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Occupational Therapy Program for the Homeless Population in Grand Forks

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Running Head: OCCUPATIONAL THERAPY PROGRAM FOR HOMELESS

Jaime Plamann and Melissa Holt

Occupational Therapy Program for the Homeless Population in Grand Forks

University of North Dakota
Table of Contents

Chapters                                      Pages
1: Introduction                               .................................................. 3
2: Literature Review                          .................................................. 4
   Definition of Homelessness                 ............................................. 4
   Homelessness Trends                        .................................................. 5
   Current occupational therapy-based homelessness programs ............................................. 15
   Guiding principles                         .................................................. 19
3: Process                                    .................................................. 32
4: Program Protocol                          .................................................. 33
   Program Availability                       .................................................. 33
   Program Objectives                         .................................................. 34
   Program Goal                                .................................................. 35
   Assessments                                .................................................. 35
   Program Evaluation                         .................................................. 36
   Funding                                     .................................................. 38
   Marketing Plan                             .................................................. 40
   Treatment Protocols                        .................................................. 41
5: Summary                                    .................................................. 47

Appendix

Appendix A
   Subjective Survey                           .................................................. 52

Appendix B
   Objective Survey                            .................................................. 53
Chapter 1: Introduction

Homelessness continues to be the most visible and troubling social problem confronting the United States. There are several factors of homelessness which contribute to poor health including: inaccessibility to health care, stressors associated with homelessness, lack of support systems, poor nutrition, and drug and alcohol addictions. Occupational therapists are recognizing the need of services for the homeless population to increase quality of life. The goal of this scholarly project is to develop a functional program suitable for use at a homeless community shelter or program that will increase clients' engagement in meaningful occupations such as self-care, productivity, and leisure. Clients will learn daily living skills which will maximize their independence within the community. The intent is to make the program available for the Northlands Rescue Mission which is a shelter for the homeless population in the Grand Forks area, housing both men and women eighteen years and older.

A literature review has been conducted regarding homelessness and successful community-based occupational therapy programs for this population. Using the information gained from the literature review, occupation based therapeutic groups were developed to directly meet the clients' needs. Additionally, specific treatment protocols are included in the areas of job skills, appropriate relationships, and freedom from drug/alcohol abuse.

Upon completion, the project consists of a comprehensive community-based occupational therapy program directed toward the homeless population. An occupational therapist will be able to utilize the program in order to provide direct services for clients in a homeless shelter.
Chapter 2: Literature Review

Definition of Homelessness

Homelessness continues to be the most visible and troubling social problem confronting the United States (Plumb, McManus, & Carson, 1996). This problem impedes homeless individuals' ability to live independently within the community, as they often become deskillled in their capacity to form and sustain relationships, maintain personal care, plan time and/or direct themselves in productive activities (Totten & Pratt, 2001). According to the National Coalition (February, 1999), the Stewart B. McKinney Act states,

A person is considered homeless if he or she lacks a fixed, regular and adequate night-time residence; if he or she has a primary night time residence that is publicly supervised or privately operated with the intention that it is to be used as a temporary living accommodation and/or temporary residence for individuals intended to be institutionalized; if he or she utilizes a public or private place not typically used as a regular sleeping accommodation for human beings. (p. 1)

This definition can be interpreted to include those who sleep/live on the streets, those living in shelters, or those who have no residence or resources to obtain housing that has been taken away due to eviction (Westermey, 2001). Adequate shelter is one of the most basic human needs, however, throughout the world an estimated 100 million people have no place to live. Fortunately, public awareness of homelessness has been heightened by media coverage and a realization that the homeless population can no longer be stereotyped as "lazy crazy drunks" but are "people like us" (Mitchell & Jones, 1997). The growing problem of homelessness is essential to address so that homeless
individuals can live more safe and productive lives.

**Homelessness Trends**

The number of homeless individuals has been increasing over the past years. This population is also becoming younger, which includes more families, women, and persons with mental illnesses (Tryssenaar, Jones, & Lee, 1999). According to the June 1999 report of the National Coalition, there are two trends that are largely responsible for the increase in homelessness, which include a growing shortage of affordable rental housing and an increase in poverty. In 1997, 35.6 million people in the United States lived in poverty. Although the number of poor people in recent years has not changed dramatically, the number of those living in extreme poverty has greatly increased.

Increasing poverty levels are related to falling incomes and less secure jobs which offer few benefits and the declining value or availability of public assistance. Declining wages, in turn, have put housing out of reach for many workers in every state; research demonstrates that more than a minimum wage job is required to afford a one or two bedroom apartment at fair market rent. In the median state, a minimum-wage worker would have to work 87 hours each week to afford a two-bedroom apartment at 30% of his or her income, which is the federal definition of affordable (National Coalition, June 1999).

**Impact of Homelessness on Individuals with Mentally Illness**

Individuals with mental illnesses make up approximately 20-25% of those who are single adults and coping with homelessness. The number of individuals who experience homelessness greatly increased in the 1980's when incomes and housing options for those living on the margins began to decrease. Another factor contributing to
the increase of homeless mentally ill individuals revolves around managed care. Managed care brought about a new era where the goal is to keep individuals out of institutions, an increase in denial of services, and unplanned or premature discharges. Although only 5-7% of the mentally ill population is in need of institutions, many of the remaining individuals still need supportive housing in order to live successfully in the community. Additionally, due to the increase in the economy, there are few affordable housing options for individuals who suffer from mental illnesses. Benefits that these individuals receive, such as supplemental security income, has not kept up with the increases in cost of rent, therefore these individuals are not able to afford adequate housing.

Appropriate housing can eliminate homelessness for many who suffer from a mental illness when combined with supportive services, meaningful daily activity in the community (including work), and access to therapy. Findings have indicated that individuals with mental illnesses who are homeless are willing to utilize services that are easy to access and meet their needs (National Coalition, April 1999). However, there is minimal research that solicits the self-perceived needs of individuals who are homeless, in turn a primary reason that many homeless individuals don’t make use of available treatment services. Therefore it is important to explore homelessness from the perspectives of individuals who are homeless and to obtain their views on the potential success of various strategies to alleviate deprivation in the homeless population (Westermey, 2001).

Researching the Homeless Population

Estimating the exact number of homeless individuals in the United States can be a
difficult process due to the many factors that come into place. Underestimations of those who are homeless is problematic because most studies only include individuals who are utilizing the services and researchers are unaware of how many are in unstable housing arrangements for instance living with family members or friends. There is also a group of individuals that researchers refer to as the “hidden” homeless which are those individuals who stay in automobiles, campgrounds, boxcars, or other places that researchers cannot effectively search. A review of homelessness was done in 50 cities and found that in every city the number of homeless individuals greatly exceeded the number of emergency shelters and transitional housing. Additionally, these cities did not include those of rural areas where there are few if any shelters available to individuals. There are two main methods used to measure homelessness; point-in-time counts and period prevalence counts. Point-in-time counts refer to the number of people who are literally homeless on a given day or during a given week. Period prevalence counts refer to the number of people who are homeless over a given period of time. The National Coalition for the Homeless conducted a research project from 1987-1997 in 11 communities and 4 states. Through their research, they found that shelter capacity more than doubled in 9 communities and 3 states (National Coalition, February 1999).

**Homelessness in the United States**

Herzberg and Finlayson (2001), report that approximately 700,000 people are homeless in the United States on a given night. At least 3.5 million people are likely to experience homelessness during a year in the United States. In this number 45% are employed, 39% are children, 27% are disabled, and 55% have neither private nor public health care insurance (HUD, March 2002). As previously stated, there are many different
people who experience being homeless; the following are results from a survey conducted by the U.S. Conference of Mayors' in 1998 within 30 urban cities. It was found that single men make up 45% of the urban homeless population and single women make up 14% of the population. Out of 30 cities being surveyed, children under the age of 18 accounted for 25% of the urban homeless population. Families with children were found to be the fastest growing population of homelessness accounting for approximately 40% (National Coalition, February 1999, Who is Homeless). It was also found that one third of families have to be turned away due to a lack of shelter space (HUD, March 2002). When referring to the ethnic backgrounds represented within the urban population; 49% were African-American, 32% were Caucasian, 12% were Hispanic, 4% were Native American, and 3% were Asian. Domestic violence was identified by 46% of the individuals as a cause or distributing factor to homelessness. Out of the 30 cities, 22% of this population was veterans and 22% of the population was employed (National Coalition, February 1999, Who is Homeless). It was found that as many as 70% of homeless individuals struggle with substance abuse/dependence (Herzberg & Finlayson, 2001). It is important to note, the results gained through the US Conference Mayor’s survey are based on a specific geographical location, therefore data cannot be generalized throughout the United States. (National Coalition, February 1999, Who is Homeless).

Homelessness in North Dakota

Homelessness is a problem that also affects individuals within the geographical region of North Dakota. A point-in-time survey was conducted in March of 2002 throughout the state of North Dakota by the North Dakota Division of Community Services (DCS) and the North Dakota Coalition for Homeless People Incorporation. The
survey was given to agencies or organizations that work with individuals who are homeless such as: shelters, social service agencies, community action agencies, regional human service centers, and other local facilities. Individuals were given the survey during intake or other forms of agency contact. The agencies were allowed to pick one day between March 18 and March 22 that they felt was their peak day in order to produce maximum contact with homeless individuals. The individuals received assistance to complete the survey by staff when needed. Agencies involved were provided with a definition of homeless families and homeless individuals. All completed surveys were delivered to the DCS for processing, excluding those who stated they stayed in their own home the previous night. The following is a summary of the statewide totals pertaining to homelessness (see Figure one for homelessness in North Dakota). There were a total of 690 individuals who were homeless, 315 of which were males and 239 who were females. The average age presented by the male population was 40 years old and the average age of the female population was 34 years old. Children 17 and under consisting of both sexes made up 136 individuals. Of the 690 individuals who were homeless, 39 were veterans. Individuals reported staying the previous night in the following locations: 267 in shelters, 165 at friends or relatives, 159 in transitional housing, 85 in other locations (hotel, motel, or local detoxification center), and 14 outdoors or in a vehicle. The homeless individual or their families expressed problems in these areas: unemployment/underemployment 292, affordable/safe housing 267, mental health 209, alcohol/drugs 186, physical health 141, domestic violence 93, and HIV/AIDS 3. The following individuals ranked these problems as the cause of their homelessness: 202 unemployment/underemployment, 193 affordable/safe housing, 152 alcohol/drugs, 148
mental health, 81 domestic violence, 61 physical health, and 3 HIV/AIDS (T. Doan, personal communication, Sept. 3 2002).

The previous survey that was described was also broken up into the eight major cities and surrounding areas in North Dakota that included: Bismarck and Mandan, Fargo, Minot, Grand Forks, Dickinson, Williston, Jamestown, and Devils Lake. The cities located near the state borders only include the individuals who are specifically in North Dakota. The following information pertains to those individuals who are homeless in the Grand Forks area (see Figure two for homelessness in Grand Forks). There are a total of 147 homeless individuals in the Grand Forks area, 82 males, 46 females, and 8 are veterans. Children aged 17 and under accounted for 19 percent of homeless individuals. Individuals were asked the question, “Where did you stay the previous night?” Responses were as follows: 49 in transitional housing, 46 at a shelter, 31 at a relatives or friends, 20 stayed at other locations, and 1 outdoors or in a vehicle (T. Doan, personal communication, Sept. 3 2002).
Figure 1
North Dakota Homeless Population

(T. Doan, personal communication, Sept. 3 2002)
Figure 2

Grand Forks + Surrounding Areas

<table>
<thead>
<tr>
<th>Homeless Individuals</th>
<th>Number of Homeless Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>160</td>
</tr>
<tr>
<td>Males</td>
<td>80</td>
</tr>
<tr>
<td>Females</td>
<td>40</td>
</tr>
<tr>
<td>Children</td>
<td>20</td>
</tr>
<tr>
<td>Veterans</td>
<td>10</td>
</tr>
</tbody>
</table>
Barriers to Health Care

The situation of homelessness profoundly affects the health status of homeless individuals. There are both structural and individual barriers which impede the access to health care. Many homeless individuals rely on Medicaid to cover their health care costs. However, several families are dropped from this source secondary to a change or loss of a mailing address, lack of necessary supporting documents, or failure to reapply by a designated date. The lack of a telephone number and/or limited access to telephone services makes it difficult to schedule health care appointments and discuss health care concerns with a health care provider. Public transportation and appropriate time management is often a challenge for homeless individuals in order to travel from job sites to appointments and shelters for a warm, safe place to sleep at night. Often homeless individuals are forced to ignore health problems because physicians’ offices may refuse to see someone who is unable to pay for services or lacks proof of eligibility for health insurance.

In addition, there are factors in the personal backgrounds of homeless individuals that create barriers to care. They often lack support and stability that is essential to develop and sustain a positive self-esteem and dignity. In order to survive on the streets or in the shelter, individuals deny or minimize significant health problems. Individuals may have difficulty adjusting to a foreign setting such as the hospital. There are also fears of leaving belongings or space because they feel someone may steal from them (Plumb, et al., 1996).

For these reasons homeless individuals often present themselves for medical treatment at a much later stage of their illness than members of the general population.
These individuals are found to use the emergency departments and inpatient services at a higher rate than the general public. The high rate of admission could be interpreted as being due to more serious health problems or to common problems becoming serious because of a lack of access to early intervention. A problem is early discharge policies for people with no place to go and scarce or negligible aftercare facilities leading to readmission (Mitchell & Jones, 1997).

**Occupational Therapy's Response**

With the rise in the number of homeless individuals, many of who are especially vulnerable due to physical or mental health, it is fitting that occupational therapists consider how to meet the needs of this diverse group (Mitchell & Jones, 1997). According to Herzberg & Finlayson (2001), both internal and external changes have occurred within the profession. Internally, there has been a reorientation to occupation and occupational-based practice along with a growing focus on health promotion and community practice. Externally, there are noted shifts in the structure of health, social, and educational systems, and particularly in regards to reimbursement and insurance caps for services. Secondarily to these changes, occupational therapists have been encouraged to consider applying skills and knowledge beyond the traditional health care system.

The experience of illness and impairment and its effects on an individual’s ability to function in day-to-day activities is the domain of occupational therapy, which is fitting to meet the needs of the homeless population (Mitchell & Jones, 1997). Occupational therapy has the theory base, knowledge, and skills to provide meaningful interventions and facilitate occupational performance among homeless individuals. Occupational therapy emphasizes the importance of client centered engagement in meaningful and
purposeful occupations. Also, the importance of the spiritual core is emphasized, which helps to minimize the residual effects of substance abuse, mental illness, domestic violence, low self-esteem, and feelings of inadequacy (Herzberg & Finlayson, 2001).

Utilizing the knowledge and skills that occupational therapy possesses, several homeless programs have been implemented in various regions of the United States. In order to develop effective services for the homeless population, an occupational therapy-based program was developed for the homeless population in Ft. Lauderdale, Florida. The program was developed at the Salvation Army of Broward County Shelter which is a 164-bed facility housing men, women, and children. There are two programs within the facility: 1) short-term programming to help stabilize homeless individuals, and 2) transitional programming to provide extended time and training that is structured to prepare residents for self-sufficiency (Herzberg & Finlayson, 2001).

Two occupational therapists, Amy Russell and Elisa Honeyman (1999) conducted a needs assessment to guide the development of the program. Participant observation was utilized to learn information about the clients while gaining their concerns, perspectives, and experiences. It was also helpful in gaining information about the setting of the shelter and its rules and routines. Individuals staying at the shelter were required to remain free from the influence of drugs and alcohol. Focus groups were conducted to increase occupational performance among homeless individuals. There was four main themes which emerged from the focus groups: 1) the perceptions of what homelessness means differed, 2) staff and residents did not share same priorities, the residents' goals were to find meaning and direction in their lives while the staff members' goals were to find jobs for clients so they would be able to move out of the shelter, 3)
residents hoped to develop skills and seek jobs, enabling the opportunity to become a productive member of society, and 4) the extent to which the organization influenced the ability of staff members and residents to end the cycle of homelessness. The findings emphasized that occupational therapy clients at the shelter were both residents and staff members. Staff members would benefit from information regarding ways of helping residents reach their goals within the environment of the shelter. It will be important to advocate the necessity for changes to create a supportive and enabling environment, making it easier for residents to experience success (Finlayson, et al., 2002).

The Canadian Model of Occupational Performance (CMOP) and Community Building were used to provide a theoretical approach and ensure incorporation of the needs of the shelter. Community building emphasizes collaboration between service providers and service recipients and focuses on problem resolution using strength-based assessments and interventions. This approach uses an interactive model with individuals, which is important to incorporate individual perspectives. The CMOP was chosen because of its emphasis on client-centered occupational performances. The dynamic relationship between the person, environment, and his or her occupation is considered throughout the treatment process. Finally, spirituality is identified as an important component, as it is the core of a person and provides meaning to one’s life (Herzberg & Finlayson, 2001).

Interventions were developed to increase occupational performance of individuals living at the shelter, based on information gained through the needs assessment. Interventions incorporated to increase occupational performance include: prevocational skills, stress management, self-care training, social and interpersonal skills, and
community living skills training. In order to help clients practice skills needed to gain control over their lives, empowerment opportunities were provided through therapeutic groups while enabling decision making and leadership roles. Additionally, a client advisory board was developed in order to further incorporate client decision-making. Clients were provided with the opportunity to raise and discuss issues of personal importance with occupational therapists and staff. Occupational therapy services helped to change the "homeless hotel" image to a dynamic place to get yourself together. Clients learned and developed skills in order to increase occupational performance, while overcoming personal barriers to self-sufficiency (Herzberg & Finlayson, 2001).

This program was funded through a three-year grant, provided by the Health Resources and Service Administration. A goal of this organization was to create an interdisciplinary student training program at the homeless shelter. The grant provided an opportunity to further expand personnel, develop groups, and purchase equipment (Herzberg & Finlayson, 2001).

Kannenberg & Boyer (1997) report another program developed by the following principle, “the development of occupational therapy practice in homeless shelters builds on occupational therapy’s rich tradition of working with individuals who face barriers to full participation in community life.” The program was titled the Working Zone, which is a collaborative project designed to serve the employment needs of homeless youths from the ages of 15-22. This program focused on developing participant employability and job skills, in order to improve their housing status. An occupational therapist was included on the staff to address the developmental issues of youth through both program design and individual evaluation and intervention. This staff member provides both
direct and consultative services to the youth. Working with mental health providers and social workers, the occupational therapist is a significant contributor to this area of social services.

The City Rescue Mission in Oklahoma City developed a program called Strategies for Using Choices and Challenges for Experiencing Self-Sufficiency (SUCCESS). This occupational therapy-based program consisted of enrollment of a 12-month course to obtain employment and independent living. Groups were based on basic hygiene skills, leisure skills, social appropriateness, work preparedness, and other skills necessary to live independently in the community. The program focuses on changing the non-functional cycle that the clients are in. These people take what they are learning in their studies and apply it to their goal of maximizing independence in their environment. The outcomes of the program have exceeded expectations. Of the 77 clients completing the program, 12 have residences and a means of financial support, 19 are working and living with relatives or in motels, 14 are still in the program, 23 have returned to the streets or other shelters, and the whereabouts of 7 is unknown (Diffendal, 2000).

Taken together, these programs provide relevant and beneficial information that will be needed to implement the proposed program for community based homeless shelters. All of the reviewed programs focused on the homeless population and increasing their satisfaction and involvement within the community. Clearly, it is important to develop a program that involves the client perspective with treatment. This will increase the compliance rate as their feedback is considered in the process of developing therapeutic groups to their area of interest. The goal of this project is to develop a functional program suitable for use at a homeless community shelter or
program that will increase individuals' engagement in meaningful occupations such as self-care, productivity, and leisure. The program will enable homeless individuals to maximize their independence through the use of therapeutic groups focusing on prevocational skills, appropriate relationships, and freedom from drug/alcohol abuse.

**Guiding Principles:**

Furthermore, literature was reviewed regarding occupational therapy-based guiding principles to increase success of the homelessness program. Implementation of these principles will assist in providing a holistic approach which fits the personal needs of the homeless population. The information gathered will be utilized to develop and guide the program.

**Theoretical Approach:**

The Model of Human Occupation (MOHO) fits well within programming for the homeless population. An important component of this frame of reference is commitment to a client-centered approach. The client-centered approach defines the therapeutic process as one that respects, informs, and enables clients to become active partners in determining the goals and strategies of therapy. Additionally, MOHO seeks to explain occupation in regards to how it is motivated, patterned and performed. Individuals have an innate drive to explore and master their environment which results in occupational behavior. Within MOHO humans are composed of three interrelated components: 1) volition defined as motivation for occupation, 2) habituation defined as the process by which occupation is organized into patterns or routines, and 3) performance capacity defined as physical and mental abilities that underlie skilled occupational performance. Specifically, volition can be further defined as the pattern of one’s personal thoughts and
feelings that are shaped through anticipation, choices, experiences, and interpretations. It is important to consider volition in combination with environmental conditions, which influences activity choices. The environment is an important factor which may either facilitate positive patterns of behavior or sustain maladaptive patterns of behavior. How one is motivated, what one does, and how one performs is dependent on environmental conditions. MOHO encourages gaining an occupational profile of clients, which includes one’s personal characteristics, life history, environment, and actual “doing” or performance in occupation. This information helps to define the client’s perspectives on life and identify occupational areas which may be threatened (Kielhofner, 2002).

The homelessness program will be designed to provide a mutually supportive community for homeless individuals to belong. Residents may have noted difficulty performing within their roles secondary to factors of homelessness. The environment is designed to facilitate a sense of belonging, self-esteem, and confidence among residents in a variety of positive social roles. Meaningful occupations are used within the program to engage residents in exploration, competency, and achievement within the environment. Additionally, the societal environment facilitates productive and playful participation which influences a sense of capacity, efficacy and occupational performance. Through the homelessness program residents gain skills, develop habits and routines, and organize behaviors needed for successful role performance.

**Importance of Occupation:**

Occupational therapy holds the unique belief that meaningful occupation has an intrinsic power to maintain, restore, and transform. In other words, meaningful occupation is fundamental to the health and wellbeing of all humans. Occupation is
defined as activities and tasks in which a person engages to meet his/her intrinsic needs for self-maintenance, expression, and fulfillment. They are carried out within the context of individual roles and multiple environments (Law, Cooper, Strong, Stewar, Rigby, & Letts, 1996). It is through occupation that people further understand their hopes and aspirations, satisfy their needs, and cope with their environment. According to Mee and Sumsion (2001), individuals with mental health needs are prone to occupational deprivation which causes deterioration both mentally and physically and can result in death. The lack of participation in occupation results in difficulty finding meaning and purpose in life, contributing to a lack of motivation. Furthermore, a lack of structure (temporal dysfunction) contributes to low self-esteem, lack of motivation, and hopelessness which exacerbates the original problem (Mee & Sumsion, 2001).

Mee and Sumsion (2001) reported a research study that was conducted to further investigate the value related to personal meaning of occupation from the perspective of individuals with enduring mental health problems. A qualitative approach was utilized at two mental health day service settings: a workshop and a drop-in facility. Information was gathered describing clients' occupational experiences and their interpretation of these experiences. An open-ended interview approach using an interview guide was used to allow flexibility in exploring the meaning of occupation. Additionally, an ethnographic approach was used to increase understanding of the cultural and environmental influences that impact the experiences under investigation. Three main themes, each with three sub-themes, emerged through research: 1) generating motivation; sense of purpose, organization of time, and environmental influences 2) building competence; acquisition of skills, coping with challenge, and experiencing of achievement 3) developing self-
identity; drive to create, usefulness, and sense of self. In regards to occupation, the first theme generating motivation and its associated sub-themes will be further discussed. The findings show that participants valued their attendance at each day service as they identified the benefits of engagement in purposeful occupation. Participants identified occupation as a means to meet their need for motivation, due to the sense of purpose and structuring of time inherent in occupation. Also, environmental influences appeared to play a vital role in generating intrinsic motivation. Participants identified important components that contributed to increasing motivation which included a welcoming, friendly, and sociable atmosphere, free from pressure. They shared their value of group experiences which provided a sense of belonging. The company of others with similar experiences provided the opportunity to openly talk about problems and concerns within a trusted and supportive environment. A flexible and safe environment where individuals were able to exercise self-determination and control, enabling members to create what needed within services. Overall, it was identified that through occupation, individuals organize their time, discover meaning and engage in occupations that lead to pleasure, fulfillment, and control over their environments (Mee & Sumsion, 2001).

In regards to homelessness, individuals experience several life changes and with a lack of appropriate coping skills, dysfunction is further exuberated. The importance of occupation during life changes or transitions is important to consider for this population. Throughout the life span, one experiences many transitions requiring adaptation in role changes, occupational performance; in turn affecting one’s self-concept. Adaptation to transitions and the effects on one’s health and well-being has is essential to consider in regards to homelessness. According to John Adams (1976), a psychologist aimed at
understanding and managing personal change, a transition is a discontinuity in a person’s life space. This discontinuity requires alteration to routine, habit, and occupations. It requires personal awareness and recognition of the event and new responses to deal with results of discontinuity. Unfortunately, this does not always happen productively which leads to dysfunction and negatively affects both physical and mental health. The function of occupation at points of transition may include: 1) to celebrate personal distinctiveness but recognize that this can be endorsed by others from their own experience, 2) to protect self-esteem and generate a sense of managing the transition, 3) to show discernible patterns in habit/routine, 4) to reveal something about the pace of occupations and the response to the dynamics of a situation, 5) to reveal the dimensions of time and subsequent shifts in occupation and balance of occupations, and 6) to recognize concomitant effects upon role and social construction of role. Through personal interviews with individuals negotiating transitions, it has been found that adaptive ability increases in difficulty when the transition is unexpected, numerous transitions occur, the resulting strain is unremitting or if one transition triggers other adjustments (Blair, 2002).

Client-Centered Practice:

According to Mitchell and Jones (1997), many homeless individuals, specifically those with a mental illness lack motivation and insight into their problems. This will make it important to involve residents in the process of group activities/goals and discussions so that it's meaningful and important to the individual resident. There are several essential components to consider in order to involve the client in the treatment process. The occupational therapy profession refers to this process as the client-centered
approach. Historically, the term client-centered practice was first discussed in a book written by Carl Rogers in 1939, titled The Clinical Treatment of the Problem Child. He emphasized important components of a therapeutic relationship to include a dynamic therapist-client interaction, while the client has an active role in approaching problems and concerns within an open and honest environment (Law, Baptiste, & Mills, 1995).

Ideas about client-centered practice have evolved and now reflect the importance of a client-therapist partnership. These ideas involve the rights of clients to make choices about occupations, the influence of the environment, and the need for intervention at a societal and policy level. In a client-centered practice, the client has an active role in defining both the goals and outcomes of intervention. Clients' goals, interests, environment, and culture are central to the occupational therapy process. It is recognized that each client is unique, each with different perceptions and experiences affecting the occupational therapy experience. The client is the expert and only he/she can fully understand the experiences of their daily lives, express their needs, and make choices about occupations. The therapist is a facilitator while working with the client to meet his/her needs. Within the therapeutic relationship, therapists need to provide information to enable client choice and utilize their expertise to facilitate a broad range of solutions to occupational performance issues. The strengths and resources that a client brings to the occupational therapy experience are recognized and used to facilitate the achievement of occupational performance goals. Clients' goals are achieved through a variety of means including changes in individual in skills, changes in environment, and changes in occupations (Law, Baptiste, & Mills, 1995).

According to Reberio (2001), the trilogy of mind, body, spirit assists in clearly
defining client-centered practice. Occupational therapists value the body, mind, and
spirit as components that each client brings to the therapeutic process. In the realm of
client centered practice, it is important to consider each of these components. The mind
is defined as the element or complex of elements of an individual that feels, perceives,
thinks, wills, and reasons. It is important to utilize the strengths of the mind to help
clients reach their goals. The mind is a control center for the body and the window to the
spirit of the individual. The body is defined as the material part of nature of a human
being. The therapeutic experience is lacking if one enables physical function, however
neglects the body’s interrelatedness and interconnectedness to the mind and spirit. The
spirit is defined as an animating or vital principle held to give life to physical organisms.
Overall, the spirit is necessary to give and maintain life. The spirit is an essential aspect
of client-centered practice to enable people to exist as an individual and have a life
beyond illness and disability. Considering the trilogy of mind, body, and spirit will
facilitate a holistic approach to treatment, as each client has unique needs in each area.

In summary, the development of client-centered practice has been demonstrated
to increase client participation, increase client self-efficacy, and improve satisfaction with
service (Law et al., 1995). Using client-centered practice with homeless individuals will
better serve and facilitate positive outcomes for the residents.

Spirituality:

Spirituality is an important concept to incorporate within homelessness services.
According to Swarbrick & Burkhardt (2000), spiritual health affects coping, adaptation,
and occupation. Spirituality is defined as an inner perception and source of strength,
which is reflected by one’s being, knowing, and doing. Additionally, it involves a belief
in a unifying power that gives meaning and purpose to life. A sense of purpose has a positive and organizing effect on behavior and strengthens one’s ability to continue to engage in purposeful occupations despite illness, disability, and crises. This sense of purpose for a homeless individual may enable him/her to accept, overcome, and cope with barriers and challenges encountered. The pursuit of wellness, meaning the attainment of a high level of functioning within all domains has been acknowledged for improving quality of life. Spirituality is an important realm in the concept of wellness which includes components such as faith, values, beliefs, and attitudes.

It is important for occupational therapists to incorporate the spiritual domain within services because it provides knowledge regarding clients’ thoughts and perceptions about life meaning, purpose, and occupational behaviors. (Swarbrick & Burkhardt, 2000). Additionally, it enables the therapist to understand resources that the client utilizes to manage daily occupational needs during health crises and challenges. Individual may be lacking positive coping strategies during life’s challenges, which further exacerbates the problem. In this case, gaining information regarding the client’s spirituality will provide suggestions for positive coping strategies. Finally, interventions focused on occupational goals without considering the impact on occupational identity crisis of the client may be unproductive regardless of quality of intervention (Unruh, Versnel, & Kerr, 2002).

Disability may separate individuals from the capacities that previously permitted them to experience and express spirit. According to McColl (2002), spirit is “the force that animates the body of living things.” This may cause the individual to remove themselves from previous sources of spirituality, impeding the search for meaning. In
order to restore meaning, individuals are often impelled to re-examine their basic beliefs and search for renewed meaning. McColl and colleagues (2002) conducted interviews with individuals experiencing disabilities and reviewed literature to determine ways that people experience spirituality during disability. Four themes evolved through the process including: 1) disability as a reminder of humanity; disability was a reminder of their vulnerability and mortality; 2) disability was a mission; disability is accompanied by a special purpose or mission; meaning that their life has changed; 3) disability as a punishment, some people experience their disability as a moral judgment; and 4) disability was a warning, a personalized message to make a change. This information is beneficial to further understand the client's perspective and experiences in the midst of disability.

**Group Programming:**

Therapeutic groups will be implemented three to five times per week for one-hour sessions or as tolerated by residents. It is recommended that the group sessions consist of eight to ten members. The time frame for the treatment groups will be one month.

Three types of groups will be implemented in this program. 1) Discussion-based groups will be emphasized in group settings to encourage feedback among group members. Group members will be encouraged to initiate and maintain conversation with peers. They will be encouraged to identify support systems utilizing resources such as newspapers and the phone book; in turn increasing members' interpersonal skills, self-esteem, and identification of coping skills. 2) Task-oriented groups will be presented within the group setting. This will create a tangible product for the members of the group, which will facilitate a sense of accomplishment. 3) Educational groups will be
implemented to discuss with the residents topics such as job readiness, appropriate relationships, and drug/alcohol abuse. This will increase the individual’s insight into their areas of difficulty and solutions for freedom from their problems.

Howe and Schwartzberg (as cited in Duncombe & Howe, 1995) documented that the interpersonal process inherent in occupational therapy groups promotes wellness. The following factors were found to influence the use of group treatment: 1) the enduring importance of occupation to health, 2) the ability to adapt group structures and goals to the changing paradigms of treatment, 3) the importance of interpersonal relationships to wellness, and 4) the socioeconomic pressures that mold health care, such as the limited personnel or shrinking funds available to health care programs. Group activities are used extensively to provide the structure needed to keep clients involved and interacting during the day. Sladyk's study (as cited in Duncombe & Howe, 1995) used small structured groups to address the client's cognitive, task oriented, and social skills development and to provide reinforcement for desired behavior. He concluded that peer support and encouragement as major reasons for the group members' success.

Additionally, Duncombe and Howe (1995) conducted a survey in 1993 to study the use of group treatment as a treatment process within occupational therapy facilities. A group was defined as “an aggregate of people who share a common purpose which can be attained only by group members interacting and working together”. It was found that out of 188 respondents, 52% of occupational therapists, used group treatment as a therapeutic modality. Characteristics of the groups were as follows: 1) they were predominately small (10 or fewer members), 2) they had general therapeutic goals, and 3) they had primarily specific group goals that included increasing task skills, facilitating
communication and socialization, and increasing physical abilities. A small group size was found to be an important determinant of group process that relates not only to the goals of the group but also to the number of interactions between members. According to Trahey (as cited in Duncombe & Howe, 1995) respondents from the survey identified group treatment to be superior to individual treatment in facilitating clients' functional status and behavioral changes. The majority of the groups identified were considered to be activity-based, or activity and verbal; however, few were found to be strictly verbal. Duncombe and Howe (1995) discovered that mental health day treatment centers utilizing primarily activity therapy facilitated treatment goals faster and achieved greater symptom reduction than clients receiving primarily verbal therapy.

Individuals encountering stressful experiences often require emotional support, advice and guidance, and positive feedback about their value. This is important to consider for the homeless population, as it has been found that these individuals are often coping with breakdown in relationships and lack of positive support systems (Mitchell & Jones, 1997). Groups provide individuals with five main functions that include; belonging, intimacy, generativity, support, and exploration. The belongingness hypothesis suggests that groups meet the human need to be included in an interpersonal network. Groups provide members with a sense of inclusion and security. Friendship groups, cohesive work groups, and families are all examples of groups that create strong bonds of affection between members. Generativity in groups is often the means people use to achieve their personal and interpersonal goals. Groups enable individuals to engage in activity to increase productivity, accomplish their personal and shared goals, and complete tasks that individuals could not accomplish if working alone. Support
Occupational Therapy Program

provided through groups help members to cope with minor and major life crisis by providing them with emotional and tangible resources. Group members compliment and encourage one another, express their friendship for others, and listen to others' problems while offering advice for solutions. Exploration provides group members with opportunities to increase their creativity, refine their ideas, and improve themselves. Groups are also a source of new experiences, information, and insights (Forsyth, 1997).

**Importance of Environment:**

Another factor to consider is the environment which may impede or enable occupational performance for individuals with a disability. According to Rebeiro (2001), the environment has been cited as the single most important reason that individuals continued to attend programs. The environment is important to both the experience of occupational engagement and ongoing satisfactory occupational performance. Therapists are encouraged to remain aware of the handicapping effects of the environment, social circumstances which sustain disability, and focus less on interventions which target the individual as a problem to be fixed. Occupational therapists must provide environments that provide a range of opportunities for occupational behavior and provide a just right challenge between the skills of the individual and the demands placed upon the performance (Rebeiro, 2001).

A qualitative research study was conducted by Rebeiro in 2001 to gain individual perspectives regarding the importance of environment, specifically relating to the context of occupational therapy practice. Interviews and observation were used as primary data collection methods. Common themes were the importance of a safe and supportive social environment which included opportunities for both private and community space, and the
assistance of members to address their individual needs. Participants identified the
importance choosing occupations which were meaningful to them and collaboratively
setting goals with the therapist. The social environment was described as integral to the
experience of occupational engagement. Through successful participation and
accomplishment, participants developed self-identity and potential capability.
Chapter 3: Process

In order to guide the development of a community-based occupational therapy program for the homeless program, the literature was reviewed regarding homelessness and current successful programs. Information was gathered through a personal interview with two staff members at the Northlands Rescue Mission; a non-profit homeless program in Grand Forks, North Dakota. The information from this personal interview assisted in gathering data that was applicable to the state of North Dakota.

Specifically, the literature gathered regarding current occupational therapy-based homelessness programs was utilized to develop guiding principles for the program. Following the development of the guiding principles, additional literature pertaining to each principle (i.e. importance of occupation) was gathered to gain additional objective and subjective data. This data ensures a holistic service approach that meets the personal needs’ of the homeless population.

Finally, information gathered through the literature and personal interview was utilized to develop therapeutic groups to directly meet the clients’ needs within the areas of: appropriate relationships, drug/alcohol abuse, and employment. In addition, the funding and marketing plan was developed to guide future practitioners in the building blocks of the program. The completed project provides a comprehensive community-based occupational therapy program for the homeless population.
Chapter 4: Program Protocol

Program Availability:

The community-based occupational therapy program will be available specifically for the Northlands Rescue Mission (NRM). The NRM is a non-profit organization located in downtown Grand Forks, North Dakota with the purpose to feed and shelter the homeless population. The NRM offers an educational program to those clients willing to pursue their GED. Written homework and computer programs are used to develop skills in areas such as mathematics, reading, and writing.

Staffing at the NRM consists of the director, chaplain, educational supervisor, accountant, and kitchen staff. Additionally, there are five on-site resident managers, who assist in chores and responsibilities to maintain the atmosphere. The resident managers are selected by staff and peers based on criteria such as behavior, attitude, and dependability. They assist with security and check-in for the NRM. Check-in is recommended by 5:00 p.m. and consists of paperwork and a drug/alcohol screening (K. Northey & J. Warner, personal communication, October 1, 2001).

Residents at the NRM are primarily males between the ages of 18-65, with the average age under 40. Males constitute 80-90 percent of the resident population. Individuals utilizing the shelter provided by the NRM have to be at least 18 years old. However, there are meals provided which are available to anyone in the community, regardless of age and socioeconomic status. It was indicated by staff that there is a high rate of drug and alcohol abuse amongst the NRM residents. It has also been found that they have few job skills and minimal experience with spirituality (K. Northey & J. Warner, personal communication, October 1, 2001).
Some of the services provided by NRM include shelter, meals, spiritual guidance, and educational programs. Shelter is provided free for the first thirty days in exchange for daily chores consisting of cleaning rooms, cleaning kitchen, and taking out the garbage. The cost is negotiable following the first thirty days depending of their financial status, ranging from $28-36 per week. There is an on-site feeding program that provides three meals a day for both residents and non-residents. There is an emphasis on spirituality, incorporating beliefs of the Judeo-Christian church. A long-term Scriptural-based rehabilitation is provided for the residents. Regular chapel services provided two times per week on site, which residents are encouraged to participate in. Additionally, on Friday evenings, there is an informal Christian program which provides contemporary entertainment such as music and guest speakers, in order to give residents the opportunity to participate in positive uplifting experiences (K. Northey & J. Warner, personal communication, October 1, 2001).

**Program Objectives:**

The community-based occupational therapy program will be utilized for homeless individuals to maximize their independence within the community. The objectives of the community-based homelessness program include: 1) to promote and maintain social interaction and social support systems, 2) increase awareness of individual’s strengths and weaknesses 3) to promote and maintain independence within the community and, 4) to educate residents regarding job readiness, appropriate relationships, and drug and alcohol abuse.
Program Goal:

Residents will learn daily living skills, which will maximize their independence within the community. Residents will develop skills in their environment through the use of groups focusing on prevocational skills, appropriate relationships, and freedom from drug and alcohol abuse to maximize personal satisfaction within their environment and increase engagement in meaningful occupations.

Assessments:

An initial assessment will be given to each resident as they check into the NRM to determine their strengths and weaknesses in the areas of prevocational skills, appropriate relationships, and drug/alcohol abuse. Residents will be retested every two weeks in order to measure progress. This assessment will consist of a simple checklist format that can be performed within ten minutes. The data obtained will be evaluated by the occupational therapist and residents will be referred to a therapeutic group that best fits their needs. There are several assessments that may be used to document the resident’s progress within the group. Some suggestions include: Occupational Performance History Interview II (OPHI-II), Neuro Psychiatric Institute (NPI) checklist, Kohlman’s Evaluation of Living Skills (KELS), or Allen’s Cognitive Level (ACL). The OPHI-II consists of a semi-structured interview based on the MOHO frame of reference. It is designed to gather information about an individual's work, play, and self-care activities. The interview consists of three parts: the semi-structured interview, rating scales, and life history narrative (Henry & Mallinson, 1999). The NPI is an interest checklist based on the MOHO frame of reference that the client fills out with the therapist. In completing the checklist the client's interests can be identified in order to help the occupational
therapist establish treatment that is meaningful to the client (Rogers, 1988). The KELS is an occupational therapy evaluation that is designed to determine a person’s ability to function in basic living skills tasks. The assessment consists of seventeen living skills tested under five areas: self-care, safety and health, money management, transportation and telephone, and work and leisure (Thomson, 1999). The ACL is a brief screening tool that is used to determine ordinal levels of cognitive functioning, relevant to activities of daily living. This standardized assessment requires a person to replicate three increasing complex stitches which enable the therapist to evaluate client’s problem solving skills, ability to follow directions and attention span. It also provides a quick estimate to the client’s capacity to learn (Allen, 1996). These are merely suggestions, the occupational therapist will determine specific assessments that will be utilized.

**Program Evaluation:**

The group is not a progressive series and does not require the individuals to attend all of the daily sessions. Criteria for admission into this program includes homeless individuals with demonstrated weaknesses in one or more of the following areas; prevocational skills, appropriate relationships and drug/alcohol abuse. This information will be gathered from the initial assessment.

The occupational therapist will evaluate the success of the program based on participant responses to the activities presented during each session. To measure participant responses, a subjective survey (See Appendix A) will be administered prior to engaging in the group and at its completion. To ensure quality programming in the continuation of the program, questionnaires will be distributed bi-monthly and analyzed by the appropriate staff. Comment cards will be available each group session, for the
members to complete, in order to provide feedback for the occupational therapist.

An occupational therapist will be employed to implement group programming. This staff member will select the topic of discussion, therapeutic activities, and time frame of groups with assistance from the residents’ feedback. This individual will also be responsible for providing the quality assurance studies and analyzing the data. An objective survey (See Appendix B) will be conducted at the start of the group sessions and thereafter given monthly to determine the individual’s progress regarding job skills, appropriate relationships, and freedom from drug/alcohol addictions.

The occupational therapist will be responsible for discussing pre-discharge planning from the program with the resident. Residents who have made no progress or attempt at progress within two months as demonstrated on the surveys provided, will be evaluated for discharge from the group. These individuals will be closely examined prior to discharge to prevent denying services to individuals who are attempting to make improvement. A Client Advisory Board will be implemented, meeting once per month which allows residents to raise and discuss issues that are important to them with representatives of the shelter staff.

Discussions will be emphasized in group settings to encourage feedback among group members. Group activities will be implemented including interventions such as board games and role playing to facilitate socialization amongst group members. Group members will be encouraged to initiate and maintain conversation with peers. Additionally, they will be responsible for planning group sessions which facilitates development of personal ownership for the treatment process. Residents will be encouraged to identify support systems through the use of resources such as newspapers
and the telephone book. This will increase the residents’ interpersonal skills, self-esteem, and identification of coping skills.

Task-oriented activities will be performed within the group setting amongst peers. A specific example is engaging the residents in a craft group including activities of choice such as woodworking. This will develop a tangible product for the members of the group to provide them with a sense of accomplishment, which will in turn increase their self-esteem. Paper and pencil activities will be implemented throughout group sessions. Some of these activities may include journaling personal successful and challenging experiences to facilitate increased insight. Educational groups will be implemented to discuss with the residents topics such as job readiness, appropriate relationships, and drug/alcohol abuse. This will increase the individual's insight into their areas of difficulty and solutions for freedom from their problems. They will also discuss the topics with peers in the group. The therapist will provide suggestions and strategies to implement into their daily routine for increased freedom from their problems. Throughout the educational component, residents will be responsible for journaling experiences to utilize as an insightful reference through personal growth and recovery.

**Funding:**

There are barriers in the area of funding that will need to be overcome in order to implement the program. The majority of homeless shelters are non-profit organizations receiving funding through church donations, community support and grants, therefore revenue is not generated. A few of the primary grants located through the internet that homeless shelters may be eligible for include: United Way, Bush & Heartz Foundation, Otto Bremer Foundation, Pew Charitable Trusts, and the Wal-Mart Foundation. The
United Way brings communities together to focus on the most important needs in the community. It invests in the programs and services that strengthen the ability of local United Ways to identify and build a coalition around a set of community priorities and measure success based on community impact. The Otto Bremer Foundation is making a commitment to strengthen the non-profit sector and helping ensure that the organizations serving communities are healthy, strong, and focused on their mission. "Promoting human rights" has become the framework with which the foundation analyzes all proposals. The Foundation is looking for proposals that meet the Foundation's mission of promoting human rights, demonstrate effective systemic change, show how the program or project is sustainable, and has a broad-base support. The Minnesota Common Grant Application contains grant guidelines available on the internet and is an accepted format at the Foundation. Additional information regarding the Bremer Foundation can be found at www.ottobremer.org. The Pew Charitable Trusts is designed to promote the development of a stronger public health system that can protect Americans from existing health threats as well as new and emerging ones. The Wal-Mart Foundation has four areas they fund one of which is the community. They believe in community welfare by taking great pride in getting involved and seeing their results of their efforts in person. All requests for funding must be directed through to Wal-Mart Stores, SAM'S CLUBS, Neighborhood Markets and Distribution Centers. Information pertaining to the other three grants can be found at www.med.und.nodak.edu/depts/rural/ found_rural01.htm.

Results from a research study conducted by Trahey (as cited in Duncombe & Howe, 1995) show that group treatment was as effective as one-to-one treatment for the clients, but that group treatment cost one third less than individual treatment.
Occupational therapy departments are pressured to increase productivity by handling more clients with fewer staff members than they did in the past. The fact that almost half of the respondents from a survey indicated that they were reimbursed at the same rate for individual and group treatment indicates that group treatment is more cost-effective than individual treatment. This finding suggests that the use of small groups to treat clients may increase productivity as well as promote treatment (Duncombe & Howe, 1995).

**Resources:**

<table>
<thead>
<tr>
<th>Supplies Needed</th>
<th>Estimated Cost (per month)</th>
<th>One Time Starting Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Paper/copying supplies</td>
<td>$50.00</td>
<td>$150.00</td>
</tr>
<tr>
<td>-Pencils/crayons/markers</td>
<td>$25.00</td>
<td>$30.00</td>
</tr>
<tr>
<td>-Activity supplies/books</td>
<td>$50.00</td>
<td>$180.00</td>
</tr>
<tr>
<td>-Total</td>
<td>$125.00</td>
<td></td>
</tr>
<tr>
<td>-Table and 10 chairs</td>
<td>$150.00</td>
<td></td>
</tr>
<tr>
<td>-Locked File Cabinet</td>
<td>$30.00</td>
<td></td>
</tr>
<tr>
<td>-Total</td>
<td>$180.00</td>
<td></td>
</tr>
</tbody>
</table>

**Labor:**
Full time Occupational Therapist (OTR) $17.54 per hour ($36,483.20 annually)

These estimates are based on the cost of living in North Dakota, and will vary depending on where the program will be implemented.

**Marketing Plan:**

Through implementation of the community-based occupational therapy program, homeless individuals will learn skills needed to live independently in the community. The program will use therapeutic groups to increase the individual’s development in the areas of personal goals, motivation, and insight regarding their personal strengths and weaknesses. The services will be provided at the homeless shelter for residents free of charge. This is a benefit to the residents because access to care and treatment is onsite and therefore not requiring travel. There are no similar programs within the facility or
area with which to compare the cost.

A primary goal is to make the program appealing to the residents by involving them in the process of selecting topics for therapeutic groups. This will ensure that the group’s focus is a perceived need of the residents. It is important that therapeutic groups are provided at times that are both convenient for the staff and residents. A way to promote this program is to increase the resident’s awareness of these services by placing interesting and creative posters regarding the therapeutic groups available throughout the facility.

The implementation of the program will rely on the staff at the homeless shelter which may include but not limited to; the director, chaplain, educational instructor and occupational therapist. In order to gain staff interest, the occupational therapist will provide each staff member with a brochure that explains the role of an occupational therapist and the services that the profession provides. The brochure will focus specifically on the areas that can benefit the homeless shelter. The occupational therapist will also conduct an inservice to the staff members, informing them of the benefits that occupational therapy services can provide their facility. Following the in-service, the occupational therapist will be available for staff members to address questions and concerns.

**Treatment Protocols:**

Following are the treatment protocols established for three therapeutic groups including: appropriate relationships, recovery from drug and alcohol abuse, and job skills group.
Treatment Protocol #1:
Name of Group: Building Appropriate/Supportive Relationships

Theoretical Orientation: The Model of Human Occupation (MOHO)

Criteria for Inclusion in the Group:
- Client must be a resident of the homeless shelter
- Client must be 18 years of age or older
- Demonstrate or express dysfunction in the area of relationships
- Client must have ability to follow simple commands
- Clients must have difficulty in one or more of the following areas:
  a. Relations
  b. Roles
  c. Social Contexts
  d. Social Participation

Expected Outcomes:
1.) Clients will identify positive attributes about one-self in order to improve self-concept.
2.) Clients will actively participate in group activities by providing and accepting positive feedback from other group members.
3.) Clients will gain and demonstrate insight into maladaptive behaviours used to function in their environment.
4.) Clients will identify activities to use as positive coping strategies and express oneself in a positive manner.
5.) Clients will identify three positive support systems to increase independence within environment.

Methods for Goal Achievement:
1.) Expressive media such as art, music and dance will be used so that group members may gain insight into their self and interactions with others. An example includes having clients draw a picture that represents themselves using markers and paint; discussion will follow with the group members. Additionally, client will be asked to journal their social interactions and experiences on a weekly basis. This will provide opportunities for self-expression/reflection, development of insight into behaviors and documentation of improvement for the client

2.) Clients will be given expectations for the group activity with an emphasis on providing and accepting positive feedback. Clients will be encouraged to provide feedback to peers and accept this feedback appropriately. The acceptance of feedback will help the client to develop a positive self-concept. Interactive games can be used to encourage this interaction with group members.

3.) Educational materials will be given regarding the importance of positive support systems while developing relationships. Discussion of the topic will encourage socialization but also develop insight into their problems. Clients will identify positive...
support systems through the use of resources such as newspapers and the telephone book.

4.) Client will be asked to identify roles and activities in which they are interested and find personally meaningful. These activities will be implemented to make treatment personally rewarding and increase self-concept. Activities such as role-playing will be used to perform an activity/task implementing learned skills. This provides an opportunity to practice skills which are learned. This will also provide further insight into maladaptive behaviors.

Method of Referral: Clients will be referred by a social service agency or homeless shelter. The occupational therapist will conduct an interview to assess client’s abilities and awareness of self.

Termination from Group: Discharge from the homeless shelter, or achievement of individual/group goals.

Location of Group: This group will be conducted in a distraction-free room at a homeless shelter or social service organization.

Frequency and Duration: This group will be conducted three times for four weeks, 2-3 p.m.

Group Size: The group will consist of a maximum of eight individual in the group at one time.

Treatment Protocol #2

Name of Group: Education for Recovery from Drug/Alcohol Abuse

Theoretical Orientation: The Model of Human Occupation (MOHO)

Criteria for Inclusion in the Group:
   Client must be a resident of the homeless shelter
   Client must be 18 years of age or older
   Drug/alcohol addiction with insight into problems; admittance of addiction
   Client must have difficulty in one or more of the following areas
      a. Health Management and Maintenance
      b. Leisure Exploration
      c. Habits (useful, impoverished, and dominating habits)

Expected Outcomes:
   1.) Clients will gain and demonstrate insight into maladaptive behaviors used to function in their environment.
   2.) Clients will gain understanding of the physiological and psychological nature of addiction.
3.) Clients will gain understanding the importance of proper nutrition and how to reduce craving using good eating habits.
4.) Clients will develop a scheduled routine while incorporating positive activities/occupations to increase role performance.
5.) Clients will develop positive coping skills rather than “using” during difficult situations.

Mechanisms for Goal Achievement:
1.) After rapport has been built and the comfort level has increased, clients will be encouraged to plan and facilitate group sessions. This will encourage group ownership while facilitating a sense of belonging, in turn increasing self-concept.

2.) Expressive media will be used so that group members may gain insight into themselves and interactions with others. Expressive media may be used for clients to appropriately express their emotions. Areas that may be included are art, music, and dance, and journaling. Additionally, clients will be asked to journal the recovery process while recording thoughts, interactions, successful moments, trying moments. This will provide opportunities for self expression/reflections, development of insight into behaviors and documentation for the client.

3.) Educational materials will be utilized for clients to learn the effects of addiction which in turn facilitates recovery. Education will also be utilized for the importance of proper nutrition. Clients may engage in cooking groups to further encourage proper nutrition. Additionally, it provides an opportunity to socialize with peers within a relaxed environment.

4.) Clients will participate in an activity-based recovery group. Activities will be used to facilitate leisure exploration. It is important for clients to develop meaningful and positive occupations to incorporate into their routine. Also, time management skills will be explored with developing a scheduled routine, reducing down time and boredom.

5.) Coping skills will be explored through skill training. Positive coping skills will provide clients with strategies to deal with stressors and prevent relapse. Coping skills include relaxation, journaling, use of support system, music, etc.

6.) Clients will be encouraged to identify roles and activities in which they are interested in and find personally meaningful. This facilitates positive occupational performance to increase self-efficacy. Note: This may be a challenge for clients in the group at the beginning of treatment. These activities will be implemented to make treatment personally meaningful and increase self-concept. Activities such as role-playing will be used to perform an activity/task to implement learned skills.

Method of Referral: Clients will be referred by a social service agency or homeless shelter. The occupational therapist will conduct an interview to assess client’s abilities and awareness of self. The interview that will be conducted is the Occupational Performance History Interview II (OPHI-II).
Termination from Group: Discharge from the homeless shelter, or achievement of
individual/group goals.

Location of Group: This group will be conducted in a distraction-free room at a
homeless shelter or social service organization.

Frequency and Duration: This group will be conducted three times a week for four
weeks, 11-12 a.m.

Group Size: The group will consist of a maximum of eight individuals.

Treatment Protocol #3:

Name of Group: Job Skills Group

Theoretical Orientation: The Model of Human Occupation (MOHO)

Criteria for Inclusion in the Group:
1. Clients must be 16 years of age or older.
2. Clients must have the ability to follow simple commands.
4. Clients must have difficulty in one or more of the following areas:
   a. Communication/Interaction Skills
   b. Employment Seeking and Acquisition
   c. Employment Interests and Pursuits
   d. Job Performance
   e. Sequencing and Timing

Expected Outcomes:
1.) Clients will be able to identify at least 3 resources to achieve employment.
2.) Clients will be able to identify interests and strengths that will assist them
    including the appropriate job.
3.) Clients will be able to fill out a resume or know what resources can assist
    them with the process.
4.) Clients will be able to respond appropriately to interview questions during an
    interview for a job placement.
5.) Clients will be able to communicate effectively and appropriately with others.

Mechanisms for Goal Achievement:
1.) Clients will write a list of previous job experiences, interests, and strengths.
    They will then be expected to share their list with the group and the group members may
    be able to give them some more ideas.

2.) Clients will be asked to brainstorm different ways they can find out about
    employment opportunities in a group setting and then record their ideas on paper.
Discussion group will be implemented to assist group members in gaining new ideas for employment. This also facilitates appropriate communication skills.

3.) Clients will be given an assignment to return to group with a resume from an employment site in which they would like to work. The OT will assist them in filling out the resume and let them know of different social service agencies in which they can go for assistance if needed.

4.) Clients will brainstorm possible interview questions that may be asked of them with the OT’s assistance. They will then practice answering the questions in an appropriate manner.

5.) Clients will role play different situations that may occur with a co-worker in a job setting with the members in their group. This will allow them to practice interpersonal skills and appropriate behavior. The OT and other group members will be present to critique the interaction of both clients and instruct them on more effective ways they could interact and on what they did do effectively.

Method of Referral:
Clients will be referred by a social service agency or homeless shelter. The Occupational Therapist will conduct an interview to assess client’s abilities and awareness of self. The interview that will be conducted is the Occupational Performance History Interview II (OPHI-II).

Termination from Group: Clients have achieved the overall goals of the group and are able to effectively hold a job within the community.

Location of Group: This group will take place in a distraction-free room at a homeless shelter or social service organization.

Frequency and Duration: This group will take place three times per week, for four weeks, 10-11 am.

Group Size: The group will consist of a maximum of eight individuals.
Chapter 5: Summary

Homelessness continues to be the most visible and troubling social problem confronting the United States. Homeless individuals may become deskill in their capacity to form and sustain relationships, maintain personal cares, plan time, and/or direct themselves in productive activities. Occupational therapists are recognizing the need of services for the homeless population to increase quality of life. The community-based occupational therapy homelessness program will increase clients’ engagements in meaningful occupations such as self-care, productivity, and leisure. Clients will learn daily living skills which will maximize their independence within the community. Through attending therapeutic groups, clients have an increased potential to become productive members of the society.

Future direction of services to assist the homeless population may be further enhanced through additional research. Throughout the occupational therapy program for homeless individuals, research was conducted specific to homeless shelters within the United States. As demonstrated throughout the literature, homeless individuals represent a diverse population, presenting with a variety of problem areas to be addressed. Information may be gathered from additional social service organizations (i.e. battered women shelters, counseling centers, Alcoholics Anonymous, and youth organizations) to further facilitate a holistic approach for occupational therapy services.

Additionally, further data may be gained in order to show the effectiveness of therapeutic services for the homeless population. Through the literature review, several occupational therapy homelessness programs were located, however a common missing component was the results of the program. Objective data will assist in selling the
program to organizations throughout society to further assist the growing homeless population.

Finally, as demonstrated funding is a primary barrier to overcome in order to successfully implement an occupational therapy homelessness program. Several social service organizations are non-profit, which limits available resources. Further investigation of charity organizations with available donations to increase the quality of life for people in need will be beneficial to this program.
REFERENCES


APPENDIX A

Subjective Survey

Directions: On a scale from 1-5 rate the following areas with 1 being little satisfaction and 5 high satisfaction.

1. Do you feel the group provides information that you will be able to use in the future?

   1  2  3  4  5
   Lowest  Highest

2. Is the information provided in a way that is easily understandable?

   1  2  3  4  5
   Lowest  Highest

3. How interesting is the information to you?

   1  2  3  4  5
   Lowest  Highest

4. After group how do you feel about yourself?

   1  2  3  4  5
   Lowest  Highest

5. How comfortable do you feel in the group setting?

   1  2  3  4  5
   Lowest  Highest
APPENDIX B

Objective Survey

Directions: Answer the following questions to the best of your knowledge.

1. Are you currently employed?
2. Have you contacted places for employment?
3. Have you participated in an interview for employment? If so how many?
4. Do you feel comfortable starting a conversation?
5. What are some positive qualities about yourself?
6. Do you have people that you can go for help? If so, who?
7. Are you currently using drugs or alcohol?
8. What are some things that you can do to get through difficult times in your life?