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Understanding the Occupational Therapy Perspective of Working with the Homeless Population: Self-Care Interventions

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UNDERSTANDING THE OCCUPATIONAL THERAPY PERSPECTIVE OF WORKING WITH THE HOMELESS POPULATION: SELF-CARE INTERVENTIONS

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ABSTRACT

Successful interventions, focused on self-care, have been implemented by occupational therapists in homeless populations. Yet, no study has attempted to explore experiences of occupational therapists implementing self-care interventions. This qualitative, descriptive study sought to understand the experience of occupational therapy practitioners implementing self-care interventions for individuals experiencing homelessness. The interventions took place in various healthcare practice settings. Four participants, recruited through purposive sampling, engaged in semi-structured interviews pertaining to their experiences. The interviews were transcribed and coded using an emergent approach. Three major themes emerged from the data, including experiences in different settings, client-centered care, and institutional barriers and supports.

KEYWORDS: Activities of daily living, housing security, mental health, sheltered, supportive housing

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I. Introduction

Purpose Statement

There is a gap in the literature surrounding occupational therapy-initiated self-care interventions among homeless populations implemented in a variety of healthcare practice settings. The purpose of this descriptive qualitative study is to understand the experiences of occupational therapy practitioners implementing self-care interventions for individuals experiencing homelessness in various healthcare practice settings.

Research Questions

What is the experience of occupational therapy practitioners addressing self-care among homeless populations in various healthcare practice settings?

What are the opportunities and challenges to addressing self-care in various health-care settings?

Definition of Terms

The operational definitions of the following terms will be used throughout this research:

Adult: age 18 and older

Healthcare Practice Setting: the type of organization and location of the intervention and includes acute care, homeless shelter, supportive housing center, and outpatient, for this study.

Homeless: "an individual or family who lacks a fixed, regular, and adequate nighttime residence, such as those living in emergency shelters, transitional housing, or places not meant for habitation" (Supplemental Security Income/Social Security Disability Outreach, Access, and Recovery (SOAR), 2019, para. 2).

Mental health: “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2016).

Mental illness: “a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities” (American Psychiatric Association, 2013).

Self-care: typically categorized as activities of daily living, focuses on caring for one’s body and includes toileting, toilet hygiene, bathing, showering, dressing, personal hygiene and grooming (AOTA, 2014).

Sheltered homeless: “a person residing in an emergency shelter, including temporary emergency shelters only open during severe weather; transitional housing for homeless persons who originally came from the streets or emergency shelters” (U.S. Department of Housing and Urban Development, 2008).

Supportive housing: “housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability” (U.S Department of Housing and Urban Development, 2019).

Unsheltered homeless: “a person residing in a place not meant for human habitation, such as cars, parks, abandoned buildings, or on the street” (U.S. Department of Housing and Urban Development, 2008).

Literature Review

Homelessness is a national issue within the United States with 552,830 individuals experiencing homelessness on any given night in 2018 (National Alliance to End Homelessness, 2019). Homelessness is defined as "an individual or family who lacks a fixed, regular, and adequate nighttime residence, such as those living in emergency shelters, transitional housing, or places not meant for habitation" (Supplemental Security Income/Social Security Disability Outreach, Access, and Recovery (SOAR), 2019, para. 2). There are a variety of reasons an individual may become homeless, including lack of affordable housing, unemployment, poverty, mental illness, and substance abuse (The National Law Center on Homelessness and Poverty, 2015).

According to the National Institute of Mental Health (2009), 20-25% of homeless individuals have a severe mental illness, yet only 6% of the total United States population is diagnosed with a severe mental illness. The disproportionately high statistic emphasizes the importance of recognizing, understanding, and assisting in treatment of mental illness symptoms while assisting with homeless populations.

The American Occupational Therapy Association (2018) explains that occupational therapy (OT) interventions can be successful for individuals who have severe mental illness. OT interventions for clients with mental illness focus on education, work, skills training, health and wellness, and cognitive remediation and/or adaptation (AOTA, 2018). Skilled OT services for individuals with severe mental illness have proven effective and provide a functional and improved quality of life (Noyes, Sokolow, & Arbesman, 2018; Lloyd & Bassett, 2012). There is strong

evidence to support OT interventions in the form of individual placement and support, cognitive interventions, and social skills programs (Noyes, Sokolow, & Arbesman, 2018). Further, Lloyd and Bassett (2012) found several benefits to homeless individuals of including OT on the healthcare team of an outreach program, including reestablishment of roles, medication management, and overall occupational performance priorities.

Because occupational therapists are equipped to assist others in psychosocial factors, such as coping strategies, routine development and self-efficacy, they offer a unique perspective when helping individuals develop the skills and qualities necessary to regain housing security (AOTA, 2018). Studies have explored the experiences of homeless individuals and opportunities for occupational therapy services in the various settings of unsheltered (Cunningham & Slade, 2019; Dufor, 2015), sheltered (Tyminski, 2018; Schultz-Krohn & Tyminski, 2018; Simpson, Conniff, Faber & Semmelhack, 2018; Munoz, Dix, & Reichenbach, 2006; Bradley, Hersch, Reistetter, & Reed, 2011) and within supportive housing programs (Quinn, Dickson-Gomez, Nowicki, Johnson, & Bendixen, 2017; Gutman & Raphael-Greenfield, 2017). Unsheltered homelessness is defined as "a person residing in a place not meant for human habitation, such as cars, parks, abandoned buildings, or on the street" (U.S. Department of Housing and Urban Development, 2008). Sheltered homelessness is defined as "a person residing in an emergency shelter, including temporary emergency shelters only open during severe weather; transitional housing for homeless persons who originally came from the streets or emergency shelters" (U.S. Department of Housing and Urban Development, 2008). Further, supportive housing, a form of sheltered homelessness, is defined as "housing

with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability" (U.S Department of Housing and Urban Development, 2019).

Individuals who are homeless experience imbalance, including partial to complete lack of productive occupations, limited social participation and inability to develop meaningful routines due to their situation (Simpson, Conniff, Faber, & Semmelhack, 2018). Because homeless individuals are unable to engage in routine occupations, tasks such as self-care may lack priority and lead to the inability to obtain employment and stable housing (Simpson, Conniff, Faber, & Semmelhack, 2018). Self-care intervention falls within the domain of occupational therapy (AOTA, 2014). Therefore, it is important to explore the role of occupational therapy services in the implementation of self-care tasks among individuals who experience homelessness.

Self-care, typically categorized as activities of daily living, focuses on caring for one's body and includes toileting, toilet hygiene, dressing, bathing, showering, personal hygiene and grooming (AOTA, 2014). Although self-care skills may not be typically prioritized by individuals who are homeless (Simpson, Conniff, Faber, & Semmelhack, 2018), they serve as fundamental skills in obtaining stable employment and housing. However, individuals with mental illnesses often experience personal limitations, such as poor time management, initiation, planning, social interaction skills and emotional regulation, which leads to the inability to effectively perform self-care tasks (Holmqvist & Holmefur, 2018). Even when self-care is prioritized, individuals find it overwhelming and stressful to manage their personal hygiene due to harsh

environments (Durfor, 2015). The combination of personal and environmental factors can limit the homeless individual's ability to successfully complete self-care tasks (Holmqvist & Holmefur, 2018; Dufor, 2015).

Bradley, Hersch, Reistetter, & Reed (2011) looked at roles, habits, and contexts of homeless individuals and found only 13.33% of participants were able to facilitate occupation, such as participation within their roles, habits and values, while living in the homeless shelter. Occupational therapists strive to provide client-centered care to the homeless population, focusing on the client's wants and needs in order to facilitate improved outcomes (Helfrich & Chan, 2013). Although there is a need to implement meaningful interventions, the quantity and quality of resources available to OTs to develop those interventions are limited (Bradley, Hersch, Reistetter, & Reed, 2011). The lack of OT contact with homeless individuals through a time of housing change leads to a reemergence of a lack in self-perceived competence (Helfrich & Chan, 2013). Specifically, individuals with thought disorders experienced a reduction in the ability to perform self-care tasks during this period of housing change (Helfrich & Chan, 2013).

Successful life skill interventions, with a focus on self-care, have been implemented by occupational therapists in homeless populations who have a psychiatric disability (Helfrich & Chan, 2013). The OT interventions resulted in increased awareness of competencies, knowledge of further needs, higher rates of transition to supportive housing, and increased quality of life (Helfrich & Chan, 2013; Gutman & Raphael-Greenfield, 2017). However, no study has yet to understand the experiences of occupational therapists implementing self-care interventions among homeless populations in various healthcare practice settings. Healthcare practice setting refers to

the type of organization and location of the intervention and includes acute care, homeless shelter, supportive housing center, and outpatient, for this study.

The purpose of this qualitative descriptive study is to address the gap in the literature surrounding the experiences of occupational therapy practitioners implementing self-care interventions for individuals experiencing homelessness in various healthcare practice settings. The researchers sought to explore the following objectives:

1. To understand the experience of occupational therapy practitioners addressing self-care among homeless populations in various healthcare practice settings.
2. To explore the opportunities and challenges to addressing self-care in various health-care settings.

II. Research

Materials and Methods

Research Design

This study utilized a descriptive approach in attempt to gain an in-depth understanding of the experience of occupational therapists working with homeless individuals on self-care tasks. Qualitative descriptive research aims to study people in their context and how they make sense of the world (Guba & Lincoln, 2005). A semi-structured questionnaire was developed and utilized in the interview process (Appendix A). The Person Environment Occupation Model was utilized to inform the development of the semi-structured questionnaire (Law et al., 1996). This model considers personal factors such as, interests, values, sensory and motor abilities, and decision-making abilities as well as environmental factors such as, available resources, physical characteristics, and social support, and occupation-specific demands on the impact of occupational participation (Law et al., 1996). The questionnaire was developed through an in-depth review of current and foundational literature, and back and forth discussion and revisions with the faculty mentor. The questionnaire consisted of seven demographic questions, followed by eleven questions pertaining to the occupational therapy practitioner's experiences in working with the homeless population on self-care tasks.

Participants

Participants were recruited through the use of a written prompt shared on the American Occupational Therapy Association community research forum, called "CommunOT" and other relevant occupational therapy social media platforms.

Participants were recruited utilizing purposive sampling. After participants reached out to the investigator, a written prompt was utilized as a screening tool for verification of meeting inclusion criteria. Inclusion criteria consisted of being an occupational therapy practitioner, student or faculty member who has worked with individuals experiencing homelessness on self-care tasks for at least three months, age 18 or older and English-speaking. Once the participant was screened and identified as meeting the inclusion criteria, informed consent was obtained. A completed copy of the informed consent was given to each participant for their record prior to scheduling the interview. Participants were given direct contact information to the primary investigator and prompted to direct any questions to the investigator as needed. No incentive was given for participation in the study.

The sample consisted of four female occupational therapy practitioners. Participants' age, ethnicity, state of practice, years of OT experience, main practice area, practice setting, and length of time working with individuals experiencing homelessness are illustrated in Table 1. Information is presented collectively to conceal participant identities.

Table 1. Participant Demographic Information							
Age	**Gender**	**Ethnicity**	**State of Practice**	**Main Practice Area***	**Practice Setting***	**Years of OT Experience**	**Years Working with Homeless Individuals**
31	Female (4)	Asian-Pacific Islander	Alabama	Academic Education	Acute Care	3	3
45		Caucasian (3)	New York (2)	Community and Home Health (2)	Homeless Shelter (3)	6.5	4
46			Pennsylvania	Mental Health (2)	Supportive Housing (2)	18	6
55				Rehab and Disability	Outpatient Substance Use Rehab	32	15
					Outpatient Program for Domestic Abuse Survivors		

Table 1. Participant Demographic Information

Data Collection and Analysis

Qualitative data was collected by the primary investigator through semi-structured, audio-recorded phone interviews. The interviews were transcribed verbatim and analyzed using Creswell's emergent coding method (Creswell & Poth, 2018). Emergent coding is the process of reading the transcripts multiple times to allow the codes to emerge from the data (Creswell & Poth, 2018). The transcripts were read and reread to emerge codes, categories and themes from the data. Initial transcripts were read, and notes were made regarding participant experiences with little interpretation. The primary author utilized HyperRESEARCH version 4.0.3 to aid in the organization and analysis of the data (ResearchWare, Inc., 2019). HyperRESEARCH 4.0.3 is a computer software that offer tools for uploaded transcripts, such as highlighting words and phrases for coding, with further capabilities for organizing categories and themes.

Coding was completed by maintaining participant phrasing as closely as possible. Categories emerged from the coding by maintaining participant phrasing and adding interpretation. Added interpretation of participant phrasing was done using an in-depth search of the literature and reviewing transcripts several times. Finally, categories were grouped into themes. The theme concepts were analyzed over time and agreed upon by all researchers. The 383 codes were transformed into 12 categories which emerged as three major themes. Several measures were taken to increase trustworthiness of the study. The researcher participated in reflexivity journaling throughout the interview, emergent coding, and theming processes. An audit trail was developed through reflexivity and memoing. Member checking was done by verifying themes with one of the participants. The combination of literature, member checking, and collaboration of all researchers on thematic development triangulates the data.

Protection of Human Rights

For this study, the researchers completed and obtained approval by Eastern Kentucky University's Institutional Review Board (IRB), IRB #2482. Informed consent was provided and explained to each participant. Further, participants were given direct contact information of the primary investigator for any questions and/or concerns. Upon completion of informed consent, participant names were removed from data and replaced with a pseudonym. Once data collection was completed, items were stored in a locked area and a protected flash drive. All data will remain concealed with the researcher.

Results

Three major themes emerged from the data, each with four categories. Each theme is supported with multiple verbatim participant quotes. The major themes are: experiences in different settings, client-centered care, and institutional barriers and supports. Categories within the experience in different settings theme are: transiency nature versus supportive housing, use of standardized and non-standardized assessments, range of intervention utilizing available space/objects, and the benefit of OT students. Categories within the client-centered care theme are: fluctuation of needs and motivation to work with OT, connecting self-care to a personal goal, related to client physical and mental health, and physical and social environmental factors. Categories within the institutional barriers and supports theme are: institutional rules/resources, communication with other staff, adaptive equipment, and related to OT reimbursement.

Experiences in Different Settings

Transiency nature versus supportive housing. The participants each described unique experiences based on the setting of care. The transient nature of a homeless shelter impacted the follow though of the self-care interventions. Participant 3 said, "Yeah also that (self-care) tends to be difficult to track because of what I mentioned – the transiency nature of folks we work with, they could be there two weeks and then gone". Further challenges, related to the follow through of self-care, were present in the homeless shelter setting. Participant 1 explained:

> I mean they're on their own completely, they don't have anyone checking on them, they don't have friends or home health and, in the shelter, they really get dropped off in an uber and they walk in, sign themselves in.

Individuals in a homeless shelter do not have any form of accountability in maintaining their self-care habits. However, in a supportive housing setting, OTs spend more time with each participant, getting to know their personalities and self-care routines. Participant 3 explained:

> These are the same set of clients for four years now, and they will be the same set of clients until they move out or get kicked out or decide to move and get replaced by someone else generally, so I've seen them in their good points and also in their not so positive things in their lives.

Participants working within the supportive housing setting found benefits to establishing rapport and trust over time with the same set of clients.

Use of standardized and non-standardized assessments. Participants had varying experiences of using standardized and non-standardized assessments for measuring levels of self-care. Participant 4 identified utilizing several standardized assessments within the homeless shelter and supportive housing settings. The assessments included: Canadian Occupational Performance Measure (COPM), Allen's cognitive level screen, University of Rhode Island Change Assessment Scale (URICA), Timed Up and Go (TUG) and Berg Balance Scale. However, she did not feel any one assessment grasped the entire nature of homelessness and how the context may impact self-care. This participant worked to develop her own, non-standardized assessment after spending several years with the homeless population. She explained, "It's something I developed because we struggled with the other tools, they were a bit too drilled down". Other participants were unable to utilize standardized assessments. Participant 1 explained, "Yeah, we really don't use any in acute care which I wish we did more" when speaking about standardized assessments used. Participant 2, in a homeless shelter setting, shared similar experiences when asked about using

assessments for self-care: “my nose haha other, you know, reports from staff members”. Each participant had a unique approach to self-care assessment, but none utilized an assessment specific to the homeless population.

Range of intervention utilizing available space/objects. Participants described a wide range of self-care interventions that fluctuated based on the setting and available resources. Participant 1, working in acute care, focused almost entirely on self-care intervention:

> Well yes, it’s definitely crucial, it’s their whole focus, you know, their ADLs and stuff they need to be independent before they leave so it is the most crucial I think for sure I mean that’s the main part of my treatment usually.

Other participants found it beneficial to be in a homeless shelter setting, where there is direct access to the individual’s belongings, “You know, working in a shelter, we also have access to our client’s walkers and bed areas so we can get an idea of how they keep their area”, participant 2 explained. Interventions also varied in the supportive housing setting, as there was greater opportunity for group therapy sessions and outings. Participant 4 explains:

> Some of it is social participation, other times it may be more of your ability to maintain your job and get somewhere, how to dress properly for work, where to find places you can obtain either like consignment shop clothing or um but actual self-care like grooming, hygiene like that we typically do in the group format on-site you know like the hygiene kits, we’ve done like pedicure, manicure because footcare is a big issue with individuals who have a history of homelessness.

Benefit of OT students. In each practice setting, participants saw many benefits related to having OT students on site. In the outpatient and homeless shelter setting, students were able to spend more time with clients who had more extensive self-care needs. Participant 2 explained, “I supervise students all year long, I almost

always have at least two … so they can really dig in with clients". Similarly, in the supportive housing setting, there were ample opportunities for OT students to run group interventions. Participant 4 explained,

> We have several Level I opportunities where they go out in groups of six and learn how to run groups … we do Level II programming … and eight to nine months out of the year, we're doing the doctoral capstone where students are on-site September-April and run programming, so we kind of just really collaborate heavily with them.

The OTs expressed being able to provide a wider outreach with having OT students on site at the various settings.

Client-Centered Care

Fluctuation of needs and motivation to work with OT. Although each participant had varying experiences based on their setting of care, all expressed the need to provide client-centered care when implementing self-care interventions. The homeless individuals had a fluctuation of self-care and motivation which changed based on life circumstances and readiness to change. Internal factors, such as motivation, may impact a client's desire to engage with OT. Participant 2 explained,

> I mean really its people who people who want to participate and ask to be seen for hygiene use… a lot of people who live in the shelter do have difficulties with hygiene, but they may not ever come to OT.

Further, Participant 4 explained the importance of meeting a client where they are, "if you're not ready to change for some reason, we can come up with 3,000 really amazing strategies and if the person is not ready just for whatever reason, we typically don't see any change". In the homeless shelter setting, participants described the homeless individual's focus to be on immediate safety needs, rather than self-care needs.

Participant 4 specifically highlighted this difference in the supportive housing setting as compared to the homeless shelter:

> Yeah, I think where people are so committed to recovery (in supportive housing), they'll take medications if needed, so they kind of have a little bit more balance whenever we feed into their day and more structure, but you know can be really random in the safe havens (homeless shelters) just because of the things I was talking about so couldn't get sleep at night, feelings of insecurity, not wanting to take medications, you know, a lot of addiction issues go along with that but amazingly many people come in and move up and out – they're just ready for it or ready to take on the cognitive demand of requests.

Individuals finding shelter within a homeless shelter typically were focused on their immediate safety needs. However, in the supportive housing locations, clients tended to be ready for change and open to self-care intervention.

Connecting self-care to personal goal. Once an individual was ready to make a change, the participants relayed the importance of connecting self-care to a personalized, client-centered goal. Participant 3 discussed one client's goal to maintain permanent housing, "They will have interviews for housing at some point cause that's what they need to do in order to get into the place where they're going to be living, and they might pitch self-care goals centered around that". Participant 2 further highlighted this approach by stating,

> Trying to connect the hygiene issue with the client's personal goals, so for instance if they want to go and become employed or whatever the goal, they're going to have to address the hygiene issue in order to accomplish that goal.

The clients may not have prioritized self-care, but the OTs connected self-care as a foundational goal to obtaining a larger, client-centered goal.

Related to client physical and mental health. Participants further emphasized the importance of understanding each client's physical and mental health while

implementing self-care interventions. Physical impairments, especially in acute care, impacted the intervention and length of stay. Participant 1 explains:

> definitely motor and sensory because that one I had for 8 months, he came in completely paralyzed; so he had a lot of sensory issues, like his shoulders and elbows, so it was really hard for him to wipe and tie his shoes.

Participant mental health also impacts the level of intervention. Participant 2 stated:

> I think it's almost all the time schizophrenia spectrum disorder in terms of sensory awareness. From what I understand the sense of smell is affected first or early and then they may not notice. And the body awareness issue too.

Clients may not be aware of their self-care needs or lack of self-care habits due to mental health conditions. Interventions may vary based on the individual's physical and mental needs.

Physical and social environmental factors. Recognition of the physical and social environments impacted the client-centeredness of intervention. The harsh social environment impacts individuals with physical disabilities and their ability to complete self-care tasks. Participant 1 explains,

> They are too embarrassed like won't go shower even though there is a shower they don't want to be called out or get made fun of or they have to get dressed under the sheets so the social stuff hard to deal with people watching.

The physical environment often did not afford the access to necessary facilities, such as the laundry machines. Participant 2 describes. "it's on the second floor and we're in a building that's over 100 years old, so we don't have an elevator to climb up there". Often, both the physical and social environments impacted self-care completion. Participant 4 describes the impact of both the physical and social environments of homeless shelters:

> The two areas are very much like giant rooms with beds separated by a little wall, so you have people up all hours of the night responding to hallucinations, screaming, going through withdrawal, coming in high, and sleep is a huge thing that impacts almost everything so the clients who we try to work with, cause you know we don't work during nighttime hours, are sleeping because they're up all night so then they just stay in this cycle which tends to feed into a bit of depression.

Institutional Barriers and Supports

Institutional rules/resources. Self-care interventions were often influenced by the institutional barriers and supports in place. Each institution had unique rules and resources. Often, homeless shelters had rules of having the individuals out of the shelter by a certain time. For individuals with physical impairments, it was often difficult to complete self-care tasks in the allotted amount of time. Participant 1 explains, "sometimes I'll help them change there…but they're in a hurry too because they (the shelter) kick them out of there pretty early and some of them it takes them an hour to get dressed". Participant 3 further emphasizes having little space within a supportive housing facility:

> There's limitations in terms of what they can bring into shelter, how much they can keep with them, their closet. I had a guy once complain to me about how can he possibly do well during an interview where his shirts are always so wrinkled because the closets when he put the shirts are not large enough.

Communication with other staff. Communication with other staff members was often lacking, with other staff completing self-care tasks for the homeless individuals. Participant 3 explains,

> They were admitted that evening or they came in, immediately the residential aids do that so it wouldn't even be my role, it would be their role to make sure the person gets a proper shower and gets cleaned up.

Participant 1 further demonstrates this, "some of them just get used to the nurses doing it". However, when team members work together, participants saw success with

homeless individuals progressing. Participant 4 explains, “we’re seeing over time that our collaborative efforts with case management, occupational therapy, and collaborating with the residents, they get up and either move out of the shelter in permanent supportive housing”.

Adaptive equipment. Adaptive equipment choices were made based on the practicality of use and availability, rather than what might be best for the client. Participant 1 explains,

> There was this one guy in a walker, and I was thinking he can’t walk around the whole city all day cause he would get tired and he could only do what like 15 feet so he couldn’t walk around the streets all day so we had to fit him with a wheelchair.

Other OTs found supports within the community when looking for proper equipment. Participant 3 explained,

> We also tend to look to our other not for profit partners you know there’s other organizations that provide free used equipment for folks if they ever needed something or required some kind of specialty or was more expensive then we have partners to look to.

Related to OT reimbursement. Barriers and supports were found within the confines of billing and reimbursement for OT services. One participant explained the potential in the opportunity of having more OTs on site if services were reimbursable. “there’s just not reimbursement, I mean if we had more OTs on site, we could bill for some of these needs which we can’t currently” Participant 4 examined. However, participant 2 found benefits to not billing for services provided: “OT doesn’t bill here, we don’t bill Medicaid for budget lines, so we do have a lot of freedom of how we spend our time”. The OTs each saw benefits of their interventions but were unable to provide consistent services due to lack of reimbursement and billing.

Discussion

Varying experiences in different practice settings was a prominent theme to emerge from the data. The transient nature of homeless individuals residing in a homeless shelter made it difficult to consistently implement and track progress of self-care interventions. Similarly, Simpson, Conniff, Faber, and Semmelhack (2018) found participant transiency to negatively impact follow up opportunities. However, a participant working in a supportive housing setting found it beneficial to work with the same set of clients in order to develop a rapport and comfort surrounding self-care intervention implementation. Similarly, current literature suggests the number of residential moves is associated with increased unmet healthcare needs and problematic substance use (Harris et al., 2019). Having a lasting relationship with the clients allowed comfort and ease in suggesting and implementing changes to self-care habits.

Although one participant utilized standardized assessments, many other participants did not have a standardized method of evaluating self-care. The assessments used varied based on the setting. There was not an assessment which was portrayed to be an accurate picture of the homeless client's self-care habits and routines. This prompts the development of a non-standardized assessment tool which is sensitive to the unique context and environment of homelessness.

OT students contributed to the reach of OT intervention and served as a valuable learning experience in an authentic setting. The students implemented group and individual interventions, with no time restrictions. This afforded the opportunity to spend more time with clients who needed in-depth services at no cost to the institution. Consistent with the literature, Tyminski (2018) found that institutions serving the

homeless with Level II fieldwork students increased occupation-based activities within the setting, reduced work-load, and provided needed services to clients. Fieldwork placement for OT students within a homeless shelter or supportive housing environment benefit the student learning experience and provide a wider outreach of services to clients at no additional cost to the institution.

Many of the clients had a fluctuation of self-care needs based on their current life experiences, and consequently, the desire to engage with OT varied. Participants emphasized the need to be client-centered and referenced the recognition and understanding of the individual's readiness to change. Similarly, Helfrich, Chan, Simpson, and Sabol (2012) utilized the transtheoretical model to understand a client's readiness to change within a life skills intervention but recognized that a homeless individual's readiness to change fluctuates over time and is often cyclical. The transtheoretical model encompasses stages of change, including precontemplation, contemplation, preparation, action, and maintenance, and may be beneficial to use with homeless populations (Prochaska & DiClemente, 1983). Utilizing the transtheoretical model to understand a client's current level of readiness to change may be beneficial in the assessment and implementation of self-care OT intervention. Further research to determine the appropriate stage for intervention is recommended to facilitate effective OT practice with this population.

Client readiness to change may be associated with the level of needs being met. A participant of this study discussed OT clients focusing on survival, rather than self-care, in the homeless shelter setting. This is portrayed in current research; Cunningham and Slade (2019) found that individuals experiencing homelessness facilitate

occupations primarily surrounding physiological and coping survival situations. Further literature suggests offering OT intervention during the recovery phase, when fewer symptoms are present and the client is committed to the process, is important to the success of the intervention (Bjørkedal, Torsting, & Møller, 2016). This suggests that it may be inefficient to implement self-care interventions in a homeless shelter setting, and individuals may be more ready to engage in self-care when immediate survival needs are met, such as living in a supportive living environment.

Once a client was ready to change, participants found success in the implementation of self-care interventions that connected to a personal goal of the client. The personal goals ranged from obtaining stable housing and work to receiving primary custody of children. Client-centered interventions that considered the client's unique personal goals, mental and physical health, and physical and social environments were successful in facilitating effective self-care practices in homeless individuals, regardless of setting.

A large opportunity for education and advocacy is presented to combat the wide range of institutional barriers. OTs have an opportunity to educate homeless shelter staff surrounding the nature of physical and mental disabilities. OTs working with the homeless staff can facilitate a surface-level understanding of the processing and timing needs of individuals with disabilities. After education, OTs can advocate for extended time in the morning, extended time to utilize facility features, including laundry facilities, and opportunity for private showers to combat harsh social environment. Ideally, OTs can also work with contractors of supportive living environments to

promote universal design and development of effective spaces for the homeless individuals with and without disabilities.

OTs can work to facilitate communication with other staff members by educating nurses and intake workers on the importance of allowing the client to complete their own self-care practices. Collaborating with other providers and community members is crucial to the success of homeless individuals' self-care. This is in line with current research; multidisciplinary intervention following hospitalization led to improvements in physical and mental health, improved quality of life, and reduction of mental health symptoms (Stergiopoulos et al., 2018). A participant also found success in collaborating with the local community for obtainment of low-cost adaptive equipment. Advocacy for community partnership for recycling and donation of adaptive equipment provides opportunity for homeless individuals with disabilities to complete self-care tasks independently. Finally, although the OTs saw benefits of their interventions within the homeless population, services were inconsistent at times due to lack of reimbursement. Therefore, further evidence of OT's effectiveness within this population and advocacy for increased reimbursement for OT services is warranted.

OTs working within a supportive housing setting were able to develop rapport with clients and get to know their individual needs, providing opportunity for client-centered care in connecting personal goals to self-care needs. Clients within this setting seemed to be ready for change and able to focus attention outside of their immediate, survival needs. However, the OTs face a wide-range of institutional barriers and should work to educate facility and staff members. Further research to understand long-term outcomes of OT-initiated self-care intervention within supportive housing and the

potential for increased development of supportive housing centers for homeless individuals is needed. Similarly, current literature suggests the number of residential moves is associated with increased unmet healthcare needs, increased use of acute care, and problematic substance use (Harris et al., 2019). This suggests that supportive housing may better meet healthcare needs and reduce costs surrounding acute care than sheltered living facilities.

This study was successful in gaining an in-depth understanding of the experience of occupational therapy practitioners working with the homeless population on self-care tasks in a variety of practice settings. As demonstrated in the results section, three major themes emerged from the data offering insight to the unique experiences of OTs. This knowledge contributes to the body of literature surrounding the implementation of intervention with homeless populations. It also presents several opportunities for future research to be conducted in this area. Research surrounding the long-term outcomes of OT-initiated self-care intervention, specifically in the supportive housing setting, is warranted. Further research suggestions include using the transtheoretical model to determine the appropriate stage for intervention and the development of an assessment tool that considers the nature and aspects of homelessness.

Limitations

The authors acknowledge several limitations within the study. Recruitment for the study primarily took place on the American Occupational Therapy Association's social media platforms. Therefore, practitioners who do not utilize social media may not have had the opportunity to participate in the study. Due to time constraints of the

study, the sample size was small and did not allow for saturation of data to be reached. Participants practiced OT primarily in the eastern United States, which may have influenced the data. Climate and other geographical information of central and western United States may have influenced the experience of practitioners and contributed new information to the study. Due to small sample size and limited geographical areas, this study cannot be generalized to all occupational therapy practitioners working with homeless individuals on self-care tasks.

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APPENDIX

Appendix A: Interview Questionnaire

Appendix A: Interview Questionnaire

Understanding the occupational therapy perspective of working with the homeless population: Self-care interventions

Interview Questionnaire

Demographics:

1. Age?

2. Ethnicity?

3. Where do you live/work?

4. Are you an OT, OTA, or student?

5. How many years of practice/what level of student/years of clinical experience + years of academic experience/years of supervising fieldwork?

6. Please describe which OT setting are you currently working in? (acute care, inpatient, outpatient, skilled nursing, etc.)

7. What do you consider your main practice area?
    a. Academic education
    b. Children & youth
    c. Developmental disabilities
    d. Home & community health
    e. Mental health
    f. Productive aging
    g. Rehab & disability
    h. Sensory integration & processing
    i. Work & industry

Interview Protocol:

8. Describe the length and capacity that you have worked with individuals experiencing homelessness. (Length: years, months, weeks, etc. Capacity: volunteer, saw individuals in the OT practice setting, full-time, volunteer on the weekend, etc.)

9. Tell me about how you address self-care with individuals in your practice who are homeless?

10. What assessments do you use? This can include clinical, standardized or any type of assessment.

11. How do you work on self-care tasks with individuals experiencing homelessness?

12. Explain the effectiveness of the intervention.
    a. How are you tracking progress?

13. What kind of follow through with self-care do you see with individuals who are homeless?

14. How do you view the barriers and challenges of individuals experiencing homelessness following through with self-care tasks?

15. (PEO) Which personal factors or attribute of the person experiencing homelessness impact success or challenges to completing self-care tasks?
    Probes: Interests/values, Sensory/motor abilities, Decision-making, Problem-solving abilities, Financial, Other

16. (PEO) How does the homeless environment impact the ability for an individual to complete self-care tasks?
    Probes: Available resources, Physical characteristics, Social support, Other

17. (PEO) What occupational demands of self-care tasks impact the ability to complete them?
    Probes: Relevance/importance to client, Objects used and their properties, Space demands, Social demands, Sequence and timing, Required actions and performance skills, Required body functions, Required body structures, Other

18. What are the opportunities and challenges of addressing self-care with individuals experiencing homelessness specific to your setting of practice?