Community-Built Occupational Therapy Services for Those Who Are Homeless

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ABSTRACT
More than 500,000 people experience homelessness on any given night in the United States (U.S. Department of Housing and Urban Development, 2017). Although there is no definitive cause of homelessness, the National Coalition for the Homeless (2009) reported that substance abuse; mental illness; domestic violence; and recent economic factors, such as decreases in public assistance programs and loss of jobs, are the most prevalent causes of homelessness. Homelessness has been identified as an issue within the United States for more than 8 decades, but the composition of the homeless population has changed dramatically in the past 40 years. In the 1950s to 1970s, the overwhelming majority of those who were homeless were single men (Burt et al., 2001). During the 1980s, more families were experiencing homelessness, and currently more than a third (35% to 37%) of the homeless population are members of homeless families (National Alliance to End Homelessness, 2018). This change in the homeless population created the need for new services and supports. In 2017, approximately 65% of the total homeless population was living in emergency shelters or transitional housing programs, and more than 184,000 were homeless individuals in families with children (HUD, 2017). Nearly 30% of the total sheltered homeless population is individuals in homeless families (HUD, 2017). Homeless families typically consist of a single mother younger than 30 years of age and with two or three children younger than 5 years of age (Bassuk Center on Homeless and Vulnerable Children & Youth, 2015). Homeless mothers experience higher levels of mental health issues, poor physical health, increased stress, loss of social supports, and deterioration of parental roles than housed low-income mothers (Helfrich et al., 2006; Schultz-Krohn et al., 2006).

Even with the large need for services to support occupational engagement, health, and well-being, the National Coalition for the Homeless (2009) reported that the majority of homeless individuals have access to few supportive services. Individuals experiencing homelessness often do not have access to housing, health-related, or transportation resources, and are not provided education for health maintenance, skills attainment, or home management. Often, underserved populations are not covered by traditional medical or educational services, yet they still have occupational needs. This article outlines the theoretical foundation for occupational therapy treatment for homeless individuals as well as treatment options for occupational therapy practitioners working with this population.

LEARNING OBJECTIVES
After reading this article, you should be able to:
1. Identify barriers preventing full occupational engagement among various populations experiencing homelessness
2. Discuss the role of occupational therapy within the homeless population
3. Identify the differences between community-based and community-built services
4. Identify the occupational needs of various subgroups in the homeless population

INTRODUCTION
More than 500,000 people experience homelessness on any given night in the United States (U.S. Department of Housing and Urban Development [HUD], 2017). Although there is no definitive cause of homelessness, the National Coalition for the Homeless (2009) reported that substance abuse; mental illness; domestic violence; and recent economic factors, such as decreases in public assistance programs and loss of jobs, are the most prevalent causes of homelessness. Homelessness has been identified as an issue within the United States for more than 8 decades, but the composition of the homeless population has changed dramatically in the past 40 years. In the 1950s to 1970s, the overwhelming majority of those who were homeless were single men (Burt et al., 2001). During the 1980s, more families were experiencing homelessness, and currently more than a third (35% to 37%) of the homeless population are members of homeless families (National Alliance to End Homelessness, 2018). This change in the homeless population created the need for new services and supports. In 2017, approximately 65% of the total homeless population was living in emergency shelters or transitional housing programs, and more than 184,000 were homeless individuals in families with children (HUD, 2017).
Occupational participation because of race, religion, and/or sexual orientation are examples of occupational apartheid. Occupational imbalance refers to excessive engagement in one occupation or group of occupations to the exclusion of other occupations. This imbalance can compromise health, such as when parents need to work two to three jobs to support the family. Occupational alienation is when individuals or populations are not able to engage in meaningful activities and instead engage in tasks whose requirements do not reflect their full capabilities. An example of occupational alienation could be when a woman living on the streets rummages through garbage cans to find plastic bottles to recycle for cash. Occupational deprivation is a common form of occupational injustice where illness or disability prohibits engagement in meaningful occupations. An example could be when a musician with severe arthritis is no longer able to play the piano. Occupational marginalization is the injustice seen when everyday options or choices are not available to every member of the society or community. An example could be persistent gender roles that restrict an individual’s options.

Occupational therapy services are continuing to evolve to meet the occupational needs of an ever-expanding number of client groups. The American Occupational Therapy Association’s (AOTA’s) Vision 2025 calls for the profession to “maximize health, well-being, and quality of life for all people, populations, and communities” (AOTA, 2017, p. 7103420010p1). To help achieve this vision, practitioners can identify not only the occupational needs of current groups served, but also the needs of underserved people, populations, and communities.

Community Built, Not Community Based

When attempting to address the occupational needs of new and underserved populations and communities, a community-built model offers guidance and structure. Although many occupational therapy services are provided within a community-based setting, there is a distinct difference between a community-based and a community-built model of service delivery (Schultz-Krohn, 2012). In a community-based model, the occupational therapist determines what services will be provided and the frequency of services. Although the services are physically provided within a community setting, presumably close to the client’s living situation, the control and focus of the services primarily lies with the practitioners. This model is contrasted with a community-built model, which begins with an occupational analysis of needs within the setting (i.e., people, populations, community) and is a collaborative effort (Elliot et al., 2001; Herzberg & Finlayson, 2001). The foundation of community-built services is clearly aligned with AOTA’s Vision 2025 to promote “health, well-being, and quality of life.” The control for determining services’ focus, frequency, and outcome is located in the population and/or community and derived through collaborative interactions. This allows the services to meet occupational needs.
prioritized by the recipients of services, combined with the expertise of occupational therapy practitioners. This does require careful balancing of various community partners and occupational concerns. When providing services to homeless families residing in an emergency shelter, for example, practitioners need to consider not only the occupational priorities of the parents and children, but also the priorities and mission of the shelter (Schultz-Krohn, 2009). The foundation of this approach is broadly client-centered to simultaneously engage all participants.

**INTERVENTIONS FOR INDIVIDUALS IN A HOMELESS SHELTER**

Along with always allowing their clients to embody the role of the “expert” in being homeless, occupational therapy practitioners providing interventions within the homeless population must focus on increasing occupational engagement through large-scale environmental modification and occupational exploration (Illman et al., 2013). Interventions addressed at a personal and institutional level may achieve the greatest effect on occupational performance. Institutionally, occupational therapists can assist in reviewing shelter policies, such as intake processes, curfews, and access to resources, to integrate occupational engagement and the safety of all staff and residents. On an individual level, practitioners can address occupational engagement through group and individual skill-building opportunities, as well as community-based experiences that explore free and local resources (e.g., libraries, museums, parks).

As an example of skill-building group intervention, Helfrich and colleagues (2006) described a 4-week module consisting of four individual and four group interventions targeted solely at addressing skills for employment. Group sessions focused on identifying career interests, searching for jobs, and developing pre-employment skills and skills for maintaining a job. Individual sessions were designed to supplement the group material and encourage self-exploration of job interests and skills. Other group-based interventions described in the occupational therapy literature for this population include creating a client advisory board within a homeless shelter; implementing art and drama classes to improve socialization and self-concept; and implementing a structured life skills module designed to address hygiene, clothing care, money management, leisure, and work (Fieldhouse et al., 2011; Herzberg & Finlayson, 2001; Shoredike & Howell, 2002).

**INTERVENTIONS FOR FAMILIES**

Homeless families comprise nearly half of the total sheltered homeless population (HUD, 2017), and like the homeless population in general, parents within these families face various barriers to obtaining employment that occupational therapy practitioners can help address (Lloyd & Bassett, 2012). Although the profession has a history of working with the homeless, there is limited research addressing the effectiveness of occupational therapy services in shelters to develop work readiness skills (Thomas, Gray, & McGinty, 2011). However, occupational therapy practitioners are addressing the need to help homeless parents with children transition to work. In a program involving faculty and students from San Jose State University (SJSU), for example, a family shelter runs work readiness programs for all parents at the shelter. Parents design individual goals related to work readiness skills, and programs are developed to help them reach those goals, which include expanding job search skills, developing a résumé, or improving interviewing skills, which are often particularly useful if the parent has been incarcerated. Parents have reported that the individual and group support has been critical in taking the initial steps to finding employment.

**INTERVENTION FOR PARENTS**

Homelessness entails specific and unique risk factors that make effective parenting especially difficult, including providing a safe and stable home for children to learn and play (David et al., 2012; Schultz-Krohn, 2004). Over the last several years, occupational therapists have responded to the crisis in homelessness by developing interventions and research to explore how to facilitate the occupational participation of homeless individuals (Grandisson et al., 2009; Herzberg et al., 2006; Roy et al., 2017; Thomas, Gray, & McGinty, 2011). For example, because homeless parents experience high stress and lack of leisure time, it would be valuable to offer occupational therapy craft groups to parents living in a homeless shelter. Studies have shown that engaging in crafts offers participants a vehicle for choice, provides purpose, restores the balance between work and leisure, encourages the construction of new routines and roles, and reduces stress (Adams-Price & Steinman, 2007; Griffiths, 2008; Thomas, Gray, McGinty, & Ebringer, 2011). To meet this need, SJSU occupational therapy faculty and students provide low- to no-cost craft activities that are free for participants. Participants receive the materials and instruction on how to complete the project. During the group, the occupational therapy graduate students and faculty member identify the process of planning the project, collecting needed materials, beginning the project, monitoring progress, and completing the project. This process to some degree mirrors the actions needed to find housing or employment and helps participants develop related skills. In participating in such projects, parents (typically the mothers have shown the most interest in participating) have formed supportive relationships with other group members and have encouraged each other in job and housing searches.

Shelters provide basic needs for parents and their families but often have a negative effect on parental authority and add stressors to the maternal role (Roy et al., 2017; Schultz-Krohn, 2004, 2009). The role of occupational therapy is to establish or re-establish occupations. This includes parenting and infant occupations (Mindell et al., 2018). Occupational therapy
practitioners are able to teach mothers how to use infant massage to enhance their roles as caregivers. Infant massage is known to decrease levels of stress, improve depressive moods, increase confidence levels in parenting, and enhance bonding (Cheng et al., 2011; Feijó et al., 2006). Infant massage is also a safe and cost-effective intervention for both mothers and their infants (Feijó et al., 2006; Mindell et al., 2018). In the program designed collaboratively by SJSU and a local family shelter, infant massage was taught to mothers on a weekly basis, with an emphasis on how to incorporate the massage strokes into daily routines, such as bedtime, bath time, and meals. Additional weekly parenting groups were held to foster and support positive parenting approaches to manage behaviors, establish family fun routines using no-cost or low-cost games and activities, and teach stress management techniques that could be used with the entire family.

INTERVENTIONS FOR DOMESTIC VIOLENCE SURVIVORS
Among mothers with children experiencing homelessness, more than 80% have been shown to have experienced domestic violence (National Center for Children in Poverty, 2009). Survivors of domestic violence demonstrate a decreased ability to maintain friendships and function appropriately within social environments (Helfrich et al., 2008). Additionally, survivors of domestic violence experience mental health disorders, such as depression, posttraumatic stress disorder, and anxiety, at a higher rate than the general population (Phillips, 2014). Such disorders may affect every aspect of the individual’s occupational performance. In fact, 44% of domestic violence survivors residing in homeless shelters reported concerns about their ability to function in work, social, and social environments (Helfrich et al., 2008). The women reported difficulty managing daily responsibilities, poor self-concept, the inability to develop new relationships, and concerns with managing their current relationships.

Interventions for survivors of domestic violence should focus on enabling participation in new and previously held roles, adapting the person’s environment, building independent living skills, and engaging in vocational or education-related activities (Helfrich & Aviles, 2001). For example, one program for female survivors of domestic violence experiencing homelessness delivered a 6-month curriculum of group and individual interventions targeted at addressing life skills (Gutman et al., 2004). Interventions were focused on IADLs (i.e., cooking, money management, nutrition) paired with maintaining healthy relationship and communication skills. After the program, 21 out of 26 female participants achieved at least one goal, as measured by the Goal Attainment Scale, a method of scoring goal attainment through numeric representation (Gutman et al., 2004). Another program implemented at a homeless shelter for survivors of domestic violence focused on increasing job skills using a 4-week group module. Over the course of the program, participants were taught pre-employment, job finding, and job maintenance skills through activity- and discussion-based groups. Feedback from the participants and staff at the shelter noted that interventions were effective in creating job skills for future employment (Helfrich & Rivera, 2006).

CASE EXAMPLE: FAMILY “A”
The “A” family was a two-parent family living in a small apartment with two young boys, one in first grade and the other in a Headstart preschool program. The father was a day laborer, often working 7 days a week, and the mother worked at a convenience store for fewer than 20 hours per week. The school-aged boy had asthma and the youngest boy had developmental delays. The father had a history of drug abuse as a teenager and had been incarcerated in juvenile hall after a conviction for selling a controlled substance. He had not completed high school and did not have a general education diploma (GED). The mother had been in several different foster care settings throughout her teenage years and met the father after he was released from juvenile hall. The mom, who did not use drugs or alcohol, also did not have a high school degree or a GED.

After being injured on a job, resulting in severe back pain, the dad had been unable to work for more than 4 months, leading to the family’s eviction from their apartment for failure to pay rent. Occupational therapy services were provided at the shelter and were designed to support the family during this challenging period. Services were individualized for each parent to meet their various needs. Back safety techniques became an important part of the services provided for the father, particularly in caring for the children. The mother welcomed the opportunity to participate in the craft program as a way to diminish the stress of looking for full-time employment. Sessions were also designed to guide and support the parents in selecting games and activities to engage both children during “family time,” giving the dad a way to play with the kids besides the more physical type of rough-and-tumble play he primarily did before his injury.

Support was provided to both parents to help obtain their GEDs. The parents also participated in the shelter’s work readiness program to search for new employment, with the mom seeking a full-time job and the dad searching for less physically taxing employment. As part of his employment search, the dad expressed concerns about his previous incarceration—he did not know that juvenile records could be sealed if requested after completing probation. The occupational therapist and case manager at the shelter supported the father in making this request, and his juvenile court records were successfully sealed.

The children participated in the occupational therapy services provided at the shelter. The older boy participated in the Handwriting Without Tears program, which led to substantial gains in his writing skills. The youngest boy participated in the...
occupational therapy imaginative play group and displayed gains in problem-solving and decision-making skills.

After 3 months at the shelter, the dad was in the midst of seeking new job opportunities and the mom had found a full-time position at a local grocery store that provided employee benefits. She was also pursuing her GED. With financial support from the family shelter in the form of an initial rent deposit, the family found a small apartment close to the grocery store and within walking distance of the school.

INTERVENTIONS FOR YOUTH
Approximately 1.6 million youth, ages 12 to 17, experience homelessness within the United States in a given year (National Alliance to End Homelessness, 2018). For these adolescents, basic necessities of survival, such as food, shelter, and safety, are compromised. This can result in threats to physical, cognitive, and psychological development during a critical time associated with learning and acquiring the living skills needed to transition into adulthood (Oliveira & Burke, 2009). Homeless adolescents have self-reported they lack the important skills of managing money, locating safe and permanent housing, and searching for employment. Developing financial literacy and money management skills is best done using a collaborative model to support acquisition of these vital skills (Ssewamala et al., 2012). For teens who experience homelessness, developing the habits and routines to support financial literacy and money management is an important need. In the collaborative program between SJSU and a local family shelter, group sessions were provided twice weekly to help teens practice decision-making and budgeting skills for an intended goal. At the beginning of the week, the session focused on selecting an activity, such as making English muffin pizzas, smoothies, or cookies, or doing a craft activity, such as making duct tape wallets. The teens were then guided to select low- to no-cost activities using materials available at the family shelter or that could be purchased using a small fund provided by the shelter. Teens formed small groups to identify materials and a budget for the selected group activity. The groups competed to find the least expensive way to obtain the items needed for the activity. During the second session, the teens completed the activity. Teens also developed individualized goals regarding money management and financial literacy skills and were introduced to basic financial literacy skills, such as differentiating “wants” versus “needs” and potential problems in using credit cards to make purchases. Teens and parents have commented on the helpfulness of these sessions in reducing arguments about items teens “want” versus those they “need.”

INTERVENTIONS FOR CHILDREN
Children who experience homelessness are faced with many challenges. Deficits caused by homelessness lead to impoverished development of academic, play, and social skills (Jozefowicz-Simbeni & Israel, 2006). Homeless children frequently change schools within a single school year, often causing them to miss school for long periods of time or to miss key parts of the curriculum (Darden, 2009). As a result, these children are at high risk for educational deficits. Homeless children are included as an identifiable eligible population to receive educational services under the Individuals with Disabilities Education Improvement Act of 1990. This at-risk population may need additional educational services to meet their academic needs (Peterson & Nelson, 2003).

Studies have indicated that occupational therapy intervention in handwriting improves the academic outcome of children who are socio-economically disadvantaged (O’Mahony et al., 2008). Although poor handwriting is frequently addressed by school-based occupational therapy practitioners, homeless children often do not have access to these services at school because of inconsistent school attendance (Darden, 2009; Peterson & Nelson, 2003). Schultz-Krohn and colleagues (2008) provided occupational therapy services at a family shelter to foster handwriting skills for early elementary children. The Handwriting Without Tears (Learning Without Tears, 2017) program was provided three times per week for 15- to 20-minute sessions for 4 consecutive weeks over the course of 3 months to support children in first and second grade (Schultz-Krohn et al., 2008). Although only a small number (15) of the children completed the 12 sessions, major gains were noted in their handwriting skills after this brief intervention. The results demonstrated that improvements can be made using a short-term intervention for homeless children whose education has been disrupted by frequent changes in school attendance.

Currently, 1 in 30 U.S. children experience homelessness each year (American Institutes for Research, 2014). Children living in high-stress contexts, such as homelessness, are at risk for developing hopelessness and have decreased opportunities to participate in developmentally appropriate activities, such as play (Savina, 2014). This lack of access to play and developmental activities can negatively affect a child’s cognitive, emotional, social, and physical development (Gilpin et al., 2015; Hoffman & Russ, 2012). The weekly group occupational therapy sessions provided by graduate occupational therapy students and a professor from SJSU to a local family shelter fostered imaginative play skills to counteract the negative effects of homelessness. Materials used included low- and no-cost items, such as plastic milk bottles that were converted into astronaut gear and paper towel rolls converted into a spy glass. Children were offered materials to build on an imaginative story line while constructing and decorating their items. Children gained various play skills exhibited during a standardized play observation period. Parents and other caregivers noted the ability of the children to consider different options and alternative solutions for playing with the materials.
INTERVENTIONS FOR INDIVIDUALS EXPERIENCING MENTAL ILLNESS

The National Coalition for the Homeless (2009) reported that nearly 26% of the homeless population experience symptoms of severe and persistent mental illness, further noting that mental illness is the third largest cause of homelessness for single adults. Research demonstrates the benefits of mental health self-management programs in reducing psychiatric symptoms and increasing hopefulness and quality of life, including Wellness Recovery Action Plans (WRAPs; Cook et al., 2012). A WRAP is a self-directed plan the occupational therapist and client create together to provide daily maintenance, find triggers, and identify steps to take during a mental health crisis (Copeland, 2002). Occupational therapists attempting to address mental health concerns with individuals experiencing homelessness can assist them in creating WRAP plans that may be used daily and in cooperation with their available community-based resources (Gibson et al., 2011).

CONCLUSION

There is an increasing need for occupational therapy services for people experiencing homelessness (Roy et al., 2017; Thomas, Gray, & McGinty, 2011). Occupational therapy practitioners can blend expertise from various practice areas to meet the diverse needs of this population. 😊

REFERENCES


How to Apply for Continuing Education Credit

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Final Exam

Article Code CEA0618

Community-Built Occupational Therapy Services for Those Who Are Homeless

June 2018

To receive CE credit, exam must be completed by June 30, 2020

Learning Level: Intermediate
Target Audience: Occupational Therapists and Occupational Therapy Assistants
Content Focus: Professional Issues; Occupational Therapy Interventions

1. A community-built program should:
   - A. Focus on producing outcomes that can be measured with well-accepted external instrument(s)
   - B. Require occupational therapy practitioners to possess substantial expertise in the area of practice before providing services
   - C. Always be aligned with the specific occupational therapy practice guidelines directing the services to be provided
   - D. Be developed through collaborative efforts between all stakeholders and occupational therapy practitioners

2. Occupational justice is built on several factors, including:
   - A. Social justice, the Americans with Disabilities Act, and engagement in occupations as health promoting
   - B. The Americans with Disabilities Act, occupational therapy expertise, and social justice
   - C. Client-centered services, social justice, and engagement in occupations as health promoting
   - D. The Occupational Therapy Practice Framework, the Americans with Disabilities Act, and social justice

3. Occupational injustices take several forms. When an individual is unable to engage in a preferred occupation because illness or disease, it is referred to as:
   - A. Occupational deprivation
   - B. Occupational alienation
   - C. Occupational apartheid
   - D. Occupational imbalance

4. When a mother is working three jobs to pay the rent and has very limited time to spend with her children, this form of occupational injustice is referred to as:
   - A. Occupational deprivation
   - B. Occupational alienation
   - C. Occupational apartheid
   - D. Occupational imbalance

5. Family homelessness has become an increasing problem in the United States. Homeless families generally make up what percentage of the total homeless population in the United States?
   - A. 20%
   - B. 35%
   - C. 60%
   - D. 75%

6. Homeless elementary school-aged children are often at risk for academic delays and poor educational achievement. The main reason this occurs is:
   - A. Parents are unable to provide adequate study time for children to learn.
   - B. Homeless children have a high frequency of school moves and absences.
   - C. Teachers do not need to teach children who do not permanently reside in the school district.
   - D. The public educational laws do not include homeless children as an identified group.

7. Homeless families constitute approximately what percentage of the total sheltered homeless population:
   - A. 30%
   - B. 50%
   - C. 75%
   - D. 90%

8. Which of the following has consistently been demonstrated in the literature as a barrier to working within this population?
   - A. Violence among the population
   - B. The transient nature of the population
   - C. Difficulty partnering with community agencies
   - D. Lack of interest among the occupational therapy community
Earn .1 AOTA CEU (one contact hour and 1.25 NBCOT PDU). See page CE-7 for details.

9. What percentage of domestic violence survivors living at a homeless shelter report difficulty engaging in work, school, and social interactions?
   - A. 5%
   - B. 10%
   - C. 25%
   - D. 44%

10. Which of the following should practitioners not do when working with a youth experiencing homelessness?
   - A. Acknowledge the client’s strengths and abilities
   - B. Collaborate with the client to create goals for therapy
   - C. Focus on developing healthy roles and routines for the transition to adulthood
   - D. Provide interventions focused on the age-appropriate occupation of education

11. The majority of the literature available that explores interventions for co-occurring mental illness and homelessness focuses on:
   - A. Peer-based and self-management programs
   - B. Life skills curriculums
   - C. Medication management
   - D. Assistance with attending psychiatric appointments

12. Occupational therapy practitioners working with the homeless population should:
   - A. Require clients to design their own treatment sessions independently
   - B. Demonstrate expert knowledge in homeless culture
   - C. Assist clients in avoiding participating in tasks that are difficult
   - D. Allow clients to embody the role of the “expert” in being homeless

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