Occupational therapists’ perceptions of their role with people who are homeless

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Key words: Occupational therapy, homelessness, role.

Introduction: The needs of individuals who are homeless are often unmet. This study identifies the potential role of occupational therapy with adults who are homeless.

Method: This was a qualitative study of occupational therapists working in Montreal, Quebec, Canada, consisting of two survey modes: focus group and self-administered questionnaires. A moderate inductive strategy was used in the analysis of the responses.

Findings: Twenty-two occupational therapists participated. The traditional roles of assessing, treating and conducting research were discussed, as well as the emerging role of occupational therapists as case managers, outreach workers and advocates. The challenges to implementing services included health care structures and processes. The potential facilitators included active leadership and advocacy by occupational therapists regarding the needs of those who are homeless.

Implications: There is a clear and pertinent role for occupational therapy services with those who are homeless. The traditional process of service delivery presents challenges that must be addressed. The topic of homelessness and role-emerging practice placements with this population should be included in the occupational therapy curriculum.

Introduction

Homelessness is a complex problem (Roy and Hurtubise 2007). Even in countries where health care is said to be accessible, universal and comprehensive, care is often centred around an administrative system whereby accessibility is based on having a residential address (Roy et al 2006). Similarly, social welfare is difficult to access for those without a home and basic needs for food and housing are challenging. This structure creates a potential deterrent to accessibility for many vulnerable groups, especially those who are homeless (Roy et al 2006). Indeed, although this population is recognised to be one with numerous needs, it is one that, at least in some health care systems, may receive few health and social services (Riley et al 2003, Roy et al 2006).

The homeless population is multifaceted and includes individuals living on the streets, those fleeing domestic abuse, migrant workers, those experiencing a short-term difficult event and others who are at risk of becoming homeless (Kuhn and Culhane 1998, Homeless Individuals and Families Information System Initiative 2007). This population is greatly diverse in terms of age, sex, ethnicity and mental health status (Canadian Institute for Health Information 2007). A cluster analysis of public shelters in the United States categorised individuals who are homeless into three categories: transitionally homeless (use the shelter for one short stay), episodically homeless (go in and out of the shelter or supervised housing) and chronically homeless (use shelters on a long-term basis) (Kuhn and Culhane 1998). The transitionally homeless are the ones who use shelters more whereas the chronically homeless tend to be older and to be more at risk for more severe mental health, substance abuse or medical problems (Kuhn and Culhane 1998).
Literature review

The needs of the homeless

A number of qualitative studies have described the needs of people who are homeless (Kuhn and Culhane 1998, Weinred et al 1998, Hunter and Power 2001, Finlayson et al 2002, Roy et al 2006, Roy and Hurtubise 2007). Kuhn and Culhane’s (1998) cluster analysis of two shelters in the United States suggested that people who are homeless have varying degrees of health care needs depending on their level of homelessness, with the chronically homeless often needing the most services. The need for food, clothes, care, comfort, training and financial assistance, along with basic daily life skills and a desire to develop skills that would help them to contribute to society, are themes that emerged from studies about homelessness (Finlayson et al 2002, Roy et al 2006). A case-control study emphasised unmet needs related to decreasing emotional distress, building supportive relationships and increasing economic self-sufficiency (Weinred et al 1998). Interestingly, it appears that health is not immediate priority for people who are homeless, even though their physical health problems are exacerbated by their living conditions (Hwang 2000, 2001, Hunter and Power 2001, Roy and Hurtubise 2007).

Petrenchik (2006) pointed out that, although poverty is not directly related to homelessness, it increases dramatically the likelihood of an individual experiencing homelessness, especially in the absence of affordable housing (Burt 2001). In a study by Muñoz et al (2006), over half of the occupational performance problems identified by a sample of 65 homeless individuals fell in the self-care domain, such as obtaining housing and maintaining sobriety. Mental health has also been associated with homelessness (Canadian Institute for Health Information 2007), as studies suggest that those who are homeless are at increased risk for compromised mental health while other studies suggest that those with compromised mental health are more likely to become homeless.

These studies indicate that in recent years there has been an increasing focus on the needs of those who are homeless. The question arises as to the various health and social structures in place to address these needs.

Existing services for the homeless

A number of innovative programmes have attempted to meet the needs of the homeless. A study by Muñoz et al (2005) found that those who were homeless appreciated assistance in stress management and improving social skills, independent living and job skills. Unfortunately, in Canada, there is evidence that the homeless population rarely accesses community and home-based services, largely because these services are based on a home-care concept (Roy et al 2006). More precisely, because those who are homeless do not have a residential address, they are usually outside the typical referral and access channels. In contrast, in countries like the United Kingdom, services for the homeless population tend to be provided directly in day centres or in other accommodation services (Briheim-Crookall et al 2008). While most of these centres offer basic advice services, some also offer meaningful occupational opportunities, including sports, leisure, cultural and educational activities, and a small percentage offer life skills courses, such as budgeting and cooking. Training related to employment is uncommon (Briheim-Crookall et al 2008).

Adding complexity to the provision of services is the global international push towards shortened hospital stays (Roy et al 2006). These shortened stays have an important impact when they touch vulnerable populations who, for example, after early discharge from hospital, return to the streets and to the shelter while still in a relatively acute phase.

In summary, there is strong evidence that there are gaps between the needs of those who are homeless and the services available to them (Hatton et al 2001, Hunter and Power 2001, Riley et al 2003). It is timely to explore the possible contribution of occupational therapists to enhancing the community engagement and overall participation of those who are homeless.

The potential role of occupational therapists

Occupational therapists have a unique approach whereby they provide care in a client-centred manner. They have a distinctive educational background focused on helping people with physical and mental challenges to be autonomous and to participate in meaningful occupations (Canadian Association of Occupational Therapists 2007). Tryssemaar et al (1999) suggested that developing occupational therapy programmes in homeless shelters builds on the profession’s vision of decreasing barriers to participation. They indicated that the role of occupational therapy is well justified for this clientele, who have identified work and contribution to society as being important. Moreover, Muñoz et al (2005) suggested the need for occupational therapy interventions that focus on training in life skills, job skills, interpersonal skills and money management.

Lauckner et al (2006) suggested that although occupational therapists may recognise and value their role with marginalised groups, they often feel unprepared to fill the role. They emphasise the need for education on the topic of homelessness in the undergraduate curriculum and the need for continuing education for those clinicians who are already in the field (Lauckner et al 2006).

It is speculated that occupational therapists could play a greater role in developing community programmes. Unfortunately, there is evidence that, at least in Canada, shelter workers are typically unaware of the profession of occupational therapy and the important role that the profession could play in enabling autonomy in the areas of self-care, productivity and leisure (Finlayson et al 2002). Tryssemaar et al (2000) proposed that there is a concordance between the values of occupational therapy and the needs of the homeless population, making occupational therapists ideal candidates to work with this population.
The Canadian Model of Occupational Performance (CMOP) and the theory of occupational adaptation used in occupational therapy seem particularly well suited to framing the assessments and interventions provided to those who are homeless. Muñoz et al. (2006) and Herzberg and Finlayson (2001) suggested that the Canadian Occupational Performance Measure, created using the theory of the CMOP, facilitates a person-centred and culturally responsive assessment with people who are homeless. Chan et al. (2007) proposed that using the CMOP with people who are homeless can facilitate the development of meaningful and balanced occupational repertoires. Tryssenaar et al. (2000) also discussed the relevance of the CMOP for interventions with this population, in that it takes into account the dynamic interrelationship between the person, the environment and his or her occupations. Johnson’s (2006) study results suggested that the theory of occupational adaptation could also support occupational therapists as they create intervention plans, given that it considers the person in his or her occupational environment.

Given the possible role for occupational therapy with this client group, it was deemed valuable to conduct a study that would provide a better understanding of the potential role of occupational therapists in providing services to those who are homeless, as seen through the eyes of occupational therapists. Specifically, this qualitative study was designed to elicit information from occupational therapists (those who have an academic role and those working in clinical practice) regarding the potential for services for those who are homeless and their perceptions regarding the facilitators and barriers to the introduction of services.

Method

Participants
The target sample was occupational therapists working in physical or mental health services from both the English and French sectors in Montreal, Canada. In addition, members of McGill University’s occupational therapy faculty were targeted for participation. Participants were recruited using direct contact, informational posters at various work locations and snowball sampling. Efforts were made to reach occupational therapists in direct contact with the homeless population by inviting those holding positions in case management teams and at local health centres. Demographic information was collected related to the participants, their work setting and the patient populations with whom they worked.

Data collection
A qualitative study design was used to study occupational therapists’ perceptions of the potential role of occupational therapy in the provision of health services to homeless adults. Two modes were used to elicit information in 2007, a focus group and a postal survey consisting of a self-administered questionnaire that presented the same questions as those posed to the focus group. The two-mode strategy was used to encourage the participation of those who lived outside the Montreal core and thus had difficulty participating in person. This study was approved by the Institutional Review Board, Faculty of Medicine, McGill University.

Question development
The questions posed to participants were developed by the research team to address the domains important to the goals of the study. The specific questions can be found in Appendix 1. The questions were created in English according to the guidelines of Morgan and Krueger (1998). The questions were pre-tested by three individuals with expertise in occupational therapy and in qualitative research design; they reviewed each question to ensure clarity and accuracy. When necessary, wording was adjusted to increase clarity.

Process
The focus group session was held after working hours. Participants provided written consent for participation and audio-taping of the session. The session was run by the four authors, who fulfilled the roles of moderator, flipchart recorder and note takers. The focus group participants were invited to share their thoughts in response to the specific questions, along with any other relevant thoughts. Comments were recorded on a flipchart. These were reviewed at the completion of each question to validate the collected data, make corrections or clarifications if necessary and ensure that the essence of each discussion point had been captured fully.

The questionnaire for those who participated by post was sent by email and returned to the research team by fax or email. When the questionnaire was completed in French, one bilingual researcher translated the French responses into English using direct translation strategies. The research team, all of whom are bilingual, validated these translations.

Data analysis
The data from the focus group discussion and the self-administered questionnaires were brought together and examined for recurrent themes and key points using a content analysis procedure (Mayer et al. 2000). Specifically, the research team met to review and highlight the salient points, and analysed the content with an inductive approach. Discrepancies in data coding were managed through discussion among the four members. In order to ensure the trustworthiness of the data, all four authors reviewed each section of the analysis independently.

Findings

Participants
A total of 22 occupational therapists participated: six attended the focus group session and 16 completed the
written questionnaire. The focus group session lasted 2.5 hours and was conducted in English. When responding to the written questionnaire, six participants chose to provide their answers in French.

The majority of the participants were clinicians (n = 20), some of whom were also academic faculty (n = 7). Their practice settings included community-based settings (n = 9), acute care settings (n = 4.5), outpatient settings (n = 3.5) and private practice (n = 3) (Table 1). Ninety-one per cent (n = 20) were female. Nine participants had direct experience of working with the homeless population. Of these, two worked in an intensive case management model with people with severe mental illnesses, one in a community resource, one in a detoxification programme, four in a hospital and one in a day centre. The 13 participants who did not have prior experience with this population were asked to apply their occupational therapy expertise to respond to the questions.

### Table 1. Distribution of settings of practice of participants (n = 22)

<table>
<thead>
<tr>
<th>Settings of practice</th>
<th>Participants (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community-based</td>
<td>9</td>
</tr>
<tr>
<td>Acute care</td>
<td>4.5</td>
</tr>
<tr>
<td>Outpatient</td>
<td>3.5</td>
</tr>
<tr>
<td>Private practice</td>
<td>3</td>
</tr>
</tbody>
</table>

**Perceived needs**

The participants identified many themes in response to question 2 regarding the needs of the homeless. Analysis revealed that they fell within three global themes: basic needs, the need for support and the need for identity. Most participants indicated that this population requires their ‘basic needs’ be fulfilled, including ‘food, shelter, basic hygiene’, ‘security’ and ‘medical and mental health and dental care’. The respondents emphasised the need for housing and ‘somewhere to be safe during the day’.

Support as a need emerged repeatedly. It was discussed in three categories: social, family and practical support. Social support was identified as the need ‘to be treated as a person’, ‘to be heard’, ‘to break isolation’ and ‘for empathy’. Family support was mentioned as a frequently missing piece because ‘families have given up because they did not know what to do anymore’. Examples of practical support were also given, including ‘getting meals’, ‘help looking for a job, access to a phone’, ‘support with things related to justice’, ‘guide them to appropriate resources’, ‘money management’ and ‘follow up on their health’, pointing out the dilemma that those who are homeless ‘need[ing] an address to receive their welfare’ in Canada.

The need to have an identity and to maintain self-identity was another recurrent theme. This was described as ‘doing and being’ and being engaged in ‘meaningful occupations’.

**Potential role of occupational therapists**

In terms of the potential role of occupational therapists with people who are homeless (question 3), one participant stated strongly:

Individuals who are homeless present with a myriad of problems that occupational therapists are uniquely qualified to address.

The responses to this question fell into two main categories: traditional roles and emerging roles. Fig. 1 shows these roles.

**Traditional roles**

Traditional roles were described as those typical to occupational therapy: assessment, treatment and research to address gaps in knowledge. In terms of assessment, a number of participants pointed out the need for ‘assessment of functional capacities’, including the ability to ‘live on their own’, ‘organise themselves’ and ‘go to the welfare office’. Some participants referred to ‘assessment of needs, cognitive abilities, emotional status, and environmental resources’, ‘safety’ and ‘physical, cognitive, behavioural, and psychosocial needs’ as being important roles that occupational therapists could fulfil. Screening was also seen by some as an important role that should be performed ‘for people at risk for homelessness’ following discharge from acute mental health care, and ‘for physical illnesses, medical needs, and psychosocial needs’ in community sites such as shelters.

With regard to traditional treatments, the participants suggested specific skill training, such as ‘independent living skills training’, ‘money management and budgeting’ and ‘self-validation activities’. These activities were suggested to help build skills such as ‘problem solving’ and ‘responsibility taking’. Similarly, ‘social skills training’ was suggested, including ‘anger management’, ‘developing self-esteem and motivation’ and ‘assertiveness’. ‘Social and spiritual support’ was also brought up as a topic that occupational therapists are trained to address. A focus on ‘vocational and pre-vocational skills training’ was seen as an important intervention. One respondent mentioned that individuals could ‘set up a project that generates money for the shelter to encourage engagement’. Another potential role was related to addressing the addiction problems often prevalent in this population. One participant stated that it was important for people who have an addiction to find ‘pleasure in any activity other than taking substances – to find substitutes, positive and healthy substitutes’.

Most participants identified group therapy as a valuable treatment method because ‘group therapies increase mobilisation’ and provide a ‘sense of belonging’ that would assist people who are homeless to realise ‘I am not alone!’ Individual consultation was also suggested as being appropriate to meet unique individual needs that cannot be addressed in a group.

Some respondents stated that it would be important that occupational therapists considered being ‘researchers’ in this topic area to increase awareness about the different problems related to homelessness and to inform clinical roles.

**Emerging roles**

In terms of emerging roles, some participants identified the role of advocate, outreach worker and case manager. ‘Advocacy is a big one’, emphasised one participant, who
added that to ‘advocate at a structural level’ and to inform those who were homeless of their rights was important. Along these lines, education to numerous stakeholders, including those who were homeless, the staff working in community centres and the general population, about ‘health, drug and alcohol abuse, stress management’ and ‘resources available’ was seen as a potential advocacy role.

A common theme was ‘outreach’. ‘They need us [occupational therapists] to go to them’ in their territory, where they live’. In addition, ‘flexibility of the therapist that goes beyond a ‘9 to 5 schedule’ would help to promote access to this population, who might be more nocturnal’.

Through case management, it was said that the occupational therapist could help to ‘find housing that corresponds to their functional capacities’ and become a ‘liaison’ between health and social services. This role was also seen as one of a health promotion agent to ‘promote healthy habits and prevent disabilities’.

Perceived challenges and facilitators to implementing occupational therapy services

Questions 5 and 6 focused on factors that influence the implementation of occupational therapy services. Table 2 demonstrates the perceived challenges and facilitators. The participants discussed the ideas of building a rapport, providing services in the community, addressing the public’s beliefs about people who are homeless and introducing the topic in the university curriculum to increase awareness.

Numerous focus group members indicated that poor ‘motivation’ and ‘compliance with the proposed interventions’ might have a negative impact on the implementation of services. A number emphasised that the therapist must first ‘develop a rapport’ through ‘client-centred’ and ‘holistic’ approaches because all the interventions are only beneficial ‘once a rapport has been developed’.

Another proposed facilitator was the delivery of services ‘in their territory’ to establish this ‘rapport’ and build ‘trust’. One participant suggested that creating an ‘occupational therapy position in these centres’ would be beneficial. All participants identified the community as the environment of choice for service delivery. Services could be offered in ‘the street, in parks, at community centres’, ‘walk-in clinics’,

| Table 2. Challenges and facilitators in implementing occupational therapy services |
|-------------------------------|---------------------------------------------------------------|
| Challenges                                    | Facilitators                                                  |
| Structure (rigidity of the system, lack of collaboration) | Advocate at a structure level and collaborate with known agencies and other professions |
| Lack of knowledge and expertise               | Encourage research and add the topic in the curriculum (course and role-emerging practice placement) |
| Poor compliance                               | Develop a rapport of trust through client-centred interventions in the community (for example, in shelters) |
| Budgetary constraints and unwillingness to pay for this population | Advocate (lobbying, conferences) and promote occupational therapy by tracking successes |
| Beliefs about people who are homeless (social stigma) | Advocate in the general population |
‘day centres’, ‘centres for mental health and addiction’, ‘temporary housing’ facilities and ‘through shelters to be at the front line’.

In terms of the structure of the health care system, some participants mentioned the ‘rigidity of the system’ in Canada, specifically the administrative structure that is ‘bureaucratically-oriented’. It was suggested that ‘the focus should not be placed on recording statistics of how many clients are seen in a day’, but should be comprehensive and ‘humanistic’. One participant suggested that Medicare cards that are required in order to access health services in Canada are ‘societal identity markers to access resources’ that make health care inaccessible for people without an address.

Some pointed out that collaboration with ‘known and trusted agencies’ as well as with other disciplines would be likely to facilitate the implementation of occupational therapy services. In addition, most participants emphasised budgetary constraints in serving this marginalised population. The general consensus was that having more support from the professional orders for providing services in an atypical way, and recognising the difficulty of keeping accurate statistics specific to any one client, would facilitate the implementation of occupational therapy positions in the community.

More than structural health care barriers, some participants perceived ‘social stigma’ as a barrier that prevented the development of programmes for the homeless: ‘disinterest by the public’ due to a lack of education, with a belief that ‘homelessness is a choice’ and that homeless people ‘contribute nothing to society’. It was further suggested that ‘taboos and blaming’ might be reduced by ‘increasing awareness in the [general] population’. Another barrier was ‘lack of knowledge’ and expertise in the occupational therapy world related to this clientele, with a need for ‘pilot projects and published results’. ‘Tracking successes’ was one way mentioned to increase visibility and to demonstrate the benefits of occupational therapy for this clientele.

**Occupational therapy curriculum**

Question 7 focused on the potential relevance of including homelessness in the occupational therapy curriculum in educational programmes in Canada. Although homelessness is included in some educational programmes in the United Kingdom, it is seldom covered in programmes in Canada and in other parts of the world. The participants were unanimously interested in the idea. Several emphasised the effects that it would have on students.

One respondent suggested:

... this clientele can be found everywhere. It is important for the open mindedness of the young therapists.

Another stated that it would:

help students apply theoretical frameworks to this population and identify the varied roles of the occupational therapists.

Yet another indicated:

... housing is a perpetual issue for people with psychiatric conditions ... therefore, occupational therapists ... should learn how to treat people when the structure and stability of housing is no longer present, even if the occupational therapist is working in a hospital as opposed to a community organisation.

It was emphasised that it would be pertinent to the training of future health care professionals to understand the complex needs of those who are homeless. More specifically, one participant said: ‘It would be great if occupational therapy students were to do role-emerging placements in shelters.’ However, there was a shared concern about occupational therapists not being able to maintain a role in this type of setting due to present realities of the Canadian system:

Most shelters cannot afford to pay any professionals but recognise the need for qualified staff in order to provide good service ... most shelters do have paid staff who would be able to implement the designed programme once the students left.

There was also concern regarding the lack of readiness within the academic and clinical settings to support students in role-emerging placements:

I do not know whether there is the expertise in our community to teach such a course.

Concerns were also mentioned regarding the feasibility of hiring an occupational therapist in a shelter or another community centre for people who are homeless as there is a lack of existing structure. The participants stated the need to address these concerns at a government level in order to obtain ‘money for new positions’ for occupational therapists to work with the homeless.

**Discussion**

This qualitative study set out to explore the role of occupational therapists in addressing the needs of those who are homeless given the evidence suggesting that this clientele has important unmet needs (Hunter and Power 2001) that could, in part, be met by occupational therapy services (Tryssenaar et al 2000, Herzberg et al 2006). The review of the literature and the results of this study suggest that, at least in our clinical community, there is an unmet need. There are few occupational therapists working with this population in Canada and those who do are facing multiple challenges.

The findings suggest that those who are homeless represent a multifaceted clientele for occupational therapists and an excellent match with the fundamental expertise of the profession. Those who are homeless often experience difficulties with daily life functioning and with their physical and mental health: occupational therapists are particularly well suited to promote engagement in meaningful and healthy occupations in the environment of the person.
When it comes to educational content, the respondents' comments suggest that the occupational therapy curriculum might be easily adapted to introduce a greater emphasis on homelessness. Indeed, the faculty members who did participate from one university in Canada were able to identify key sections within the curriculum that would be well suited for the integration of this instructional material. As the profession goes forward, it would be important to reach out to the international community of occupational therapists to learn from them. For example, other countries such as the United Kingdom may provide educational curricula on homelessness that could be shared with academic environments where training related to homelessness is currently sparse. Similarly, the potential for role-emerging practice placements seems realistic given that these have been used in other arenas with excellent success. This finding supports the suggestions of Lauckner et al (2006), who called for increased community development training through the inclusion of the topic of homelessness in the curriculum and in the continuing education of occupational therapists.

When exploring roles, the survey participants mentioned that several traditional occupational therapy assessments and interventions would be useful with this population. This is consistent with ideas raised by Finlayson et al (2002), Muñoz et al (2005), Herzberg and Finlayson (2006), Johnson (2006) and Chan et al (2007) about using an occupational performance model and occupational adaptation theory when working with individuals who are homeless. Tryssenaar et al (2000) have suggested that a non-traditional outreach approach is needed to address needs. Similarly, participants in the current study emphasised an emerging role for occupational therapists as advocates, outreach workers and case managers. It appears that this domain of clinical practice is well suited to occupational therapists who are innovators, those who are willing to take on a new challenge to provide services to a clientele that is not easy to access from the common comforts of typical work settings.

In terms of service provision, a strong message from the findings is that the structure of the current Canadian health care system includes bureaucratic procedures that hinder occupational therapists from pursuing initiatives with this clientele. Traditional working hours and the need to record the name of each client and the time spent is often not suitable with this clientele. Furthermore, from a productivity standpoint when measured in clients seen during a day, it is likely that community outreach by occupational therapists is unlikely to satisfy rigorous statistical guidelines on productivity. Yet, a number of studies suggest that the most efficient method of providing services to this population would be to intervene in their environment (Hatton et al 2001, Hunter and Power 2001, Riley et al 2003). Community development must be considered as a key strategy to promote the health of a marginalised population. The clash of professional expectations is likely to be one of the major stumbling blocks to the provision of occupational therapy services for those who are homeless. This block is likely to occur in many countries, regardless of the health care structure that is currently in place.

While the review of the literature provided insight into the potential role of occupational therapists and greater or lesser implications for occupational therapists in various countries, it identified an international lacuna when it comes to research on the effectiveness of interventions with this clientele. A research agenda directed at this clientele's needs would be well justified.

Limitations of the study
The study has both strengths and limitations. Two different modes of interview were used, which could have resulted in different responses. However, the themes that emerged between modes were similar. Also, although the initial goal was to interview only occupational therapists that worked with this clientele, it was soon realised that they were few in number and this led to the decision to broaden the inclusion criteria to include those who could potentially work with this clientele. Indeed, it was felt that having participants from different clinical backgrounds helped in capturing additional thoughts and themes. Finally, this study was undertaken in one urban area in Canada and thus does not reflect the diversity of the issue across the country and internationally. Thematic saturation was not reached, suggesting that further exploration of this topic is warranted.

Conclusion
The findings suggest a logical and natural fit between the competencies of occupational therapists and the needs of those who are homeless. Existing barriers, such as the structure of some health care systems, hinder services to those who do not have a permanent address. The paucity of occupational therapy academic training relevant to this clientele will need to be addressed before occupational therapy services for those who are homeless become commonplace. It will be important in the future to investigate the available occupational therapy curricula focused on homelessness worldwide, as well as the services that are offered internationally, so that the profession can advance this domain rapidly.

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Key findings

Although there is a perceived need for occupational therapy services for people who are homeless:

- Health care structures and processes, as well as lack of knowledge, make it challenging to implement occupational therapy services with this marginalised population.

- Leadership and advocacy are needed to develop this field of practice through research, introduction of the topic in university curriculum and pilot initiatives that enable occupational therapists and people who are homeless to work together.

What the study has added

This study provided insight about the potential roles of occupational therapists with the homeless population and about the challenges and facilitators that must first be addressed.

References


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Appendix 1. Topic questions

1. Have you had any experience with people who are homeless? If yes, can you share some of those with us?

2. Given the role of occupational therapists, be it in physical or mental health, how would you describe the needs of people who are homeless?

3. What potential roles, if any, do you see occupational therapists fulfilling with people who are homeless?

4. Where would you see these services best provided to this client population?

5. What do you think would facilitate implementation of occupational therapy programmes, what do you think would make it doable?

6. What do you believe are the main barriers to implement occupational therapy services for this population?

7. What are your thoughts about including the topic of homeless individuals in the occupational therapy curriculum?