Review the health and safety reasons for the clean-out (e.g., blocked entrances and exits, difficulty navigating through the home, poor sanitation, pests).
- Assess other concerns (e.g., eviction risk, physical health or mental health concerns, cognitive functioning concerns).
- Determine harm reduction goals based on the concerns and the client’s personal goals.
- Communicate these harm reduction goals to whoever is the source of external pressure (e.g., landlord, fire inspector).

#### Assemble Clean-Out Team
- Contact relevant service providers, family/friends, and volunteers to enlist their help.
- Hire a cleaning/removal company (or a professional organizer).
- Designate someone to be the client’s support person on the day (e.g., a mental health professional or a loved one who can remain non-judgmental and prioritize the client’s needs).
- Educate/train team members to use respectful language at all times whether the client is present or not.

#### Logistics
- Determine clean-out time frame.
- Schedule clean-out day(s).
- Assemble required tools (e.g., PPE, dumpster rental).
- Determine budget and arrange payment for cleaning/removal company.
- Determine plans for final location of items removed from the home (e.g., thrift store donations, garbage and recycling arrangements, storage facility).
### GETTING READY FOR THE CLEAN-OUT DAY: PRE-SORTING

#### Create Plans for Sorting/Discarding
- Based on the clean-out harm reduction goals, set guidelines around the percentage of items to be removed or the areas where a reduction is required (e.g., in the bedroom).
- Let the client make decisions about which particular possessions will be removed.
- Ask which categories of items are of significant value to the client (e.g., jewelry, photographs, tools) and if there are any items that need to be found.
- Collaborate with the client to create rules for what can be discarded or saved.
- Help the client to understand that soiled, rotten, or infested items cannot be saved due to health concerns.
- Identify the client’s level of involvement for various categories of items (e.g., the clean-out team can make decisions about food items, but the client wants to make all decisions about which books to keep).

#### Communicate Plans to Team

**All of the following steps may take place during a clean-out team meeting at an offsite location prior to the intervention day(s).**

- Provide the clean-out team (and the client) with the list of rules collaboratively developed with the client.
- Alert the clean-out team to items of significant value and obtain agreement that they will locate and preserve these items to the best of their ability.
- Explain to client and team that mistakes can and will likely be made. Plan how mistakes will be addressed.
- Brief the team on what to expect, pictures may be helpful.
- Review roles that each member of the team will take.
- Introduce the client to team members.

#### Spend Time Decluttering Prior to the Clean-Out

- Meet with the client in their home at least once (although multiple times is preferable) to practice sorting possessions into categories of keep, donate, or discard.
- Do any pre-sorting work that will facilitate how efficient the clean-out day(s) will be (e.g., identifying categories of items that the clean-out team can take away without consulting the client).
- Set up the home to facilitate the clean-out (e.g., label items to be kept).
- For continuity of care, the same person who assisted with decluttering should be involved in the clean-out.
### 3. During the Clean-Out

#### Follow the Clean-Out Plan
- Start the day with an onsite team meeting to review the plan.
- Stick to the plan to achieve the harm reduction clean-out goals.
  - Only discard items that pose a health/safety risk, and leave the rest; focus on reducing clutter only in areas of concern.
  - For items that are not represented in the plan, ask client or established decision-maker what to do.
  - Follow donation and disposal plans for discarded possessions.
- Depending on the situation, some options for sorting and removal include:
  - Bringing items outside to sort on the lawn or in the driveway (although be prepared for all weather conditions)
  - Assigning a dedicated team member to different rooms
  - Following professional recommendations from the cleaning/removal company (or professional organizer)
- Ensure the client retains some of their items.
- Check in with team members throughout the day, make sure to allow for rest and refreshment.

#### Engage Client in Decisions
- Support the client in being onsite for the entire intervention, or as much as possible (if the client wishes to be present).
- Ensure that the client has a role (e.g., sorting items in the living room, being stationed outside and making decisions as team members bring out items).
- Involve the client in as many decisions and as much of the process as possible.

#### Emotional Check-In
- Check on the client regularly and provide comfort as needed.
- Offer praise and encouragement abundantly.
- Ask the client if anything would make the experience easier (e.g., playing music, getting coffee on a break)
- Acknowledge progress towards meeting harm reduction goals.
- With input from the client, decide when to take break(s) in the clean-out work and when to stop for the day.
### Steps to Consider When Conducting a Client-Centered Clean-Out

#### 4. AFTER THE CLEAN-OUT

| Debrief with the Client | • Ask how the client is feeling following the clean-out.  
| | • Engage the client in activities to promote their wellbeing.  
| | • Ask if anything could have been improved related to the clean-out process.  
| | • Arrange follow-up mental health care.  
| Debrief with the Clean-Out Team | • Debrief what went well, what went wrong, and if anything could have been improved related to the clean-out process.  
| Post Clean-Out Services | • Conduct pest control inspection and service.  
| | • Arrange for completion of necessary maintenance and repairs.  
| | • If necessary, sanitize and clean surfaces, floors, appliances, bathroom fixtures, etc.  
| Home Organization | • Assist the client in organizing possessions to their liking.  
| Maintenance | • Plan for ongoing maintenance visits or decluttering and organizing assistance.  
| | • If necessary and financially feasible, arrange for regular cleaning services.  

6. Overcoming Barriers to a Client-Centered Clean-Out

**BARRIER #1 TO A CLIENT-CENTERED CLEAN-OUT**

Your client has consented to the clean-out, but they refuse or are resistant to engage in the clean-out process.

**Case Example:**

Over the past year, Melody has received numerous neighbour and bylaw complaints due to the condition of her backyard. The buildup of recycling containers, garbage bins, and boxes, along with an accompanying odour, has attracted unwanted animals into the neighbourhood. Melody reluctantly agrees to an outside clean-out to stop what she describes as “harassment”. Her social worker begins to plan for the clean-out, but cannot seem to engage Melody in any discussions about the upcoming intervention. Melody brushes off her social worker’s inquiries about her concerns or fears and refuses to discuss her personal goals for the clean-out. She is also reluctant to identify anything she wants to keep and says she plans to remain inside until the clean-out team is finished and off her property.

**STRATEGIES TO OVERCOME BARRIER #1**

- Remember that few clients actually want a clean-out, so resistance is very common.
- Attempt to empathize and understand what is driving your client’s behaviour.
- Talk with the client outside of their home about their concerns.
- Patiently and calmly reiterate the reasons for the clean-out.
- Emphasize it is your personal goal to involve them in the clean-out, but it is their choice to participate.
- Ask what you can do to help them retain some degree of control over the situation.
- If required, explain the consequences of their decision not to engage in the process. That is, the clean-out will proceed without their involvement, and the team will not be aware of their involvement, and the team will not be aware of their wishes regarding which items are to be removed or retained.
6 | Overcoming Barriers to a Client-Centered Clean-Out

**STRATEGIES TO OVERCOME BARRIER #2**

- If the client is willing to have a conversation, attempt to empathize and understand what is driving the client’s behaviour.
- Ask if there is anything you can do to help.
- Remain calm. Avoid appearing confrontational.
- Reiterate the clean-out rationale (emphasizing safety concerns especially).
- Ensure the clean-out is addressing harm reduction goals only. Emphasize any progress that has already been made towards meeting harm reduction goals.
- Agree to follow-up with the clean-out team regarding possibly stolen items, but emphasize that the clean-out team had agreed to follow the rules to the best of their abilities (i.e., in certain situations an item may have been discarded that was not on the discard list because it was heavily soiled or water damaged).
- Offer choices to help the client regain a sense of control (e.g., pause the clean-out for an hour, stop removal of possessions in certain areas, slow the pace down).
- If required, explain the consequences of the clean-out ending prematurely and harm reduction goals not having been met (e.g., the client may be evicted or forced to relocate).
- Allow the client to weigh the pros and cons of continuing or terminating the clean-out and to make a decision for themselves, understanding the likely consequences of either choice.
- After a decision has been made, debrief with the clean-out team and client (possibly 1-2 days later) about what went wrong and what could have been improved during the intervention.

**BARRIER #2 TO A CLIENT-CENTERED CLEAN-OUT**

Your client stops the clean-out prematurely.

**Case Example:**

Raj lives in a housing co-operative. Due to the amount of possessions in his unit, it has been challenging to treat a persistent bedbug infestation. His co-op association is threatening to fine him, or potentially evict him, for bylaw infractions (e.g., untreated pest infestation, excessive combustibles, unkempt balcony and entryways). Raj initially agrees to a clean-out to appease his fellow co-op members. However, on the second day he withdraws his consent and stops the clean-out before it is completed. He is angry and believes various items have been stolen by the clean-out team.
**BARRIER #3 TO A CLIENT-CENTERED CLEAN-OUT**

Your client is in hospital and cannot participate in the clean-out.

**Case Example:**

Amelia falls in her home and is unable to get up by herself. She calls 911 for assistance. Upon arrival, the paramedics discover narrow pathways and conditions of poor sanitation. Based on these conditions and Amelia’s mobility limitations, her care team decides her discharge from hospital is contingent on a safe and sanitary home environment. Amelia’s daughter hires a removal company to complete the clean-out quickly while her mother remains in hospital.

**STRATEGIES TO OVERCOME BARRIER #3**

- Facilitate client decision-making by visiting the client in hospital.
- If you cannot visit the hospital, set up a phone or video call OR have a family member or friend do the following:
  - Ensure the client is aware the clean-out is happening and understands why such an intervention is necessary.
  - Show them photos of their items. Make lists detailing what they want to keep.
  - Prioritize their attention on bigger categories of items, rather than decisions about individual items or items that are unsanitary or rotten (e.g., food).
- Act as an intermediary between the client and the clean-out team (e.g., cleaning company, contractors).
- Communicate client preferences to the larger clean-out team.
- Stay in communication with the client through text messages or phone calls during the clean-out.
- During the clean-out, prioritize harm reduction goals only.
- Have a meeting with the client once they are out of hospital. Review the changes that you made in their home. Give the client an opportunity to ask questions and to express their feelings regarding the clean-out. Explore options for follow-up support.
BARRIER #4 TO A CLIENT-CENTERED CLEAN-OUT

A change in risk has created an urgent push to complete the clean-out quickly.

Case Example:

Aaliyah is very concerned for her elderly father’s safety. Her father likes to frequent the local thrift stores and flea markets, but has limited space to store his items. Aaliyah offers to visit her father once a week to help with the decluttering process. During these visits, Aaliyah starts to notice changes in her father’s behaviour. He has become more irritable and confused regarding his surroundings. Aaliyah contacts her family doctor for assistance. As her father’s cognitive abilities decline rapidly, a more gradual decluttering approach no longer appears feasible. Aaliyah’s priorities shift to completing a clean-out as quickly as possible, as her father may be required to move into a care home.

STRATEGIES TO OVERCOME BARRIER #4

- If the situation allows, communicate this change in risk to the client and explain the reasons for a change in the team’s approach.
- Re-assess the harm reduction targets and revise the clean-out goals.
- If possible, create an opportunity for the client to state their wishes for the clean-out under these new circumstances. If this is not possible, as a clean-out team, agree to continue prioritizing the client’s previous goals for the clean-out.
- Continue to involve the client as much as possible and stay in communication throughout the clean-out process.
- Communicate with the client’s healthcare team to ensure everyone is aware and in agreement with the clean-out plan.
- Although there may be increased pressure to remove more possessions from the home, continue to prioritize harm reduction goals and reduce clutter only in areas of concern.
**BARRIER #5 TO A CLIENT-CENTERED CLEAN-OUT**

**Goals of external stakeholders (e.g., the fire department, building officials, family members) are prioritized over your client’s.**

**Case Example:**

Asher lives in a social housing building and is at risk of eviction. Their home is in violation of the fire code and they have received numerous warnings from their landlord, but they struggle to discard possessions on their own. Their landlord offers to pay for a clean-out to ensure the unit satisfies fire safety requirements. Asher agrees to the clean-out with the condition that they will have a say in which possessions are removed. However, on the clean-out day, the landlord takes charge and tells the clean-out team which items need to be removed without any input from Asher. Asher feels blindsided and as if they have lost control over their home.

**STRATEGIES TO OVERCOME BARRIER #5**

- Validate the client’s emotions.
- Involve the client in the discard process, even if it takes longer or there is pushback from other members of the clean-out team.
- Ensure only the reduction of health and safety risks are prioritized.
- If necessary, ask staff or family members to take a break from making discard decisions or to slow down.
- In order to prevent the likelihood of such a situation:
  - Before the clean-out, have a conversation with the client on their own. Ask them about their personal goals, concerns, and fears for the clean-out independent of any external stakeholders.
  - Designate someone to be available and present for the client during the clean-out. This individual may be required to intervene on behalf of the client if there are unforeseen challenges or conflicts.
  - Educate external stakeholders and family members about the mental health aspects of hoarding disorder and about the importance of the client retaining some degree of control. The client’s goals are still relevant, even if the clean-out is intended to meet the goals of an external agency (e.g., the fire department, condominium board, or building officials).
Clean-outs as a strategy for community agencies to address hoarding

RESEARCH REPORT

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FINANCIAL SUPPORT
UBC’s Public Scholars Initiative
Social Sciences and Humanities Research Council

THE UNIVERSITY OF BRITISH COLUMBIA
Contents

1 About the Study
2 Results
12 Conclusion & Future Research Directions
13 Recommendations for a More Client-Centered Approach

Definitions

**HOARDING**
Hoarding is characterized by difficulty discarding and intentional saving of items that most people would remove from their home. Accordingly, clutter accumulates in the home and prevents the person from using some or all parts of their home. For example, a client with hoarding behaviour may have difficulty finding a place to prepare or cook food because of the amount of possessions in their kitchen.

Hoarding can violate the terms of a tenant’s lease and can be a public safety threat due to the risk of fire, pest infestations and health hazards.

**CLEAN-OUT**
A fast-paced intervention in which a large amount of clutter is removed from the living spaces of a client’s home. A clean-out may last several days and is usually completed in a condensed time frame (e.g., under a month). The client may not be involved in every decision about which items are kept or discarded.

**DECLUTTERING ASSISTANCE**
A gradual intervention where clutter is sorted and then removed or organized within a home. Decluttering often occurs during periodic scheduled visits across several months. Due to the gradual nature of decluttering assistance, a client is typically responsible for — or a full partner in — decisions about which items are kept or discarded. Decluttering assistance may precede or follow a clean-out, but it is a separate intervention, distinct from a hoarding clean-out.
About the Study

Why we did this study

Reality television shows have dramatized clean-outs as fast and effective interventions for hoarding. The shows portray a certain kind of clean-out, but almost no research has examined clean-outs that occur off-camera in other settings. The lack of research into how clean-outs are conducted and how they work leaves communities in the dark with regard to client responses to having a clean-out and best practices. We aimed to document how clean-outs unfold and discover the implications of conducting more client-centered clean-outs.

What we wanted to find out

1. what makes a clean-out necessary
2. how are clean-outs conducted
3. what are client responses to having a clean-out
4. which client-centered strategies are being used, and
5. what are the short-term outcomes

What we did

- We talked to frontline professionals who had actively participated in at least one clean-out intervention in the past three years.
- Individuals who identified an interest in participating in the study were scheduled for a preliminary phone screen. If participants met the inclusion criteria, a one-hour appointment was scheduled for them to complete the study virtually.
- Participants answered questions about the most recent clean-out they conducted including how long did it take, how much clutter was removed, and how involved was the client.

Who was involved

The final sample included 65 community providers, mostly from Canada or the US, although some were also from Australia or the UK.

42% were mental health professionals (including social workers and case managers)
21% were organizing/cleaning professionals
11% were support workers or family members
11% were health and safety professionals (including fire inspectors)
8% were housing professionals
7% were from other occupations such as pest control or gerontology.

Each provider reported on one recent client who had a hoarding clean-out:

Most clients described were female (60%), most were older than 65 (66%), and most lived alone (77%).

Approximately 50% of clients lived in a rental apartment.

Most had not had any previous hoarding-specific intervention (e.g., peer support, cognitive behavioural therapy for hoarding, or decluttering assistance).

Client homes:

Homes of clients who had a clean-out were significantly hoarded. The average initial clutter image rating was a 6 out of 9.

Providers gave several descriptions that illustrated poor conditions in the home related to the level of clutter, including narrow pathways, non-functional bathrooms, and limited places to sit other than the toilet seat and the bed.
Results.
What we learned.

1. WHAT MADE A CLEAN-OUT NECESSARY

Providers described complicated and serious concerns that required immediate attention. They characterized the clean-out as an intervention of last-resort to prevent dire outcomes such as eviction, a forced move, incidents of fire, or worsening physical and mental health. Most cases had more than one serious problem from the list below.

<table>
<thead>
<tr>
<th>Reason for Clean-Out</th>
<th>Percentage</th>
<th>Details</th>
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<tbody>
<tr>
<td>Unsafe conditions in the home</td>
<td>86%</td>
<td>blocked entrances and exits, difficulty navigating through the home due to limited pathways, combustibles near the stove and heat sources</td>
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<tr>
<td>Eviction risk</td>
<td>63%</td>
<td>an eviction notice had been posted, and clients were at risk of losing their housing</td>
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<tr>
<td>Poor sanitation</td>
<td>60%</td>
<td>rotting food, urine and or feces in the home, sewage, noxious odours</td>
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<tr>
<td>Physical health concerns</td>
<td>59%</td>
<td>poor conditions in the home intensified mobility difficulties and aggravated life-threatening or medically complex health conditions</td>
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<tr>
<td>Pest infestation</td>
<td>51%</td>
<td>bedbugs, cockroaches, ants, mice, rats, fruit flies</td>
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<tr>
<td>Client refusal to engage</td>
<td>49%</td>
<td>client did not want to accept assistance or was unwilling to change conditions in their home</td>
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<tr>
<td>Neighbour complaints</td>
<td>31%</td>
<td>concern about insect and rodent infestations, odours, water leaks, risk of fire, unkempt yard</td>
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<tr>
<td>Discharge from hospital</td>
<td>25%</td>
<td>safe discharge required a safe and sanitary home environment for medical reasons</td>
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<tr>
<td>Cognitive functioning concerns</td>
<td>17%</td>
<td>concern about client capacity to continue living in the home due to possible dementia or cognitive decline</td>
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As a result of these conditions, most clients (62%) did not voluntarily choose to have a clean-out. Stakeholders, such as the fire department, property manager, family members, or hospital staff, made the decision instead.

Even clients who had a voluntary clean-out may have felt coerced into agreeing to a clean-out to prevent eviction, qualify for in-home caregiving services, or to pass a housing or fire inspection.
**Clean-Out Decision**

**VOLUNTARY**
It was the decision of the client
“The client said, ‘I don’t like how I’m living — I know I need to make a change, but I’m not physically capable of doing so on my own.’”

27%

**IN VOLUNTARY**
It was **not** the decision of the client
“If it wasn’t for the client going to hospital, it wouldn’t have happened.”

62%

**NEUTRAL**
The decision was neither fully involuntary or voluntary
“The client didn’t want a clean-out, but he wanted to stay in his apartment.”

11%
2. HOW CLEAN-OUTS WERE CONDUCTED

Although each clean-out was unique, most followed certain stages:

1. Planning Stage, in which the clean-out was organized
2. Pre-sorting Stage, where items within the home were reviewed and general decisions were made about what to discard or keep
3. Clutter Removal Stage
4. Cleaning, Sanitation, or Pest Removal Stage.

Who participated in the clean-out

- The average clean-out involved about five people, such as a social worker, the property manager, two hired workers for clutter removal, and the client’s family member.
- A professional cleaning or removal service was hired in 79% of cases.
- Family members or partners were involved in 32% of cases.

Where the client was during the clean-out

- 51% were at home
- 15% were at home for a portion of the intervention
- 34% were not at home for any part of the intervention (e.g., they were in hospital)

How long the clean-out took to complete

- On average, clutter removal took a total of 16 hours (across three workdays).
- Approximately 40 person-hours were required for clutter removal per clean-out.
- These durations did not include time spent planning the clean-out, getting the client ready for the clean-out day (e.g., rapport building, preparatory sorting), or completing any post clean-out services (e.g., sanitation, pest control).
How much clutter was removed

- On average, clean-outs reduced clutter volume by more than 50%.

Photos are taken from the Clutter Image Rating Scale developed by Gail Steketee and Randy O. Frost, 2013. 
https://hoarding.iscfd.org/professionals/clinical-assessment/

- Most clean-outs focused on reducing clutter in areas of concern.
- Several providers emphasized that clean-outs had specific harm reduction targets, e.g., removing items from entryways, staircases, hallways for egress purposes; clearing away items near heat sources and gas appliances to reduce the fire risk; clearing away wet and soiled items to enable home care to gain access; and ensuring bathroom appliances (e.g., tub, sink, toilet) were useable.
2 | HOW CLEAN-OUTS WERE CONDUCTED

Amount of Possessions Removed from Each Room During the Clean-Out

- 8% Some possessions removed from 1-2 rooms
- 9% Some possessions removed from every room
- 17% A lot of possessions removed, but only from 1-2 rooms
- 52% A lot of possessions removed from every room
- 14% Everything was removed from the home

- Even though many possessions were removed during the clean-out, most clients still retained some of their belongings.
- The removal of clutter facilitated several other interventions, including pest control, electrical and plumbing maintenance, renovations, and repairs.
3. CLIENT RESPONSES TO HAVING A CLEAN-OUT

In this study, providers reported on their perceptions of the client’s emotional response to a clean-out. By its nature, a clean-out involves losing a large number of possessions — often a hoarding client’s worst fear.

- In almost 70% of cases, clients seemed at least “somewhat” distressed about having a clean-out on a scale from “not at all” to “extremely” distressed.
- Clients were less distressed about having a clean-out when they were more involved in the decision-making process (i.e., when it was more of a voluntary decision).

![Client Distress Chart]

<table>
<thead>
<tr>
<th>Client Distress</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all distressed</td>
<td>4.8%</td>
</tr>
<tr>
<td>Slightly distressed</td>
<td>20.6%</td>
</tr>
<tr>
<td>Somewhat distressed</td>
<td>27%</td>
</tr>
<tr>
<td>Very distressed</td>
<td>34.9%</td>
</tr>
<tr>
<td>Extremely distressed</td>
<td>12.7%</td>
</tr>
</tbody>
</table>

**Provider Quotes about Client Distress**

- “The client was very laid-back, he kept saying ‘doesn’t matter’.”
- “She wasn’t sad about having a clean-out...but she was sad things weren’t able to be donated [because of COVID-19].”
- “I never really saw the client’s fear, but [I] assumed it was there.”
- “The client was afraid of the unknown; ‘What else is [the clean-out team] going to take?’ and ‘What will be left?’”
- “She felt like we were throwing her whole life away.”
- “The client was sad that her home got to that point and that [the clean-out team] had to be there. She was extremely sad and embarrassed.”
- “Since the move/clean-out, the client has become increasingly angry and is talking about suing the city.”
4. CLIENT-CENTERED STRATEGIES THAT WERE USED

As researchers, we were interested in client degree of involvement in the clean-out process, what emotional support they received, and how often providers used shared decision making practices (i.e., how often they incorporated the client’s preferences).

Client Role During the Clean-Out

- Most clients (75%) were directly involved in sorting their possessions, and some of these clients also assisted in the physical removal of items.
- The remaining 25% of clients had no role in sorting or removal. In most of these cases, the client was in hospital. In the client’s absence, family members, friends, or service providers were primarily responsible for decision-making about the client’s possessions.

Emotional Support

- In almost all cases (91%), emotional support was offered to the client during the clean-out. This support was offered by the service provider who participated in our study, other service providers involved in the clean-out, or the client’s family or friends.
- Providers explained how they offered emotional support:
  
  “I get involved and keep an eye on the client. I decide if we need to pause for a bit.”

  “My role was to calm down the client, while my supervisor was in the front hall trying to get as much out as she could.”

  “I went in and reassured her we were not evicting her — we just needed clear pathways.”

Shared Decision Making

- Shared decision making is a process in which clients and providers make healthcare decisions together.
- Most providers (67%) put considerable effort into conducting a collaborative clean-out that maximized the client’s influence and control over the process.
- Examples of collaborative practices included having multiple conversations about the upcoming clean-out, working with the client to develop guidelines about which items should be saved (versus removed), and listening to the client’s concerns, including fears that too many items would be discarded and worry about who was in control of the clean-out.
- Highly experienced providers — those who had more experience working with hoarding clients and had more experience conducting clean-outs — tended to use more shared decision making practices.
- Client hospitalization was a barrier to shared decision making because clients were unable to be onsite to participate alongside the clean-out team. In response, several providers visited clients in hospital to show them photos of their items and to make lists detailing what they wanted to keep.
5. **SHORT-TERM OUTCOMES**

This study focused on short-term outcomes, including preventing eviction, addressing health and safety risks, and immediate improvements in the client’s hoarding behaviour. The long-term outcomes of clean-out interventions are difficult to track, as the provider’s professional commitment to the client usually does not persist beyond the clean-out. For example, a hauling company only works with a client until the job is complete and a fire inspector does not return to a home unless there is a new complaint.

**Eviction Prevention**

- Housing was preserved for two-thirds of clients who had been facing eviction prior to the clean-out.
- Most of the clients who were relocated were forced to move because of significant health issues. They were relocated to long-term care homes or assisted living facilities.

**Housing Outcomes**

*Total number of cases = 65*

- **At risk of eviction (41 cases)**
  - Housing retained (27 cases)
  - Evicted (10 cases)
  - Relocated (4 cases)

- **Not at risk of eviction (24 cases)**
  - Housing retained (20 cases)
  - Relocated (2 cases)
  - Remained in hospital (2 cases)
Addressing Health and Safety Risks

- Almost all clean-outs reduced unsafe and unsanitary conditions in the short-term.
- Clean-outs were successful in ensuring entrance/exit doors could open completely, improving mobility throughout the home, and reducing the risk of falling. Providers also stated there were fewer complaints from neighbours and a reduction in noxious odours.

**How much the clean-out helped to resolve health and safety issues in the home**

- The clean-out helped to make things worse: 1.5%
- The clean-out did not really help: 21.5%
- Neutral: 1.5%
- The clean-out helped somewhat: 76.9%

"Because of the clean-out, the home was a lot safer, the client was able to get caregiving services in the home, and the neighbours felt reassured."

"There are still falls risks, and the client still smokes (which is a fire risk)."
Addressing Hoarding Behaviour

• Most providers said the clean-out did not really help to resolve their client’s difficulties with discarding and intentional saving.

• Clean-outs had a better resolution when clients were more involved in the decision-making process (e.g., they had a role in sorting, it was a voluntary clean-out).

• In 28 cases (43%), clients were provided with in-home decluttering assistance or cleaning services following the clean-out to help with maintenance or to teach clients decluttering skills. Several providers noted these ongoing visits were helpful in preventing the re-accumulation of items following the clean-out.

How much the clean-out helped to address the client’s hoarding behaviour

- The clean-out was a means to an end; it only helped to buy us time.
- It looked really good — new carpets and new bathroom tiles. She seemed relieved and pleased. She seemed motivated to keep it like that.

<table>
<thead>
<tr>
<th>How much the clean-out helped</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clean-out seemed to make things worse</td>
<td>6.3%</td>
</tr>
<tr>
<td>The clean-out did not really help</td>
<td>51.6%</td>
</tr>
<tr>
<td>Neutral</td>
<td>7.8%</td>
</tr>
<tr>
<td>The clean-out helped somewhat</td>
<td>25%</td>
</tr>
<tr>
<td>The clean-out helped a great deal</td>
<td>9.4%</td>
</tr>
</tbody>
</table>
Conclusion

1. WHAT MADE A CLEAN-OUT NECESSARY.
   - Most clients did not voluntarily decide to have a clean-out. Rather, clean-outs were conducted due to a complex set of risks (e.g., unsafe conditions, eviction threat, poor sanitation).

2. HOW CLEAN-OUTS WERE CONDUCTED.
   - On average, five individuals formed the clean-out team and clutter was reduced by more than 50% over an average of three days.

3 & 4. WHAT WERE CLIENT RESPONSES TO HAVING A CLEAN-OUT AND WHICH CLIENT-CENTERED STRATEGIES WERE USED.
   - Clean-outs were distressing for most clients. Many providers responded to this distress by using a more client-centered approach: providing emotional support, involving the client in sorting and discarding decisions, and listening to their concerns and fears.
   - Clients seemed less distressed about having a clean-out when they were more involved in the decision-making process. Additionally, providers reported a better clean-out resolution when clients were more involved in the decision-making process.

5. SHORT-TERM OUTCOMES.
   - Providers were largely in agreement that clean-outs helped to resolve health and safety issues in the home in the short-term, but the long-term outcomes are unknown. Unlike mental health interventions, clean-outs did not target difficulty discarding or excessive acquisition.

Future Research Directions

- A primary limitation of this study was that the client’s perspective was not taken into consideration. Although we attempted to recruit clients who had experienced a clean-out intervention, we encountered several challenges recruiting a sample of interested research participants.
- Future studies need to focus on the client perspective of a hoarding clean-out. Most importantly, interviews should be tailored towards understanding their emotional experience, what went well during the intervention, and what they would have liked the clean-out team to have done differently.
- Future research should also focus on documenting the long-term outcomes of clean-out interventions (e.g., how long is clutter reduction maintained?)
- It would also be helpful to learn what contributes to a client being able to maintain health and safety changes following a clean-out (e.g., is there evidence regular monitoring or participation in a peer support group helps to maintain gains over time?)
Recommendations for a More Client-Centered Approach

Providers recommended taking a client-centered approach to clean-out interventions. This approach focused on client engagement and prioritizing the individual needs of the client. Based on our research, prioritizing the client’s involvement in a clean-out intervention may lead to less client distress and may improve their ability to maintain changes once the clean-out is completed. Here are some of their recommendations:

- Discuss the client’s personal goals related to their clutter (e.g., preserving their tenancy, being able to have family or friends visit, improving living conditions for pets).
- Ensure the client knows why the clean-out is necessary. Have a fire inspector (or another professional) explain the safety risks to the client.
- Discuss client concerns and fears and help to prepare the client emotionally for the clean-out.
- Plan for the client’s role during the clean-out (e.g., does the client want to be onsite or offsite?)
- When possible, provide decluttering assistance at a more gradual pace prior to the clean-out.
- During the clean-out, actively involve clients in decisions about what is removed from the home by setting guidelines around the percentage of items to be removed. Allow the client to make decisions about which particular possessions will be removed.
- Donate items instead of discarding them.
- Minimize the number of people onsite.
- Use a slower approach when possible.
- Remove as little as possible. For example, leave rooms alone that do not pose a safety risk.
- Support the client emotionally.
  » Have someone onsite whose entire role is emotional support.
  » Debrief how the client feels before, during, and after the clean-out.
  » Connect the client to ongoing mental health support.
- Organize resources to help with maintenance (e.g., make follow-up visits or arrange for regular cleaning services).
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https://doi.org/10.1093/wentk/9780190946395.003.0010


https://doi.org/10.1192/bjp.bp.114.158931


Appendices

Appendix A  Scoping Review Search Strategy

This appendix presents the search terms related to community-based interventions for hoarding used across all six electronic databases.

PsycInfo

Note. Below, TI indicates Title and DE indicates Subject Heading.

1. TI ‘hoard*’ OR SU ‘hoard*’
2. DE ‘Community Advocacy’
3. DE ‘Mental Health Programs’
4. DE ‘Communities’
5. AB ‘community health’
6. AB ‘community mental health’
7. AB ‘community services’
8. DE ‘Social Services’
9. AB ‘task force*’
10. AB ‘multidisciplinary’ OR AB ‘interdisciplinary’
11. DE ‘Policy Making’
12. DE ‘Fire Prevention’
13. DE ‘Harm Reduction’
14. DE ‘Risk Perception’
15. DE ‘Risk Assessment’
16. DE ‘Accommodation (Disabilities)’
17. DE ‘Disability Discrimination’
18. DE ‘Occupational Safety’
19. DE ‘Housing’
20. DE ‘Aging’
21. DE ‘Case Management’
22. 2 or 3 or 4 or … 21
23. 1 and 22

CINAHL

1. MH “Obsessive Hoarding”
2. AB ‘hoarding’
3. 1 or 2
4. MH “Community Health Nursing”
5. AB ‘community health’
6. AB ‘community services’
7. MH “Multidisciplinary Care Team”
8. AB ‘task force*’
9. AB ‘multidisciplinary’ OR AB ‘interdisciplinary’
10. MH “Fire Safety”
11. MH “Harm Reduction”
12. MH “Health Services for the Aged”
13. MH “Case Management”
14. MH “Public Policy”
15. MH “Housing for the Elderly”
16. MH “Frail Elderly”
17. 4 or 5 or 6 .. or 16
18. 3 and 17

**MEDLINE (OVID)**

*Note. Below, “/” indicates exploded major subject heading and “.ab” indicates abstract.*

1. Hoarding/ OR Hoarding Disorder/
2. Patient Advocacy/
3. Mental Health Services/
4. Program Development/
5. ‘community health’.ab
6. ‘community mental health’.ab
7. ‘community services’.ab
8. ‘task force’.ab
9. ‘*disciplinary’.ab
10. Policy Making/
11. Public Policy/
12. Clinical Decision Making/
13. Harm Reduction/
14. Risk Assessment/
15. Safety Management/
16. Public Housing/
17. Housing for the Elderly/
18. Aged/
19. Frail Elderly/
20. Case Management/
21. or/2-20
22. 1 and 21

**Embase (OVID)**

*Note: Below, “/” indicates subject heading and “.mp” indicates keyword.*

1. hoarding disorder/ or hoarding/ (explode concept and include all subheadings)
2. mental health programs.mp
3. community health.mp
4. community mental health.mp
5. community services.mp
Social Services Abstracts

1. TI (hoard*) OR mainsubject(hoard*)

Web of Science

hoard* in TI and “community”; English language; exclude prior to 1993; include research areas of “arts humanities other topics”, urban studies, “social sciences other topics”, rehabilitation, pediatrics, psychology, sociology, psychiatry, nutrition dietetics, family studies, nursing, “health care sciences services”, public administration, behavioral sciences, geriatrics gerontology, legal medicine, social work, “public environmental occupational health”; include Web of Science categories of psychiatry, clinical psychology, multidisciplinary psychology, behavioral sciences, gerontology, interdisciplinary social sciences, geriatrics gerontology, sociology, psychology, environmental studies, health care sciences services, public environmental occupational health, nursing, applied psychology, social work, pediatrics, health policy services, urban studies, law

[hoard* OR clutter] AND…

1. ‘community services’ OR ‘task force’
2. ‘social services’ OR ‘human services’
3. ‘home care’ OR ‘assisted living’ OR nursing
4. ‘fire code*’ OR ‘fire prevention’ OR ‘fire safety’
5. housing OR tenancy OR landlord*
6. harm OR risk OR hazard*
7. protection OR prevention OR safety
8. ‘older adult*’ OR ‘elderly’
9. inspection OR compliance OR violation OR court
10. clean* OR clear* OR removal
11. policy OR procedure
Appendix B  Scoping Review Targeted Website Search Documentation

This table presents the complete list of websites searched, their URLs, and the number of documents identified on each website that appeared to meet eligibility criteria.

<table>
<thead>
<tr>
<th>Retrieval Date</th>
<th>Organization Name</th>
<th>URL</th>
<th>Potentially Relevant Items Identified (based on eligibility criteria)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020-07-23</td>
<td>CAMH Evidence Exchange Network</td>
<td><a href="https://www.eenet.ca/resource/what-are-effective-interventions-hoarding-0">https://www.eenet.ca/resource/what-are-effective-interventions-hoarding-0</a></td>
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<tr>
<td>2020-07-21</td>
<td>Hoarding UK</td>
<td><a href="https://www.hoardinguk.org">https://www.hoardinguk.org</a></td>
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</tr>
<tr>
<td>2020-07-15</td>
<td>Metro Housing Boston</td>
<td>metrohousingboston.org</td>
<td>4</td>
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<tr>
<td>2020-07-11</td>
<td>Sage Seniors</td>
<td><a href="https://www.mysage.ca/help/this-full-house">https://www.mysage.ca/help/this-full-house</a></td>
<td>4</td>
</tr>
<tr>
<td>2020-07-18</td>
<td>Hoarding Connection of Cuyahoga County</td>
<td><a href="http://www.hoardingconnectioncc.org/index.cfm">http://www.hoardingconnectioncc.org/index.cfm</a></td>
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</tr>
<tr>
<td>2020-07-23</td>
<td>Institute for Challenging Disorganization</td>
<td><a href="https://www.challengingdisorganization.org">https://www.challengingdisorganization.org</a></td>
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<tr>
<td>2020-07-14</td>
<td>International OCD Foundation</td>
<td><a href="https://hoarding.iocdf.org">https://hoarding.iocdf.org</a></td>
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<tr>
<td>2020-07-18</td>
<td>Hoarding Task Force of Washtenaw County</td>
<td><a href="http://htfwashtenaw.org/resources">http://htfwashtenaw.org/resources</a></td>
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<tr>
<td>2020-07-11</td>
<td>Toronto Hoarding Network</td>
<td><a href="https://www.torontohoardingnetwork.ca">https://www.torontohoardingnetwork.ca</a></td>
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<tr>
<td>Date</td>
<td>Task Force Name</td>
<td>URL</td>
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<td>------------</td>
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<td>----------------------------------------------------------------------</td>
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<td>2020-07-29</td>
<td>18. Children of Hoarders</td>
<td><a href="https://www.childrenofhoarders.com">https://www.childrenofhoarders.com</a></td>
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<td>2020-07-18</td>
<td>20. Kane County Hoarding Task Force</td>
<td><a href="https://www.kchooding.org/copy-of-resources-1">https://www.kchooding.org/copy-of-resources-1</a></td>
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<tr>
<td>2020-07-18</td>
<td>22. Mental Health Association of San Francisco</td>
<td><a href="https://www.mentalhealthsf.org/san-francisco-task-force-on-compulsive-hoarding/">https://www.mentalhealthsf.org/san-francisco-task-force-on-compulsive-hoarding/</a></td>
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<td>2020-07-18</td>
<td>23. Milwaukee County Hoarding Task force</td>
<td><a href="https://milwaukeehoarding.weebly.com">https://milwaukeehoarding.weebly.com</a></td>
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<td>2020-07-18</td>
<td>32. Greater Brockton Area Hoarding Task Force</td>
<td><a href="https://www.ocesma.org">https://www.ocesma.org</a></td>
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<td>2020-07-18</td>
<td>33. Greenwich Hoarding Task Force</td>
<td><a href="https://www.greenwichct.gov/538/Human-Services">https://www.greenwichct.gov/538/Human-Services</a></td>
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<td>2020-07-18</td>
<td>34. Missoula Hoarding Task Force</td>
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<td>2020-07-18</td>
<td>35. Multnomah County Hoarding Task Force</td>
<td><a href="https://multco.us/ads/hoarding">https://multco.us/ads/hoarding</a></td>
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<td>Date</td>
<td>Organization</td>
<td>Website</td>
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<tr>
<td>2020-07-18</td>
<td>37. North Shore Center for Hoarding and Cluttering</td>
<td><a href="https://nselder.org/contact-us/">https://nselder.org/contact-us/</a></td>
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<tr>
<td>2020-07-23</td>
<td>38. Orange County Task Force on Hoarding</td>
<td><a href="https://sites.google.com/site/ochoarding/">https://sites.google.com/site/ochoarding/</a></td>
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<td>2020-07-18</td>
<td>40. Portland Hoarding Task Force</td>
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<td>2020-07-18</td>
<td>41. Rhode Island Hoarding Task Force</td>
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<td>2020-07-18</td>
<td>42. Rochester Hoarding Support Group</td>
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<td>2020-07-18</td>
<td>43. Summit Ohio Hoarding Task Force</td>
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</table>
Appendix C  Codebook for Broader Scoping Review on the Targets and Strategies of Community Interventions for Hoarding

This table presents the complete codebook of the broader scoping review on community interventions for hoarding.

<table>
<thead>
<tr>
<th>Target Codes</th>
<th>Definitions</th>
</tr>
</thead>
</table>
| **Functional Capacity** | physical, social, or psychological capacity to participate in making changes to maintain satisfactory quality of life and decrease harm potential  
*Examples: insight into or awareness of potential risks, willingness to engage or accept help, physical ability to clear clutter, presence of social networks, ability to manage own finances* |
| **Safety Risks**      | Concerns about safety of the home, including public safety risks                                                                                                                                 |
| Fire Safety           | conditions that violate common fire codes regarding fire ignition, prevent swift and safe emergency exit, or impede safe and efficacious entry of first responders  
*Examples: egress (including windows), access (to any emergency personnel, not just fire), smoke detectors, sprinklers, combustible items near heat source, external door swings, flammable items* |
| Degradation           | neglect of the home that results in structural or environmental risks or substandard housing conditions  
*Examples: structural deterioration, maintenance neglect, non-functioning or inadequate utilities or appliances, mold or chronic dampness* |
| **Health Risks**      | Risks to those living in the home                                                                                                                                 |
| Routine Self Care     | inability to engage in daily activities for maintaining life and well being  
*Examples: eating, sleeping, bathing, dressing, toileting, meal preparation* |
| Sanitation            | filth  
*Examples: garbage, odour, rotting food, urine/feces* |
| Medical Care          | inability to comply with medical treatment plans (does not include use of mobility aids)  
*Examples: finding medications, safe conditions for home-based healthcare, release from hospital to home, use of medical equipment* |
| Mobility              | inability to move safely and easily within the home  
*Examples: avalanche risks, slips and falls, use of mobility aids* |
Pests

presence of vermin or pests

*Examples: bedbugs, fruit flies, cockroaches, rodents, ability to effectively prevent or treat pest infestations*

Housing Security

instability of housing

*Examples: tenancy preservation, ability to live independently, lease violations, eviction threat*

Social Risks

social isolation or conflict that is relevant to the community

*Examples: isolation, conflict with family or neighbours, poor social network, loneliness, clutter or debris that spills into communal areas*

Vulnerable Occupants

residents who are less able to ensure their own welfare and quality of life

*Examples: child, older adult, person with disability, pets*

<table>
<thead>
<tr>
<th>Strategy Codes</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capacity Building</strong></td>
<td>strategies to increase skills or resources for communities to respond effectively to problems related to hoarding</td>
</tr>
<tr>
<td></td>
<td>development of organizational infrastructure to facilitate and coordinate knowledgeable and effective care for clients who are affected by problems related to hoarding; includes macro-level advocacy</td>
</tr>
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<td><em>Examples: establish workflow and referral streams; establish interdisciplinary networks; systems and protocols for assessment, triage, and intervention; provide training and professional development for staff within the agency or network; advocate for agency resources or reduced red tape</em></td>
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<td><strong>Organization/System</strong></td>
<td>formal or informal teaching and modeling to increase knowledge, understanding, and empathy among those who encounter hoarding in the community; does not include professional development within the agency</td>
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<td><em>Examples: conduct formal workshop at a conference for fire professionals, train professionals in various disciplines</em></td>
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<td><strong>Community</strong></td>
<td>teaching and modeling to promote functional capacity and support identified clients</td>
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<td><em>Examples: home organization skills, problem-solving skills, coaching to help client engage their support network, build motivation through discussion, conduct support groups for service users, informally educate a specific client’s family or neighbour</em></td>
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<td><strong>Client</strong></td>
<td>planning and coordination of care and services to stabilize and enhance wellness</td>
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<td><strong>Case Management</strong></td>
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| Case Finding | ways to identify potential clients who need help to avoid serious consequences  
|             | *Examples: referral streams, monitor court cases, actively establish and educate community network* |
| Supportive Relationship | establishment and maintenance of a trusting relationship; interventions to support rapport-building  
|             | *Examples: friendly visiting, gain cooperation, engage client, emotional care and support* |
| Initial Inspection/Assessment | evaluation of the home and residents; can include regular inspections as well as referral-based assessment  
|             | *Examples: establishing date, documentation of findings and recommendations, use of established hoarding assessment tools* |
| Planning and Goal Setting | intervention planning and goal setting that reflects the unique situation of both the client and the stakeholders  
|             | *Examples: establish priorities for addressing risks; set both longer-term and small immediate goals* |
| Monitoring and Evaluation | ongoing monitoring of the environment to track progress and outcomes following interventions  
|             | *Examples: follow-up or maintenance visits, documentation of progress and outcomes, repeated visits* |
| Referral Brokering and Linking | connecting specific clients with community resources to assist them with problems related to hoarding or other concerns  
|             | *Examples: referrals for decluttering assistance, legal representation health care, and meeting basic needs for food, clothing, shelter; referrals to specialized mental health and substance use treatment; temporary emergency housing* |
| Client Advocacy | efforts undertaken on behalf of a specific client or a population of clients to influence decisions in ways that support the clients and promote effective and equitable interventions; includes teaching/modeling for stakeholders holding power in a particular case  
|             | *Examples: accessing financial supports, arranging pro bono legal representation, identifying and attempting to reduce barriers to receiving community supports, psychoeducation for housing provider or inspector* |
Decluttering Assistance
instrumental assistance in consensual and collaborative efforts to gradually reduce volume of clutter and arrange items in a safer way; client is primary decision-maker for what to keep

Examples: helping client to sort and organize items, removing items client has decided to part with (e.g., dropping clothing at donation centre), arranging for removal services at client’s request, providing materials such as boxes or garbage bags for client to use

Clean Out
rapid removal of a large volume of materials from the home; may be consensual or coerced; client’s decision-making power is low or none

Examples: housing provider forced removal, family cleaned out, “Safety Day”, clean-out company

Rationale for Clean Out
conditions that necessitate a clean-out intervention; may include imminent risks in the home, external pressures, or client characteristics

Examples: extreme level of risk that cannot be ameliorated without a clean out, imminent hospital discharge delayed due to conditions in the home, client unable to participate in consensual decluttering due to cognitive decline, housing provider ultimatum of clean out or eviction

Practices
procedures used for a clean-out; includes preparation for clean-out and follow-up with client; includes policies that guide practices

Examples: official notice is given, outsourced to clean-up company, family member to attend clean-out as support person, policy against doing clean-outs

Outcomes
results or consequences of a clean-out; can include changes in level of risk, client reactions, long- or short-term follow-up

Examples: lower clutter volume, tenancy preservation, client stopped the clean-out, client distress, clutter rebuilt quickly

Perspective
statement that reflects a perspective about clean-outs

Examples: “A clean-out does not address the resident’s underlying attachments to clutter”, “Clean-outs are a tool that we use under some conditions”, “Client previously had a clean-out and it was a negative experience”

Regulations and Laws
use of legal powers to gain compliance with laws, rules, or regulations; includes notices of violation and disability accommodation

Examples: lease violation, order to permit inspection, fire order, eviction threat, making accommodation for disability

Eviction
interventions that involve removing the client or other occupant from the home

Examples: eviction, condemnation
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<th>Rationale for Eviction</th>
<th>conditions that necessitate removal; may include imminent risks in the home, external pressures, or client characteristics</th>
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<td>Examples: <em>client unable to safely remain in housing alone due to cognitive decline, noncompliance with city orders, housing court ruled in favour of removal</em></td>
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Appendix D  Scoping Review Included Documents and Relevant Themes

This table provides a summary of the included published and grey documents in the scoping review. A checkmark signifies that a document had at least one code pertaining to clean-outs or eviction.

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Appendix E  Interview-Based Survey Questions

This appendix presents the interview questions for the Hoarding Clean-Out interview-based survey.

Provider Sample Characteristics

1) With which gender do you most identify?
   a. Man
   b. Woman
   c. Transgender woman/ Trans woman
   d. Transgender man/ Trans man
   e. Non-binary
   f. Two-spirit
   g. Not listed ______
   h. Prefer not to answer

2) What is your cultural background? Choose all that apply.
   a. African
   b. European
   c. East Asian (China, Mongolia, North Korea, South Korea, Japan, Hong Kong, Taiwan, Macau)
   d. South Asian
   e. South East Asian
   f. First Nations or Indigenous (please specify) __________
   g. Hispanic or Latinx
   h. Middle Eastern
   i. Other (please specify)
   j. Prefer not to answer________

3) Roughly, how old are you? _________

4) I’m using the term “clean-out” to describe a fairly rapid (1 day to 1 month) intervention that removed a large amount of possessions from a client’s home. What terms did you use to describe this intervention to [client’s name] or other service providers? Did you call it something other than “clean-out”? _____

Hoarding Client Characteristics

5) With which gender did [client’s name] most identify as?
   a. Man
   b. Woman
   c. Transgender woman/ Trans woman
   d. Transgender man/ Trans man
e. Non-binary
f. Two-spirit
g. Not listed ______
h. Prefer not to answer

6) Approximately, how old was [client’s name]?
   a. Young adult 19-29
   b. Adult 30-44
   c. Mid-life adult 45-64
   d. Older adult 65+

7) Did [client’s name] live alone or with others?
   a. Alone
   b. With others
   c. I don’t know

8) Did [client’s name] live in a house, apartment/condo/townhouse, or suite in house?
   a. Detached (single family) house
   b. Duplex/Apartment/ Townhouse
   c. Suite in house

9) Did [client’s name] rent or own?
   a. Rent
      i. If rent, did [client’s name] live in subsidized or social housing? Yes/No/I Don’t Know
   b. Own
   c. I don’t know

10) Did [client’s name] participate in any of the following in the weeks leading up to the clean-out?
    a. Peer support group Y/N
    b. Cognitive behavioural therapy Y/N
    c. Decluttering work with a professional (e.g., case manager, professional organizer, health professional) Y/N
       i. If yes, was this professional also involved in the clean-out? Y/N
    d. Other ______________
    e. I don’t know

11) Who was involved in the clean-out? (e.g., you, [client’s name]’s sister, and two workers from a clean-out company) ____________

12) Who physically removed the items during the clean-out? ____________

13) Did [client’s name] assist in the physical removal? Y/N
14) Did [client’s name] assist in sorting? Y/N

15) Did anyone provide [client’s name] with emotional support during the clean-out process? Y/N
   Was it a family member, friend, or professional (what kind)? ____________

16) Where was [client’s name] during the hoarding clean-out?
   a. They were on-site [at home]
   b. They visited on and off throughout the intervention
   c. They were off-site [not at home]

17) Some clean-outs take hours, some take days. Do you remember how many hours or days the
   physical removal of items took? (e.g., 8 hours in 1 day, 3 hours across 3 days) ____________

---

**Clean-Out Rationale**

18) In the decision to have a clean-out, how important were concerns about [client’s name]’s
    physical health?  
    (e.g., extremely important because [client’s name] was having difficulty getting around their
    home due to mobility problems or because they were using a wheelchair/walker)

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| Not at all important  
(Not a part of the decision) | Slightly important | Important | Very important | Extremely important  
(One of the most important deciding factors) | I don’t know |

19) In the decision to have a clean-out, how important were concerns about [client’s name]’s
    cognitive functioning?  
    (e.g., extremely important because you were concerned [client’s name] was unable to live
    independently in their home and because their memory was declining rapidly)

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| Not at all important  
(Not a part of the decision) | Slightly important | Important | Very important | Extremely important  
(One of the most important deciding factors) | I don’t know |

20) In the decision to have a clean-out, how important was [client’s name]’s refusal to engage?  
    (e.g., extremely important because [client’s name] flat-out refused any other offer of help)
21) In the decision to have a clean-out, how important were concerns about **unsafe conditions in the home**?
(e.g., extremely important because exits were blocked and there was clutter near heat sources)

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22) In the decision to have a clean-out, how important were concerns about **squalor or filth**? (e.g., rotten food, feces, wet garbage) *(if they don’t know what squalor is – ask about the examples)*
(e.g., extremely important because there was rotten food and feces throughout the home)

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23) In the decision to have a clean-out, how important were concerns about **the presence of insects or rodents**? (e.g., extremely important bedbugs and mice had infested the neighbouring units)

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24) In the decision to have a clean-out, how important were concerns from **the neighbours**? 
(e.g., extremely important because [client’s name]’s strata was taking them to court)

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25) In the decision to have a clean-out, how important were concerns about **eviction or loss of housing**? (e.g., extremely important because their landlord said this was their final warning)

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26) In the decision to have a clean-out, how important were concerns that [client’s name] **would not be discharged from hospital**? 
(e.g., extremely important, even though [client’s name] was cleared medically, hospital staff were concerned there was risk of infection due to the conditions of the home)

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27) Were there **other reasons** for the clean-out that have not been mentioned? [repeat the reasons they did say were important factors] Y/N
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Clutter Removal

28) Now I’d like to know about how many of [client’s name]’s possessions were removed during the clean-out. Possessions here refers to all the contents of the home, including both treasured items and less treasured items, like recycling or garbage.

I’m going to read several statements. Please tell me which one fits the clean-out best.

1- Not a lot of possessions were removed from the home, but things were re-arranged so that it was safer.
2- Some possessions were removed from 1 or 2 rooms, but the rest of the home stayed the same.
3- Some possessions were removed from every room.
4- A lot of possessions were removed from 1 or 2 rooms, but the rest of the home stayed pretty much the same.
5- A lot of possessions were removed from every room. [at least 3 rooms]
6- Everything was removed from the home.

Now I’m going to show you the Clutter Image Rating scale. This is the Clutter Image Rating scale. As you can see picture 1 is not very cluttered, and picture 9 is the most cluttered.

29) The day before the clean-out [reference whatever duration they described earlier e.g. at 9am when you started], which photo most accurately reflects the total amount of clutter that was in the living room? (even if it wasn’t arranged exactly like this)

30) The day after the clean-out finished [reference whatever duration they described earlier e.g. at 7pm when you finished], which photo most accurately reflects the total amount of clutter that was in the living room?

31) The day before the clean-out, which photo most accurately reflects the total amount of clutter that was in the bedroom?

32) The day after the clean-out finished, which photo most accurately reflects the total amount of clutter that was in the bedroom?
33) **The day before the clean-out**, which photo most accurately reflects the total amount of clutter that was in the kitchen?

34) **The day after the clean-out finished**, which photo most accurately reflects the total amount of clutter that was in the kitchen?

35) Were there any rooms other than the living room, bedroom, and kitchen where **more** possessions were removed? *(where there was more of a dramatic change)*

---

### Client-Centered Approach

36) I’ll read a statement and then I want you to tell me how true the statement is, from completely false to completely true.

It was [client’s name]’s decision to have a clean-out.

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<tbody>
<tr>
<td><strong>Completely False</strong></td>
<td>Mostly false <em>(More false than true)</em></td>
<td>Neutral <em>(In between)</em></td>
<td>Mostly true <em>(More true than false)</em></td>
<td><strong>Completely True</strong></td>
<td></td>
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</table>

37) Now I’m going to ask you to rate how much [client’s name] was involved in the clean-out, from not at all involved to extremely involved.

### Shared Decision Making During Clean-Outs

How involved was [client’s name] in the decisions about which items were removed during the clean-out (including recycle/donate)?

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<tbody>
<tr>
<td><strong>Not at all involved</strong> <em>(client’s name] made no decisions about which items were removed)</em></td>
<td>Slightly involved</td>
<td>Somewhat involved</td>
<td>Moderately involved</td>
<td>Extremely involved <em>(client’s name] made every decision about which items were removed)</em></td>
<td>I don’t know</td>
</tr>
</tbody>
</table>
38) Did you (or any of the professionals involved) discuss with [client’s name] **why the clean-out had to happen**? Y/N
   How much did you/they talk to [client’s name] about **why the clean-out had to happen**?

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<td>A little</td>
<td>Somewhat</td>
<td>Quite a bit</td>
<td>A great deal</td>
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39) Did you (or any of the professionals involved) talk to [client’s name] about **their role** during the clean-out (for example, what they would be doing during the clean-out?, where they would be?) Y/N
   How much did you/they talk to [client’s name] about **their role** during the clean-out?

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40) Did you (or any of the professionals involved) talk to [client’s name] about **their personal goals** for the clean-out (e.g., which areas they would like decluttered)? Y/N
   How much did you/they talk to [client’s name] about **their personal goals** for the clean-out?

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41) Did you (or any of the professionals involved) talk to [client’s name] about their **concerns and fears** about the clean-out? Y/N
   How much did you/they talk to [client’s name] about their **concerns and fears** about the clean-out?

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**Affective Reaction**

42) **Affective Reaction**
   From your perspective, how **angry** was [client’s name] about having a clean-out?

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<td>Slightly</td>
<td>Somewhat</td>
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43) From your perspective, how sad was [client’s name] about having a clean-out?

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44) From your perspective, how frightened was [client’s name] about having a clean-out?

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45) From your perspective, how relieved was [client’s name] about having a clean-out?

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46) From your perspective, how pleased was [client’s name] about having a clean-out?

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**Health and Safety Outcomes**

47) Did you (or any professional involved) provide any follow-up support after the clean-out?
   a. Yes
   b. No
   c. I don’t know

   [If yes,] what kind of follow-up did you provide?
   a. Emotional support following the clean-out? Y/N
   b. Health/wellness check? Y/N
   c. Re-inspection? Y/N
   d. Decluttering support/maintenance? Y/N
   e. Another clean-out? Y/N
   f. Other ________
   g. I don’t know what kind of follow-up support was provided

48) Is [client’s name] currently living in the same residence?
   a. Yes, they are living in the same residence
   b. No, they are not living in the same residence
   c. I don’t know
49) If no, do you know why they are no longer living in the same residence?
   a. They were evicted
   b. They moved to a care home
   c. Other ______
   d. I don’t know

50) Do you know how long the clutter level was maintained after the clean-out? (can repeat the CIRs the clean-out finished with)
   a. In months ______
   b. I don’t know
   c. Client no longer lives in residence; maintenance n/a

51) From your perspective, how much did the cleanout help to resolve [client’s name]’s overall problems with clutter? [i.e., their hoarding symptoms of difficulties with discarding and intentional saving]

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<td>The clean-out didn’t really help</td>
<td>Neutral</td>
<td>The clean-out helped somewhat</td>
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52) From your perspective, how much did the cleanout help to resolve the health & safety issues in [client’s name]’s home?

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53) If you could have made the clean-out experience better for [client’s name] (e.g., less distressing, less overwhelming), what would you have done? ________________________

54) We have put a lot of questions to you, is there any question you thought we were going to ask, but didn’t? ________________________