Evaluation of an Occupational Therapy Intervention Service within Homeless Services in Bristol

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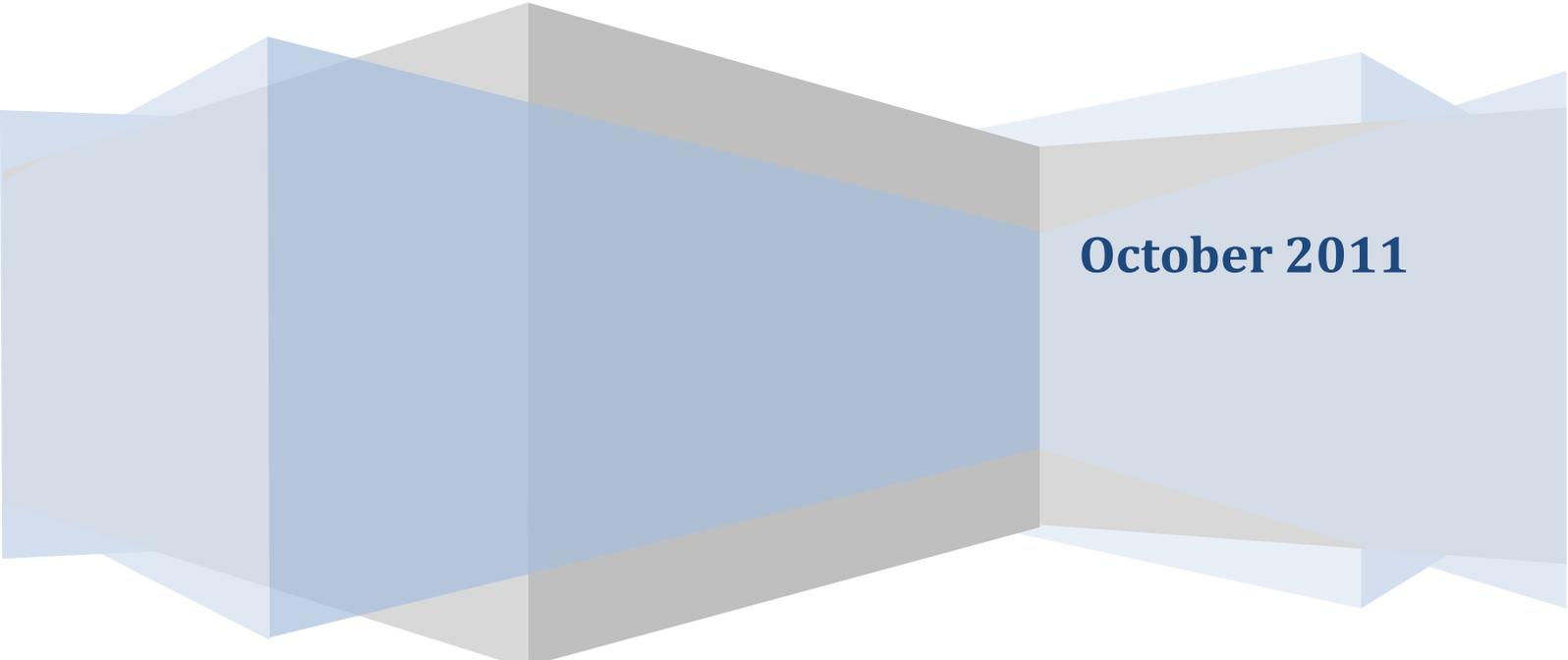
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Executive Summary

Set-up

Following a series of successful placements at Redwood House hostel for occupational therapy (OT) students from the University of the West of England (UWE), Places for People (PfP) secured funding for two full-time, temporary OT posts and set up an *Occupational Therapy Intervention Service* (OTIS). Professional supervision was provided by UWE senior occupational therapy lecturers. Originally intended to operate for a year, the OTIS ran from November 2010 to August 2011.

OTIS intervention

The OTIS' initial aims were to increase the percentage of vulnerable people progressing towards independent living from emergency accommodation in Bristol, and to improve service user involvement within hostels. The OTIS' remit was to focus on the hardest to engage residents who were most at risk of eviction across eleven hostels. OTIS assessment highlighted a range of needs among these residents encompassing interpersonal, intrapersonal (internal or emotional), and life skills; and a programme of individual and group interventions were set up to address these.

Outcomes

The OTIS had 688 service user contacts. The initial aims were refined in recognition of the reduced time-scale and the lessons that were learned about the efficacy of OT with this client group as the project unfolded. Intervention became more focused on building rapport, increasing levels of residents' involvement in the hostels, and the acquisition of life skills. Service users demonstrated some improvement across a range of areas: motivation for occupation, structuring occupation, life skills, and engagement with their environment – as measured by a standardised OT screening tool. Group work provided a useful medium to foster positive relationships, and address engagement, motivational and skill issues. Individual work proved particularly successful in supporting services users during times of transition.

Conclusions

Occupational therapy provided an alternative person-centred and holistic perspective on the complex needs of this client group and much was learned to inform existing practice within the sector. The occupational, 'here and now' focus of OTIS input was an asset in engaging and working with service users. The focus on constructive time use was recognised as having the potential to positively influence relationships, address negative behaviours, and enhance motivation levels. Useful lessons have been learnt regarding the structure and set up of such services across multiple hostel locations and regarding collaborative working.

Aims of the Report

This report has three overarching aims:

1. To evaluate the OTIS' contribution to service delivery in emergency accommodation and the supported housing sector generally.

2. To identify how occupational therapy practice could potentially inform the ongoing work of staff within the supported housing sector.

3. To examine cultural issues within the supported housing sector from the perspective of OT practice and propose alternative ways of working.

Part One was drafted by Dave Peregrine (Scheme Manager at Redwood House) and incorporated material provided by Ruth Barham (OTIS practitioner). It provides an account of the service start-up and delivery, and reflects on the service in the light of its stated aims.

Part Two was written by Jon Fieldhouse and Vanessa Parmenter – Senior Occupational Therapy Lecturers from the University of the West of England (UWE) – in October 2011. Vanessa and Jon, along with Alice Hortop, provided professional supervision to the OTIS and worked in partnership with PfP prior to and during service delivery. This section provides an OT professional insight into the issues raised in *Part One* and summarises what was learned – aiming to inform potential future OT input within Bristol's supported housing sector.

The two parts of this report were written separately with only limited opportunities for PfP and UWE to confer, due to Dave and Ruth's departure from their PfP posts in August 2011. The report was therefore compiled and formatted by Jon Fieldhouse and Vanessa Parmenter.

OTIS Personnel

The OTIS consisted of two full-time, newly qualified OTs – Ruth Barham and Fiona Stoppard – who commenced work in November 2010. Fiona moved to another post in April 2011 and Ruth continued single-handedly until August 2011. The OTs were line managed by Dave Peregrine, Scheme Manager at Redwood House hostel. There were no PfP staff members qualified to conduct professional OT supervision, so this role was contracted to a team of OTs from the Department of Allied Health Professions (Faculty of Health and Life Sciences) at UWE, as follows:

· UWE OT project management and OT reflective team member: Jon Fieldhouse
  (Senior OT Lecturer – jon.fieldhouse@uwe.ac.uk Tel: 44(0)117 328 8941)
· Face-to-face professional supervision: Vanessa Parmenter
  (Senior OT Lecturer – vanessa2.parmenter@uwe.ac.uk Tel: 44(0)117 328 8869)
· OT reflective team member: Alice Hortop
  (Senior OT Lecturer – alice.hortop@uwe.ac.uk Tel: 44(0)117 328 8588)

Part One:
A *Places for People* Commentary on the OTIS

Service Background

Funding for OTIS came from Bristol City Council's Supporting People Team following an application made to the Innovation Fund in January 2009. The desired impact of OTIS was twofold:

1. *To increase the percentage of vulnerable people progressing towards independent living from emergency accommodation in Bristol*

   It was hoped that engagement with OTIS would equip vulnerable people with the skills for independent living and with other life skills and interests that would enable them to minimise the risk of subsequent relapse into addictive behaviour, isolation, low self esteem and, ultimately, failure of their tenure in hostel accommodation or beyond.

2. *To improve service user involvement within hostels*

   Occupational therapy seeks to empower and build self-esteem in its service users (see *Part Two*). It does this by focusing on the normal activities of daily life, which differentiates it from the standard supported housing model where service user involvement can often, if not intentionally, be seen as distinct from the broader agenda of support provision. A significant aspect of occupational therapy work relates to encouraging service users to engage with their immediate environment and part of the remit of OTIS would be to encourage service users to have a positive impact on the service where they are resident.

The intention was that these goals would be achieved through a combination of one-to-one casework and group work taking place within emergency accommodation services in Bristol. OTIS referral eligibility criteria were deliberately broad to encourage an inclusive service. Hostel workers were invited to refer:

Individuals in emergency hostels across Bristol at risk of unplanned move-ons through abandonment, non-engagement with staff, eviction or other causes, as well as people who have experienced repeat homelessness in the past 12 months.

The rationale behind the eligibility criteria was two-fold:

· Firstly, working with those residents at risk of unplanned move-on was likely to have a greater impact on the percentage of planned move-ons from emergency accommodation.

· Secondly, there was an implicit assumption, based on experience within the hostel sector, that many of those eligible for the service would be cases of 'repeat homelessness' for whom the traditional model of assessment and

support planning that operates within many emergency schemes had thus far failed to engender any meaningful or lasting change in their personal circumstances.

Occupational therapy

Occupational therapy focuses on the nature, balance, pattern and context of occupations and activities in the lives of individuals, family groups and communities. It is concerned with the meaning and purpose that people place on occupations and activities and with the impact of illness, disability or social or economic deprivation on their ability to carry them out. The main aim of occupational therapy is to maintain, restore or create a match, beneficial to the individual, between the abilities of the person, the demands of her/his occupations in the areas of self care, productivity and leisure, and the demands of the environment (Creek 2003).

The decision to tender for this type of service was based on PfP's previous positive experience in accepting occupational therapy students from UWE on role-emerging placements (REPs). An REP may be set up by a higher education institution to capitalise on a potentially rich learning experience in a setting that does not have an existing occupational therapy service (COT 2006). REPs are now reasonably common and may be set up to explore potential new employment settings or to simply enhance student learning and develop new skills (Fieldhouse and Fedden 2009).

These placements demonstrated the benefits of having clinically trained staff working alongside the existing staff teams and offering interventions outside of the standard support planning model. With many of the needs presented by service-users being chronic in nature and frequently inter-dependent, it was found that the holistic approach of occupational therapy was able to prompt and encourage change in a manner that the more traditional support provision was not always able to do.

Further, although the need for support around housing, substance misuse, physical and mental health and offending behaviour have long been accepted as the 'typical' support needs of those resident in emergency accommodation, the overarching need for sustained meaningful and satisfying day to day activity is arguably less readily identified by support staff. Routines for homeless people are often imposed and determined by meetings to ensure ongoing receipt of benefits, probation or court appointments, or collection of methadone prescriptions, for example. These routines can therefore lack meaning (Chard et al 2009). It was hoped that by addressing this lack of meaningful activity, interventions made by the OTs might also serve to assist in meeting those more 'typical' needs described above. Recognising how this could be achieved was integral to the refining of aims that took place during the course of the OTIS.

Service Delivery

Start-up

The project began with the OTs visiting all emergency accommodation services funded by Supporting People in Bristol. These initial visits were intended to be an introduction to both the OTIS and also the practice of OT, as both OTs felt that for the service to be utilised appropriately it was important that referring workers had a clear understanding of OT. These visits were followed up by invitations to support staff to refer any eligible residents and the offer of conducting group work within the service. Various **introductory groups** were set up at services.

The aims of these introductory groups were:

1) To build trust and rapport with hostel staff and residents

2) To promote greater take up of OTIS amongst residents and referrers

3) To provide a forum for the assessment of individuals' needs

Once residents' needs had been identified a group programme was developed (see below) whereby more structured groups were offered with closed membership and more defined goals such as tenancy skills and goal-setting. Individual work was offered to those who were assessed to have needs that would best be addressed on a one-to-one basis.

Over the period of the project this group work was scaled down to take place at three, and then two hostels. There were a number of factors that contributed to this decision:

· Time constraints made it difficult for two staff to run groups across 11 services
· Groups in certain services were much better attended, and as such represented more effective use of OTIS input.
· The loss of one OT (Fiona) in April 2011 required further rationalisation of Ruth's time.

By the end of the service, groups were being conducted at Stonebridge Park and Redwood House. All other services were made aware that individual residents could still be referred to the service. In addition to the groups that were being run within the hostels, three further groups were set up to be run at a neutral location – a venue where none of those attending the group would be resident. The venue chosen was PfP's Head Office in St.Pauls because of its central location and also to explore what the impact of using such a venue might be on attendance.

Overall, the service received a significantly lower number of individual referrals from hostel staff than had been anticipated but this was more than compensated for by an increase in the provision of group work.

Professional supervision

UWE professional supervision comprised service planning, face-to-face supervision, continuing professional development, and preceptorship (see *Part Two*), and contribution to this final report. A supervision programme was set up to include individual and joint supervisions for the two OTs, review meetings attended by Dave Peregrine, and reflective team discussion between the three UWE OT lecturers. Additionally, supervisors were available via telephone on an ad hoc basis provision was in place for supervisions to be bought forward if circumstances demanded.

Assessing Needs

The OTs began the process of assessing the residents' needs by talking to the residents in one-to-one sessions and in the introductory groups. In addition, observations of skills was done (using structured OT assessment tools) while residents engaged in activities in group settings. OTs also liaised with support staff to obtain their perspectives.

The following needs were identified:

· To increase motivation to participate in new activities.
· To increase activity levels to develop more structured and productive routines.
· To build skills in activities of daily living such as cooking, budgeting, and self care.
· To build social skills.
· To increase involvement in community-based activities.
· To increase self esteem and expectations of success.

These needs were meaningful to the residents and considered relevant to meeting both the original and refined service aims – particularly regarding the aim of increasing the level of service user involvement.

OTIS interventions

A range of group and individual interventions were developed by the OTIS to address the areas of need highlighted. In order to maximise the therapeutic potential, the development of each intervention considered the impact of:

1. The individual – e.g. motivation, confidence, interests and values.

2. The environment – e.g. the group, the particular hostel, potential for adaptation, the wider community, whether it was indoors/outdoors, etc.

3. The activity itself – e.g. Was it health/well-being promoting? Was it skill-building? Could it be graded and adapted?

Specific Interventions over the 7 months included:

· Breakfast Group (tea, toast and topical discussions from newspaper).
· Library and Internet sessions
· Tenancy skills group
· Job/voluntary work hunting
· Individual cooking
· Group Cooking
· Running/jogging
· Gardening
· Park activities (walking, ball games, etc)
· Shopping
· Goal-setting

Aims of Intervention

These were based on consideration of the needs listed on p.6.

· Developing rapport and building therapeutic relationships
· Increasing motivation for occupations
· Providing healthier structures to resident's routine
· Providing opportunities to use time in a self-directed way
· Providing opportunities for developing skills
· Providing opportunities for confidence building and to experience success
· Increasing engagement within the hostels
· Promoting inclusion within the social milieu of the hostels and the wider community

OTIS Contacts

Total client contacts	688
Total individual referrals	16
Total individual contacts	168
Redwood House group contacts	379
Stonebridge park group contacts	122
Dean Crescent group contacts	9
Spring House group contacts	6
Molitor house group contacts	3
St George's House group contacts	23
Neutral venue group contacts	0

Table 1: OTIS Client Contacts – for the 7 month period Dec 2010 to July 2011

Individual Work

As stated on p.5, the volume of referrals for individual work was significantly lower than expected or desired, and this contributed to the decision to focus on group work. It is hard to be certain about the reasons for the lack of referrals. Questionnaires were sent to staff at participating hostels in order to explore this but no replies were received within 3 weeks of their dispatch. This may be a reflection of one of the reasons for the low volume of individual referrals – hostel staff attitude.

At the initial OTIS introductory meetings the OTs perceived a resistance from some hostel staff to the service they were offering and believed that this was based on the notion that the OTIS was 'treading on their toes'; that OTIS staff were asking for referrals so that they could do the job of the hostel staff. Additional invitations to refer were sent out in December, February and March and received no direct responses.

No. of Residents	Outcome of referral	Comments
6	Successfully engaged and completed OT intervention	· Goals set were achieved and residents reported improvement in functioning both within the hostel environment and in the community e.g. in their own accommodation with floating support or in drug rehabilitation services
4	Were assessed but did not engaged in further OT intervention	· Resident A slipped back from 'contemplation' into 'pre-contemplation' (Prochaska and Di Clemente 1982) · Resident B had mental health problems and was known to staff to disengage completely periodically · Resident C was satisfied with his life and felt he did not want to make any additional changes other than housing. · Resident D remained in his room at his hostel only coming out for food
3	Referred on to other services due to pressing and complex health needs	· Resident E required hospitalisation and ceased to be a hostel resident. · Resident F required additional services to address specific health needs · Resident G was transferred into drug rehabilitation
3	Evicted from hostel accommodation	· Residents H and I were evicted prior to OTIS assessment for violent behaviour · Resident J was evicted following assessment due to violent behaviour, preventing engagement

Table 2: Outcomes of individual OTIS referrals received in 7 months (Total = 16)

Although final outcomes for individuals regarding their move-on from emergency accommodation did not improve over the 7 months of the OTIS this is likely to have been an unrealistic target over such a short time. Each service user who attended one or more case-working sessions demonstrated an improvement, as shown in their screening assessment (using the MOHOST screening tool (Kielhofner 2008) – see *Part Two*). This tool assesses a service user's motivation for occupation, pattern of occupation, communication and interaction skills, process skills, motor skills and engagement with their environment. The service user is assessed to be either facilitating, allowing, interfering or restricting different aspects of their performance – how they 'do' things – within these categories. A clearer understanding of achievable targets was gained using the MOHOST.

Lack of engagement is a long-standing issue within emergency accommodation. This may be related to individuals' chaotic lifestyles and residents not wanting to receive the service that is being offered. It is not unusual for hostel residents to simply want a roof over their head and a bed to sleep in, rather than the provision of support. Essentially, their goals are different from those of the support provider. The OTIS aims (see p.10) of building rapport and a therapeutic relationship are relevant in this respect because the focus is negotiated shared goals.

Group Work

Attendance

It was observed that groups were well attended when the OTs had first established a rapport with the hostel residents and the staff. Residents were encouraged to attend because the group was felt to be less threatening which, in turn, built further trust and confidence. The residents needed to feel that the session would not exceed their capabilities and they would not leave feeling foolish or rejected.

A 'here and now' focus

Groups operating in real time and focused on the 'here and now' were more successful than future-focused groups, such as the goal-setting group. One resident stated;

> "I'm not going to that, I don't want to think about the future, not while I'm in this hostel, that's what I want to avoid."

This was understood to be due to the particular therapeutic capital in working with people who are experiencing themselves in action, in real time. This is a fundamental aspect of occupational therapy and will be expanded on in *Part 2* of this report.

The benefits of this approach are that the groups boost the individual's self esteem and stimulate their motivation. For example, cooking groups produced tangible results and immediate gratification for those involved. Service users made it clear that a key component of this satisfaction was the fact that they had produced something that could benefit somebody else. Cooking groups ended with the meal being served to other residents and staff of the hostel. The opportunity to take on

the role of 'provider' had a significant impact on the self esteem of a client group for whom low self esteem is often a barrier to contemplating change. This 'here and now' approach contrasts with other activities that may typically feature on a support plan where the 'pay-off' is deferred and often not directly experienced by the service user, such as completing an application for housing benefit, where the service user will never actually see the payment being made to their landlord.

Use of time

The sessions were intended to provide an opportunity to structure time in a meaningful way. The aims were to enable a resident to have a positive experience from a legitimate activity. The groups that were established – such as cooking groups, 'smoothie' groups, and a gardening group – were organised to stimulate people's interest and their appreciation of structured, meaningful time use which was identified as a need of the residents. In short, engagement offered residents the opportunity to 'experience themselves differently' and to experience the potential for change.

Self esteem

All groups focused on building confidence and self esteem, based on the facilitation of positive interactions with staff and other residents. As described, the cooking groups provided the opportunity for immediate gratification. One resident described the increased self esteem that was produced from making a smoothie;

> *"I've seen people with smoothies but I never thought I'd try one, I feel like a proper person with one of these"*.

Service Evaluation

In summary, due to the chaotic nature of this client group, the challenges involved in achieving change within a short time-scale, the detailed assessment of need derived from MOHOST screening, and experiential learning by the OTs about the particular efficacy of their approach, the original service aims were refined to become:

1. building rapport
2. promoting engagement (monitoring engagement and assessing barriers)
3. developing life skills

The larger hostels became a priority over the smaller hostels because the smaller staff to resident ratio in the larger hostels created higher need for involvement of OTIS input. Some of the smallest hostels were already running daily groups (albeit with a different focus) and were closely supported by staff as the ratio was 1:1 staff/resident such as at The Well.

As described earlier, having 11 hostels to serve made it difficult for the OTs to focus their work and operate in a person-centred way – in order to optimise effectiveness. Furthermore, the OT's felt pressure to show results quickly to justify the setting-up

of the OTIS and were aware of the challenge of identifying and measuring specific outcomes with a complex client group.

The time constraint also impacted on the OTIS' input because of the need for systems to be established for all aspects of the service; such as choosing the most appropriate assessments, the format report-writing, storing records and client information in accordance with the College of Occupational Therapy Code of Ethics (COT 2010), and establishing the referral pathway. In addition the OT's had to gain an understanding of several hostels, which included assessing the feasibility of running groups in different hostel environments, getting to know the facilities each hostel had and what equipment was available as well as resources such as hostel budgets and the availability of staff.

Partnership working

From the beginning OT's were eager to involve the hostel staff, hoping that they may support some of the recommendations from the OT assessments through their own work. However, this opportunity was not taken up by hostel staff as they were initially very defensive about their own practice, asking the OT's: '*What qualifications do you have to carry out this work?*' and stating: '*We help people with budgeting and life skills.*' However PfP's perception was the strategies used by hostel staff were very different from OT strategies.

Another obstacle preventing support workers from supporting OT interventions was the limited hostel staff numbers, preventing support workers from leaving the hostel premises. This limitation meant they were unable to support the residents in extending OTIS programmes to include community-based activities.

Working across 11 hostels compounded some of these difficulties because of the challenge of establishing good rapport with all the staff of all the hostels. Good rapport improves understanding of the OTIS role and also helps the OTs to understand the support workers' aims. It was important to know the individual hostels' systems for communication. For example, does it use a log book to leave messages? Or does it use notes or a diary to convey information about residents? Does the hostel use computers to which the OTs do not have access? The need for effective communication was increased because of staff working shifts and having irregular hours compared to the OTs. Important, relevant information about mutual clients could be lost without effective communication methods. Additionally, without a good working relationship hostel staff could be defensive about providing client information which would assist the OT's work with residents.

Barriers to engagement

All the hostels provide accommodation for male and female residents who were 18 years old and above – except for St. George's which serves 16-24 year olds. Whilst

residents showed a wide variety of strengths there was a great diversity of needs such as drug and alcohol problems, mental health problems issues, learning difficulties, social problems, extreme vulnerability, financial problems and relationship problems. OTIS assessment suggested that underlying the external factors were intrapersonal difficulties such as low self esteem and limited self-belief and self-efficacy.

Working with 'hard to engage' residents carried implicit challenges such as their chaotic nature and their consequent difficulties in organising their time to commit to interventions. Many of the 1:1 referrals appeared mistrustful of services; blaming previous contact with other services for their current situations:

> *"The probation officer has written a report that prevents me from moving on anywhere."*

> *"The social worker claimed I was unfit to look after my daughter so that was that, here I am now."*

> *"I can't do anything while I'm in this hostel: work, see my family, stop taking drugs".*

The clients often lacked a sense of responsibility and concern for their own lives:

> *"I get up and get drink and sit with the boys. That's it, that's what I do".*

Reduced motivation
A major barrier to OT intervention was residents' reduced motivation to make changes and establish goals. Another significant barrier was the common difficulty of structuring time. Many individuals had established maladaptive routines around drinking and drug use and spent all their time with other hostel dwellers, appearing unable to participate in the community groups and activities based outside the hostel. They preferred to hang around the hostel stating 'I've got nothing to do'.

Newton-Scanlan et al (2011) have shown that unemployed 18-25 year old people spend more time 'doing nothing' (non-directed use of time) than engaging in leisure pursuits compared to people in employment despite the increased time available to them, and that they also spent more time on activities that are associated with poor health and premature death. The OTs also observed this to be the case in the hostels and believe that more support than was originally realised would be needed to enable people to structure their time, extend their range of activities, and keep appointments. This also influenced the refinement of project aims (see p.10).

However, a few people were fully co-operative in discussing their needs, saying that they were dissatisfied with their lives;

> *"I spend all day and night drinking, I've forgotten what interest me"*

When it came to them engaging in activities outside these habitual roles many individuals failed to take action, demonstrating a need for high levels of support to participate in the initial activities. Once an individual began to engage, self esteem, confidence, and motivation frequently increased – sometimes called 'occupational spin off'. It has been shown that if a person becomes involved in one activity it can lead to an increase in activity levels as the success they experience creates increased motivation to try additional activities (Rebeiro and Cook 1999).

Low expectations of success
On initial presentation residents did not lack cognitive and physical skills to be able to engage but appeared to be hindered by intrapersonal factors such as poor self belief and low expectation of success amplified by the negative impact of the hostel environment. The occupational demands of living in a hostel are low and require minimal effort with low risk of failure. However, the step up to mainstream activities could prove daunting and perhaps alienating. This was observed when one of the OT clients went to a local running club and stated:

> "This aint my kind of place. These ain't my kind of people. It just makes me want to hit someone".

His attendance at the club was a long term aim of his support plan devised with the OT and followed several sessions of running with one OTIS practitioner.

Difficulty making decisions
Residents have been observed to find it difficult to make choices and decisions. It might be because many of them have been disempowered by institutional systems such as social care and prison and also by life events which have occurred beyond their control such as death in the family and forced unemployment, leading to a loss of roles. The support systems in the hostel itself also remove the decision-making process for individuals. They would benefit from increased involvement in the decision making process and responsibility for the hostel environment.

The difficulty of coping with choice and decision-making has been noticeable in people who have been recently released from prison, one resident stating:

> 'I find choices over-whelming, I can't cope with deciding what to do with myself'.

This resident found OT interventions particularly useful. He was given support to fill out a diary sheet with an expanding range of activities and gradually given more responsibility to manage his own time enabling him to be independent from the OTIS.

Addiction
A further barrier for people to engage with occupational therapy is the lack of experience of non-alcohol/drugs-related activity. Many of the hard to engage residents have never had a job, nor volunteered or participated in socially acceptable

activities. Past experiences have often been negative in that family life was dysfunctional, as was school, and many have been in prison. Past experiences shape future choices. Individuals have limited reference points of positive things they would like to do to replace their marginalising activities; reducing motivation to carry out unfamiliar tasks and reducing their sense of belonging to the community because they lack a common shared experience people in our wider society.

A study published by the homelessness charity Crisis (National Addiction Centre 2002) found that 81% of homeless people are addicted to either drugs or alcohol. This statistic resonates with the experiences of emergency accommodation services and highlights another challenge in engagement; that addictions entail a pattern of occupation of their own and the nature of addiction means that these occupations will almost always take priority.

Heuchemer and Josephsson (2006) have examined the conflict that arises when addiction becomes a life role;

> *"As a result, an unhealthy imbalance of daily occupations may lead to an internal conflict between what people should do and what they want to do. This internal conflict can lead to feelings of self deprivation and can result in a relapse into addictive behaviour, thereby reinforcing the cycle of addiction. The risk factor of occupational deprivation, which occurs as the result of external forces that prevent a person from engaging in an occupation, is closely linked to the effects that have been presented as possible causes and consequences of drug addiction, such as lack of sensory stimulation, reduced opportunity to use physical, mental and social capacities, reduced personal development or lack of meaning in life"* (p.161).

The challenge for support staff in hostels is how to help resolve the conflict between 'what people should do' and 'what they want to do.' An addiction is frequently an immediate and pressing demand for the addict; a demand that their entire day is structured around. For example, a person with a heroin addiction needs to find money to fuel that addiction (often involving illegal activity), they then need to use the money to buy the heroin and so arrange a meeting with a dealer, they will then need to use the heroin and the majority of users will seek a 'safe' place for this. Immediately subsequent to heroin use, their time use will be dictated by the effects of the drug. Within this daily occupation, they must also find time to eat, drink and sleep. This leaves little time to attend a support planning meeting.

Lack of autonomy
Another difficulty observed in many of the residents is dependency on others. Residents appear to need to be with others to carry out occupations such as going to the doctors, going to drug services or any other appointment and will miss an appointment unless they have support to get there. It can be suggested from this observation that hostel staff are needed to be positive role models and to motivate people to attend appointments by accompanying them. A graded approach to this could increase independence; initially accompanying them to and from the

appointment, and then phasing out one journey at a time until their confidence has increased enough to attend without support. This could potentially reduce missed appointments and the repeated failure that residents currently experience; which only serves to reinforce the individual's sense of helplessness.

Key Challenges and Strengths of the OTIS

Challenges

· *The number of emergency accommodation schemes involved*

The scale of the project presented an unforeseen barrier to establishing trust and rapport with the staff and getting to know different hostel policies, procedures and resources. Similarly, it made it difficult to influence the routines and habits of the residents. If OT's had been based in one hostel daily groups could have been provided to implement structure into the residents chaotic maladaptive routines such as daily breakfast groups, daily planning meetings and evening relaxation groups.

For example, providing one group a fortnight in the women's hostels proved unsuccessful because it was too irregular to build relationships with the clients and influence hostel structure. It appeared to be a surprise to the staff and residents when the OTs arrived, even when the event had been pre-arranged and reminders were sent to them. Bearing in mind the relative cost of a qualified OT (and associated on costs such as clinical supervision) in comparison to a front-line support worker, it is unrealistic to expect that the funding would be in place to employ a therapist in each hostel. This issue will be considered further in *Part Two* of the report.

· *Working with clients in pre-contemplation stage of change*

Working with people who are hard to engage requires regular supportive contact; initially by having brief chats at Reception or in the corridor to build up a relationship and trust with the client. This enables the OT to build up an understanding of the client and discover motivating factors to encourage them to engage. Without daily contact with the residents obstacles to establishing relationships occur as the individuals are generally trying to avoid interaction with workers. While these contacts were essentially casual and impromptu in their nature, they have a therapeutic value that will be expanded upon in *Part Two*.

· *The short duration of project and selection of appropriate outcome measures*

The OTs were advised in professional supervision to establish outcome measures at the beginning of the project. This was difficult as the OTs felt unable to select outcome measures prior to assessing residents' needs. The OTs felt pressure to be visible in the hostels rather than doing paperwork. Throughout much of the project a tension existed between PfP's desire for consistent assessment and outcome measures and the OTs desire to choose measures based on the individual service user. Ultimately, it would not have been appropriate for a Project Manager lacking the relevant profesional qualifications to make a judgement call on this, but it

highlights an issue that potentially could have had broader implications if significant change amongst residents is not captured and recorded – both in terms of proving worth, and developing the service.

The short duration of the project also posed difficulties with regards to final outcomes from supported accommodation for OTIS service users. The majority of these residents were still living in the hostels where they initially received OTIS input when the service came to its end. The nature of their 'move-on' from the hostels could not form part of the evaluation of the OTIS as it had not yet happened.

Strengths

· *High client contact*
During the 7 month project OTs have achieved a high number of client contacts through group and individual work.

· *Creating positive experiences*
The OTs created groups providing residents with a positive experience of socially acceptable activities and positive interactions with each other and staff. This provided the opportunity for individuals to experience success which increased self-esteem and positive expectations. Groups also provided a platform to deliver health messages such as information about health and nutrition and mental wellbeing. They also helped to create more structure for the residents to develop positive routines.

· *Working with addiction*
In the light of the Heuchemer and Josephsson's (2006) quote presented earlier, the cookery groups run by the OTs was an attempt to break maladaptive routines and establish an activity that a person 'should' do, but which also had a strong appeal. The criteria for such groups were:

· The activity needs to be attractive to the service user
· The activity needs to have enough gratification in itself to compete with the immediate demands of an addiction
· If it is accepted that the addiction is the prevalent motivation in a person's life, then the activity should not try to threaten this status directly; the purpose of a cooking group is not to stop the members taking drugs, but to cook.

In addition to these, the cookery groups had further effects: a service-user spending two hours cooking, serving and eating a meal has not only developed basic skills for independent living, they have also spent two hours outside of illicit, addiction-driven occupations and without being under the influence of any substance. They have also given themselves, however temporarily, a legitimate role in the place where they live and with their peers: that of someone who is preparing and supplying food to others. This foray into, and positive experience of, legitimate roles and activities could provide a foundation for further change.

The other benefit of group work in relation to substance misuse is that it provides a positive shared experience. Heuchemer and Josephsson (2006) also found that:

> *"Social relationships could have a strengthening influence by supporting the lifestyle that [homeless people] were leading"*

For an addict, much of their social interaction will revolve around the occupational aspects of addiction mentioned above. This legitimises and reinforces behaviours that are not desirable. A positive shared experience can have the opposite effect.

· *Using different strategies in order to remain client-centred*
Occupational therapists use client-centred assessments to establish individual strategies to enable clients to overcome obstacles to reach their goals. Two individuals may present with similar difficulties but will need individual plans to overcome them depending on their personal strengths.

· *Flexibility in meeting residents in their own hostel*
It was found that residents were less likely to attend groups, activities and appointments based in the community. The capacity to see residents in their usual environment is likely to have increased engagement, as is the willingness to be flexible in making appointments.

· *Building rapport with Redwood and Stonebridge staff*
By providing activities regularly at these hostels the OTs were able to build effective working relationships with the staff which aided communication and ensured the efforts of hostel staff and OTIS practitioners was better integrated. It is believed that by co-operating with the OT activities the hostel staff gained a clearer understanding of the role of OT and saw the benefit for the residents; thus reducing defensiveness and mistrust towards the OTs. Significantly, the hostel manager of the hostels became more agreeable with funding the groups and providing resources.

· *Embedding occupational therapists within emergency accommodation*
There was anecdotal evidence to suggest that the presence of OTs within the hostel was of benefit to partner agencies beyond the supported housing sector. On two occasions, one of the OTs was contacted by different counterparts at Bristol Royal Infirmary and Frenchay hospitals with requests for advice about discharging patients who would be homeless upon leaving the hospital. Both of these calls came in the last month of the service. It could well be that it took this period of time for awareness of OTIS to spread to those OTs within the hospitals, which suggests that this relationship could have become more valuable over time.

Reflecting on Part One

One of the key challenges in working in emergency accommodation is to get service users to engage with the support that is on offer. OTIS experienced the same

challenge. Although the number of client contacts was high, the majority of these came through group work rather than for individual casework.

It was hoped that by offering a service that was based on occupations rather than on 'problems' (which the service user might not have chosen to address themselves) the support on offer might be more attractive to service users. This was clearly the case in the groups. The *experience* of occupational therapy was more engaging for people than the *idea* of being referred to what may have been seen as yet another deficit-focused service.

The presence of a programme of engaging activities within supported accommodation is crucial. The government (Department for Communities and Local Government 2006) has recognised the impact that the standards of accommodation could have on the residents living within it, as have Chard et al (2009);

> *"The shelter environment reinforced the reality of homelessness rather than compensating for it. Lifestyle, stigma and lack of privacy and choice, as well as the constant pressure of stress, all shaped how each man experienced the shelter environment."*(p121)

Not all providers have the financial capacity to change the physical structure of their building to ensure that it does not reinforce homelessness. Occupational therapy practice is able to address the interaction of service-users with their environment (see 'micro-environments' in *Part Two*) and the presence of legitimate activities and occupations within hostels can serve to mitigate the impact of the buildings and the way they reinforce certain behaviours associated with homelessness.

Residents of emergency accommodation schemes in Bristol have, more often than not, been referred there by the local authority and this referral is often made on the basis of available units within hostels as opposed to preferences of the resident. As such, in many cases they arrive with little or no personal investment in the success of their tenure there. Many hostel residents will arrive in the pre-contemplation stage of change, so that interventions designed to directly address drug use and/or mental health difficulties, for example, may frequently be destined to fail. If the service user does not recognise a need for change then change is unlikely.

Further, in order to progress toward independent living, aspects of the lives of many of these people need to change. Identifying, encouraging and engendering this change is the job of support staff within these services.

One of the greatest strengths of occupational therapy practise in this sector is that it is able to address one of the key causes of negative behaviours – individuals' lack of occupation and their unstructured use of time – rather than merely focusing on the negative behaviours themselves. The process of addressing and changing daily routines can take a service user to a point where they may be ready to contemplate or even act on a need for change and from that point, progress becomes possible.

Part Two:
An OT perspective of the OTIS

This section highlights some of the issues raised in *Part One* and examines them from the OT professional supervisor's point of view, under the following headings:

1. Addressing the complexity of service users' needs
2. Understanding service dynamics and their impact on OTIS service delivery
3. Appreciating the role of professional supervision

Part Two takes the notion of *evaluation* to mean not only considering the 'worth' of the OTIS, but also identifying criteria against which to assess that worth appropriately. It therefore reflects on the refined service aims (see *Part One* p.10) and underlines that this refinement was done in recognition of particular strengths of an occupational therapy approach that became more apparent as the project unfolded. It therefore evaluates the OTIS in terms of building rapport, improving engagement (including tackling barriers to engagement) and skill acquisition.

Part Two concludes with a summary of lessons learned and recommendations for when considering the inclusion of occupational therapy within homeless services in the future.

Addressing the complexity of service users' needs

OTIS assessments highlighted the depth and complexity of residents' needs and pointed to the logical and natural fit between the competencies of OTs and the physical, psychological, and social needs of homeless people, as has been noted in qualitative studies of OT/homelessness services elsewhere (Grandison et al 2009).

Overlaying and compounding the already complex needs of individuals, the social exclusion experienced by homeless people as a marginalised group further impacts on individuals' health by denying them access to the mainstream services required for them to make changes in their lives.

Social exclusion has been defined as non-participation in the key activities of the community in which a person lives (Burchardt et al 2002) and is recognised as both a cause and a consequence of poor physical and mental health (Huppert 2008). Occupational therapy's focus on 'activity' makes it ideally suited to micro-level work with service users and also macro-level work with local agencies to support their access.

What follows is an overview of occupational therapy as an approach to helping homeless people make changes in their lives.

Why occupational therapy?

For occupational therapists, the term *occupation* means any activity that a person engages in that is goal-orientated, personally meaningful, repeatable, and perceived as 'doing' by the individual (McLaughlin Gray 1997). Occupation mobilises all facets of a person – their physical being, their psychological functioning, and their social and cultural identity; and so has huge transformative potential when harnessed as occupational *therapy* to address specific needs or challenges met in daily living.

Occupational therapy is fundamentally an 'active' intervention (as opposed to a 'talking treatment') because it is through 'doing' things differently that a person gains greater awareness of *themselves* as the most crucial agent of change in their own lives. The therapist is an enabler, or facilitator, of the change process. Occupational therapists talk about engaging people in a health-promoting process of 'doing, being, becoming, and belonging' (Wilcock 2007a). By changing their own ways of *doing* an individual is empowered with a renewed sense of self-efficacy (*being*), with an awareness of the potential to make changes in their life – both within themselves and in their relationships (*becoming*) – and ultimately with the means to re-establish their place within a social network, a community, a culture, and society (*belonging*). Crucially this process begins with active engagement in the 'here and now'; by engaging with residents 'in the moment' – as highlighted in *Part One.*

Strengths of an occupational therapy perspective

Certain features of the OTIS were felt to be particularly advantageous in working with this needy client group, as follows:

1. Acknowledging complexity of need
2. Adopting a person-centred approach
3. Clinical reasoning to support engagement
4. Activity analysis
5. Creating supportive micro-environments
6. Remotivation
7. Working with individuals during periods of transition

1. Acknowledging complexity of need

Occupational alienation and deprivation, histories of homelessness and poor access to health services, institutional living, addictions, low motivation, and defensiveness against change all underline the complexity of the needs and challenges faced by service users.

Occupational therapy is recognised as a complex intervention (Creek 2005) because it comprises and integrates a number of separate elements. It offers an approach to working with this complexity because it implicitly recognises that positive change in individuals' lives often involves the abandonment of other 'activities' or coping strategies – such as using drugs and/or alcohol – that individuals may have developed over time. OT is 'activity-based', so it offers alternative activities. In

certain situations, without such alternatives, the prospect of change can reinforce the profound sense of alienation and deprivation experienced by many:

> Resident A: *"I spend all day and night drinking. I've forgotten what interests me"* (*Part One* p.12).

> Resident B: *"This ain't my kind of place, these ain't my kind of people. It just makes me want to hit someone"* (*Part One* p.13).

2. Adopting a person-centred approach

The importance of a person-centred approach has been experienced across many service providers, especially in mental health. There is wide recognition that individuals' non-engagement is often a reflection of limitations in service provision as much as the characteristics of the individual identified as 'not engaging' (Priebe et al 2005). In this project a person-centred and holistic perspective enabled both OTs to engage well with service users, to gather information, and to advocate on service users' behalf to hostel staff, and on one occasion to the courts, regarding accommodation and perceived unacceptable behaviour.

3. Clinical reasoning to support engagement

Underpinning these therapeutic interventions is the therapists' *clinical reasoning* – which blends together theory, knowledge of individual service users, and a 'therapeutic use of self'. It allows evidence-based interventions to be delivered. The OTs employed a professional model of practice called the Model of Human Occupation (MOHO) (Kielhofner 2008) to frame their thinking. The MOHO informs all aspects of the OT process – assessment, identifying needs, negotiating goals, planning, intervention, and measuring outcomes.

The MOHO specifically puts the individual's own thinking, feeling, and meanings *behind* their 'doing' at centre-stage – highlighting personal strengths and aiming to harness the individuals' own momentum for change. It respects the fact that "*habits and roles are naturally resistant to change*" (Forsyth and Kielhofner 2006:74) and emphasises the environment as a starting-point for working with individuals who may be defended against changing their habits.

4. Activity analysis

Building on the use of MOHO, the OTs applied their specialist skills in *activity analysis* and enablement to structure their interventions. Activity analysis involves dissecting an activity into its component parts to determine how it might be rendered more 'do-able' for a particular individual – through methods of grading and pacing. It also includes an analysis of the physical and social environment in which the activity takes place to see how that might be engineered to facilitate engagement also.

5. Creating supportive micro-environments

The OT's individual and group work aimed to complement existing hostel services. It aimed to create psychosocial micro-environments within which residents could experience the hostel environment and themselves differently – such as by providing a meal for other residents, in order to facilitate a process of change. These groups (and the micro-environments they created) were multi-faceted. For example, a 'breakfast group' simultaneously offered:

· an engaging social milieu focused on the immediate gratification of a good meal
· information-giving about nutrition and healthy living
· skill acquisition (cooking)
· interpersonal connections – trying out new roles and developing new relationships with peers (and positive relations with staff)
· intrapersonal change – such as greater self awareness and self esteem
· an experience of hostel life that was focused on positive change

6. Remotivation

To be motivated means to *recognise* a need. While OT assessments underlined that individuals had multiple and complex needs, the individuals themselves often experienced only a state of general deficiency and demotivation. They were often unable to conceptualise what change might be like;

> Resident E: *"I don't want to think about the future, not while I am in this hostel, that's what I want to avoid."* (*Part One* p.9)

Consequently, the MOHO's *remotivation* process (De las Heras et al 2003) was an important tool. Similar in concept to the *Wheel of Change* (Prochaska and Di Clemente 1982), it recognises that different interventions are appropriate for different levels of motivation and suggests a continuum of these, ranging from 'exploration', to 'competency', to 'achievement'.

Many services users said they wanted to develop more meaningful day time routines to feel healthier and better; but identified their addictive behaviours as providing the only structure they had to their days and this prevented contemplating change for many.

Aside from the physical dependency, drinking and drug taking was understood by the occupational therapists to represent meaningful occupations for many service users; it provided roles, routines, social contact and to a certain extent informed individual identities. The potential loss of these roles and routines inhibited many from contemplating change and trapped individuals in dependency.

The 3 stages of motivation were used to structure OTIS interventions as follows:

1. *Exploration* (comparable with *pre-contemplation*)
   This took the form of informal, ad hoc, casual contacts (see *Part One*) and open/drop in groups held in visible, accessible locations – all with these overall aims:
   · to begin a process of rapport-building
   · to carry out a rapid assessment of individual needs
   · to highlight other OTIS input available
   · to offer an opportunity for service users to experience themselves differently

   Positive short term impacts were captured in qualitative feedback:

   > Resident F: *"… I feel like a proper person with one of these [smoothies]."* (*Part One* p.10).

   Similarly, hostel key workers made the following observations:

   · more residents were using the kitchen and cooking for themselves following the start of the Cooking Groups
   · attending the Breakfast Group in the morning had a positive impact on individuals' time for the rest of the day e.g. engaging in exercise and managing their affairs better.

2. *Competency*
   At this level, interventions were more focused on developing specific skills and working towards goals identified by the service user – such as:
   · planning and cooking a meal
   · using local bus services
   · pursuing leisure occupations – eg. ice skating or running.

3. *Achievement*
   Given the 'hard to engage' remit, it was rare for OTIS work to extend to this level – with one notable exception. Some work was done on building time management skills to assist a comparatively highly-motivated individual to structure their own time away from drug use.

7. *Working with individuals during periods of transition*

There were notable strengths in working with individuals at a time of transition – such as:

· working with Resident C to develop community living skills in the weeks before moving out of hostel accommodation into his own tenancy.
· working with Resident D in his move from a prison environment into the community.

A key feature of both these interventions was skill-building focused on supporting the person to develop the habits and routines which would provide a day-to-day structure; something that had been lost from their lives through their experiences of homelessness and institutional living. The long term impact of these interventions is not known but in the short term both service users successfully engaged in new routines and reported growing confidence.

Measuring outcomes

The OTIS used the following assessment and outcome measurement tools:

Two MOHO-based Tools

· *Occupational Circumstances Assessment Interview and Screening Tool* (OCAIRS)
· *Model of Human Occupation Screening Tool* (MOHOST)

These were helpful in providing a framework for clinical reasoning. The OCAIRS was used to help service users to articulate their needs and aspirations. For one individual a detailed occupational therapy report was instrumental in positively influencing the outcome of legal proceedings.

The Recovery Star (MHPF 2007)

Residents' chaotic lifestyle, dislike of 'forms', and limited motivation made the MOHO tools difficult to use. The *Recovery Star* (MHPF 2007) was trialled because it was originally conceived within the homeless sector as the *Outcomes Star* (Onifade 2011) and this was felt to be potentially more conducive to inter-professional communication. However, in practice, the OT's found the categories too general and it lacked sensitivity.

The Engagement Measure (Hall et al 2001)

This was recognised to have the potential to measure small shifts in levels of engagement with OTIS for those service users who were harder to engage. In practice little meaningful data was captured because of the limited duration of the OTIS

Whilst structured outcome measurement was only minimally used during the OTIS, the 'road testing' of these four measures above generated useful ideas for future use in this sector.

Service dynamics and their impact on service delivery

Collaborative working

All organisations have their own social dynamics and from the outset both OT's recognised that service users perceived the OT role as being different to that of the other hostel staff. There were strengths and difficulties arising from this.

Strengths

·   The perception that the OTs were independent from decisions about eviction, for example, enabled service users to build rapport with OTs and develop a more open relationship with them.

Difficulties

·   Without the traditional hostel staff/hostel resident boundary in place, the OTs had to assert their professional boundaries and remain focussed on their therapeutic goals to ensure that service users did not misunderstand their role as 'friend'. This was a recurring theme in supervision and emphasised the demanding and challenging nature of work of this kind and the need for good quality regular supervision.

·   Being seen as 'other' by hostel staff had several implications for the OTs – both in terms of the quality of working relations, and in terms of the impact these had on the number of OT referrals received from hostel staff. The benefits and challenges of collaborative inter-professional and inter-agency working within health and social care are well documented (CAIPE 2010, 2010a) and instances of professional 'tribalism', rivalry, suspicion and lack of understanding were experienced during the OTIS. It should be noted that where hostel managers were enthusiastic and supportive the OTs experienced a more positive and interested approach from hostel staff. The desire to develop joint working practices and to work with hostel staff as co-facilitators in groups, for example, was a frequent supervision topic. Collaborative working was seen to have the potential dual functions of:

(a) Developing the skills of hostel staff in more person-centred, facilitative approaches to working with residents. This was seen as a staff development issue; a way of maximising skill-sharing amongst the staff group.

(b) Developing understanding of the occupational therapy role which would then be reinforced across the staff group. This would be a way of generalising an approach; maximising the consistency of staff input and the quality of service users' experience. OT intervention would be 'owned' by the hostel team and even implemented by key workers in the OTs absence.

These two potential benefits of closer joint-working offered the means to make the most of OTIS during its brief duration and, in many ways, both were missed opportunities.

Enhancing collaborative working

Overall, the project highlighted three areas where collaborative working could be enhanced.

1. *Developing joint-working protocols within the homeless sector and beyond*

The need for collaborative working partnerships with a single, unifying, shared care planning process at its heart was abundantly clear. The cross-fertilization of ideas and perspectives that comes from working collaboratively needs to be harnessed to share best working practices and to provide better support for both staff and service users.

The contact made by external non-OTIS occupational therapists seeking advice on discharging potentially homeless patients from hospital also highlights the value of developing joint working practices across statuary and voluntary agencies to improve access to services for marginalised people.

2. *Concentrating OT input into certain areas*

As detailed in *Part One* the demands of being spread across 11 hostels impacted negatively on meaningful joint working relationships with hostel staff.

When the OTIS' focus was narrowed and the OTs were able to have a more regular presence across fewer hostels they reported greater ease in developing relationships and discussing referrals and consequently more appropriate individual referrals and higher attendance at groups. A visible and more constant presence also enabled hostel staff to recognise the impact of occupational therapy interventions on service users which lead to interventions becoming more integrated into hostels' ways of working.

3. *Working at a macro or community-level, as well as a micro-level with individuals*

A significant barrier to facilitating change was the discrimination faced by service users in accessing mainstream community services. An example of this was the difficulty accessing voluntary work. There were limited opportunities for homeless people and where they did exist they were often excluded due to policies such as needing to have been drug-free for at least 6 months. This effectively prevented voluntary work from being used to support lifestyle change away from drug use.

By the end of the project the OTs recognised there was value in developing a role to work with community groups in reducing stigma and developing voluntary work opportunities as means to increasing social inclusion and building self esteem and skills.

The role of professional supervision

The OTIS enabled rapid and significant professional development for both OTs. Active reflection, an integral part of professional supervision, allowed their experiences – positive and negative – to be processed in such a way that they informed the development of the OTIS and potential future services also (see *Lessons Learned* and *Recommendations*).

The structure of supervision

The OTs chose a continuous supervisory relationship with a single occupational therapy supervisor (Vanessa Parmenter), rather than supervision by series of supervisors over the course of the OTIS . This allowed the emergence of an ongoing narrative thread and better understanding (for the supervisor) of the individual residents seen by the OTs – which enhanced the quality of the supervision provided.

A supervisory or *reflecting team* at UWE (comprising Jon Fieldhouse and Alice Hortop) provided reflective space for the supervisor to seek support and shared expertise. A reflecting team can be an important means of discovering new ideas and options. It is a group of colleagues (typically 3-6) who adopt an observational position in relation to a key relationship which one of them (Vanessa Parmenter) has with an external person; which in this case was the OTIS practitioner(s). It adds a meta-position to the supervision which was felt to be essential to breaking new ground in the OTIS (Hornstrup and Johansen 2009).

Long-arm supervision was provided initially every two weeks alternating joint supervision with individual supervision of the OTs. Joint supervision focused more on service development issues whereas individual supervision enabled a more private space for the OT to reflect on their work as autonomous practitioners and on their one-to-one work.

The OTIS therapist's narrative

There was a tension between what the OTs saw as the expectations or demands of the service and their own personal and professional development needs. This was acutely felt because of the short duration of the OTIS and the 'long-arm' nature of the supervision. The supervisor was UWE-based, making it difficult to field ad hoc queries as they arose in real time in the hostel setting. Though email/phone support was offered by the UWE team, this was rarely taken up.

Whilst both newly qualified OTs brought a great deal of knowledge, skills, innovation and enthusiasm to their work the demands of setting up a new service and achieving measurable results within a limited time scale were challenging. On reflection the employment of a more experienced OT to pair with a newly qualified OT might have enabled some of the service establishment issues to be resolved more quickly. For example the OTs were expected to establish a referral system, a record keeping system, and outcome measurement practices with very little experience of using

these. The long-arm nature of the supervision meant gaps in the OTs knowledge/ experience were difficult to establish as they were not always aware what they did not know. For example, the OTs initially reported that they were recording group outcomes, but the method chosen did not lend itself to easy analysis of data gathered. Picking up these issues in a timely manner in supervision was not easy because the supervisor was limited by what the OTs brought to supervision and the off-site location of supervision meant the supervisor had no oversight of the OTs' day-to-day clinical paperwork.

Greater experience would also have allowed more rapid adoption of the established systems policies and procedures, but this was complicated by the OTs having to work across multiple teams all with their own cultures and environments to which the OTs initially felt little sense of belonging. This was particularly important for the safe management of risk in each of the environments.

Preceptorship

If newly qualified OTs are employed in the future, access to preceptorship should be noted. This is a structured approach to building knowledge and skills for new graduate OTs (Morley 2009) and was part of the professional supervision provided for one OT in the OTIS. Although this process was not completed due to the OT moving on to a permanent position before the end of the project, it was valued by both OT and supervisor. It enabled the identification and development of relevant skills and attributes through structured reflection and analysis of professional practice and the mapping of this development to traditional career pathways for occupational therapists.

Concluding OTIS

The short term nature of the project also impacted on the service provision as both OTs had to consider their long term career prospects. One OT (Fiona) left the service in April 2011 when a permanent job was secured. Whilst the remaining OT (Ruth) agreed to continue with an extended contract, working single-handedly required rationalisation of the level of service she was able to offer. Furthermore, delays in confirming the extension of her contract meant that she had to work towards discharge and group endings prematurely with some service users in order to professionally manage the ending process. This disrupted the final months of the work.

Conclusions: 20 lessons learned

What was learned about the efficacy of OT with this client group?

1. Occupational therapy can address the complexity of homeless individuals' needs including working with addiction.

2. Positive change in individuals' lives often involves the abandonment of other 'activities' – such as, using drugs and alcohol – which can make change daunting, and create defensiveness.

3. Clinical reasoning using an OT model of practice (MOHO) allowed the OTs to engage with this complexity and maintain a flexible person-centred approach.

4. Occupation-focussed interventions stimulate residents' motivation and prompted changes in patterns of time use for some residents.

5. Different levels of motivation require different approaches and this was supported by the Remotivation Process (De las Heras et al 2003).

6. Meeting residents 'in the moment' through the medium of occupation is an effective assessment, engagement, and intervention medium.

7. Creating 'micro-enviromments' that fostered positive experiences was an effective way of engaging residents and developing transferable skills.

8. Occupational engagement enables service users to experience themselves in new roles – such as cooking for other people. This had a significant impact on individuals' self-image and their perceptions of the hostel environment.

9. Changes in self-image through changed occupations enabled some residents to accept the possibility of change in their life more generally and move from pre-contemplation to contemplation (Prochaska and Di Clemente 1982).

10. OT interventions can support service users at times of transition; supporting the person to re-establish /develop community living skills which are eroded by institutional living.

What was learned about supporting residents' engagement with hostel life?

11. Therapeutic relationships allow insight into the residents' perspectives enabling the OTs to adopt an advocacy role which can foster greater service user involvement in hostel life.

What was learned about supporting residents to participate in their community?

12. The OT focus on 'activity' makes it ideally suited to both micro-level work with individual service users within the hostels and also macro-level advocacy work with local agencies aimed at reducing stigma and supporting residents' access to ordinary mainstream activities, promoting self esteem and social inclusion.

What was learned about delivering an OT service in the supported housing sector?

13. The perceived 'independence' of the OTs within the hostel environment and 'hostel culture' can be constructive (because it helps develop therapeutic relationships with hostel residents) but it may also have divisive effect whereby the OTs are seen as 'other' – creating challenges to collaborative working with hostel staff.

14. The consistency and visibility of the OTs was important in developing therapeutic relationships which build gradually through informal and formal contacts.

15. The OTIS (practitioners and supervisors) recognised the challenging work carried out by hostel staff and understood that a priority OTIS task was to develop a fully integrated OT service that was embedded with the sector, both physically and conceptually. This would not only optimise the efficacy of the OT input but the effectiveness of existing service provision too.

16. The role of the hostel managers is important in establishing collaborative relationships amongst staff which ultimately enhances the effectiveness of OT interventions also.

17. The time limitations had a significant impact on the outcomes which could realistically be addressed and prompted a modification of service aims to reflect the therapeutic processes that OTIS fostered in its one-to-one and group work.

18. In such a time-limited project the time taken to manage issues such as re-negotiating contracts, had a significant impact on service delivery.

19. Consistent professional supervision was essential in supporting the newly qualified OTs but difficulties arising from their comparative inexperience could not always be immediately addressed by long-arm, off site supervision.

What was learned about outcome measurement?

20. Meaningful outcome measurement is challenging with this level of complexity and in such a time-limited project. The outcome measurement tools trialled had different strengths and weaknesses.

Recommendations

The following recommendations are made for consideration when planning any future occupational therapy input within the supported housing sector:

1. Protocols for collaborative working practices should be established as early as possible. This would enable skill-sharing, minimise 'tribalism', promote consistent approaches to maximise the effectiveness of an *integrated* service, and enhance the service user experience

2. OT input should be concentrated in few hostels initially in order support relationship-building with staff and service users and then rolled out more widely.

3. OT input should embrace work at a micro level with individuals, a meso level with hostels and a macro level with communities to facilitate engagement, involvement and social inclusion.

4. Any future occupational therapy team would benefit from a differential between OT staff members in terms of clinical experience. This would enable on site supervision which would mean service establishment issues could be resolved more quickly.

5. Professional supervision is provided on site to offer appropriate support for the challenging nature of the work and to facilitate professional development such as through preceptorship for newly qualified staff.

6. Clear outcome measurement procedures are established early on in any future project.

PfP is welcome to discuss these recommendations with the UWE OT team whose contact details are given on p.2.

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