What interventions are occupational therapists using with refugee and asylum seeker populations: Findings of a survey

ABSTRACT

Introduction

Current trends in forced displacement have resulted in significant numbers of refugees and asylum seekers. The health needs of this population have been documented and occupational therapists are well placed to address their occupational needs (WFOT, 2014). Little research has been conducted to identify occupational therapy interventions currently used with refugees and asylum seekers, thus prompting this study.

Methods

An electronic survey incorporating open and closed ended questions was used to identify interventions being used within occupational therapy with refugees and asylum seekers. Twenty-nine participants met the inclusion criteria and completed the survey. Statistical analysis of the quantitative data were performed and responses to the open questions were thematically analysed.

Results

Data analysis found that the participants spent the most time on: report writing / documentation, education, and leisure integration. Data from the open category question revealed that participants were also engaging in: education, mental health / counselling, research, community development, mentoring, recreation, and non-traditional occupational therapy interventions. Participants identified that the interventions they were not using, but which they thought would be useful were: addressing sexuality, support groups, driving assessment / practice, home visit / assessment, and self care assessment / practice. The main barriers encountered when providing interventions to refugee and asylum seeker populations were: language, cultural challenges, and lack of resources.

Conclusion

The findings of this research contribute to the knowledge base identifying interventions that occupational therapists and occupational therapy students are currently doing with refugee and asylum seeker populations in either a paid or voluntary capacity. Occupational therapists are well placed to meet the occupational needs of refugees and asylum seekers given their focus on facilitating health and well-being through participation in meaningful occupation, their stance on occupational justice and human rights, their holistic perspective, and their broad range of knowledge and expertise.

Key words: Occupational therapy, refugee, asylum seeker, intervention

INTRODUCTION

Forced displacement is becoming an increasingly prevalent issue as the population of refugees and asylum seekers increase. Recent statistics have identified an unprecedented 65.3 million people who have been forcibly displaced worldwide, among them are nearly 21.3 million refugees and 3.2 million asylum seekers (UNHCR, 2016). As a result of pre- and post- migration trauma, refugees and asylum seekers are considered to be a particularly vulnerable group in society. It is likely they will have experienced pre-migration trauma including: war, violence, torture, sexual abuse, a lack of adequate shelter, food, water, healthcare, and education (European Parliment, 2016). Political and social issues are present post-migration in the form of: restrictive policies on healthcare, education, accommodation, financial support, and employment, which can function to exclude and marginalise refugees and asylum seekers (Mind, 2009). Exposure to such stresses can impact upon refugee and asylum seeker's ability to adapt to and function within their post-migration environment and thus is of relevance to occupational therapy.

The World Federation of Occupational Therapists' (WFOT) position statement on Human Rights (WFOT, 2006) and the revised position statement on Human Dispacement (WFOT, 2014) both highlight that engagement in meaningful occupation is a human right, even when forcibly displaced. The occupational therapy Human Displacement position paper (WFOT, 2014) identifies humans as occupational beings and stipulates that engagement in meaningful occupations enhances health and well-being, and that restricted participation in occupations constitutes occupational injustice. It could be argued that refugees and asylum seekers are subject to various forms of occupational injustice of concern to occupational therapists given that they may be detained under conditions that cause concern to humanitarian agencies, including restricted freedom of movement, reduced access to medical care and meaningful occupations, and the inability to participate within the community (Australian Human Rights Commission, 2011). Various authors have argued this point and state that the economic, social, and political context of asylum results in occupational deprivation, where

individuals are precluded from participating in a full range of meaningful occupations (Huot, Rudman, Dodson, & Magalhães, 2013; WFOT, 2014).

The first author´s volunteer experiences identified that refugees and asylum seekers have needs that are occupational in nature, and which would benefit from occupational therapy intervention. This prompted a literature review which identified that there were limited publications identifying the interventions conducted by occupational therapists with this population. What existed included: resettlement (Luthman, 2013; Suleman & Whiteford, 2013), paediatrics (Campbell et al., 2015; Copley et al., 2011), the arts (Adrian, 2013; Horgagen & Josephsson, 2010), craft (Stephenson et al., 2013), and gardening (Bishop & Purcell, 2013). These pieces were largely descriptive or used a qualitative design, specifically an ethnological approach with small sample sizes (Adrian, 2013; Bishop & Purcell, 2013; Campbell et al., 2015; Copley, Turpin, Gordon, & McLaren, 2011; Horgagen & Josephsson, 2010; Luthman, 2013; Stephenson, Smith, Gibson, & Watson, 2013; Suleman & Whiteford, 2013). No occupational therapy literature could be found that identified the frequency of intervention, which could have provided useful benchmarking data.

Overall, there is limited empirical evidence to guide occupational therapists providing interventions to refugees and asylum seekers. The majority of studies in this literature review have used an ethnographic design, which is a suitable choice when studying the lived culture of a group, and can generate rich information to complex questions (Best, 2012). However, there are assumptions inherent and limitations to this approach which impact on how appropriate its use with refugee and asylum seeker populations is. Quantitative methods, such as surveys, can compliment the findings

of qualitative approaches and enable systematic measurement of key variables, suggesting its use to complement existing findings.

AIMS

This research aims to compliment these descriptive and qualitative pieces with a quantitative approach and specifically: Quantify the amount of time being spent doing specific occupational therapy intervention in a typical week, identify the range of interventions currently used by occupational therapists and occupational therapy students with refugee and asylum seeker populations, identify the occupational therapy interventions not currently being used, but which would be useful, and explore the barriers to providing intervention to refugees and asylum seekers.

METHODS

Design

The central aim of this research was to identify the breadth of interventions currently being used by occupational therapists and occupational therapy students with displaced populations and thus a positivist approach, specifically descriptive surveying, was selected. This quantitative data could then be statistically analysed.

Ethics

Ethics approval for this study was obtained from the XXX. Informed consent was gained from participants who were provided with an information sheet that addressed the conditions of the study. Data were collected anonymously through an online survey and then stored electronically on a password protected computer. A risk assessment was conducted and no risks to either the

participants or researcher were identified.

The potential risks of using social media in research were also acknowledged and attempts were made to address these. The lack of face-to-face contact with participants meant that it was important to screen for occupational therapists and occupational therapy students in profession specific forums. The online survey's first question was a contingency question where participants were prompted to identify if they were an occupational therapist or occupational therapy student. In the event of a “no” response, they were re-directed to the final stage, thanking them for their participation. The lack of face-to-face contact also presented a reduced opportunity to identify reactions to the consent process. Potential participants were given the possibility of contacting the researcher if they required clarification.

Data Collection

An online survey was specifically chosen for this research due to its many advantages including a broad geographical reach, the economical collection of a large amount of data in a short space of time, and convenience for respondents as they could participate when and where they chose. Limitations with utilising online surveys were considered and addressed where possible. These included limited sampling and respondent availability as some people may not have had Internet access. The lack of an interviewer meant that clarification and probing were not possible. There was also the possibility of respondents abandoning the survey which was addressed by making the survey as short as possible while still obtaining the necessary information. For the purpose of this research, the benefits of using an online survey outweighed the drawbacks.

There were no existing measurements examining the variables the researcher was interested in, thus a new survey was developed specifically for this study. This survey consisted of 12 closed-ended, check, and open category questions examining the variables of interest, including: demographics,

work experience, client group worked with, if work was paid or voluntary, practice setting, type and length of interventions used, interventions not used but which would be useful, and barriers to providing interventions. Participants could also add comments in some questions that included an "other" option, as well as at the end of the survey. Using an open category is advantageous when the researcher is unaware of the range of responses and helps to address some of the limitations of closed questions while maintaining the advantages regarding data analysis (Best, 2012). The survey took participants approximately 10-15 minutes to complete.

A thorough review of the health literature was undertaken and discussions were held with experts in the field to brainstorm possible responses to include in the check questions. Additional survey construction considerations included ensuring clarity, avoiding ambiguity, and the survey length. Once the survey was drafted, consideration was given to face and content validity by consulting with both content and methodological experts and piloting the survey on two occupational therapists experienced in refugee and asylum seeker health. The gathered feedback was then incorporated. Once the final version of the survey was developed, a hyper-link was created and verified. The target population was then sent this hyper-link and could complete the survey at their convenience. Data were automatically recorded and stored within Google Forms.

Data analysis

The statistical analysis of the quantitative data were facilitated by using Google Forms, which automatically generates a visual summary of responses and a spreadsheet of individual responses. Frequency distributions and graphs were created to show descriptive statistics of the variables in the study for each survey question. Individual responses were viewed and pivot reports were created

within Google Sheets to enable variables of interest to be cross-tabulated for further analysis. Filters and pivot charts were used to compare and analyse these specific data views and segments.

The answers to open category questions were analysed by both authors independently using a qualitative approach which was considered justifiable, even though the responses were brief (Davies & Hughes, 2014). An inductive approach was used as the data were analysed without a framework. Affinity diagrams were used. This involved the data being recorded and gathered onto paper according to keywords. A content analysis was then performed. The data were lastly sorted into themes and named. Examples of those theme names were gathered from the text. Given that responses were anonymous, participants were unable to verify the themes identified.

Sampling and recruitment

The aim of this research was not to generalise findings, thus convenience sampling was identified as an appropriate choice for this exploratory research using an online survey (Best, 2012). Inclusion criteria included occupational therapists or occupational therapy students that had been working (or that worked since November 2014) in a paid or volunteer capacity with refugees and / or asylum seekers, had access to a reliable internet connection and were able to read and write in English.

Participants were recruited via targeting suitable social media websites where membership included both occupational therapists and occupational therapy students including Facebook groups. Administrators of suitable professional email mailing lists were also contacted and asked to send an email on the researcher's behalf requesting participation into the study.

A consideration of recruiting for surveying is the inevitability of non-responses (Best, 2012). This was considered by sending email and Facebook reminders to encourage participation. Item non-

response was considered by making the survey as short as possible while still obtaining the necessary data.

FINDINGS

A total of 29 participants completed the survey. Descriptive statistics were produced for all the variables considered in this study. One survey was not completed. There were 128 item non-responses, therefore some of the data were not available for analysis. For the purpose of this section, 'worked' will be used to refer to working and volunteering unless otherwise specified. The findings are structured according to the five research outcomes.

Context of the research: Demographics and work background

Twenty-nine participants completed the survey, 17 of whom were qualified occupational therapists and the remainder were students. The countries where the majority of participants were working in, or had recently worked in were: Australia (n=8), the USA (n=3), Canada (n=2), England / the United Kingdom (UK) (n=2), and the Netherlands (n=2) (Figure 1). Occupational therapy students were primarily located in Germany (n=4) and Australia (n=3).

The majority of participants (n=21/29, 72%) had been working with refugees and asylum seekers for three years or less. Only four participants had been working in this field for 10 years or more (Figure 1). Of these four participants, they were all either working in a paid and / or paid and voluntary capacity, however, their work was all done on a part time basis.

The majority of participants worked in a volunteer (n=15/28, 54%) or part time capacity (n=23/28, 82%). Twenty-two of the participants reported working with adults (n=22/29, 76%), 69 worked

with both asylum seekers and refugees (n= 20/29), and over half of the participants provided individual and group interventions (n=15/28, 54%).

Participants worked in a variety of practice settings, with the majority being non-for-profit human services (n=8/29, 28%), refugee specific services (n=4/29, 14%), and government health services (n=3/29, 10%). The other settings that participants identified were: community mental health service, elementary school, resettlement agency, research, academic, higher education fieldwork supervisor, charity, social enterprise, informal and NGO, 'mentor'/friend, and public school system (all with n=1/29, 3%).

Figure 1: How long have you been working with refugees or asylum seekers?

Time spent on doing occupational therapy interventions in a typical week

The interventions identified as having three hours or more spent on them in a typical week included: report writing / documentation (n=7/26, 27%), education (n=5/24, 21%), leisure integration (n=5/26, 19%), relaxation / anxiety management (n=4/25, 16%), referral to / liaison with community staff or organisations (n= 4/26, 15%), spirituality (n=3/25, 12%), support groups (n=2/27, 7%), home visit / assessment (n=1/23, 4%), work retraining (n=1/24, 4%), meal preparation (n=1/24, 4%), and mobility assessment / practice (n=1/25, 4%) (Figure 2).

Figure 2: Time spent on interventions in a typical week.

Responses that indicated that the majority of participants (more than 50%) spent time on a particular intervention in a typical week were: education (n=22/25, 88%), referral to / liaison with community staff or organisations (n=21/26, 81%), leisure integration (n=21/26, 80%), report writing / documentation (n=20/26, 77%), initial assessments (n=18/26, 70%), relaxation / anxiety

management (n=15/25, 60%), work re-training (paid or voluntary) (n=14/24, 58%), spirituality (n=14/25, 56%), and public transport training (n=13/25, 52%) (Figure 3). Additional occupational therapy interventions that participants identified spending time on in a typical week in the open category questions included education, mental health / counselling, research, community development work, mentoring, recreation, non-traditional occupational therapy roles, and other.

At least 50 percent of the respondents identified that they never did the following interventions: driving assessment / practice (n=17/24, 71%), sexuality (n=16/24, 67%), mobility assessment / practice (n=16/25, 64%), equipment provision (n=15/24, 63%), self care assessment / practice (n=14/25, 56%), support groups (n=14/26, 54%), home visit / assessment (n=12/23, 52%), meal preparation (n=12/24, 50%), or standardised assessments (n=12/24, 50%) (Figure 3).

Other possible interventions of value

Interventions that were not currently being used by the majority of participants, but which were later identified as having potential value were: sexuality (n=7/21, 33%), support groups (n=6/21, 29%), driving assessment / practice (n=5/21, 24%), home visit / assessment (n=5/21, 24%), self care assessment / practice (n=5/21, 24%), meal preparation (n=3/21, 14%), mobility assessment / practice (n=3/21, 14%), standardised assessments (n=2/21, 10%), equipment provision (n=2/21, 10%) (Figure 3).

Figure 3: Pivot chart: The interventions that were never done AND interventions that would be useful.

Responses in the open category question where participants could identify additional interventions that hadn't been listed but which they thought would be useful were categorised into the following

themes: mental health, addressing lack of host country language skills, education (of self and others), facilitating community based activities and support groups, and other.

Relevant barriers encountered

The main barriers that respondents identified when providing, or attempting to provide, occupational therapy intervention to refugee and asylum seeker populations in descending order included: language (n= 24/29, 83%), cultural challenges (n=17/29, 59%), lack of resources (n=17/29, 59%), lack of awareness of occupational therapy services available (n=14/29, 48%), and lack of research to support occupational therapy interventions (n=14/29, 48%). The least identified barrier was team resistance to occupational therapy (10%) (Figure 4).

Figure 4: Relevant barriers to providing interventions to refugees and asylum seekers.

DISCUSSION

The majority of participants sampled were qualified or registered occupational therapists, however results from this study identified a significant amount of occupational therapy students. Student engagement was also reflected in the open category questions:

'Education of OT students…'.

'...I also connect these practice (refugee) with the university teaching, bringing students to take part of it...[sic]'.

'… acting as research student supervisor...'.

These findings reflect that student placements with refugee and asylum seeker populations appear to be increasingly common. This is reflected in literature from the UK, namely from Clarke where descriptions are provided of occupational therapy placements in role emerging areas, including with refugees (Clarke, 2012; Clarke, Martin, Sadlo, & de-Visser, 2014, 2015). Within this study,

Germany is the country most represented with occupational therapy students (n=4/12, 33%). It is possible that this is a result of Germany being the recipient of the largest number of asylum applications within Europe (UNHCR, 2015), although interestingly the number of qualified or registered occupational therapists in Germany does not reflect this trend.

The research found that the majority of participants in this study (n=21/29, 72%) had been working with refugees and asylum seekers for three years or less. This finding indicates that working with refugees and asylum seekers is a relatively new area of practice within occupational therapy within the population sampled. The literature similarly identifies working with displaced populations as a role emerging area within occupational therapy (Copley et al., 2011).

The majority of participants came from English speaking countries. It is possible that this was influenced by the survey only being available in English. Australia was the country where most participants were working, or had worked, with displaced populations. Possible reasons for this may be that the role of occupational therapy with displaced populations in Australian is more recognised than in other parts of the world or that there are specialist health services for refugees and asylum seekers however this is speculative. There is no existing literature identifying where occupational therapists working with refugees and asylum seekers are located, thus findings from this research can contribute to this knowledge base.

Of the interventions where participants identified spending three hours or more on in a typical week, report writing / documentation, education, and leisure integration had the most responses.

Additional open ended responses provided specific interventions in these areas of education and leisure, although less time was spent on them:

'Education of OT students, introducing them to topics of justice in relation to enabling individual and collective occupation. One of the groups that is included in this introduction are refugee and asylum seekers. 30-60 min/week...'.

'Crafting ie clay sessions 2 h Gardening 2h [sic]'.

It is not possible to compare these findings with the occupational therapy literature, as there have been no documented studies investigating the time spent on specific interventions with displaced populations. These findings suggest that documentation, education, and leisure integration, which all fall within the scope of practice and standards of proficiency for occupational therapists (AOTA, 2014), are significant roles for occupational therapists working in this field.

The survey respondents were facilitating occupational engagement in leisure activities. This intervention may potentially facilitate participation in a meaningful activity, contribute to a sense of belonging, and depending on the activity, allow the opportunity for social engagement. These all relate to the ethos of occupational therapy and are emphasised within occupational justice (Nilsson & Townsend, 2010; Townsend & Wilcock, 2004). Given that the survey did not lend itself to identifying specific activities done within 'report writing / documentation' and 'education', it is difficult to speculate if participation in other occupations was promoted. It is possible that documentation may have included referrals to organisations to promote occupational engagement, however further investigation is required to confirm this.

Of the interventions identified by the survey participants, only education and leisure integration were identified within the occupational therapy literature. Education in the form of a resource kit for aid workers is described by Luthman (2013). Leisure activities have received significantly more attention in the literature, although these were not specifically referred to as leisure integration.

Both Adrian (2013) and Horghagen and Josephsson (2010) investigated the arts in the form of music in a community choir and theatre respectively. Weaving (Stephenson et al., 2013) and an allotment gardening group (Bishop & Purdell, 2013) with refugees were studied. A limitation of this research was that specific interventions such as 'leisure integration' were not defined by the researcher, making comparison of what was found in this study as compared to the literature challenging.

Given the trauma that displaced populations will most likely have experienced, it is not surprising that one participant identified that mental health interventions strongly featured in their work: *'...Psychosocial support (>3hrs) ...Engaging in hope, future thinking and goal setting (>3hrs)...Mindfullness [sic] >1hr Counselling (>3hrs) Interventions to reduce dependency and reestablish [sic] independence (>3hrs)'.*

The importance of addressing mental health concerns with displaced populations has similarly been identified within the occupational therapy literature (Boyle, 2014; Maroney, Potter, & Thacore, 2014). Addressing psychological issues falls within occupational therapy's holistic scope of practice (AOTA, 2014). No studies have been conducted investigating the effectiveness of mental health interventions with refugees and asylum seekers within occupational therapy to date. However, research into this would be useful to confidently advocate the benefits of occupational therapy in this area.

The majority of respondent reported spending time on: education, report writing / documentation, and referral to / liaison with community staff or organisations (Figure 2). These interventions suggest that respondents were working in roles similar to that of case coordination, which was also reflected by comments: *'My role was a Case Manager not an OT...'*. Similarly, another respondent identified that they were not working in an occupational therapy role: *'We've recently started a*

voluntary project, and what we are doing is not defined as OT. However, it is very close to the heart of OT!...'.

Clarke (2012) suggested that role emerging practice provide occupational therapists with an opportunity to revisit their philosophical roots and return to an occupation focused approach to health and well-being. It is unclear if the aforementioned interventions of education, report writing / documentation, and referral to / liaison with community staff or organisations have a direct occupational focus as participants were not interviewed to clarify this. Referral to / liaison with community staff or organisations is a possible way of facilitating engagement and participation in community-based activities.

Worthy of mention are the responses from participants who identified time spent on interventions with a community development focus:

'Community development ...30-60 min/week...'.

'... including community building/strengthening, awareness raising and capacity building...'.

'Supporting a community of practice in the area of human displacement...'.

'...Advocacy (>3hrs)...'.

Within the occupational therapy literature, community development is defined as '*... community consultation, deliberation, and action to promote individual, family, and community-wide responsibility for self-sustaining development, health, and well-being'* (Wilcock, 1998,p. 238). Community development activities may include education, public health, and urban planning (Wilcock, 1998). Community development activities are only referred to by Copley et al., (2011)

who describe the impact of education within an occupational therapy programme for refugee high school students.

Half or more of the respondents identified that they never spent time on: standardised assessments, self care assessment / practice, mobility assessment / practice, equipment provision, home visit / assessment, meal preparation, or sexuality (Figure 3). A limitation of using self-administered surveys is that responses are anonymous, so probing is not possible. Therefore, it was not possible to confidently identify why these interventions were not conducted. The following factors are speculative, however they may have contributed to these interventions not being conducted.

Over half of the population sampled were volunteer and 82 percent were part-time, thus they may have limited time to do these interventions. Alternatively, not all participants were working in occupational therapy roles, or due to the nature of generic positions, participants were unable to provide the full range of assessments and interventions available to occupational therapy:

' ...Due to contractual restrictions I was unable to provide physical interventions and had a psychosocial support and welfare focused role...'.

'...I had the best intentions of bringing specific OT assessment and interventions to the service, however without mentoring [sic] /support from an OT, and the realities of working in such a demanding and busy environment, I feel I have lost my 'OT lens' and am reduced to following the organisation's systems…'

Interventions identified as only minimally useful (15 % or less) (Figure 3) were: standardised assessments, mobility assessment / practice, equipment provision, and meal preparation. It is difficult to postulate why using standardised assessments was not considered a priority. It may be that there are limitations with existing assessments, for example, them not being culturally relevant or that participants did not have the resources or training to conduct standardised assessments. The

lack of relevance for mobility assessment / practice, equipment provision, and meal preparation may suggest that the refugees and asylum seekers being serviced did not have any physical disabilities, or were not elderly, which is where these interventions may typically be used. These findings are interesting if one considers Mirza's (2011) observations that disability in the context of refugee settings has received little attention and that 7.7 million of the world's 51 million people displaced by conflict have been estimated to have disabilities (Women's Refugee Commission, 2016). A limitation of the survey was that no question addressed if participants provided interventions to people experiencing disability, and the age worked with only specified 'adult'. In hindsight, identifying if participants had physical disabilities, and the specific ages of people worked with, would have provided richer data.

The three most identified barriers to providing interventions to displaced populations were: language, cultural challenges, and lack of resources (Figure 4). These findings are similarly reflected within the health care literature (Asgary & Segar, 2011; Fang, Sixsmith, Lawthom, Mountain, & Shahrin, 2015; Mind, 2009) and suggest that occupational therapists may have benefited from cultural awareness training to address these issues. Lack or resources may potentially be addressed by attempting to secure additional funds. The low numbers of occupational therapists working in this area and the observation that the majority of respondents are volunteers could also be a reflection of the lack of funding. Additionally, lack of awareness of occupational therapy services available, the lack of access to occupational therapy services, and the lack of

research to support occupational therapy interventions were the next most identified barriers. Two respondents reported:

' ... Working with this population is my particular area of interest, however I found it difficult to find services with occupational therapists on staff...'.

'I think this is also an iportantv [sic] key to highlight current services for these profiles do not contemplate OT, so far...[sic]'.

Encouragingly some research was being undertaken by participants. Two respondents stated:

' Research (ethnography) on the engagement of refugees in occupations and the community...'.

' Research into OT with asylum seekers 30-60 min/week'.

Limitations and future research

Limitations of this research included using non-probability sampling, participants needing access to a computer and a reliable Internet connection to participate, the survey only being available in English, key terms not being defined for the participants (for example 'leisure integration'), the inclusion criteria being limited to participants that had worked with displaced populations since November 2014, and the limitation of not being able to probe with surveys. Despite these limitations, the researcher managed to obtain valuable data within a limited time frame.

Further research could address many areas. These include: identifying how appropriate traditional occupational therapy ideology is for refugee and asylum seeker populations, further exploration of the occupational therapy interventions conducted with displaced populations, and investigating the effectiveness of these interventions. It is worth noting that the data collection from this study focused on interventions at the individual level rather than at the group or population level. Future research at these levels would provide additional insight into occupational therapy community practice interventions. Additionally, given the large number of refugees and asylum seekers, it

would be interesting to measure what percentage of refugees and asylum seekers actually have access to occupational therapy services. This would provide valuable data on whether this population have access to professionals specialised in occupational engagement and occupational justice.

CONCLUSION

This study is one of the first of its kind to quantitatively identify interventions being used with refugee and asylum seeker populations. Findings from this study shed light on an emerging area of occupational therapy where little is known. Given the current political climate and global trends, the numbers of those that have been forcibly displaced is likely to increase. However, given that only a small number of occupational therapists work with displaced populations, it would suggest that many refugees and asylum seekers are not having their occupational needs met. In order to be in a position to meet the occupational needs of refugees and asylum seekers, to facilitate occupational justice, and to fulfil the mandate of the WFOT position paper on Human Displacement (WFOT, 2014) and position statement on Human Rights (WFOT, 2006), there are challenges which occupational therapy as a profession must surmount to be in a position to provide its services to displaced populations. Not only does this include educating and equipping occupational therapists

to work in this role-emerging field, but also engaging in research activities, and increasing political and funding body awareness of occupational therapy's potential contribution in this area.

The findings of this study not only have clinical implications, but can also be directed towards academic, research, and political areas:

- ensuring holistic practice by incorporating sexuality and cultural awareness into curricula and staff training
- ensuring that occupational therapy staff are equipped with the skills and knowledge to work in this area given the multi-faceted nature of forced displacement.
- enabling assessment and interventions to take place in the environments where these service users live
- incorporating specialist driver assessment training or referral to appropriate agencies
- considering ways of increasing awareness of occupational therapy's value in this area of practice. This may include engaging in public / government / refugee service relations activities (e.g. lobbying and advocacy) to influence current or proposed funding, policies, or programmes.

Occupational therapists are well placed to meet the occupational needs of refugees and asylum seekers given their focus on facilitating health and well-being through participation in meaningful occupation, their stance on occupational justice and human rights, their holistic perspective, and their broad range of knowledge and expertise. This study clarified that occupational therapists possess the skills and knowledge required to work with refugee and asylum seeker populations as reflected within occupational therapy's domain of practice (AOTA, 2014), however, there are

unique barriers to this emerging area of practice that limit the profession being able to provide the breath of interventions to this population.

KEY POINTS FOR OCCUPATIONAL THERAPY

- Occupational therapists are well-positioned to meet the occupational needs of refugee and asylum seeker populations.
- Current occupational therapy interventions where the most time is spent with displaced populations include report writing / documentation, education, and leisure integration. Additional interventions include education, mental health / counselling, research,

community development, mentoring, recreation, and non-traditional occupational therapy interventions.

- Barriers exist to providing occupational therapy interventions to displaced populations. These need to be addressed at a clinical, research, educational and political level in order to facilitate occupational justice.

Declaration of authorship

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