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An Occupational Therapy Guidebook for Individuals with Substance Use Disorder

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Abstract

Individuals with substance use disorder (SUD) experience barriers and challenges that impact their daily occupational performance, engagement, well-being, and quality of life. In addition to disrupting and distorting an individual's unique occupational outcomes, SUDs can limit, replace, and dictate an individual's daily meaningful activities, habits, routines, and skills that support healthy occupational engagement. Occupational therapy (OT) practitioners have a unique and valuable role in SUDs treatment as they are equipped to identify these barriers and implement strategies for supportive skill development or restoration. Based on the literature review conducted, OT practitioners do not have an OT practice guideline, protocol, or manualized intervention available to guide OT practice when working with clients with SUDs. The purpose of this capstone project is to address this concern and develop an OT guidebook for OT practitioners working with individuals with SUDs using the theoretical framework of the Model of Human Occupation (MOHO). The methodology of this project consists of three phases: (a) the pre-development phase, (b) the development phase, and (c) the review and revision phase. The guidebook consists of five chapters that supply OT practitioners with recommended best-practice methods to implement the OT process while working with individuals in this client population as well as recommendations for other resources available to the community. The development of this capstone project will expand OT scholarship and practice as well as create a foundation to examine the efficacy of OT in mental health and SUD treatment.

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An Occupational Therapy Guidebook for Individuals with Substance Use Disorder

Chapter 1: Background

The purpose of this chapter is to present the context for the development of this capstone project, the development of an occupational therapy (OT) guidebook for individuals with substance use disorder (SUD). The guidebook identifies and constructs the OT process within mental health and SUD settings using the Model of Human Occupation (MOHO) as the theoretical framework. The project explores the occupation-based and occupation-focused interventions provided by OT practitioners. These interventions are thoroughly defined in the following sections. This chapter presents the capstone project's background, problem statement, purpose statement, rationale, significance, objectives, assumptions, limitations, and delimitations.

According to the *Diagnostic and statistical manual of mental disorders*, SUDs refer to the conditions in which one engages in the reoccurring involuntary or uncontrollable use of substances, such as drugs and alcohol, that cause disruptions in their daily life or performance including substance abuse and substance dependency (American Psychiatric Association [APA], 2013). A SUDs frequently co-occurs with other mental health disorders as research findings indicate that 13% of the SUDs population are diagnosed with other psychiatric conditions (Mannelli & Wu, 2019).

In 2014, there were approximately 22 million people with a SUD above the age of 12 within the United States, with males 1.3 times more likely to have SUDs than females (Merikangas & McClair, 2012). Of these youth and adults approximately, alcohol use disorder was the most common type of SUD; however, the prevalence of a specific substance or SUD cannot be clearly established as a person can have multiple SUDs from polysubstance use

(Mannelli & Wu, 2019; Lipari & Van Horn, 2017). The total number of individuals with SUDs above the age of 18 does not include individuals with marijuana use disorder (3.5 million), prescription pain reliever use disorder (1.8 million), cocaine use disorder (0.9 million), and heroin use disorder (0.6 million) as these disorders are complexly associated with the use of more than one substance (Lipari & Van Horn, 2017). Although there are many benefits to SUDs management and treatment, many people do not receive or seek treatment.

According to the National Survey on Drug Use and Health in 2015, approximately 2.3 million people over the age of 12 received treatment for their SUDs with an estimate of 19.3 million individuals not seeking treatment due to lack of awareness and availability of treatment (Lipari et al., 2016). Research indicates that the most common reasons that individuals do not seek treatment for SUDs are that they are not yet willing to stop using substances or they do not have the health coverage or personal expenses to cover the costs of treatment (Lipari & Van Horn, 2017). As the use of substances and prevalence of SUDs increase, there is an increasing need to address the concerns of this global public health emergency through developing evidence-based research to treat and prevent further occurrences of SUDs.

Substance use disorders increase the risk of health complications, especially if the individual has had prolonged use of substances and lack of treatment (Stoffel & Moyers, 2004). These health complications, both physical and psychosocial, are limitations for occupational performance, well-being, and quality of life (Stoffel & Moyers, 2004). Occupational performance refers to the outcome of the selected occupation and the influence or correlation of the activity with the client, contexts, and environments (American Occupational Therapy Association [AOTA], 2020). Well-being refers to the superior health status of one's physical, mental, and social areas of life, and quality of life refers to the self-concept of one's satisfaction

with life and capabilities of living (AOTA, 2020). SUDs impact occupational performance and participation as they limit the individual's ability to function and process behavior and emotion (Rojo-Mota et al., 2017). This prolonged distortion of performance within a specific environment leads to dysfunction and disengagement in meaningful occupations (Rojo-Mota et al., 2017).

According to Stone (2017), the use of substances negatively impacts occupations as it causes occupational disruption, controls habits and routines, changes in social engagement, family disengagement or disapproval, changes in sleep patterns, and changes in personal priorities or interests. One's lack of structure, priority, or motivation from the continuous use of substances can affect their ability to perform or maintain productivity levels at work or school. Without a healthy daily routine or meaningful occupations to fulfill one's time, a person increases their chances of developing or worsening preexisting mental health conditions with the use or abuse of substances (Stoffel & Moyers, 2004).

OT is an approach to rehabilitation that is constantly growing as it adapts to the needs and changes of society. This constant evolution allows for the focus of the field to remain client-centered to best serve the communities or populations in need. For example, OT has adapted to the needs of society by re-shifting the focus of its practice to address the current concerns of mental health (Brown et al., 2019). One of the largest public health emergencies that has created and rise of concern for global mental health is the opioid crisis, which OT has developed a unique role in by enhancing the development of researched-based interventions through holistic approaches to recovery (Daniel & Wasmuth, 2020).

Based on the impact SUDs have on occupations, occupational therapists play a vital role in the prevention and treatment of these disorders. Occupational therapists can utilize strategies to prevent the development of SUDs or provide treatment for the complications of SUDs through

pain management, medication management, stress management, goal setting, rest and sleep management, routine establishment, physical activity, and cognitive behavioral therapy (Best et al., 2019). OT practitioners have a very specific skill set that allows them to assess, identify, and develop treatment strategies such as life skills that promote the desired occupational outcomes such as money management, vocation or interest exploration, job search and employment, goal-setting, and interpersonal skills (Eggers et al., 2006). There are many other strategies that occupational therapists utilize as OT treatment is complex and unique to the individual based on their personal factors and meaningful activities.

When treating individuals with SUDs, occupational therapists utilize occupation-based and occupation-focused interventions to manage physical or psychosocial problems due to SUDs that limit occupational performance (Stoffel & Moyers, 2004). Occupation-based interventions refer to the intervention strategies based on a client's specific occupations to enhance occupational outcomes such as performance, quality of life, and well-being (AOTA, 2020). These types of interventions utilize occupations as a means of treatment such as work, education, social participation, and activities of daily living, or ADLs (Zingmark, 2015). Occupation-focused interventions refer to the methods used that are directly concentrated on one aspect of a person's occupation(s) that can be used to guide all clinical reasoning and decision-making (AOTA, 2020). These types of interventions utilize occupations as an end goal to treatment, such as improving one's skills or remediating skills to return to a prior level of functioning in occupations (Zingmark, 2015).

According to Sylling and Wilhelmi (2007), the research findings from this study indicate that occupation-based interventions are more effective in improving occupational performance as it provides an approach to treatment using 'real-life' scenarios. This allows for the education and

training completed during therapy to be more efficiently translated into one's own life as it bases therapy on one or more of the nine occupational domains. The nine occupational domains include (1) activities of daily living, (2) instrumental activities of daily living, (3) rest and sleep, (4) work, (5) education, (6) play, (7) leisure, (8) social participation, and (9) health management (AOTA, 2020). Examples of occupation-based interventions that are used for individuals with SUDs that emphasize the occupational domain of social and leisure participation include drama/theater therapy, equine therapy, horticultural therapy, and music therapy that promote a healthy daily routine and use of one's time.

The most prominent role of OT in serving individuals with SUD is to assess the influence the particular substance has on one's occupational performance, occupational capacity, and quality of life while developing strategies to manage the use or impact of these substances (Cruz, 2019). OT practitioners are equipped to identify occupational dysfunction or deprivation for clients and develop client-centered treatment plans that promote the development or restoration of skills necessary to support occupational engagement in meaningful activities (Stone, 2017). Specific skills that OT practitioners address in SUDs treatment programs include skills to improve time management, money management, self-esteem, communication and boundary setting, and coping skills (Stephenson, 2021).

To address the current wave of the global opioid crisis, research has been conducted to develop occupation-based treatment interventions, management, and prevention strategies for addiction and substance abuse (Jones et al., 2018). With numerous healthcare professionals and researchers investigating solutions to this epidemic, a large influx of literature concerning substance use was developed (National Institute on Drug Abuse [NIDA], 2015). OT has established its unique role in SUD treatment and mental health settings, however, there is a

shortage of OT professionals present in this setting due to financial, societal, and community needs elsewhere (AOTA, 2021). The recent gradual transition of OT reentering the mental health workforce leaves OT professionals with a lack of experience, knowledge, and guidance to serve this population and individuals with mental health co-morbidities (AOTA, 2021). Although there is an expansion of literature pertaining to SUDs, there is a lack of quality, efficacy, and guidance on OT evidence-based interventions for individuals with SUDs (Stoffel & Moyers, 2004). This concern has led to the disorganization of research and the inexistence of a reference tool for OT practitioners to utilize when serving this population (NIDA, 2015).

Theoretical Framework

The OT theoretical framework that will be used to guide this project will be the Model of Human Occupation. This model focuses on the complexity of a person's participation and their ability to adapt within their occupations. Occupations are defined as the daily activities in which a person engages, which include ADLs, instruments of daily living, or IADLs, rest and sleep, play, work, education, leisure, and social participation. These occupations are considered meaningful activities that fulfill one's time and can be influenced by many different factors and skills (AOTA, 2020). The model also describes how the person's internal and external factors influence occupational engagement (Kielhofner, 2009; Taylor 2017). These factors are categorized as the person and environment and can be deduced into other subsystems (Taylor 2017). The three person factors that impact occupations MOHO can be used to evaluate the impact of occupations are volition, habituation, and performance capacity (Kielhofner, 2009).

Research indicates that understanding an individual's person-related factors is the most important component in successful SUD condition management and long-term recovery (Boisvert et al., 2008). MOHO can be applied to OT practice for individuals with SUDs to guide

the development or restoration of one's desired daily routine, roles, and occupational identity to support SUDs management and recovery (Park et al., 2019; Davies & Cameron, 2010). This holistic and client-centered theoretical model is beneficial to guide the proposed capstone as it examines a client's unique person and environmental factors as they influence occupation with the SUDs limiting engagement and recovery supporting it (Taylor, 2017).

With the development of evidence-based research to address concerns of SUDs and the expansion of a multidisciplinary approach to recovery, there is a soaring need for the development of a research tool to guide occupational therapists when serving individuals with SUD. MOHO will serve as the theoretical framework for this project as it addresses the gaps in OT scholarship and practice for SUDs treatment.

Statement of the Problem

The problem that the capstone will address is that a practice guideline, protocol, or manualized intervention for OT practitioners working with clients with SUDs does not exist. OT practitioners are very limited as there is a lack recommendation tools and guidelines to provide evidence-based practice methods to support OT practice in SUDs treatment (Cruz, 2019). This leads to OT practice to be widely variant, which makes studying the OT process or the efficacy of interventions used in SUDs treatment difficult as practitioners are not implementing uniform practice methods.

Purpose Statement

The purpose of the capstone project is to develop an OT guidebook for individuals with SUDs. The guidebook will be developed based on MOHO, and will provide recommendations for OT assessment, intervention, and goal-setting when working with clients with SUDs.

Rationale for Proposed Project

The literature pertaining to OT practice and individuals with SUDs lacks organization and clarity on best-practice methods to conduct clinical assessments, interventions, treatment plans, client-centered goals, and discharge plans (Stoffel & Moyers, 2004). The disorganization and provision of evidence-based practice limit the knowledge and clinical application of OT in SUD settings (Amorelli, 2016). OT practitioners working with individuals with SUDs cannot refer to a recommendation tool that is supported by OT theory and compliments a pre-established SUDs recovery and rehabilitation program.

Significance of Proposed Project

When serving clients in clinical practice, OT practitioners must find treatment interventions most applicable to their case, provide services to clients, and document the sessions provided. This project will generate the knowledge needed to promote evidence-based practice when serving this population as it will increase the practitioner's preparedness in the setting, promote awareness, understanding, and importance of OT's role in mental health and SUDs settings, and expand the research pertaining to OT and SUDs (Volkow, 2020). The creation of an OT intervention guidebook for SUDs will be used to guide OT practitioners, OT educators, prospective occupational therapists, and advocates of the profession as they fulfill the role of OT in the multidisciplinary approach to assist individuals with SUDs in long-term recovery. This guidebook will apply OT concepts relevant to this population and provide a step-by-step process on the importance and utilization of OT interventions with critical explanations of each step. The production of this capstone will usher in the transition of OT re-shifting its focus to mental health as it provides OT clinicians and future clinicians with a resource tool to best serve individuals with SUDs and other co-morbidities impacting mental health. The detailed guidance of the

production of this capstone can be used to advocate for the role of OT and mend the gap between scholarship and practice to increase the presence of OT in mental health settings.

Project Objectives

The learning objectives for this project include: 1) Evaluate literature to identify the interventions used in OT practice for SUD; 2) Examine the presence and impact of OT practice for clients with SUD in a rehabilitation program; 3) Examine and apply OT theoretical frameworks for individuals with SUD; 4) Classify OT treatment interventions for SUD based on clinical setting and occupational outcomes; 5) Evaluate the structure, impact, and application of the 12-step program and other self-help programs; 6) Evaluate the process and protocol for developing an OT intervention reference tool; and 7) Assess the supports and limitations to occupational performance and participation for individuals with SUDs. The outcome objective for this capstone project is to create an OT intervention guidebook for individuals with SUDs.

Assumptions

It is assumed that OT practitioners want to treat clients with occupational participation and performance deficits due to SUDs. It is assumed that OT practitioners are willing to use a treatment guidebook to treat clients with SUDs. It is assumed that OT practitioners are willing to use occupation-based and occupation-focused interventions in SUDs treatment plans. Finally, it is assumed that clients with SUDs will be willing to participate in OT as part of their rehabilitation.

Limitations

The main limitation of this project is the limitation of available evidence as the amount of literature published on OT-specific strategies to address SUD is not within the control of the student researcher. The lack of quality and quantity of literature provided on evidence-based

practice interventions for SUDs within the scope of OT will be a limiting factor to the development and implementation of the guidebook. The project will be guided by one theoretical model that best frames the application of OT in SUDs; however, the theory lacks key intrinsic factors that other theories include, such as the Cognitive Behavioral Frame of Reference (Rojo-Mota et al., 2017). Other limitations include the time, effort, and level of expertise placed into the creation of the guidebook.

Delimitations

The capstone project will be guided by the theoretical framework of MOHO as it best applies to the population and purpose of the guidebook. Although this theoretical model was designed to complement other theoretical frameworks, it will serve as the only theoretical foundation for the development of this capstone to analyze the influence of person and environmental factors on occupation (Taylor, 2017). The guidebook will be focused on OT intervention for clients with SUDs who are receiving therapy services for condition management. The project will explore the influence SUDs and OT intervention have on occupational participation and performance to determine client barriers, challenges, and strategies for condition management and achievement of occupational goals (Rojo-Mota et al., 2017). It will incorporate the concepts of the 12-steps program and other alternative self-help programs to develop an OT intervention guide to support the role and process of OT in previously established SUDs treatment (Donovan et al., 2013). It will focus on best-practice OT interventions used in clinical practice for SUDs to promote the development and restoration of skills that support occupational performance and participation with the intent to be compatible with the format of other recovery models or programs (Stone, 2017; Cruz, 2019).

Chapter 2: Literature Review

The identification and examination of the literature pertaining to OT interventions for individuals with SUD are essential to conduct the proposed capstone project. The concern the proposed project will address is the lack of a practice guideline, protocol, or manualized intervention for OT practitioners to follow when working with clients with SUDs. The purpose of this chapter is to review the literature relevant to the development of an OT treatment guide for clients with SUDs. The literature presented here that relates to this capstone project includes (1) Substance Use Disorders, (2) Occupational Impact, (3) Interventions and Treatment, (4) Practice Guidebook Development, and (5) Theoretical Foundation. This chapter will discuss the literature and derived themes from research conducted between 2000 to 2022 pertaining to OT and SUDs.

Substance Use Disorders

Description and Diagnostics

According to the current *Diagnostic and statistical manual of mental disorders*, or DSM-V, SUDs refer to the conditions in which one engages in the reoccurring involuntary or uncontrollable use of substances that cause disruptions in their daily life (American Psychiatric Association [APA], 2013). SUDs occur when the continuous use of substances (e.g. alcohol, heroin, cocaine, etc.) cause significant impairment to one's health and limit the ability to perform important roles or tasks at home, work, or school (Lipari & Van Horn, 2017). A SUD can arise as the increased usage of a substance negatively impacts one's performance in daily life and develops into a habitual pattern of behavior that can lead to impaired function if not addressed (Merikangas & McClair, 2012).

With the publication of the DSM-V (APA, 2013), the term "SUD" combined the two categories of substance use conditions referred to as substance abuse and substance dependence (Regier et al., 2013). Many assumptions in the DSM-IV pertaining to these substance use conditions were problematic, but the main concern was the overlap between each of the conditions' criteria and misinterpretation of the severities. To resolve this concern, the DSM-V updated the terminology, diagnostic criteria, and severity scale of SUDs (Hasin et al., 2013).

The signs and symptoms, known as the diagnostic criteria, for SUDs include (1) use of larger amounts of a substance over longer periods than intended, (2) unsuccessful at reducing or ceasing use, (3) significant time spent using, (4) craving, (5) failure to perform roles, (6) continuation of use following recurrent interpersonal problems, (7) reduction, cease, or neglect of meaningful activities, (8) hazardous use, (9) physical and psychosocial problems related to use, (10) tolerance, and (11) withdrawal (APA, 2013). To confirm a SUD diagnosis, one must possess two or more criteria within a 12-month period and diagnoses are categorized by severity according to the number of criteria. For example, possession of 2-3 criteria in the 12-month period indicates a mild SUD, 4-5 a moderate SUD, and 6 or more a severe SUD (APA, 2013). According to the DSM-V (2013), there are ten classes of substances and each is considered a specific type of SUD. These classes and disorders of substances include alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants, tobacco, and other or unknown substances such as cortisol, nitrous oxide, and steroid/nonsteroidal anti-inflammatory drugs (APA, 2013).

Incidence and Prevalence

SUDs contribute considerably to the number of deaths in the United States as the rate of drug overdoses has more than tripled in the last two decades with approximately over 70,000

overdoses in 2019, and healthcare expenditure on SUD related costs has increased to $13.2 billion annually (Peterson et al., 2021). The annual hospital admission rate of diagnosis for SUDs or other co-occurring mental health concerns has increased 12% between 2005 to 2014, and the admission for opioid use disorder has quadrupled (Peterson et al., 2021). SUDs are considered bidirectionally correlated to mental health disorders as research findings indicate that 13% of the SUDs population are diagnosed with other psychiatric conditions (Hasin et al., 2013). Further, co-morbid SUDs and affective disorders constitute 50% of methadone-treated patients (Mannelli & Wu, 2019).

In 2014, there were approximately 1.3 million people between the ages of 12 and 17 and 20.2 million people 18 years and older with a SUD within the United States (Lipari & Van Horn, 2017). Of these adults who were 18 years old or above, approximately 14.0 million had an alcohol use disorder, 3.9 million had an illicit drug use disorder, and 2.3 million had both (Lipari & Van Horn, 2017). Of these individuals, about 2.5 million people received treatment for SUD at a skilled facility, which accounts for 1% of the total adult population (Lipari & Van Horn, 2017).

Research indicates that the most common reasons that individuals do not seek treatment for SUDs are that they are not yet willing to stop using substances or they do not have the health coverage or personal expenses to cover the costs of treatment (Lipari & Van Horn, 2017). The total number of individuals with a SUD above the age of 18 does not include individuals with marijuana use disorder (3.5 million), prescription pain reliever use disorder (1.8 million), cocaine use disorder (0.9 million), and heroin use disorder (0.6 million) as these disorders are complexly associated with the use of more than one substance, formally known as polysubstance abuse (Lipari & Van Horn, 2017).

Occupational Impact

Barriers and Challenges

Individuals with SUDs develop or experience complications with physical and/or psychosocial health that create a barrier for occupational performance and increase the risk of injury for the individual or community (Stoffel & Moyers, 2004). For example, the interferences SUDs provoke when attempting to perform and engage in occupations, such as driving, while under the influences poses a risk to the community as well as the individual (Stoffel & Moyers, 2004). SUDs impact occupational performance and engagement as it creates a challenge to one's ability to function or manage behavior and distorts their interaction(s) with the environment (Rojo-Mota et al., 2017). SUDs do not only disrupt and create barriers or challenges to occupational performance, but also replace the individual's meaningful occupations, habits, and routines to become the sole occupation over time (Rojo-Mota et al., 2017).

According to Stephenson's (2021) study to identify the occupational performance problems of individuals with SUDs, the most reported occupational performance problems by the participants in the substance use recovery center were tasks or skills specific to work, money management, self-esteem, parenting, and coping skills. Stone (2017) argued that occupational therapists are vital to the treatment process for individuals with SUDs as they identify occupational dysfunction and/or deprivation and provide strategies to promote occupational performance through the development or restoration of daily meaningful occupations.

Occupations and Roles

Research has shown that SUDs can adversely impact life roles and their supporting occupations. One study found that individuals with SUDs preferred or selected engagement in specific occupations or activities that required less commitment at the start of the disorder, and

occupational participation or interests significantly decreased as the disorder progressed (Harmon, 2017). The daily occupations that an individual with SUDs chose to engage in can either support or inhibit recovery as various activities or environments can stimulate the response to use substances and increase the risk of relapse (Harmon, 2017). As such, helping clients to identify leisure pursuits and environments that support a drug-free lifestyle is an important component of supporting recovery (Harmon & Kyle, 2016).

In a study to determine the effects of SUD on Women's roles and occupational participation, the participants reported that they felt they were failing to function, relinquishing roles and responsibilities, self-isolating, unproductive or inactive at work, and disconnected from life through their journey with SUDs (Rawat et al., 2021). The participants reported neglecting and decreasing participation and engagement in all daily occupations and roles with performing basic activities of daily living and instrumental activities of daily living the most impacted as a majority of the participants were mothers. Furthermore, the participants reported that their roles and occupations were dysfunctional or distorted as the societal expectations for a woman's roles were seen as "wife, mother, caretaker, sexual partner, and nurturer, and when they deviate from these prescribed roles, they face stigma and discrimination" (Rawat et al., 2021, p 58).

Role of Occupational Therapy

To most efficiently address the needs of the individual with SUDs, OT practitioners possess the skills and scope of practice to provide client-centered care to promote the development or restoration of life skills to promote occupational engagement and participation (Cruz, 2019). Examples of life skills that are provided by OT practitioners that support occupational performance, participation, and engagement include "vocational exploration, goal setting, development of workplace interpersonal skills, job search strategies, and money

management" (Eggers et al., 2006, p 22). OT practitioners utilize assessments, interventions, goal-setting, and management strategies for SUDs through the lens of occupational science (Bleiler, 2021). When working with individuals with SUDs, OT plays a role in condition management and recovery as the role of the practitioner focuses on "self-care, leisure, and productivity through the use of structured, purposeful activities that emphasizes the individual's strengths (Martin et al., 2008, p 82).

Treatment Options and Interventions

Settings and Programs

OT practitioners are vital members of the multi-disciplinary team assisting individuals with SUDs to manage their condition and pursue recovery and can deliver OT services in various settings. A few of the settings that OT practitioners are present in for SUDs treatment include inpatient care, residential programs, day treatment, partial hospitalization, intensive outpatient care, outpatient care, and therapeutic community programs (Dietz & Schriber, 2017). The partial hospitalization programs, or PHP, are facilities that focus and prepare individuals with SUDs transitioning from a residential inpatient facility to community reintegration following acute treatment services (Dietz & Schriber, 2017). The intensive outpatient programs, or IOPs, are secondary programs to PHPs as the participant is fully immersed and functioning in the community but attends the outpatient program weekly as they may require additional services with a few occupations or roles (Dietz & Schriber, 2017). Twelve-Step Facilitation Therapy is a 12-step structured and manualized program that is utilized for individuals with SUDs (Kingree, 2013). The program focuses on abstinence from substances and increased participation in recovery supporting activities and organizations such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (Kingree, 2013). Each step of the program represents a goal and

skill development to enhance SUDs recovery that is successive of one another (Kingree, 2013). In these programs and settings, OT practitioners use a variety of interventions and treatment strategies to manage SUDs and resolve occupational dysfunction.

Interventions

Occupational therapists have various roles within SUD programs as they address the impact of SUD on occupations and rebuild one's skills and occupational habits to promote long-term change and recovery (Cruz, 2019). The interventions utilized by OT practitioners working with individuals with SUDs can be separated into two categories, occupation-based and occupation-focused, and serve as a multidisciplinary approach where OT plays a vital role (Dietz & Schriber, 2017). Common intervention support groups include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Rational Recovery (RR), Women for Sobriety, Secular Organization for Sobriety/Save Ourselves (SOS) (Sylling & Wilhelmi, 2007).

Occupation-based interventions refer to the intervention strategies based on a client's specific occupations to enhance occupational outcomes such as performance, quality of life, and well-being (AOTA, 2020) These types of interventions utilize occupations as a means of treatment such as work, education, social participation, and activities of daily living, or ADLs (Zingmark, 2015). Occupation-focused interventions refer to the methods used that are directly concentrated on one aspect of a person's occupation(s) that can be used to guide all clinical reasoning and decision-making (AOTA, 2020). These types of interventions utilize occupations as an end goal to treatment, such as improving one's skills or remediating skills to return to a prior level of functioning in occupations (Zingmark, 2015).

According to Sylling and Wilhelmi (2007), occupation-based interventions are more effective in improving occupational performance as it provides an approach to treatment using

'real-life' scenarios. This allows for the education and training completed during therapy to be more efficiently translated into one's own life as it bases therapy on one or more of the eight occupational domains. The nine occupational domains include activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, work, education, play, leisure, and social participation (AOTA, 2020).

Of the eight domains of occupation, the three most common domains that are emphasized with SUD treatment in OT are leisure, social participation, and work (Ryan & Boland, 2021). Examples of occupation-based interventions that are used for individuals with SUDs that emphasize the occupational domain of social and leisure participation include arts and music therapy (Lakshmanan, 2014), animal-assisted therapy (Scott & Kirnan, 2021), physical activity/exercise therapy (Ashdown-Franks et al., 2020), horticultural therapy (Detweiler et al., 2015), and financial management therapy (Rosen et al., 2009) that promote a healthy daily routine and use of one's time. When treating individuals with SUDs, occupational therapists utilize occupation-based and occupation-focused interventions as a means of therapeutic intervention to manage their condition to promote long-term recovery and restore occupational performance and engagement (Cruz, 2019). The interventions utilized by OT practitioners are intended to address the occupational barriers and challenges caused by SUDs such as providing individuals with the opportunity to select and engage in meaningful and purposeful occupations as well as promote health and wellbeing (Bell et al., 2015).

Practice Guideline Development

Types of Reference Tools

The different types of reference tools explored in the literature pertaining to the proposed capstone include a treatment template, practice guideline, and a protocol or manualized

intervention. A treatment template is a structured outline of components that is used to guide to treatment process and plan (Mulvey, 2009). A template is a tool that is consists of the recommended structure for developing a treatment plan but does not consist of the intervention strategies as it is intended to have broad, general use in clinical practice (Mulvey, 2009). An OT practice guideline is a tool used to guide OT clinical practice based on specific methodology, client factors, and intervention strategies established through evidence to achieve the desired outcome (Rosenfeld & Shiffman, 2009). A manualized intervention is similar to a practice guideline and used to ensure replicability (Blanche et al., 2011). A practice guideline and manualized intervention are both designed to be replicable and are standard tools that require to be utilized exactly as the guideline or manual states (Kwak et al., 2017). These tools cannot be altered or differed in clinical practice as they are systematically developed and must abide by a certain protocol to be updated (Kwak et al., 2017; Truijens et al., 2019). Furthermore, these types of tools cannot be applied to OT intervention for SUDs as the individual and their condition is unique and cannot universally be applied to achieve the exact, replicated outcome.

Guidebook Protocol

The capstone guidebook relatively follows the protocol recommendations developed by the National Institute for Health and Clinical Excellence, or NICE, on the process to develop a practice guideline and manual (Kwak et al., 2017; NICE, 2015). This protocol consists of four phases (a) preparing the guideline for development, (b) reviewing the evidence, (c) drafting the guideline, and (d) reviewing the guideline (Kwak et al., 2017). Within these phases, the project consists of scoping the literature pertaining to the population, conducting a literature review, developing the structure of the guide, creating the guide based on evidence-based practice, reviewing and revising the guide draft based on the focus group's feedback, and creating the

final draft of the guidebook (NICE, 2015). This guidebook does not include the phases regarding publication, implementation, and update regulation as these steps are not considered part of the capstone project and are in the envisioned next steps. This protocol serves as the format for the proposed capstone guidebook.

Capstone Guidebook Development

This project is structured upon the fabrication of a recommendation reference tool utilizing concepts of a practice guideline. The practice guidebook consists of evidence-informed strategies to guide best-practice in OT, which is similar to a practice guideline and manualized intervention but does not require specific adherence for how and which strategies of the guidebook are used or modified (Rosenfeld & Shiffman, 2009). The proposed capstone must be fluid and alterable as each individual with SUD is unique due to personal factors, environmental contexts, and condition sequelae, and cannot be configured to a specific treatment approach or process. The capstone must be alterable and currently cannot be developed into a practice guideline or manualized intervention as there is a lack of literature and evidence supporting the efficacy of specific intervention strategies or processes for individuals with SUDs (Kwak et al., 2017). With the alterability of the guidebook, the selection, utilization, and specific application of the intended guidebook will be at the discretion of the OT practitioner as they discern its clinical relevance to their clientele case (Rosenfeld & Shiffman, 2009). The proposed project utilizes this approach as it is a recommendation tool using evidence-informed practice to guide OT practice when working with individuals with SUDs. The guidebook follows the development protocol of a practice guideline discussed in the prior section to ensure successful and accurate development supported by evidence.

Theoretical Foundation: Model of Human Occupation

Theoretical frameworks serve as a foundation to guide clinical reasoning and practice through more direct usage such as assessments, interventions, or re-evaluation tools. The most common occupational theoretical frameworks used for individuals with SUDs are the Model of Human Occupation (MOHO) and Cognitive-Behavioral frame of reference; however, MOHO is the most prevalent theoretical framework utilized in OT practice in SUDs settings as it is used to examine how one's occupational engagement and performance are influenced by personal factors and the environment through a dynamic systems relationship (Taylor, 2017). These two theoretical frameworks are most commonly supported and utilized to create assessments, interventions, and re-evaluation tools within the scope of occupational therapy for SUD treatment (Brown et al., 2019; Haglund & Kjellberg, 1999). MOHO and Cognitive-Behavioral frame of reference are commonly used together in SUDs treatment as they complement one another and connect the dynamic interactions among the person, environment, and internal constructs of thought, feeling, and behavior to occupational engagement (Boisvert et al., 2008). For this project, MOHO serves as the OT theoretical framework.

MOHO assessments used by occupational therapists with clients with SUDs include the Assessment of Communication and Interaction Skills (ACIS), Modified Interest Checklist, Model of Human Occupational Screening Tool (MOHOST), Occupational Circumstances Assessment – Interview and Rating Scale (OCAIRS), Occupational Performance History Interview-II (OPHI-II), Occupational Self-Assessment (OSA), Role Checklist, and the Volitional Questionnaire (Roeber & Schaeffer, 2018). MOHO explains the dynamic connection and influences of the person and environment on occupational engagement (Taylor, 2017). There are three subsystems of a person, which include volition, habituation, and performance capacity, and

six components of the environment (Taylor, 2017). MOHO utilizes these elements in clinical practice to examine how and why clients engage in their daily occupations, which is essential when working with individuals with SUDs (Taylor, 2017).

Person

The first components that MOHO identifies as a key contribution to a person's occupational engagement are the characteristics of a person. The person component of MOHO refers to the elements of a person that contribute to human occupation such as volition, habituation, and personal causation (Taylor, 2017). This aspect of MOHO is used to understand how and why individuals select, categorize, prioritize, and manage their unique occupations (Taylor, 2017). These subsystems of MOHO elaborate on specific personal traits that influence how one interacts and engages in occupations within a specific environment.

The first subsystem, volition, refers to the motivation and desire to perform and engage in specific occupations (Taylor, 2017). Volition is influenced by the person's thoughts and feelings regarding their interests, values, and personal causation (Taylor, 2017). Interests refer to one's satisfaction and fulfillment of activities, values refer to one's beliefs and perception of importance for daily occupations, and personal causation refers to one's perception of effectiveness and competence when performing occupations (Taylor, 2017). In OT practice for SUDs, this subsystem is used to identify the components of one's volition to establish motivative strategies to support recovery and rehabilitation from substance use (Davies & Cameron, 2010).

The second subsystem, habituation, refers to the structure and routine of a person's selected occupations and consists of a person's habits, internalized roles, and patterns (Taylor, 2017). Habits are the automatic tendencies in which a person engages in specific activities, internalized roles refer to a person's occupational identities derived from social and personal

expectations, and patterns are the routine or sequence of these actions or activities (Taylor, 2017). When identifying and managing substance recovery strategies related to one's habituation, OT practitioners seek to understand how these concepts influence the person's obligation to complete tasks or roles and the daily structure in which they engaged in the selected occupations (Davies & Cameron, 2010). This subsystem of MOHO can be used to guide the development or restoration of one's desired daily routine and roles to support SUDs management and recovery (Park et al., 2019).

The third subsystem, performance capacity, refers to the subjective perception of a person's performance and capability of engaging in occupations (Taylor, 2017). Performance capacity can change depending on volition and habituation and is reliant on a person's physical and mental abilities (Park et al., 2017). This subsystem can be used to guide theory and practice pertaining to specific populations as it examines how a person's system and performance abilities influence and are influenced by the condition (Taylor, 2017). This subsystem can be addressed in OT interventions in SUDs treatment to identify and develop skills necessary to support substance use recovery pertaining to physical and mental abilities, such as functional mobility, memory, and problem-solving (Taylor, 2017).

Environment

The second component that MOHO identifies as a key component that influences one's occupational engagement is the environment, which consists of six components. The six components of the environment include the physical, social, occupational, economic, political, and cultural aspects of a person's life (Taylor, 2017). It refers to the three dimensions of a person's life which include their physical, social, and occupational contexts (Taylor, 2017). A person's environments have an inseparable connection to occupational performance and has been

identified as a significant component to consider when seeking to modify one's occupational performance and engagement (Taylor, 2017). If the environment does not support the person's contexts such as volition, it creates a barrier that limits participation and causes dysfunction (Taylor, 2017). Thus, the environment is a key component to identify and establish positive physical and social environments that support recovery from substance use.

Application of Theory

The Model of Human Occupation can be used to guide this capstone project to understand the influence of one's personal factors and environment on occupations with and without SUDs to develop evidence-based treatment recommendations for OT practice. MOHO is a holistic, client-centered, and evidence-based theoretical model that was developed to complement other theoretical frameworks to determine best-practice (Taylor, 2017).

This theoretical model is beneficial to guide clinical practice and scholarship regarding SUDs treatment as it explains how personal factors and the environment are either supportive or unsupportive of recovery and rehabilitation. Alternatively, these aspects can also be either supportive or unsupportive of the use of substances. These benefits support the selection of MOHO to structure the proposed capstone project as it can be used to thoroughly analyze one's occupational profile and guide the OT process when working with individuals with SUDs. See Table 1 for more details on the impact of SUDs on occupation versus the ideal dynamic systems relationship through the constructs of MOHO.

Conclusion

In summary, the literature reviewed in this chapter serves as a foundation and guide the development of this capstone project. It is pertinent to establish an understanding of the literature themes and findings to provide a structure to manage and organize the research to create an

evidence-based guidebook of OT interventions with SUDs. This chapter successfully illustrated the literature findings of SUD pertaining to the statistics, facts, and factors, occupational impact, interventions and treatment, practice guide development, and theoretical framework.

Chapter 3: Methodology

The purpose of this project is to develop an OT guidebook for clients with SUDs. This guide is needed because the OT literature does not present clear guidelines on OT interventions for clients with SUDs, making it difficult for OT practitioners to address the occupational needs of people with SUDS. The guidebook elaborates on the role of OT and the OT process when working with individuals with SUDs and apply OT theory to understand the occupational impact of SUDs and condition management strategies to promote long-term recovery and restoration of occupational performance. The creation of the project will enhance the instruction and preparedness of OT practitioners, and facilitate the application of OT concepts and clinical reasoning when working with this population. The guidebook will increase awareness and understanding of OT's role in mental health settings and on the multidisciplinary team as well as facilitate the expansion of literature pertaining to OT and SUDs. This section of the capstone proposal presents the guidebook development process, theoretical model, outline of guidebook, plan for critical review, timeline, and envisioned next steps.

Guidebook Development Process

Development of the treatment guide consists of three phases (a) the pre-development phase, (b) the development phase, and (c) the review and revision phase. The pre-development phase consists of completing the needs assessment, literature review, data collection, data analysis, and data summarization from the literature findings. The development phase consists of identifying and categorizing OT treatment strategies for SUDs based on the type of activity, prosed supports and barriers, performance skills, client factors, goals, activity description, and recommendations for modifications (Donovan et al., 2013; Kingree, 2013). The review and revision phase consists of getting critical review on drafts of the guidebook from a panel of

reviewers. The panel selection process is discussed following sections for the plan for critical review. Further details regarding the planned process and expectations of the proposed project are included in the project timeline.

Theoretical Model

MOHO (Taylor, 2017) was used as the theoretical framework to shape the development of the guidebook. Table 1 presents the influence of the constructs of MOHO in the ideal situation, with a client with SUDs and intervention strategies.

Outline of Guidebook

The following outline served as the structure of the guidebook. The format of the interventions in Chapter IV: Section II was repeated for each OT intervention section. For example, each intervention or session in Chapter IV: Section II included a preparatory task, occupation-focused activity, and a concluding task. The key topics outlined in each intervention includes the addressed supports and barriers, targeted goals and objectives, and connection to the guidebook's theoretical framework OT theory, MOHO. These aspects are thoroughly identified in the guidebook to ensure quality of knowledge for the prospective audience. The outline of the guidebook as follows:

Chapter I. Introduction to Occupational Therapy

- **What is Occupational Therapy?**
- **History of Occupational Therapy.**
- **Settings and Practice Areas.**
- **Occupational Therapy Role in Substance Use Disorders.**

Chapter II. Substance Use Disorders

- **Background.**
- **Comorbidities and Commonalities.**
- **Occupational Impact.**

Chapter III. Theoretical Framework: Model of Human Occupation

Occupational Therapy Theory.

Levels of Theory.

History of MOHO.

Constructs of MOHO.

Application of MOHO.

Chapter IV. Occupational Therapy Process and Tools

Evaluation.

Assessment Tools.

Goal-Setting and Outcome Objectives.

Treatment Plan.

Intervention.

Guidebook Intervention Plan.

- First Session: Kawa Model Activity
- Second Session: Occupational and Financial Plates
- Third Session: Grounding Strategies
- Fourth Session: Time Management and Prioritizing
- Fifth Session: Effective Communication Strategies
- Sixth Session: Nature Self-Portrait
- Seventh Session: Social and Community Outreach
- Eighth Session: Relapse Prevention Plan

Re-Evaluation and Discharge.

Chapter V. Resources

Levels of Care.

Self-Help Groups.

Other Community Resources.

Appendix: Case Study and Examples.

References.

Plan for Critical Review

The third phase of the capstone project is the Review and Revision phase. This phase consists of creating a panel or focus group to complete a critical review questionnaire to provide the student research with feedback regarding areas of improvement to focus on in the capstone revision process. The panel consisted of the capstone committee, professionals with a high level of expertise in SUDs, and professional various disciplines to ensure accuracy and clarity. The critical appraisal form consisted of fixed and free-response questions regarding the project's organization, accuracy, relevance, and validity. The form contained fixed responses to select from satisfactory, needs improvement, and unsatisfactory as well as optional additional comments. The critical appraisal form is based on the AGREE II Reporting Checklist and Evidence-Based Practice Process Quality Assessment, or EPQA (Brouwers, et al., 2016; Lee, et al., 2013). See Appendix A for the Critical Appraisal Form and Appendix B for the Short Answer Form Questionnaire.

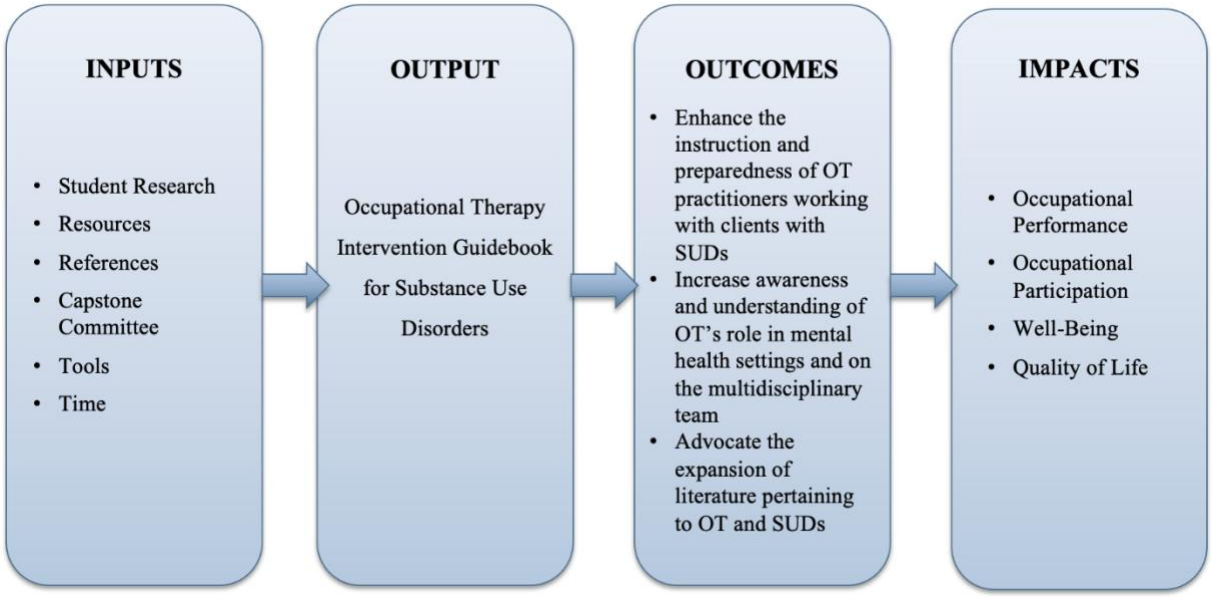
Logic Model

The development of this guidebook was informed through the use of a logic model (W.K. Kellogg Foundation). The logic model for this capstone project is presented in Figure 1. This action-oriented tool considers the inputs, output, outcomes, and impacts to create to project plan of the proposed OT guidebook (W.K. Kellogg Foundation, 2004). The inputs of the product include the student researcher and research, resources utilized, various reference sources, capstone committee, tools, and earnest time spent preparing and conducting the project. The output of the project is to create an OT intervention guidebook for SUDs with the intention of addressing and enhancing occupational performance, participation, well-being, and quality of life. The envisioned outcomes of the OT intervention guidebook are that through the provision of

a recommended OT plan, it will enhance the preparedness of OT practitioners when working in SUDs settings, educate on OT's role in mental health and SUDs settings, and advocate implications for future research pertaining to OT and SUDs. See Figure 1 below for more details.

Figure 1

Capstone Logic Model



Note. The Logic Model describes the components that contribute to the guidebook as necessary. These components are separated by the inputs, outputs, outcomes, and impacts of the capstone project.

Conclusion

The purpose of this project is to develop an OT guidebook for clients with SUDs. The creation of the OT guidebook addresses the deficits in SUD treatment as the literature lacks organization and guidance for OT practitioners to support foundational knowledge when working with individuals with SUDs (Amorelli, 2016). MOHO serves as the theoretical framework of the OT guidebook as it seeks the connection and influence personal and environmental factors have on one's occupational engagement and performance (Kielhofner,

2009; Taylor, 2017). The practice guide was developed in three phases, (a) the pre-development phase, (b) development phase, and (c) review and revision phase.

Chapter 4: Results

This chapter consists of a review and analysis of the capstone project's developmental process and summarization of the guidebook's contents. The following chapter is formatted to be submitted to AOTA's *OT Practice* magazine. The purpose of the *OT Practice* magazine is to provide OT practitioners and members of the AOTA with relevant occupation and evidence-based practice methods. The product of this capstone is consistent with this purpose. Access to the digital version of the capstone guidebook can be found at the end of this chapter through the provided QR Code.

OT for People with SUDs

Despite occupational therapy's origins in mental health settings, community mental health is an emerging practice as OT practitioners are re-establishing their unique role in assisting clients on their recovery journey. Within the mental health setting, OT practitioners have specific role when working with clients with SUDs. In collaboration with the multi-disciplinary team at various levels of care, OT practitioners evaluate an individual's barriers and challenges to occupational performance and identify strategies to strengthen their engagement and performance in daily occupations or roles that are particularly meaningful to them.

Over the years, OT practice has shifted its focused in order to meet the needs of society and there has been a significant decline in OT practitioners in mental health settings (Brown, et al., 2019). Due to the high demand of OT practitioners in settings such as hospitals, schools, and skilled-nursing facilities/long-term acute care settings, approximately 2% of OT practitioners serve in community mental health (AOTA, 2020). The lack of OT present in these settings and populations decreases the amount of literature regarding OT scholarship and practice for individuals with mental health and substance use challenges (Brown, et al., 2019). In regard to

OT scholarship and practice for SUDs, the literature lacks organization and exposition on the best-practice methods to conduct the OT process (Amorelli, 2016; Stoffel & Moyers, 2004). OT practice in these settings is widely diverse as there is not currently a practice guideline, protocol, or manualized intervention for practitioners to follow when working with clients with SUDs. In consideration of these concerns, the purpose of this capstone research project was to create a guidebook for OT practitioners to use when working with individuals with SUDs. The guidebook described in the following sections utilized MOHO as the theoretical foundation to guide the OT process and evidence-based practice methods as it serves as a recommendation tool with OT assessments, interventions, and re-assessment/discharge planning processes for client with SUDs.

Guidebook Development

The development of the guidebook consisted of three phases (a) the pre-development phase, (b) the development phase, and (c) the review and revision phase. In the first phase, a needs assessment, literature review, and data collection, analysis, and summarization were conducted. The development phase of the guidebook consisted of identifying and incorporating the evidence-based practice methods found in the literature to create a recommended step-by-step guide on how to select assessments and interventions to conduct the OT process when working with clients with SUDs. The final phase, review and revision phase, consisted of submitting each chapter of the guidebook to a committee of reviewers. The committee consisted of several clinical professionals with experience in mental health and substance use settings. The members of the review team completed surveys and completed critical review forms to provide feedback on each chapter. Each chapter was then revised according to the responses and feedback submitted by the reviewers.

Guidebook Contents

The guidebook consists of five chapters: (I) Introduction to Occupational Therapy, (II) Substance Use Disorders, (III) Theoretical Framework: Model of Human Occupation, (IV) Occupational Therapy Process and Tools, and (V) Resources. The first three chapters serve as the supporting chapters, while Chapter IV consists of the core content of the guidebook. Chapter 5 provides the guidebook user with other community resources available as well as how to navigate those resources.

The first chapter of the guidebook introduces the scope and role of OT practice. This chapter includes definitions for occupational therapy, domains of OT, occupations, and occupational outcomes to orient the guidebook user. The chapter also includes information regarding the history of OT, common OT settings and practice areas, and examines the role of OT in SUDs treatment. The second chapter of the guidebook focuses on substance use disorders specifically. This portion of the guidebook includes information on SUDs statistics, diagnostics, risk factors, comorbidities, commonalities, and occupational impact specific to use. The final supporting chapter focuses on the theoretical framework that directs the guidebook. It elaborates on the use of OT theory, levels of theory, and history and concepts of MOHO.

The core chapter of the guidebook, Chapter IV, provides relevant best-practice methods for OT practice in mental health and SUDs settings. The first section of this chapter provides examples of various OT assessment tools, goals, and outcome objectives to assist OT practitioners when determining the most applicable course of action to evaluate a client with SUDs. Based on the client in the Case Study found in the Appendix of the guidebook, this section provides examples of assessment summaries based on the Occupational Profile Template and Modified Interest Checklist. The second section of this chapter is the guidebook treatment

plan and implementation. It includes eight OT sessions that each include a preparatory task, occupation-focused activity, and a concluding task. The preparatory task for each session is a 5-10 minute guided meditation based on the theme of the session. Each occupation-focused activity includes the targeted supports, barriers, goals, outcome objectives, and connection to MOHO. The eight occupation-focused activities include: (1) Kawa Model Activity, (2) Occupational and Financial Plates, (3) Grounding Strategies, (4) Time Management and Prioritizing, (5) Effective Communication Strategies, (6) Nature Self-Portrait, (7) Social and Community Outreach, and (8) Relapse Prevention Plan. The last section of this chapter is the re-evaluation and discharge portion of the OT process. Similarly to the first section, this section also provides a discharge summary as an example to guide the documentation process based on the client in the guidebook's case study.

The final chapter of the guidebook, Chapter V, consists of various resources available to the client that support long-term recovery during and following therapeutic services. This chapter includes information on the levels of care in SUD treatment, self-help groups, and other community resources such as sober events or environments.

Guidebook Utilization

The guidebook serves as a resource tool for OT practitioners that is composed of recommended relevant evidence-based practice methods to conduct the OT process for individuals with SUDs within the outpatient setting. Although the guidebook is developed based on an individual client receiving a one-hour outpatient OT session a week for 8 weeks, the guidebook is simply a recommendation tool that does not have to be followed specifically. Instead, the guidebook users are free to use any portion of the guidebook as they see fit in various settings, timelines, treatment plans, and client levels such as individual or groups. For

example, an individual may find the preparatory tasks for each session more useful or applicable to their client(s) rather than the entire treatment plan and is able to use the resources provided to modify or assemble a new treatment plan based on the content provided.

Figure 2 Guidebook. Scan the QR code for digital access to A*n Occupational Therapy Guidebook for Individuals with Substance Use Disorder*.

Chapter 5: Discussion

Using MOHO as the guiding theoretical framework, the purpose of the capstone project was to develop an OT guidebook for individuals with SUDs. This project successfully provided background information regarding the capstone population and purpose, examined the literature, analyzed the methodology of the capstone product, and summarized the development and contents of the guidebook. The guidebook provided supporting literature on OT, SUDs, MOHO, and community resources as well as recommendations on performing the OT process in SUDs settings. The recommendations provided in guidebook include OT assessment tools, targeted goals and outcome objectives, preparatory activities, occupation-focused activities, concluding/session wrap-up activities, and documentation summaries for this client population. The remaining portion of the capstone examines the impact and following actions regarding the completion of this capstone project.

Impact of the Guidebook

The production of this guidebook will impact OT practice and scholarship for practitioners, clients, and the scope of OT. According to Hitch and Lheude (2015), emerging OT research priorities include promoting the use of occupation-focused methods, increasing client therapeutic experiences within the group setting, identifying methods to increase occupational engagement, and promoting meaningful, occupational engagement for clients at the inpatient level. This section elaborates on how the dissemination of this guidebook addresses these research goals and the current deficiencies in occupational therapy.

OT Practice

As discussed in the literature review (Chapter 2) of the capstone project, the literature pertaining to OT practice lacks organization and clarity on best-practice methods for OT

practitioners to implement during the OT process (Stoffel & Moyers, 2004). The deficiency in organization and abundance of evidence for OT practitioners in this setting limits the clinical application and effectiveness of therapeutic intervention (Amorelli, 2016). The guidebook created in this capstone project serves as a recommendation tool that organizes and summarizes relevant OT literature to increase the utilization of evidence-based practice methods in the OT process in mental health and SUDs treatment settings. The contents and methods used in the guidebook support and address emerging research priorities for OT in mental health (Hitch & Lheude, 2015).

With this guidebook, OT practitioners are equipped with copious evidence-based resources and recommendations to implement efficient and effective OT practice methods for clients with SUDs (Rosenfeld & Shiffman, 2009). OT practitioners interested in or are entering this emerging practice setting will experience more clinical preparedness and guidance as they are provided with recommendations, resources, and examples on how to conduct the OT process for this client population. This factor will provide clients with quality therapeutic services that increase the achievement of client-centered goals and outcome objectives as well as increase the presence of OT in mental health settings (Brown, et al., 2019; Rosenfeld & Shiffman, 2009).

OT Scholarship

The problem that this guidebook was constructed to address was the lack of a practice guideline, protocol, or manualized intervention of OT practitioners when working with clients with SUDs. Because of this problem, OT practice for this client population is vastly different as practitioners are able to implement therapeutic services that are subjective and cannot be replicable or studied. With this guidebook, OT researchers and practitioners can begin to examine the methods commonly utilized in this setting as well as determine the efficacy of the

strategies implemented (Rosenfeld & Shiffman, 2009). This capstone product creates a foundation as researchers can conduct clinical trials to determine the efficacy and utilization of the guidebook in order to create an OT practice guideline, protocol, or manualize intervention for individuals with SUDs that expands and increases the efficacy of OT's role in mental health and SUDs treatment settings (Blanche, et al., 2011).

Recommendations for the Future

Upon the completion of the guidebook, the envisioned steps are to disseminate the capstone product to increase the number and quality of literature and evidence-based resources available to OT practitioners. The first step of the dissemination phase would consist of submitting the capstone project and product to AOTA's *OT Practice* magazine and the University of St. Augustine for Health Sciences research database, *SOAR*. Following the submission, the next steps would be to receive feedback on the product and complete a final review and revision phase to increase the efficacy and validity of the guidebook. Future recommendations to disseminate would be to present the capstone at various conferences, create promotional materials for OT practitioners, mental health facilities, and other mental health professionals or organizations interested in the guidebook, and submit summaries or versions of the product to other OT or SUDs organizations or newsletters.

The purpose of the dissemination phase is to increase the amount of OT literature pertaining to SUDs treatment. With the development and dissemination of the guidebook, OT practitioners and researchers will have a foundation to study the efficacy of OT interventions for SUDs and create an OT practice guideline, protocol, or manualized intervention (Rosenfeld & Shiffman, 2009).

Table 1

Application of the Model of Human Occupation to Occupational Therapy Intervention for Individuals with Substance Use Disorders

MOHO		Ideal Situation	Persons with SUDs	Intervention Strategies
Summary		· Ability to explore, select, perform, and feel satisfied with engagement in activities/occupation · Supportive person factors are congruent with appropriate environment(s) and vice versa	· Abrupt changes in person/environment factors · Loss of desire and pleasure in prior meaningful activities · Distortion/dysfunction of performance and perception of person/environment factors	1. Development or restoration of activities and performance skills that support occupations congruent with desired person and environmental factors 2. Identify client's specific supports and barriers to enhance performance and engagement in healthy activities that support recovery
Volition	Interests	· Explores, selects, and finds pleasure in multi-activities/ occupations	· Loss of meaning and satisfaction in prior occupations	
	Values	· Has positive goals and beliefs parallel with daily activity and able to prioritize activities based on own sense of merit	· Loss of prior personal goals or beliefs; Loss of ability to identify and participate in important occupations	
	Personal Causation	· Has positive sense of self-confidence and competence that facilitates accurate perception of personal effectiveness and feels activities/ occupations are significant	· Distortion and dysfunction sense of performance and participation in prior meaningful	

Habituation	Habits	· Has beneficial structured and routine activities that support daily function	· Lack of stability in routine and daily structure that support performance and engagement in meaningful tasks	3. Rectify distortion and dysfunction of meaningful occupations and roles
	Internalized Roles	· Has supportive tasks that form occupational identity and reinforces occupational expectations and obligations	· Current tasks and expectations are unsupported by use of substance; Unable to meet expectations in meaningful roles	
	Patterns	Positive establishment and exploration of routine behavior and activities	· Routine behavior does not support occupational performance and participation	4. Establish condition management/intervention strategies that support recovery and client goals to return to prior level of function
Performance Capacity	Physical Abilities Mental Abilities	Supportive mental and physical abilities to engage in occupations; Positive and accurate perception of a person's performance and capability of engaging in occupations	Lacks the physical and mental abilities to support healthy and meaningful occupations; Digression of abilities such as functional mobility, memory, and cognitive functioning	
Environment	Physical Social Cultural	Selects and interacts with environment (s) that support intrinsic factors; able to adapt and meet the demands of the environment	Unable to select or interact in positive environments that support occupational balance and healthy person factors; Unable to perceive the level of influence or environment(s) that foster use of substance	

Note. This table demonstrates how the constructs of MOHO shape the guidebook as it compares the MOHO profile of the ideal situation to a person with SUDs to develop intervention strategies to resolve the discrepancy (Park et al., 2019; Cole & Tufano, 2020; Taylor, 2017; Davies & Cameron, 2010).

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Appendix A

Critical Appraisal Form

S = Satisfactory NI= Needs Improvement U= Unsatisfactory

#	Guidebook Contents	Expectations	Response
1	Title	· Identifies project as an evidence-based practice project/guide · Indicates the connection to OT practice · Succinct and relevant title	
2	Introduction/Background	· Clearly describes role and scope of OT · Clearly describes population and background information of condition (Ch 2) · Identifies occupational impact and implications for OT services	
3	Rationale	· Identifies and supports rationale of project with evidence · Clearly elaborates on the purpose and need for project · Problem and purpose are supported by evidence and is relevant to OT practice	
4	Application to Theory	· Defines OT theory and connection to project · Utilizes the most applicable theoretical model/frame of reference to guide project · Correctly utilizes and applies OT theory to population and project	
5	Methodology	· Thorough explanation of project plan and process · Methodology for guidebook development is accurate and supported by evidence · Consistency between envisioned and implemented methodology of project · Literature review and data collection are replicable, and process is clearly identified	
6	Intervention	· Clearly identifies and categorizes interventions · Selects and explains relevant interventions within the scope of OT · OT intervention is established and supported through evidence · Interventions are holistic, client-centered, and goal-oriented	
6a	OT Process and Tools	· Clearly identifies and elaborates on the OT process and tools utilized in mental health and SUD settings · Selects relevant and accurate evaluation/reevaluation, treatment, and discharge planning tools and resources · Provides examples of tools and applicability to population/setting	

		· Project process and structure is easy to follow and replicate	
6b	Activity/OT Plan	· Describes the intervention/activity thoroughly · Activity and plan for session is clearly described · Intervention/activity supports client-driven outcomes, incorporates selected OT theory, and complements the 12-Step Program	
6c	Supports and Barriers	· Clearly describes condition limitations and supports to occupational goals (performance and participation) · Consideration of supports and barriers are accurate and relevant to population/client	
6d	Targeted Skills	· Skills are clearly identified and addressed accordingly in intervention/step · Skills are relevant and commonly addressed in OT intervention for individuals with SUDs. · Skills correlate with section and intervention contents	
6e	Goals/Outcomes Addressed	· Goals/Outcomes are clearly identified and addressed accordingly · Goals are client-centered and S.M.A.R.T. (specific, measurable, attainable, realistic, and timely) and follow the OT goal COAST format (client, occupation/activity, assistance level, specific condition, and timeline)	
6f	Activity Modifications	· Considers relevant modification/alternatives and thoroughly explains recommendations to accommodate various client-specific conditions · Recommendations are achievable and accessible	
7	Next Steps	· Provides prospective steps that are supported by evidence and within the scope of OT practice · Envisioned steps are thoroughly explained and rationale for each implication is relevant	
8	Other Resources and Tools	· Provides resources, tools, and references that support the development and understanding of the project · Resources and tools are accessible and enhance knowledge necessary to support the development of the project	

Comments (optional):

Please provide any necessary comments pertaining to the Guidebook Short Answer Form above.

_____

_____

_____

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Appendix B

Short Answer Form Questionnaire

- Organization of Project

  Comments:_____
  _____
  _____
  _____

- Relevance of Project Content

  Comments:_____
  _____
  _____
  _____

- Quality of Literature/ Supportive Evidence

  Comments:_____
  _____
  _____
  _____

- Comprehension and Readability

  Comments:_____
  _____
  _____
  _____

- Clarity of Project

  Comments:_____
  _____
  _____
  _____

- Applicability to Population/Profession

  Comments:_____
  _____
  _____
  _____

Appendix C

AN OCCUPATIONAL THERAPY GUIDEBOOK FOR INDIVIDUALS WITH SUBSTANCE USE DISORDERS

CASSIDY ARDOIN, OTS

An Occupational Therapy Guidebook

for Individuals with Substance Use Disorder

Cassidy B. Ardoin

Department of Occupational Therapy, University of St. Augustine for Health Sciences

This Guidebook was Developed in Partial Fulfillment

of the Requirement for the Degree of

DOCTOR OF OCCUPATIONAL THERAPY

At the University of St. Augustine for Health Sciences

August 2022

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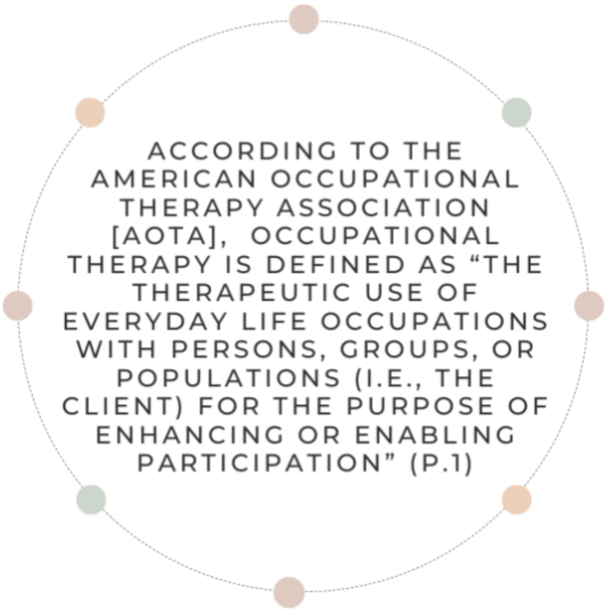
CHAPTER 1: INTRODUCTION TO OCCUPATIONAL THERAPY



What is Occupational Therapy?

Occupational Therapy (OT) is a client-centered health profession that focuses on the therapeutic use of a person(s) daily occupations (Boyt-Schell & Gillen, 2019). OT practitioners utilize the domains of the profession to evaluate an individual's current performance and engagement through the dynamic interactions of their daily occupations to determine strategies to improve, develop, or restore skills to participate in a person's desired activities. The domains of OT include occupations, contexts, performance patterns, performance skills, client factors, and occupational outcomes (AOTA, 2020).

Occupations refer to the daily activities that a person engages in that are uniquely meaningful to them. This term refers to how an individual chooses to occupy their time while incorporating the roles, responsibilities, and expectations of the person and activity (Boyt-Schell & Gillen, 2019). The nine occupations that the profession recognizes include activities of daily living (ADLs), instrumental activities of daily living (IADLs), health management, rest and sleep, education, work, play, leisure, and social participation (AOTA, 2020). The occupations are the areas of life that OT practitioners focus on to improve a person's desired occupational outcomes (Boyt-Schell & Gillen, 2019).

Figure 1.1 Domains of Occupation.
Figure was created using content from the *Occupational Therapy Practice Framework (*AOTA, 2020).

There are 10 occupational outcomes identified in the *OTPF-4* that OT practitioners focus on when providing therapeutic services to clients and are the end results of the OT process. These outcomes include participation, well-being, quality of life, improvement, enhancement, role competence, occupational performance, prevention, health and wellness, and occupational justice (AOTA, 2020). OT practitioners create client-centered goals and OT plan of care using the most applicable occupational outcomes for an individual's specific case.

This profession is a holistic approach to rehabilitation that is constantly growing as it adapts to the needs and changes of society. This constant evolution allows for the focus of the field to remain client-centered to best serve the communities or populations in need (AOTA, 2020).

History of Occupational therapy

In 1917, the profession emerged as a response to the need of rehabilitative services during World War I (Boyt-Schell & Gillen, 2019). The focus of the profession originated in mental health and has undergone multiple shifts of focus to meet the needs of society. As OT redirects focus to its original foundation in mental health, OT practitioners are redefining their unique role in mental health (Boyt-Schell & Gillen, 2019). See *Figure 1* for the historical timeline of OT.

Settings and Practice Areas

There are many settings, specializations, and practice areas that OT practitioners are qualified to work in. Common practice areas and settings include hospitals, school-based settings, long-term care or skilled nursing facilities, outpatient clinics, home health, early intervention programs and pediatric settings, academics, community and mental health (Boyt-Schell & Gillen, 2019). See *Figure 2* for the statistics of the presence of OT practitioners in each setting. OT practitioners most commonly practice in hospitals, schools, and long-term care facilities.

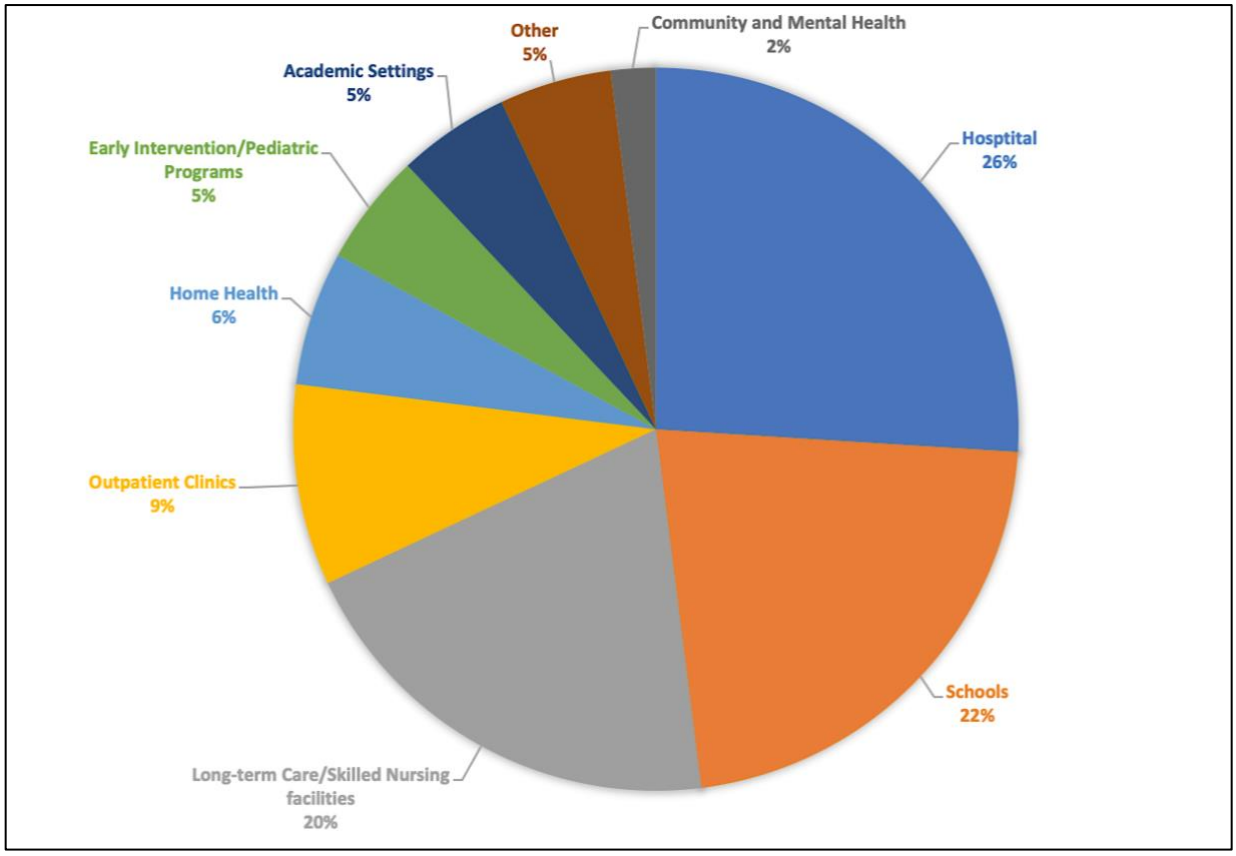


Figure 1.3 Occupational Therapy Practice Areas and Settings.
Figure created using content from the Occupational Therapy Practice Framework (AOTA, 2020).

OT Role in Substance Use Disorders

OT practitioners have a unique role on the rehabilitation team and possess necessary tools and skills to provide client-centered care through the therapeutic utilization of occupations (Cruz, 2019). When working with individuals with substance use disorder (SUD), OT practitioners apply the OT process to address client barriers and challenges of long-term recovery and promote healthy occupational performance and participation through purposeful activities to reach goals (Rojo-Mota et al., 2017; Stoffel & Moyers, 2004; Stone, 2017).

In mental health and SUDs treatment, the OT scope of practice applies specific OT theory, models, and evidence-based strategies of occupation to promote the development or restoration of skills needed to improve occupational engagement and participation to support sobriety, return to prior level of function, and meet client-specific goals for daily life (Martin et al., 2008).

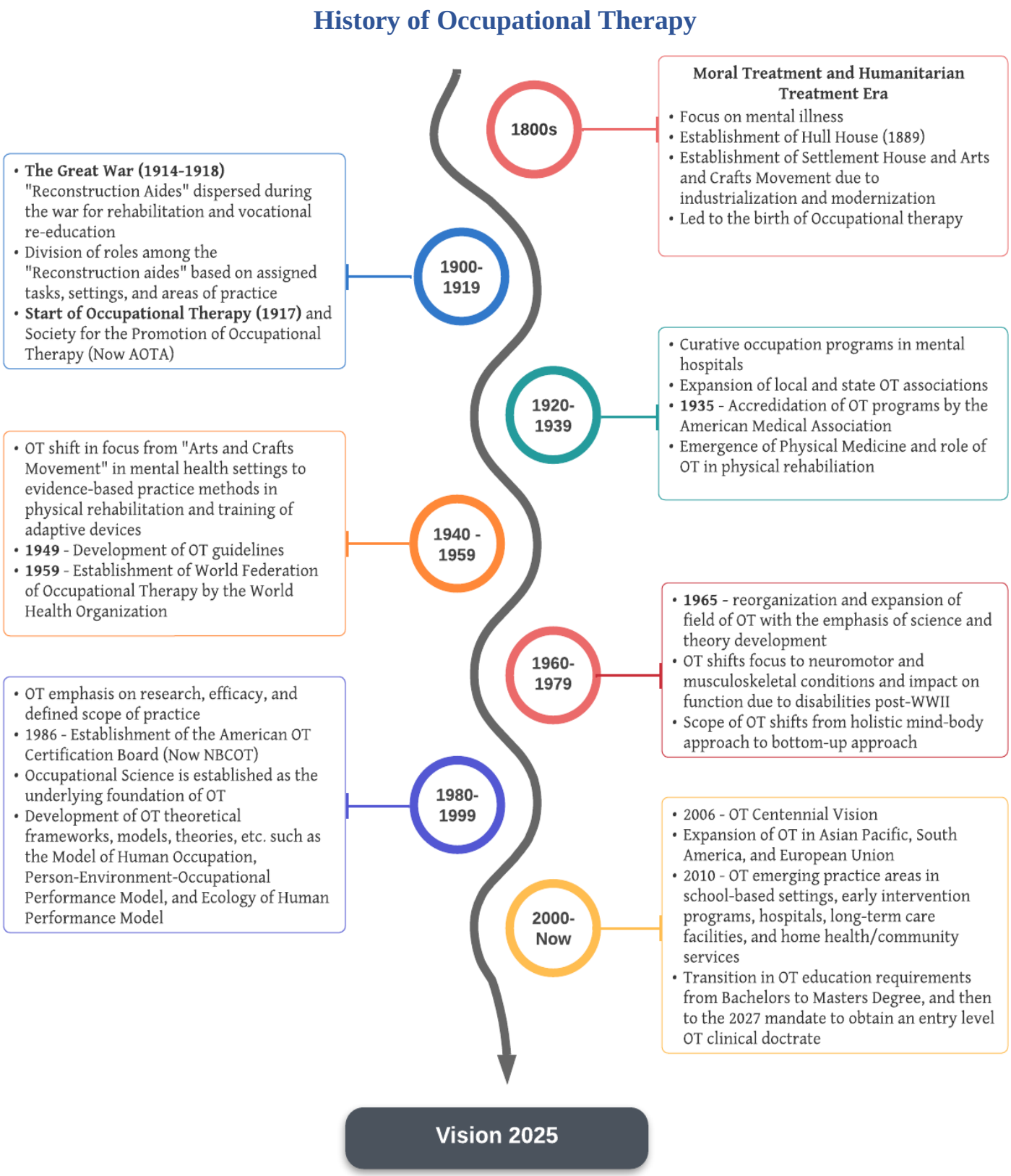


Figure 1.4 History of Occupational Therapy. Timeline created using literature from *Willard and Spackman's Occupational Therapy* (Boyt-Schell & Gillen, 2019).

CHAPTER 2: SUBSTANCE USE DISORDERS

SUBSTANCE USE DISORDER (SUD):

THE REOCCURRENCE OF INVOLUNTARY OR UNCONTROLLABLE USE OF SUBSTANCES THAT CAUSE DISRUPTIONS IN ONE'S DAILY LIFE (AMERICAN PSYCHIATRIC ASSOCIATION [APA], 2013).

Substance-related disorders can be divided into two categories: substance use disorders and substance-induced disorders (APA, 2013). This guidebook will solely focus on SUDs but will briefly examine the classifications and qualities of both as they are critical to identify and differentiate when working with individuals with substance-related disorders. This chapter will elaborate on the background characteristics and details of SUDs, occupational impact, and comorbidities and commonalities of SUDs and various SUDs subtypes.

Background

There are ten classes of substances and each can be identified as its own SUD subtype. Theses subtypes each consist of specific diagnostic features, development and course, risk and prognostic factors, and other associated features (APA, 2013). For example, an individual with a problematic use of alcohol can be diagnosed with SUD with a specification of alcohol use disorder (AUD) if they possess the necessary criteria associated with that individual subtype (APA, 2013). The *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013), or DSM-5, states that an individual can no longer be diagnosed with polysubstance use disorder and instead must be multi-diagnosed with each SUD subtype that they present with. The problematic use of a substance(s) varies among each individual as well as their risk factors, diagnostic timeline, symptoms, tendencies, comorbidities, and occupational impacts. This section will examine these unique client factors that impact SUD as well as the specific substances, statistics, diagnostics, and risk factors of SUDs

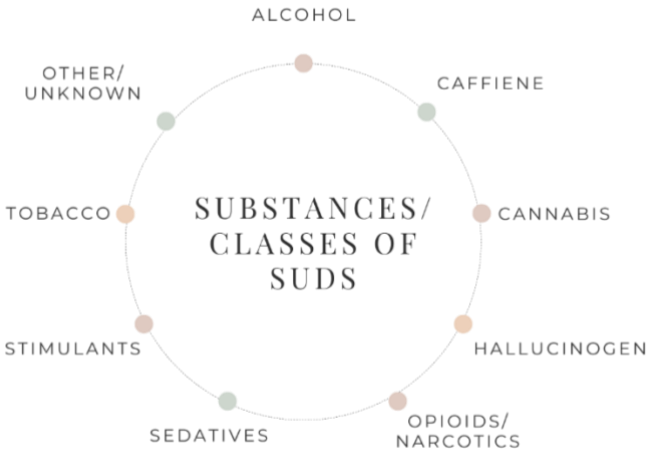


Figure 2.1 Classes of Substance Use Disorders. Figure created using literature from the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013).

SUBSTANCE/ CLASS	EXAMPLES
ALCOHOL	BEER, LIQUOR, & WINE
HALLUCINOGEN	ECTASY, KETAMINE, & LSD
INHALANT	GASES, NITRITES, & SOLVENTS
OPIOID	CODEINE, FENTANYL, & HEROIN
SEDATIVE, ANXIOLTIC, OR HYPNOTIC	AMBIEN, BARBITURATES, & BENZODIAZEPINES
STIMULANT	COCAINE, RITALIN, & METHAMPHETAMINE

Figure 2.2 Examples of Substances. Figure created using literature from the *DSM-5 Substance Use Diagnosis Guide* (Optum, 2018) and *Drugs of Abuse: A DEA Resource Guide* (Drug Enforcement Administration [DEA], 2020).

Statistics

According to the National Center for Drug Abuse Statistics (*Substance Abuse and Addiction Statistics*, 2022), approximately 31.9 million people who are 12 years and older in the U.S., or 11.7%, are current users of illegal substances and 165 million people, or 60.2%, abuse substances. This percentage referring to the abuse of substances in general which includes the use of alcohol and tobacco (National Center for Drug Abuse Statistics [NCDAS], 2022). The U.S. DEA refers to drug abuse as the use of controlled substances without medical reasoning or benefit (*Drugs of Abuse: A DEA Resource Guide*, 2020).

Alcohol is the most prevalent substance that is utilized and abused (Mannelli & Wu, 2019). Of the 139.8 million Americans 12 years and older who drink alcohol, 14.8 million have alcohol use disorder (NCDAS, 2022). Following alcohol, the most to least abused substances include marijuana, stimulants, opioids, methamphetamines, pain medication, heroin, cocaine, and sedatives (NCDAS, 2022). Since 2000, there have been approximately 700,000 drug over-dose deaths in the U.S (NCDAS, 2022).

SUBSTANCE/ CLASS	PERCENTAGE OF USE
ALCOHOL	10.6%
CANNABIS	9%
STIMULANTS	9%
OPIOID	7%
METHAMPHETAMINES	7%
PAIN MEDICATION	6%
HEROIN	3%
COCAINE	2%
SEDATIVES	1%

Figure 2.3 Percentage of Substances Used. Figure created from data collected from *Substance Abuse and Addiction Statistics* (National Center for Drug Abuse Statistics 2022).

The eleven diagnostic criteria for SUDs can be categorized into four different groupings: impaired control, social impairment, risky use, and pharmacological criteria (APA, 2013). The severity index of SUDs diagnostic criteria is based on the presence and quantity of SUD diagnostic criteria in 12-month period, and range from mild, moderate, and severe SUDs (APA, 2013).

	Diagnostic Criteria
Impaired Control	**1.** Use of larger amounts or for longer periods of time
	2. Unsuccessful reducing, ceasing, or regulating use
	3. Increased time spent obtaining, using, or recovering from effects of substance(s)
	4. Craving
Social Impairment	**5.** Failure to perform roles or obligations in daily occupations
	6. Continuation of use despite awareness of persistent/reoccurring social or interpersonal problems caused by effects of substance(s)
	7. Reduction, cease, or neglect of meaningful activities, events, or hobbies in order to use the substance(s)
Risky Use	**8.** Hazardous use (physical)
	9. Continuation of use despite awareness of persistent/reoccurring physical and psychological problems related to use
Pharmacological Criteria	**10.** Tolerance
	11. Withdrawal
***Severity**: Mild (2-3 criteria), Moderate (4-5 criteria), and Severe (6+ criteria)*	

Figure 2.4 Substance Use Disorder Diagnostic Criteria. Figure created using literature from the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2013).

Substance use disorder(s) can also be distinguished further by four specifiers relating to the course of the disorder which include "early remission," "sustained remission," "maintenance therapy," and "a controlled environment" (APA, 2013). Early and sustained remission refer to the time frame of sobriety and absence of any DSM-5 criteria. "Maintenance therapy" and "In Controlled Environment" are additional specifiers that are utilized to identify specific conditions pertaining to remission.

Early remission refers to 3 months to 1 year without the presence of any DSM-5 criteria while sustained remission refers to 1 or more years (APA, 2013). Maintenance therapy refers to if the individual is using medication assisted treatment as an agonist medication management of the disorder without the presence of any DSM-5 criteria with the exception of tolerance or withdrawal to the agonist medication (APA, 2013). This specifier applies to individuals receiving partial or full agonist/antagonist medication to assist with disorder management (APA, 2013). "A Controlled Environment" is an additional specifier that refers to if an individuals is in an environment where there is restricted accessed to substances such as a sober living facility (APA, 2013).

Risk Factors

The risk factors for developing SUDs have several overlapping factors with other mental health conditions such as concerns with brain chemistry or activity, genetic or epigenetic vulnerabilities, and environmental factors such as premature exposure to stress or trauma (National Institute on Drug Abuse [NIDA], 2020). The genetic and epigenetic vulnerabilities of an individual contribute to approximately 40-60% of their risk to developing SUDs. The genetic feature of an individual is the most

influential risk factor as it determines how an individual responds or is affected by a substance as well how long the effect lasts in the body (NIDA, 2020). These risk factors increase an individual's probability for developing SUDs as the complex interaction of one's genetics, brain chemistry, and environmental exposures can increase the risk for mental health and substance complications based on the specific bodily response of the individual (NIDA, 2020).

Comorbidities and Commonalities

Research indicates that SUDs often co-occur with other mental health disorders and that 13% of individuals with SUDs are diagnosed with other psychiatric conditions (Mannelli & Wu, 2019). This connection of conditions is theorized that an individual with an underlying or active mental health concern utilizes substances as a form of self-medication which can lead to the worsening or development of a mental health condition or SUD (NIDA, 2020). On the contrary, substance use can increase the onset or likelihood of developing a mental health disorder such as anxiety, impulse-control, mood, or schizophrenia disorder (NIDA, 2020).

The progression of these conditions is due to an individual's associated brain activity or brain chemistry as well as the risk factors mentioned in the previous section that increases one's vulnerability to develop a problematic use of substances (NIDA, 2020). This phenomenon is often referred to as *dual diagnosis*, which infers that either a mental health disorder or substance use disorder develops first and simultaneously occurs with presence of the other (NIDA, 2020). Research cannot indicate which issue is developed first nor does one cause another. SUDs are also comorbidities to physical health conditions such as cancer, chronic pain, and heart disease as the misuse or abuse of medication to manage these physical conditions can lead to the development of SUDs (NIDA, 2020). The long-term presence of a SUDs can increase one's risk for developing a substance-induced disorder which varies based on the substance(s) used, duration, and frequency (APA, 2013; NIDA, 2020).

Occupational Impact

Over time, SUDs can cause disruption, distortion, and dysfunction in daily activities, roles, or routines (Rojo-Mota et al., 2017; Stoffel & Moyers, 2004). Individuals with SUDs can experience barriers or challenges to engagement and performance in meaningful activities or distortion in motivation in activities that were once meaningful prior to the use of substances (Rojo-Mota et al., 2017).

For example, an individual who found satisfaction in engaging in daily occupations, roles, or responsibilities associated to the activities experience dissatisfaction or disengagement in activities to pursue the continued use of substances. These changes can impact their habits and routines, family dynamic or roles, sleep patterns, and personal priorities or interests that can become a long-term disruption (Rojo-Mota et al., 2017; Stoffel & Moyers, 2004).

OT practitioners work with individuals with SUDs to address these barriers and challenges by developing or restoring skills to reach a client's occupational goals (Eggers et al., 2006; Martin et al., 2008).

CHAPTER 3: THEORETICAL FRAMEWORK – MODEL OF HUMAN OCCUPATION

Occupational therapy is a profession rooted in evidence-based practice and relies on the development and application of OT theory to guide clinical scholarship and practice. The OT scope of practice is consistently shifting to fit the needs of a client population or setting (Cole & Tufano, 2020). With this continuous evolution of practice and research, the OT profession and scope of practice is dependent on theoretical frameworks to be the supportive foundation (Cole & Tufano, 2020). The current paradigm of OT is that the profession is holistic, client-centered, occupation-focused, and oriented in the dynamic systems of occupation (Cole & Tufano, 2020). The theoretical framework that has been utilized as the guiding model for the development of this capstone project is the Model of Human Occupation (MOHO). This chapter with elaborate on the definition and development of theory as well as the history, constructs, application, and implication for use of MOHO and other common theories.

OT Theory

Theory is a description or idea based on specific observable events and is considered the basis of OT frames of reference, models, and paradigms (Cole & Tufano, 2020; Dunbar, 2007). It provides organization of knowledge as it is used to define and explain observations or findings in OT practice. OT theory is critically embedded in the OT process as it guides the perspective and clinical reasoning for methods selected during the evaluation, intervention, re-evaluation, and discharge process (Dunbar, 2007). OT theory can be differentiated in to three categories, or levels.

Levels of Theory

Based on Mosey's (1992) establishment of the levels of theory, there are three levels of theory identified by AOTA and the scope of OT. These levels include (1) paradigm, (2) occupation-based models, and (3) frame of reference (FOR).

Through the lens of OT, a paradigm refers to the framework or philosophy of the profession or practice (Cole & Tufano, 2020). An example of this level of theory is the *Occupational Therapy Practice Framework: Domain and Practice,* or *OTPF-4* (AOTA, 2020). The OTPF-4 is a publication developed by the AOTA that serves as the universal guidelines of the profession as it provides practitioners with current concepts and beliefs within our domain to guide clinical OT practice. A model refers to the broader perspective and application of theory as it dynamically explains and analyzes the interconnections among occupations and various occupational profiles (Cole & Tufano, 2020; Dunbar, 2007). The occupation-based models utilized in OT practice can be applied across various client populations and settings, whereas frames of reference are applied to more specific types of settings, occupations, or client populations (Cole & Tufano, 2020; Dunbar, 2007).

History of MOHO

This theoretical model was published by Gary Kielhofner in 1980 as part of his master's thesis. He developed this conceptual model based on Mary Reilly's theory of occupational behavior (Cole & Tufano, 2020). MOHO was established while Keilhofner was completing his work with U.S. military veterans who had sustained spinal cord injuries while in combat (Taylor, 2020). The model has flourished and expanded since his first publication, but many of the core principles and concepts embedded in the theoretical model remain (Cole & Tufano, 2020). This evidence-based conceptual practice model is vastly utilized in OT practice as it helps prioritize client needs, supports occupation-focused practice, provides clinical rationale for each step of the OT process, and offers a holistic and client-centered approach to rehabilitation (Taylor, 2020). This conceptual practice model consists of four elements that dynamically interact and explain how or why a person engages in meaningful activities, or occupations (Kielhofner, 2009; Taylor, 2017). These four main elements include a person's volition, habituation, performance capacity, and environment.

Constructs of MOHO

The Model of Human Occupation focuses on the dynamic relationship between a person's occupational performance and their ability to adapt within their occupations. MOHO also analyzes how a person's internal and external factors influence occupational engagement or performance (Kielhofner, 2009; Taylor, 2017). Through the lens of MOHO, these internal factors are referred to as the *person* and the external factors are referred to as the *environment* (Taylor, 2017). Each system, person and environment, can be deduced into other subsystems as depicted in Figure 1 and dynamically interact and influence one another. The model is used to understand the relationship and influence these factors have with an individual, group, or population's occupational identity, adaptation, and competence (Boyt Schell & Gillen, 2019).

Professor Gary Kielhofner

Image from *Gary Kielhofner* (Taylor, 2010).

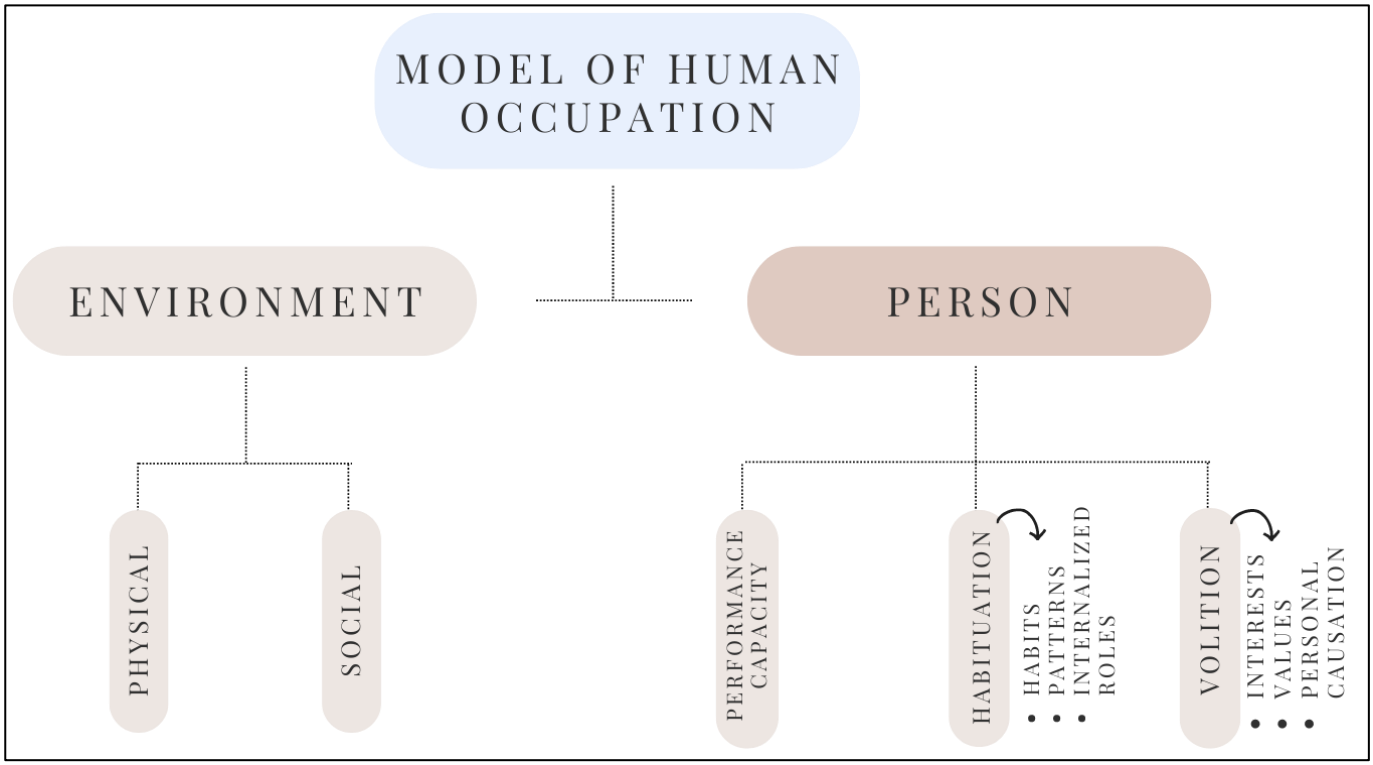


Figure 3.1 Model of Human Occupation. Figure created using literature from *Conceptual foundations of occupational therapy practice* (Kielhofner, 2009) and *Kielhofner's Model of Human Occupation: Theory and*

The first system of MOHO, the *person*, refers to the elements of a person that contribute to human occupation. The three person factors include volition, habituation, and performance capacity (Kielhofner, 2009; Taylor, 2017). This component of MOHO is utilized to understand why and how individuals select, engage, and manage their daily occupations (Taylor, 2017). These subsystems of MOHO pertain to specific personal traits or aspects that influence how one interacts and engages in occupations within a specific environment (Kielhofner, 2009; Taylor, 2017).

The second system of MOHO, the *environment*, refers to the external factors consisting of various situations and conditions that impact occupation. The two environments recognized and utilized in this theoretical model include the physical and social environments (Boyt-Schell & Gillen, 2019; Kielhofner, 2009; Taylor, 2017).

Application of Theory to Population

When applying MOHO to the population of individuals SUDs, it is important to note that each individual is unique and that their own impacts or influences is not limited to the points made in this section or guidebook. For the purpose of this guidebook MOHO was utilized as the focal lens to apply and understand the ideal situation versus situation of an individual with SUDs in regard to their personal constructs represented in the model. The table (Figure 2) below elaborates on the differences between an ideal situation for an individual's volition, habituation, performance capacity, and engagement in environments versus the generic situation or impact of an individual with SUDs.

In an ideal situation, an individual has the ability to explore, select, perform and feel satisfied with their engagement and performance in daily activities or occupations that are uniquely meaningful to them. There supportive person factors are congruent with appropriate environments and vice versa. For an individual with SUDs, there may be dysfunction, disengagement, or distortions that cause a lack of engagement or performance in occupations that were once meaningful. For example, there may be abrupt changes in person or environmental factors, loss of desire and pleasure in prior activities or hobbies, and distortion or dysfunction of performance and perception of valued person or environmental factors. The goal of OT intervention in this case would be to (1) focus on the development or restoration of activities and performance skills that support occupations congruent with desired person and environmental factors, (2) identify client's specific supports and barriers to enhance performance and engagement in healthy activities that support recovery, (3) rectify distortions and dysfunction of meaningful occupations and roles, and (4) establish condition management/intervention strategies that support recovery and client-specific goals.

	MOHO	Ideal Situation	Person with SUDs
Volition	· Interests · Values · Personal Causation	· Explores, selects, and finds pleasure in multi-activities/occupations · Has positive goals and beliefs parallel with daily activity and able to prioritize activities based on own sense of merit · Has positive sense of self-confidence and competence that facilitates accurate perception of personal effectiveness and feels activities/ occupations are significant	· Loss of meaning and satisfaction in prior occupations · Loss of prior personal goals or beliefs; Loss of ability to identify and participate in important occupations · Distortion and dysfunction sense of performance and participation in prior meaningful
Habituation	· Habits · Internalized Roles · Patterns	· Has beneficial structured and routine activities that support daily function · Has supportive tasks that form occupational identity and reinforces occupational expectations and obligations · Positive establishment and exploration of routined behavior and activities	· Lack of stability in routine and daily structure that support performance and engagement in meaningful occupations · Current tasks and expectations are unsupported by use of substance; Unable to meet expectations in meaningful roles · Routined behavior does not support occupational performance and participation
Performance Capacity	· Physical abilities · Mental abilities	Supportive mental and physical abilities to engage in occupations; Positive and accurate perception of a person's performance and capability of engaging in occupations	Lacks the physical and mental abilities to support healthy and meaningful occupations; Digression of abilities such as functional mobility, memory, and cognitive functioning
Environment	· Physical · Social · Cultural	Selects and interacts with environment (s) that support intrinsic factors; able to adapt and meet the demands of the environment	Unable to select or interact in positive environments that support occupational balance and healthy person factors; Unable to perceive the level of influence or environment(s) that foster use of substance

Figure 3.2 Application of MOHO. Figure created using literature from Park et al. (2019), Cole & Tufano, (2020), Taylor (2017), and Davies & Cameron (2010).

CHAPTER 4: OCCUPATIONAL THERAPY PROCESS

The occupational therapy process, or OT process, is a specific, fundamental process that is centered around evidence and clinical reasoning, which guides OT scholarship and practice (AOTA, 2020). This process consists of four main parts, which includes the (1) evaluation, (2) intervention, (3) re-evaluation, and (4) therapeutic outcomes (Boyt-Schell & Gillen, 2019). This chapter includes recommendations on how to conduct the OT process when working with individuals with SUDs. The sections included in this chapter will provide detail and resources on how to determine best-practice methods to perform an evaluation, treatment plan or intervention sessions, re-evaluation, and discharge planning for clients with SUDs. The application of the OT process throughout this chapter will be based on the client provided in the Case Study (See Appendix A).

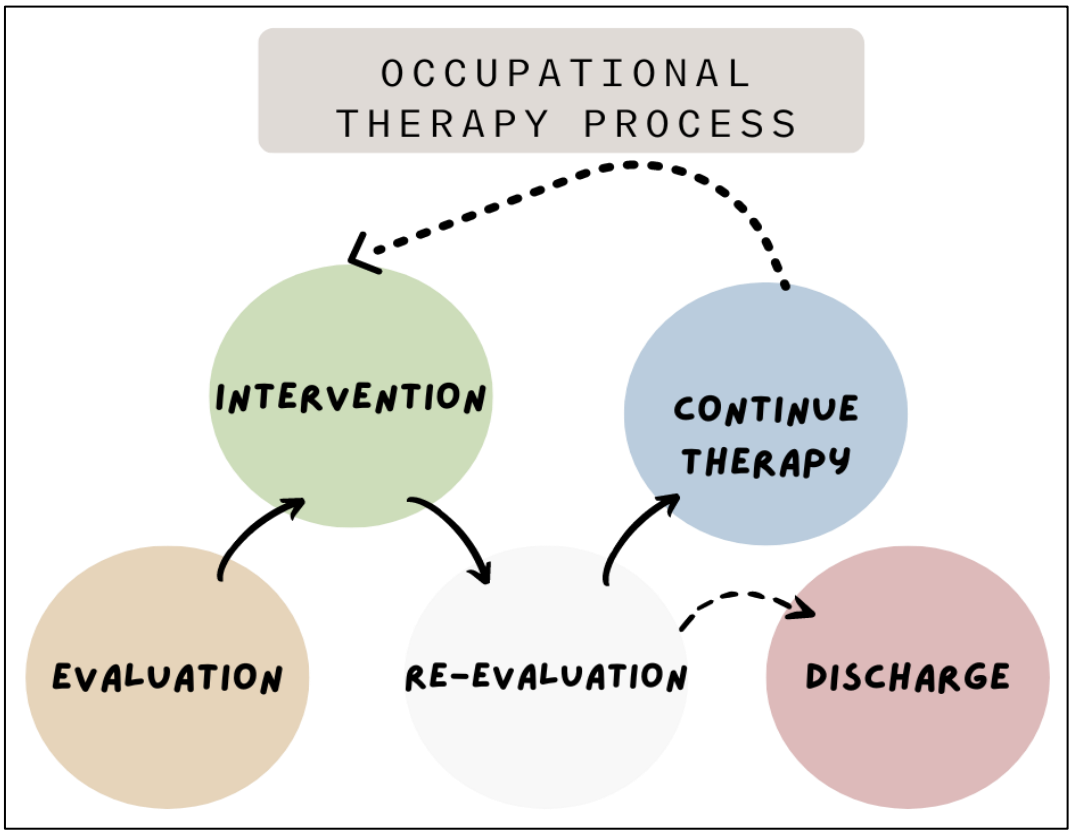


Figure 4.1 The Occupational Therapy Process. Figure created using literature from *Willard and Spackman's occupational therapy* (Boyt-Schell & Gillen, 2019) and *Occupational Therapy Practice Framework-4 (*AOTA, 2020).

Evaluation

The first step in the OT process is the evaluation or assessment of the client(s). This step consists of completing an occupational profile, analysis of occupational performance, and development of client-centered goals or outcomes (Boyt-Schell & Gillen, 2019). OT practitioners implement this step by conducting assessments or interviews and obtaining data

that will be utilized as the guiding structure of the therapeutic treatment plan. This comprehensive step is necessary as the OT practitioner gathers and analyses information regarding the client, their daily occupations, occupational performance, and occupational barriers or challenges (Boyt-Schell & Gillen, 2019). With the information obtained in this step, the OT practitioner can determine the best approach for therapeutic intervention and developing a client's treatment plan.

This section will explore the evaluation process including recommendations and resources on how to select and implement the most applicable assessment tools, goals and outcome objectives, and treatment plan for individuals with SUDs based on specific occupational barriers and challenges.

Assessment Tools

The assessment tools utilized in the evaluation process are vital in understanding who the client is, what are their daily meaningful occupations or roles, what are their specific strengths, barriers, and challenges to occupational engagement, and client-centered goals of objectives for intervention. There are many different types of assessment tools or approaches that OT practitioners can utilize when working with individuals with SUDs that are based on the occupational perspective of the practitioner. These assessments may or may not be MOHO-focused as there are other theoretical frameworks and clinical reasoning for an OT practitioner to utilize. *Figure 4.2* provides a list of common OT assessment tools that are utilized by practitioners when working with clients with SUDs and categorizes them based on the focus of the assessment. This list, however, is not all inclusive and varies based on the client population and needs of the client. The list also includes assessment tools that are not MOHO-based but are beneficial to examine a client's strengths and limitations to occupational performance based on their substance use or patterns.

The two assessment tools that will be applied and summarized in this section are the Occupational Profile and Modified Interest Checklist (MIC). These two assessments were selected as they are accordant with the guidebook's guiding theoretical foundation, MOHO. Other cost-free MOHO-based assessments can be found at the University of Illinois at Chicago's online database (MOHO-IRM Web, 2022).

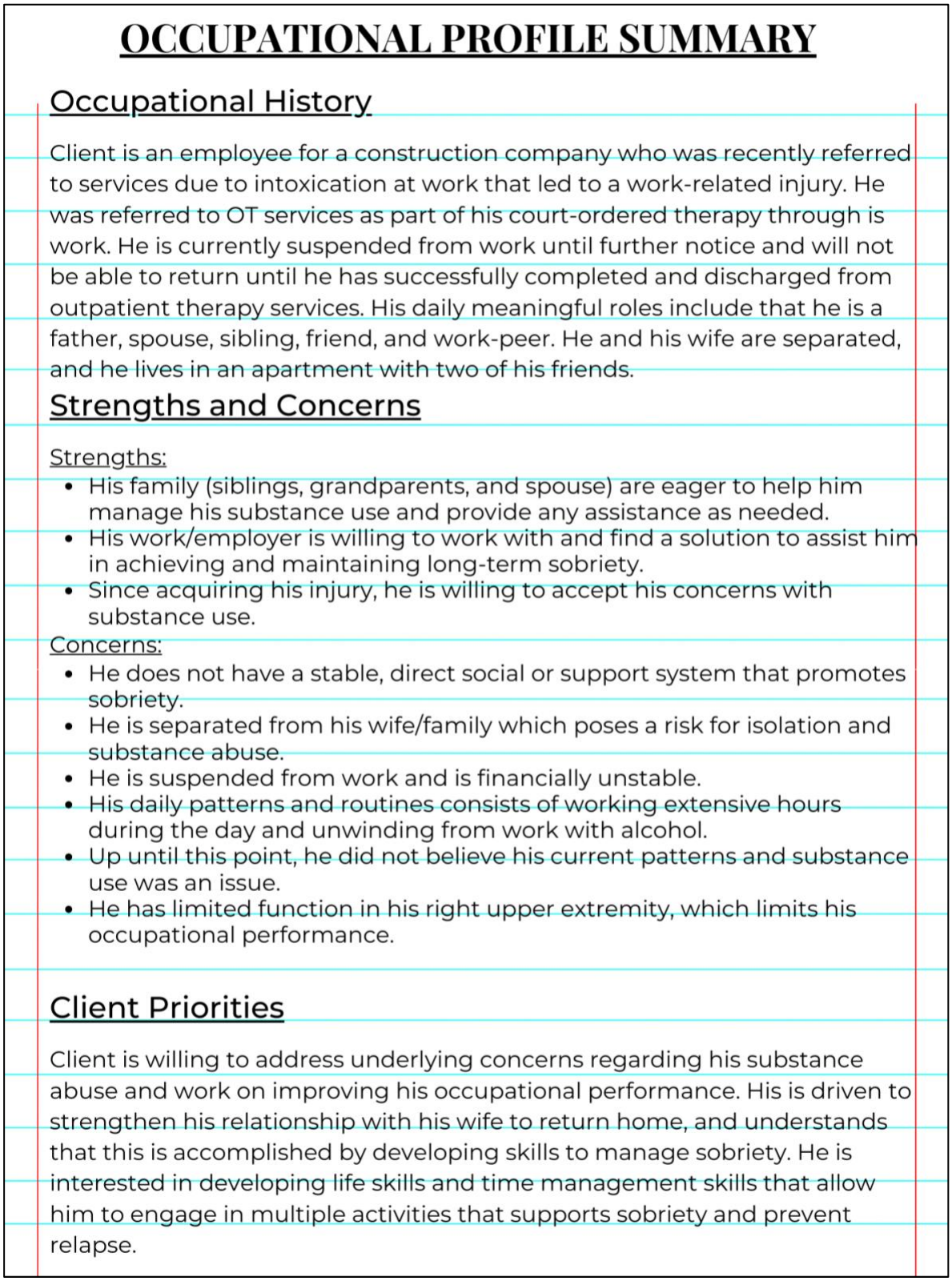
The Occupational Profile is a universal evaluation tool created by AOTA that is utilized by OT practitioners in various settings and client populations Thomas, 2015). The template is utilized to obtain a summary of the client's occupational history and create an overview of their interests, experiences, patterns, occupations, roles, and contexts to guide the development of an OT treatment plan (AOTA, 2020). The fillable template can be found at the AOTA webpage (AOTA, 2020).

The MIC is a MOHO-based assessment tool that obtains information regarding an individual's past and present levels of interests in various activities as well as any activities the individual would like to pursue. Figure 4.4 is an example summary based on the results of the assessment of the client in the case study provided in Appendix A.

OT Assessment Tools for SUDs.

Assessment	Assessment Focus
Performance Assessment of Self-Care Skills (PASS)	Self-Care Performance
Canadian Occupational Performance Measure	Occupational Profile
*Occupational Circumstances Assessment Interview Rating Scale (OCAIRS) **	Occupational Profile
*Occupational Performance History Interview II (OPHI-II)**	Occupational Profile
Occupational Self-Assessment (OSA)	Occupational Competence
Kohlman Evaluation of Living Skills (KELS)	Occupational Performance – ADLs/IADLs
Test of Grocery Shopping Skills (TOGSS)	Occupational Performance – ADLs/IADLs
Worker Role Interview (WRI)	Occupational Performance – Work
*Modified Interest Checklist **	Occupational Performance – Leisure
Adolescent/Adult Sensory Profile	Performance Skills - Sensory
Executive Function Performance Test	Performance Skills – Cognition
Dynamic Lowenstein Occupational Therapy Cognitive Assessment (DLOTCA)	Performance Skills – Cognition
*Assessment of Communication and Interaction Skills (ACIS) ** *Role Checklist (RC) **	Performance Skills – Social Interaction
*Volitional Questionnaire **	Client Factors
Work Environment Impact Scale	Contexts and Environments
**= Indicates Assessment is MOHO-Based	

Figure 4.2. OT Assessment Tools for SUDs. Figure created utilizing literature from *OT assessment in substance-use disorder (SUD): A qualitative study of current practices* (Hildebrand & Boerding, 2019) and *Occupational therapy service outcome measures for Certified Community Behavioral Health Centers* (AOTA, 2016).



OCCUPATIONAL PROFILE SUMMARY

Occupational History

Client is an employee for a construction company who was recently referred to services due to intoxication at work that led to a work-related injury. He was referred to OT services as part of his court-ordered therapy through is work. He is currently suspended from work until further notice and will not be able to return until he has successfully completed and discharged from outpatient therapy services. His daily meaningful roles include that he is a father, spouse, sibling, friend, and work-peer. He and his wife are separated, and he lives in an apartment with two of his friends.

Strengths and Concerns

Strengths:

- His family (siblings, grandparents, and spouse) are eager to help him manage his substance use and provide any assistance as needed.
- His work/employer is willing to work with and find a solution to assist him in achieving and maintaining long-term sobriety.
- Since acquiring his injury, he is willing to accept his concerns with substance use.

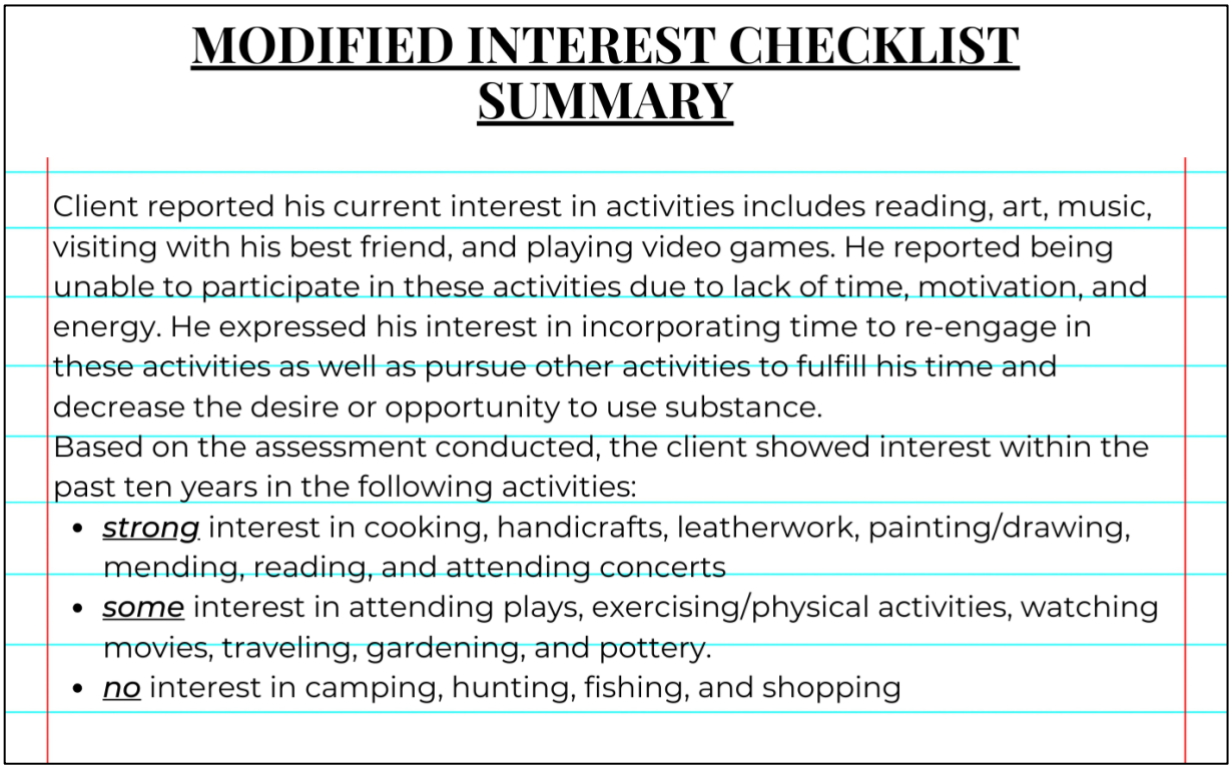
Concerns:

- He does not have a stable, direct social or support system that promotes sobriety.
- He is separated from his wife/family which poses a risk for isolation and substance abuse.
- He is suspended from work and is financially unstable.
- His daily patterns and routines consists of working extensive hours during the day and unwinding from work with alcohol.
- Up until this point, he did not believe his current patterns and substance use was an issue.
- He has limited function in his right upper extremity, which limits his occupational performance.

Client Priorities

Client is willing to address underlying concerns regarding his substance abuse and work on improving his occupational performance. His is driven to strengthen his relationship with his wife to return home, and understands that this is accomplished by developing skills to manage sobriety. He is interested in developing life skills and time management skills that allow him to engage in multiple activities that supports sobriety and prevent relapse.

Figure 4.3. Occupational Profile Summary. Figure was created using the information from the client Case Study in Appendix A and an analysis guided by the AOTA Occupational Profile (AOTA, 2017).



MODIFIED INTEREST CHECKLIST SUMMARY

Client reported his current interest in activities includes reading, art, music, visiting with his best friend, and playing video games. He reported being unable to participate in these activities due to lack of time, motivation, and energy. He expressed his interest in incorporating time to re-engage in these activities as well as pursue other activities to fulfill his time and decrease the desire or opportunity to use substance.

Based on the assessment conducted, the client showed interest within the past ten years in the following activities:

- *strong* interest in cooking, handicrafts, leatherwork, painting/drawing, mending, reading, and attending concerts
- *some* interest in attending plays, exercising/physical activities, watching movies, traveling, gardening, and pottery.
- *no* interest in camping, hunting, fishing, and shopping

Figure 4.4. Modified Interest Checklist Summary. Figure was created using the information from the client Case Study in Appendix A and an analysis guided by the Modified Interest Checklist. This assessment can be found at the University of Illinois at Chicago's online database (MOHO-IRM Web, 2022).

Goal-Setting and Outcome Objectives

This portion of the evaluation or initial visit is completed in collaboration with the client(s). It is essential that the goals and outcome objectives for treatment plan is client-centered as this is a core principle of OT practice. While discussing goals and objectives for treatment, it is important to utilize a foundation in order to create achievable client goals in the allotted timeline. For example, each goal should follow the acronym "SMART" meaning that the goal is specific, measurable, attainable, realistic, and time-oriented. In addition to this element to ensure a sustainable goal, OT practitioners follow the "COAST" format to create goals. Goals can also be categorized as long-term and short-term goals. For example, short-term goals are typically set between 1-2 weeks and long-term goals are typically 3+ weeks into the treatment plan. The outcome objectives mentioned in Chapter 1 (p. 9) should be discussed with the client to determine which objectives are meaningful and how to meet these expectations. See Figure 4.5 Goal Writing for an example on how to set therapeutic goals for clients with SUDs.

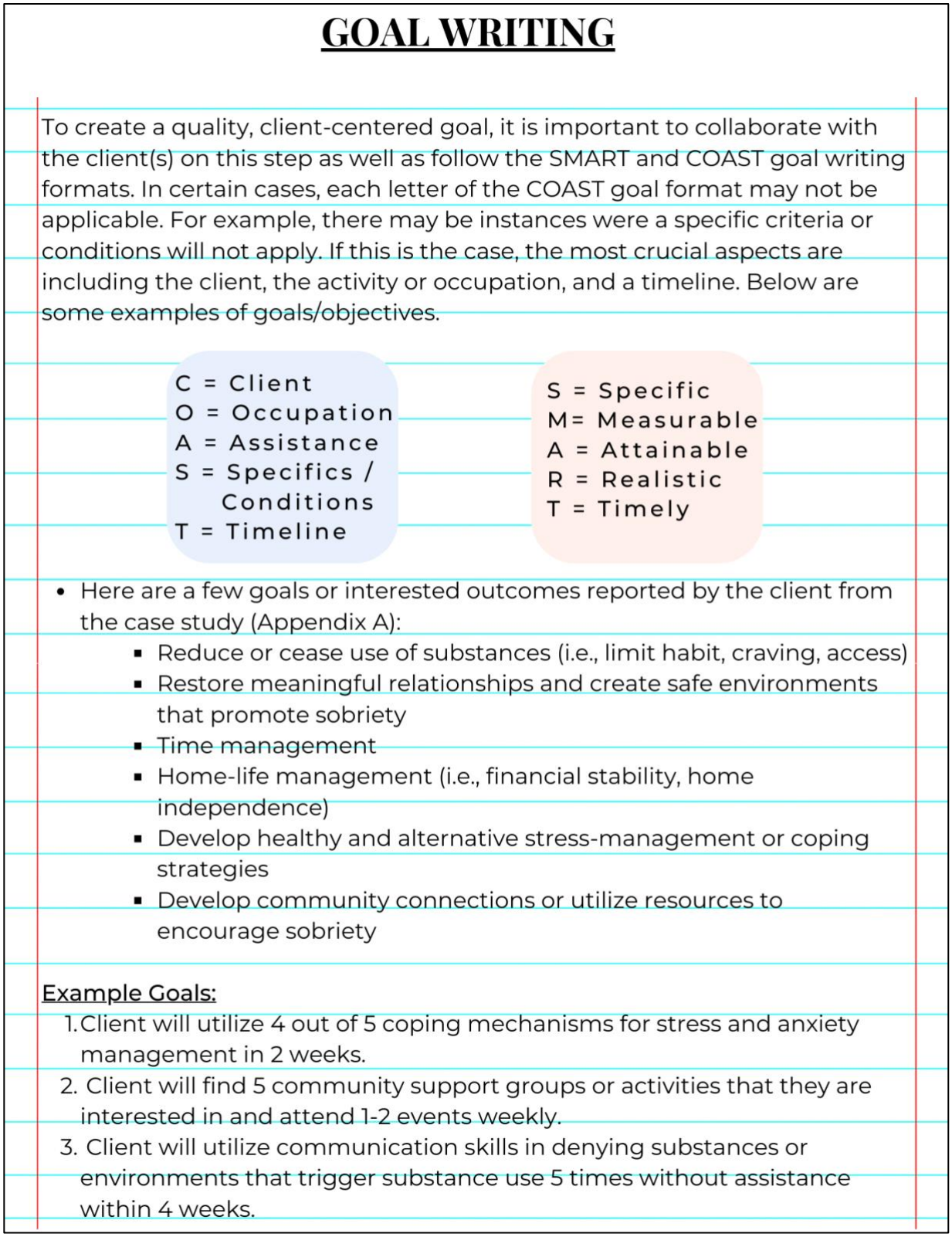


Figure 4.5. Goal Writing. Figure was created using the information from the client Case Study in Appendix A, Occupational Therapy Practice Framework – 4 (AOTA, 2020), and Willard and Spackman's Occupational Therapy (Boyt Schell & Gillen, 2019).

Treatment plan

The treatment plan developed for this guidebook is intended to be utilized in the outpatient setting. Each intervention and planned treatment session is established through evidence-based practice methods. The treatment plan developed for this guidebook is based on a client receiving 8-weeks of OT services. Based on this requirement, the guided sessions are designed for an individual receiving OT services once a week for a total of eight weeks, however, the intended frequency and duration of the guided sessions is not limited as they can be used for various treatment plans and timelines. The purpose of the treatment sessions provided in this guidebook is to provide recommendations and resources on how to select and lead a session based on a client's specific goals or outcomes and desired areas the intervention addresses.

Interventions

The next step of the OT process is the intervention portion, which consists of the intervention plan and the intervention implementation. The intervention plan is when the OT practitioner determines the best interventions in order to achieve the client's goals and address any occupational barriers or challenges to occupational performance. The plan is developed based on the goals, occupational outcomes, and current levels of performance in daily occupations assessed by the OT practitioner in the evaluation and re-evaluation portions of the OT process (Boyt-Schell & Gillen, 2019).

Once the OT practitioner and client collaborate to finalize the intervention plan, the practitioner will select evidence-based treatment interventions to support the objectives of the plan, however, the client has the final decision regarding each intervention session as the plan is significantly reliant on a client-driven approach to therapy (Boyt-Schell & Gillen, 2019). The intervention implementation is the portion of the process that consists of executing the confirmed intervention plan. Each intervention implemented needs to be relevant to the client's therapeutic process and target specific client goals or outcome objectives. There are six types of OT interventions and five intervention approaches (AOTA, 2020). See Figure 4.6a and 4.6b for the types and approaches for OT intervention.

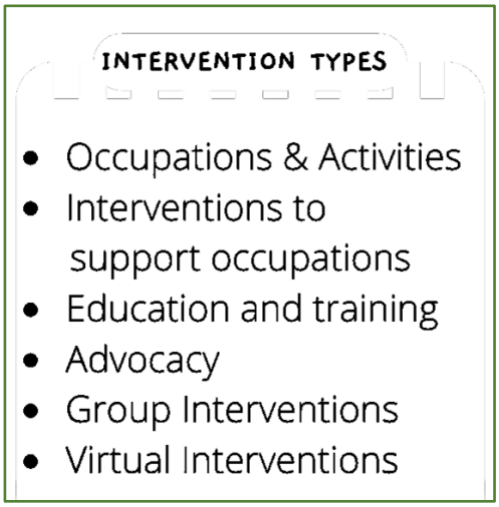


Figure 4.6a Intervention Types.

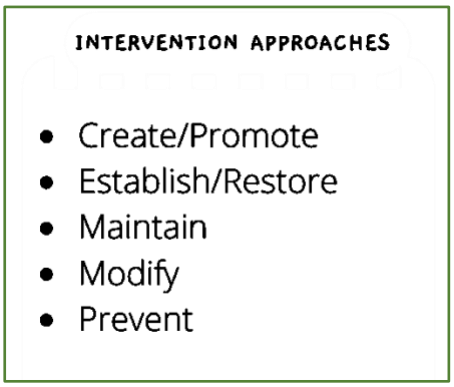


Figure 4.b Intervention Approaches. Figures created using literature from the *Occupational Therapy Practice Framework* – 4 (AOTA, 2020).

Guidebook Intervention Plan

The interventions developed in this guidebook are theoretically constructed for a client receiving eight weeks of therapy with a one-hour OT session each week. The interventions developed in this product are not required to follow this format specifically, subsequently, or within the established timeframe. Instead, the interventions are simply recommendations for interventions based on specific goals or objectives for each intervention. Each session will consist of a preparatory task, an occupation-focused activity, and a concluding task, and will provide information such as the targeted occupational performance supports and barriers, goals and objectives, activity descriptions, and connection to OT Theory. The guidebooks interventions include:

Week/Session	Intervention
One	Kawa Model Activity
Two	Occupational and Financial Plate
Three	Grounding Techniques
Four	Daily Planner and Priorities
Five	Effective Communication
Six	Nature Self-Portrait
Seven	Social and Community Outreach
Eight	Relapse Prevention Plan

FIRST INTERVENTION: KAWA ACTIVITY

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-reflection, insight, self-critique, effective communication, emotional regulation, decision-making skills, and sense of purpose
- Awareness of internal and external factors and how they specifically impact occupational performance

TARGET GOALS/ OBJECTIVES

- Emotional Regulation
- Communication
- Self-Awareness/Insight
- Occupational Areas of Concern
- Internal Factors
- External Factors
- Knowledge of Limitations and Methods to Overcome
- Mindfulness

CONNECTION TO MOHO:

The session is connected to MOHO as it promotes skill development in self-awareness of a client's daily occupations and internal and external factors influencing their daily performance such as their motivation, habits and routines, and environments. This session will enhance client involvement in their personal journey through recovery as they develop an understanding of their daily occupational performance and the various factors supporting or limiting them.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Awareness of the Problem Without Fixing It"

5 minute guided meditation

https://drive.google.com/file/d/1wkEJSaUeQterg5jRJh2hAjXd55gD8p0J/view?usp=sharing

Occupation-focused Activity

Using the Kawa Model Activity sheet and the guiding questions, create your own Kawa Model. Follow the map legend and questions to guide your self-reflection and formation of your 'life river' to understand what each component represents. Be sure to the intensity of each influence by varying the sizes of the symbol (i.e. substance use disorder may be drawn as a large rock vs boredom as a small rock).

Concluding Task - Present or explain your Kawa Model to your therapist once you have completed the activity. This activity and explanation will enhance the use of social and communication skills to portray your "life story" that encourages self-awareness and emotional expression.

KAWA MODEL ACTIVITY

"Kawa" means *river* in Japanese. The Kawa Model is used in therapeutic practice to describe and analyze the various factors that impact our quality of life and well-being. This self-reflective activity will guide you on how to create your own Kawa Model using the keys and guiding questions below.

_____'s Kawa Model

Parts of the Kawa Model:

River flow ⟶ Life flow and priorities
River banks ⟶ Contexts and Environments
Rocks ⟶ Barriers and Challenges
Driftwood ⟶ Influencing Factors
Spaces ⟶ Opportunities for Enhancing Flow

Example of a Cross-Sectional Kawa Model

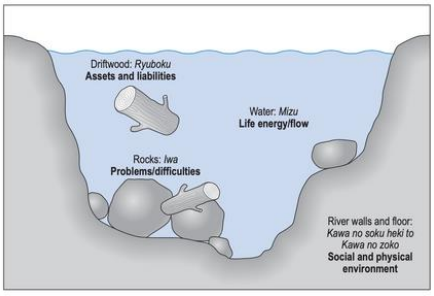


Image from *The Kawa model: Culturally relevant occupational therapy* (Iwama, 2006, p. 132)

Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CREATE YOUR OWN KAWA 'RIVER' MODEL

River Flow - Priorities and Life Flow

- What is the structure and speed of your life/river and how does your river flow?
- Reflect on any changes in your life that might impact your "river flow." What are these circumstances or events that you think has caused significant changes to your life and how do they impact you?
- Reflect on how you spend your time and what does your typical day look like? Do you enjoy the things that fill your day? Are these activities meaningful or purposeful to you? If not, what changes do you think would be more meaningful?

River Banks - Contexts and Environments

- Reflect on who or what is included in your personal contexts and environments (physical, social, cultural, virtual, and temporal). Indicate each of importance by size as the river bank "protrudes' out.
- How does your interactions, thoughts, or behaviors among these contexts and environment differ (i.e., emotionally, mentally, and physically)?

Rocks - Obstacles and Challenges

- Reflect on any challenges you are currently experiencing in your life. What are these challenges and how or why do you think theses challenges are limiting you?
- Identify these types of challenges or obstacles (i.e. mental, physical, emotional limitations,). Are these challenges in or out of your control?

Driftwood - Influences

- Think about your personal skills, characteristics, experiences, beliefs/values, and attributes that influence your life and your performance in daily activities. Are each of these traits supporting or limiting what is meaningful to you? (Note: If they are limiting you, indicate larger pieces/placement of driftwood as it hinders your river flow)

Spaces - Opportunities to Support Growth and Increase Flow

- Are there any specific activities, people, situations, or events that support and offer opportunities for you to grow and increase your life flow?
- How do you create spaces that satisfy you or increase the flow?
- If you are unable to recall any opportunities, reflect on opportunities or situations you think could support growth or flow (i.e., self-care or personal time).

Resources:

- Iwama, M. (2006). *The Kawa model: Culturally relevant occupational therapy.* Edinburgh: Churchill Livingstone Elsevier.
- Iwama, M, Thomson, N., & Macdonald, R. (2009). The Kawa model: The power of a culturally responsive occupational therapy. *Disability and rehabilitation: An international, multidisciplinary journal, 31* (14), 1125-1135. https://doi.org/10.1080/09638280902773711
- Teoh, J.Y. & Iwama, M.K. (2015). The Kawa Model Made Easy: a guide to applying the Kawa Model in occupational therapy practice (2nd edition). Retrieved from: www.kawamodel.com

SECOND INTERVENTION: OCCCUPATIONAL AND FINANCIAL PLATES

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Insight on occupational self, occupational balance, decision-making skills, problem-solving and analytics, time management, financial management, and daily motivation/priorities
- Awareness of occupational performance/participation and impact on daily life

TARGET GOALS/ OBJECTIVES

- Emotional Regulation
- Self-Reflection skills
- Self-Awareness/Insight
- OT Areas of Concern
- Time Management
- Financial Management
- Occupational Balance
- Relapse Prevention
- Mindfulness

CONNECTION TO MOHO:

The session is connected to MOHO as it promotes skill development in self-awareness of a client's daily occupations and how or why they engage in meaningful activities. The session enhances the client's understanding of their own volition, habituation, and performance capacity as they explore their daily tendencies and occupational balance/imbalance.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Imagining Your Inner Land To Build Healthy Boundaries"

5 minute guided meditation

https://drive.google.com/file/d/1naW--HClb6zt9SXsixeDuLA67U3cnC6U/view?usp=sharing

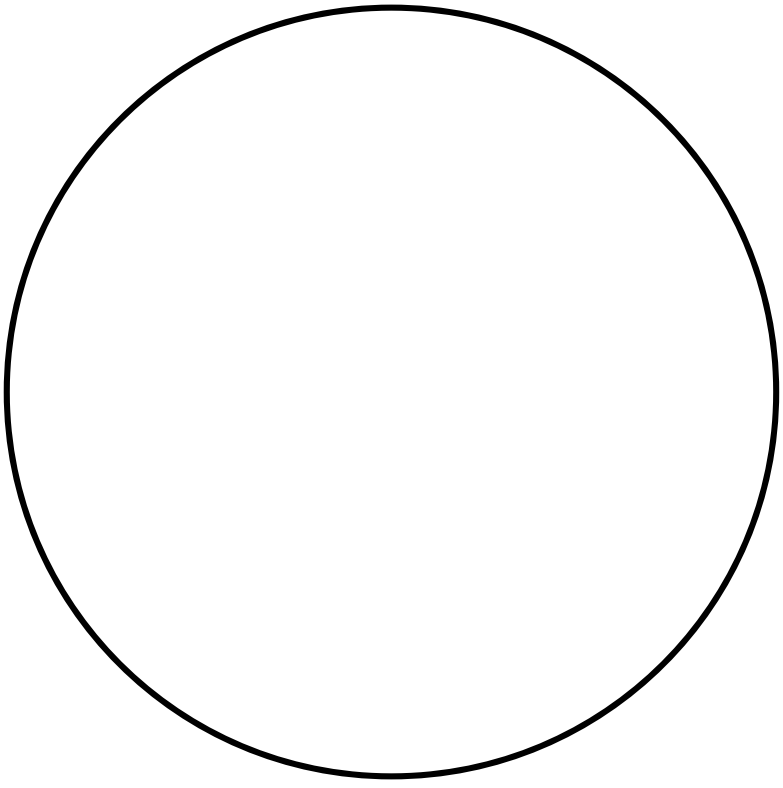
Occupation-focused Activity

- Occupational Plate - Create a chart based on how you typically spend your time and the amount of time you spend for each. Begin by listing and designating a percentage to each item then draw the according percentage as a piece of the pie chart. Explain your occupational chart and discuss your thoughts on this.

- Financial Plate - From a monthly standpoint, calculate and track your total income and expenses. Begin by listing and designating a percentage to each item then draw the according percentage as a piece of the pie chart. ****Include the amount you would typically spend on substances (i.e. $10/day = $300/month)**** Explain your occupational chart and discuss your thoughts on this.

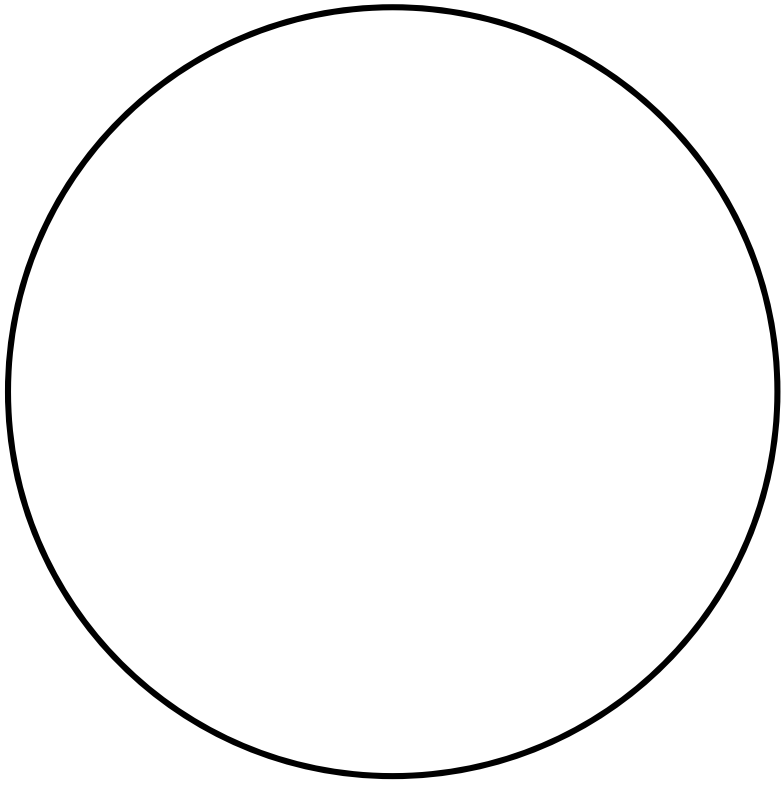
OCCUPATIONAL AND FINANCIAL PLATE ACTIVITY

Begin by listing the activities or tasks that fill your day then assign each with a specific area of the chart



Occupational Plate

Begin by listing the activities or items you purchase and how much each costs. This can be a daily or monthly chart. Then assign each with a specific area of the chart



Financial Plate

Journal Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CONCLUDE YOUR SESSION

1. HOW DID YOU FEEL LOOKING AT YOUR OCCUPATIONAL AND FINANCIAL PLATES?
2. DO YOU FIND THESE RESULTS OR INDICATIONS ACCURATE? IS IT MORE/LESS?
3. ARE THERE ANY CHANGES TO YOUR OCCUPATIONAL OR FINANCIAL PLATE THAT YOU WOULD LIKE TO WORK ON?
4. HOW DO THESE RESULTS INFLUENCE YOUR DAILY LIFE? (I.E., LIMITING OR SUPPORTING)

THIRD INTERVENTION: GROUNDING STRATEGIES

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-control, emotional regulation, sensory regulation, mindfulness, stress or anxiety coping strategies, trigger management, self-reasoning, and relaxation skills
- Coping strategies to promote self-control once triggers or traumatic responses have been activated

TARGET GOALS/ OBJECTIVES

- Emotional and Self-Regulation
- Self-Awareness or Insight
- Relapse Prevention
- Mindfulness
- Coping Strategies
- Executive Functioning
- Cognitive Functioning
- Relapse Prevention
- Sensory Regulation

CONNECTION TO MOHO:

The session is connected to MOHO as it promotes skill development in self-awareness and self-regulation that is based on a person's functionality, performance, and engagement within specific contexts and environments. The session focuses on skills that enhance performance capacity and re-regulation skills when client is in a situation where they feel overwhelmed, anxious, or not in control of their thoughts, emotions, or behaviors.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/ (Fargo, 2022).

"A Breathing Anchor for Your Wandering Mind"

(10 minute guided meditation

https://drive.google.com/file/d/1kIgm8s7yB8OQw6m1uwrW2xo7G_7I9DRv/view?usp=sharing

Occupation-focused Activity

GROUNDING STRATEGIES

THE FOLLOWING PAGE LISTS 4 GROUNDING TECHNIQUES TO TRY TO PROMOTE SELF-REGULATION, REORIENTATION, AND MINDFULNESS WHEN YOU FIND THAT YOU ARE OVERWHELMED, ANXIOUS, OR OUT OF CONTROL OF YOUR BODY, THOUGHTS, OR EMOTIONS.

TRY EACH GROUNDING STRATEGIES AND DISCUSS/TRY MORE OPTIONS TO FIND ONE THAT WORKS BEST FOR YOU. AFTER YOU HAVE FOUND A FEW STRATEGIES THAT WORK FOR YOU, COMPLETE THE JOURNAL QUESTIONS AT THE END TO CONCLUDE THE SESSION.

GROUNDING STRATEGIES

READ THE FOLLOWING INSTRUCTIONS FOR EACH STRATEGY AND TRY EACH TECHNIQUE.
DISCUSS YOUR OPINION OF THESE STRATEGIES.

5-4-3-2-1


5 things you **see**

4 things you **feel**



3 things you **hear**

2 things you **smell**



1 thing you **taste**

PROGRESSIVE MUSCLE RELAXATION

Starting with either your head or your toes, tense one muscle at a time (areas listed below) for 5-10 seconds and then relax.

Forehead, eyes, mouth, shoulders, elbows, fingers/fists, abdomen, thighs/legs, and toes

*Add more/less or repeat until relaxed

ICE-COLD IMMERSION

1. Get a bag of ice or wet rag and apply to your neck, face, hands, etc.
2. Hold an ice cube in your hand(s)until it melts
3. Submerge your face in ice/cold water for 30 seconds-1 minute at a time
4. Take a cold shower

DAILY AFFIRMATIONS/ JOURNALING

- Write down 10-20 positive affirmations about yourself
- Read them out-loud to yourself or to yourself in the mirror
- Have a journal or assigned books/paper set aside for you to journal. This can be free-form or prompted writing.
- Journal about each affirmation

Journal Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CONCLUDE YOUR SESSION

1. WERE THESE TECHNIQUES HELPFUL?
2. ARE THESE SOMETHINGS THAT YOU CURRENTLY UTILIZING?
3. ARE THERE ANY TECHNIQUES THAT YOU ALREADY USE?
4. CAN YOU THINK OF ANY MORE TECHNIQUES THAT YOU THINK WOULD HELP GROUND YOU WHEN YOU OVERWHELMED?

FOURTH INTERVENTION: TIME MANAGEMENT AND PRIORITIZING

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-control, logistics and time management, congruency with internal values and interests with occupational performance, productivity and effectiveness, reduction of stress
- Time management that supports occupational balance
- Awareness of occupational deficits and strategies to enhance engagement

TARGET GOALS/ OBJECTIVES

- Self-Awareness/Insight
- Time Management
- Decision-Making
- Problem-Solving
- Goal-setting
- Stress Management
- Relapse Prevention
- Occupational Balance
- Occupational Deficits
- Mindfulness

CONNECTION TO MOHO:

The session is connected to MOHO as it promotes skill development in self-awareness of the client's occupational performance, occupational balance, and congruency between their volition, habituation, and performance capacity. The session focuses on the client's current habits and routines as they impact occupational performance and strategies on how and what to improve to enhance desired-occupational outcomes.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Cultivating Self-Care and Extending It Out"

5 minute guided meditation

https://drive.google.com/file/d/1OaVPeRTUqdIQIdWN0m0p_uzOutZ7lnSh/view?usp=sharing

Occupation-focused Activity

TIME MANAGEMENT & PRIORITIZING

USING THE DAILY PLANNER TEMPLATE PROVIDED, FILL IN YOUR TYPICALLY DAILY SCHEDULE. INDICATE ANY FIXED TIMES THAT ARE UNAVAILABLE, AVAILABLE, OR TENTATIVE. AFTER YOU HAVE CREATED YOUR DAILY SCHEDULE, CREATE 1-2 GOALS FOR THE DAY AND PRIORITIES THE ACTIVITIES YOU HAVE PLANNED FOR THE DAY. IF YOU HAVE ANY AVAILABILITIES, CREATE A LIST OF 3 ACTIVITIES OR ALTERNATIVE EVENTS THAT YOU WOULD LIKE TO INPUT INTO THE SPECIFIC TIME SLOTS. *IT IS IMPORTANT TO HAVE OCCUPATIONAL BALANCE, SO REMEMBER TO SET ASIDE TIME FOR YOURSELF (I.E., EXERCISE, READING, SELF-CARE, ETC.)

AFTER YOU HAVE CREATED YOUR DAILY PLANNER TEMPLATE, MAKE A LIST OF PRIORITIES FOR THE DAY AND THE WEEK. EACH SHOULD BE SPECIFIC AND SET A GOAL FOR WHEN YOU WOULD LIKE TO HAVE THEM COMPLETED

CONCLUDING TASK - PRESENT YOUR DAILY PLANNER AND PRIORITY LIST AND DISCUSS YOUR THOUGHTS ON EACH.

DAILY PLANNER

SCHEDULE / TIME BLOCK		TODAY'S FOCUS / GOAL
1 AM		
2 AM		
3 AM		
4 AM		
5 AM		
6 AM		
7 AM		
8 AM		TOP PRIORITIES
9 AM		1
10 AM		
11 AM		2
12 N		
1 PM		3
2 PM		
3 PM		
4 PM		ALTERNATIVE ACTIVITIES
5 PM		1
6 PM		
7 PM		2
8 PM		
9 PM		3
10 PM		
11 PM		
12 AM		

NOTES


MY PRIORITIES
PRIORITIES TODAY
ACTION STEPS/ TIME FRAME
PRIORITIES THIS WEEK
ACTION STEPS/ TIME FRAME

FIFTH INTERVENTION: EFFECTIVE COMMUNICATION STRATEGIES

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-control, trigger management, emotional and self-regulation, interpersonal effectiveness, social relations, boundary setting, self-esteem/confidence, and internal trust/accountability
- Preparation and confidence of self with response rehearse for skill transference

TARGET GOALS/ OBJECTIVES

- Effective Communication
- Interpersonal Development and Effectiveness
- Executive Functioning
- Emotional Regulation
- Emotional Intelligence
- Conflict Resolution
- Trigger/Trauma Management
- Mindfulness
- Self-Reflection and Awareness
- Relapse Prevention

CONNECTION TO MOHO:

This session is connected to MOHO as it promotes skill development in self-reflection and awareness of current occupational performance as the client examines their current performance capacity in communication. The session focuses on the development of communication skills that is reflective of the client's performance and personal causation that supports recovery in various contexts and environments.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Compassion for Your Emotions"

10 minute guided meditation

https://drive.google.com/file/d/11psuiQRVZI1MpNRCKSqBW3idxloUJw8n/view?usp=sharing

Occupation-focused Activity

EFFECTIVE COMMUNICATION

Think of situations that have happened or that you think may happen where you were unsure of what to say or you regret what was said. Using the Verbal Judo technique, try to think of 8 situations or events that have occurred or may occur that you would like to practice effective communication. For each situation, create 2-3 phrases or responses that follow the principles and steps of Verbal Judo. Once you have completed the worksheets, practice saying them out-loud with your practitioner or role playing the situation to enhance your confidence and transference of the responses and communication skills established.

Once you have practiced the strategies, complete the guided journal section to conclude the session.

Effective Communication Technique: Verbal Judo

What is Verbal Judo?

- Judo means "the gentle way"
- A communication technique that enhances conflict resolution through effective listening and speaking approaches while maintaining an emotionally controlled situation or conversation.
- This tactic was created by Dr. George Thompson as he combined the principles of martial arts into law enforcement.
- He examined the relationship between art of conversation and defense to create a more effective communication strategy.

Key Points of Verbal Judo

- A message is mostly how it is delivered rather than what it said.
- Be mindful of your tone, speed, pitch, and inflection
- The purpose of the interaction is to move forward and not to argue or resist the counterpart of the conversation/interaction. Instead, listen and be open-minded to their perspective.

Things to Remember - LEAPS

- L - Listen - Be attentive and respectful
- E - Empathize - Be open and understanding of their perspective; Respect your differences
- A - Ask - Ask questions for details of the situation and for clarification to understanding
- P - Paraphrase - Verify understanding/listening by relaying the message you heard
- S - Summarize - Be concise and keep the conversation brief and to the point

What are the steps of Verbal Judo

- Step One: Ask - Ask if the other person is in agreeance to engage in conversation
  - Example: "Are you open to discussing?"
- Step Two: Set Context - Explain why you are asking for compliance/agreeance
  - It is important to see the other member of the conversation as a counterpart and the conversation as a settlement instead of an argument. Each member must be willing for the interaction to be fruitful and not destructive.
- Step Three: Options - Give the other person options to encourage autonomy
  - Example: "Are you able to discuss this now or would you prefer some time to process first?"
- Step Four: Confirm Non-Compliance - Offer another opportunity to engage
  - Example: "Is there anything I (or you) can do to help you be more prepared to discuss?"
- Step Five: ACT - Begin the discussion; Be mindful of your verbal and body language; Treat the other individual with respect as you resolve a conflict and seek a solution or compromise.

These examples have been modified for general interpersonal conflict resolution rather than conflict resolution for law enforcement

Verbal Judo Resources

The Art of Verbal Judo: How Tactical Communication Reduces Need to Escalate Use of Force
(Miller, 2008)

Verbal Judo: The Gentle Art of Persuasion
(Thompson, 2004)

Digital Tools in Service Competence Development - Case: Learning Verbal Judo Digitally
(Maki & Kokko, 2019)

Introduction to Verbal Judo
(Owens, 2019)

COMMUNCATION STRATEGIES

Complete the worksheet by providing situational examples and what to say that will promote your journey through recovery. (ex: Things to say when you are frustrated, offered a substance, invited to a location that has substances, approached by someone you no longer associate with, etc.)

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

COMMUNCATION STRATEGIES

Complete the worksheet by providing situational examples and what to say that will promote your journey through recovery. (ex: Things to say when you are frustrated, offered a substance, invited to a location that has substances, approached by someone you no longer associate with, etc.)

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

Things to say if/when: _____

_____

_____

_____

_____

Journal Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CONCLUDE YOUR SESSION

1. DO YOU THINK THESE RESPONSES OR PHRASES WILL BE HELPFUL?
2. DO YOU SEE YOURSELF UTILIZING THEM IN THE FUTURE?
3. ARE THESE SOMETHINGS THAT YOU CURRENTLY UTILIZING?
4. DO YOU FEEL PREPARED TO ENGAGE IN THESE SITUATIONS?
5. CAN YOU THINK OF ANY MORE PHRASES, SITUATIONS, OR INTERACTIONS WITH SPECIFIC INDIVIDUALS THAT YOU ARE UNCERTAIN ABOUT HOW TO RESPOND

SIXTH INTERVENTION: NATURE SELF-PORTRAIT

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-expression, attention and focus, problem-solving, leisure participation, self-confidence, self-awareness and insight, and interpersonal effectiveness
- The use of mindfulness, self-reflection, and insight to plan and implement the creative process through therapeutic use of occupation to prevent tendency of substance use.

TARGET GOALS/ OBJECTIVES

- Leisure Exploration
- Leisure Participation
- Emotional Regulation
- Effective Communication
- Self-reflection and Awareness
- Mindfulness
- Relapse Prevention
- Problem-Solving and Decision-Making
- Executive Functioning
- Interpersonal Effectiveness

CONNECTION TO MOHO:

This session is connected to MOHO as it promotes skill development in occupational balance and leisure participation and exploration. The session focuses on the client's ability to utilize self-regulation skills and strengthen the relation between the occupations they engage in and the things they find meaningful.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Mindfulness While Being Creative "

10 minute guided meditation

https://drive.google.com/file/d/1oXepdUJdWq5IFgI2CCAxluKU0AifP2mz/view?usp=sharing

Occupation-focused Activity

LEISURE EXPLORATION

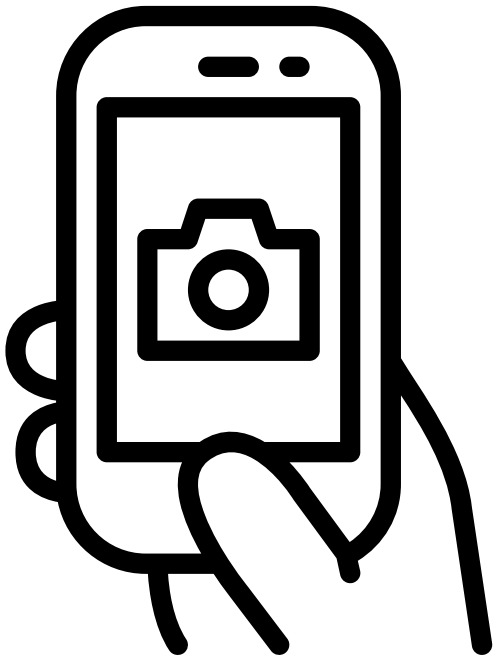
Using elements of nature, create a self-portrait (alternatives: an image, person, or scene of your choice). First, use a cup or a bag to collect the contents for the portrait. The challenge is to select elements of nature with a specific purpose (i.e. a leaf or branch of leaves that resembles or reminds you of your curly hair). This aspect will strengthen your ability to remain mindful during this nature walk as you are engaging your mind and body in physical activity with a specific purpose. When on your nature walk, pay attention to detail and utilize more than just 5 items to create your self portrait. While selecting the contents for your art, reflect on the elements' weight, texture, color, etc.

Once you have collected the items to create your portrait (or other scenes), begin to create an image of yourself or how you view yourself. Place each item with intent and try to make the portrait detailed.

Concluding Activity - Present your self-portrait to you practitioner and discuss why you choose each item of nature, what it represents, or a story attached to it (i.e. the acorn resembles my brown eyes and I choose it because it reminds me of how I used to collect them as a kid.

Image: https://greatinspire.com/wp-content/uploads/2016/06/Create-Intricate-Portraits-Out-Of-Mother-Nature-Using-Twigs-And-Flowers-15.jpg

Take a Picture of Your Portrait



SEVENTH INTERVENTION: SOCIAL AND COMMUNITY OUTREACH

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- ·Accountability, self-confidence, communication, problem-solving, critical thinking, logistics and time management, self-expression, occupational balance, and collaboration

TARGET GOALS/ OBJECTIVES

- Mindfulness
- Self-awareness/insight
- Communication
- Time Management
- Decision-making,
- Problem-solving
- Interpersonal Effectiveness
- Collaboration
- Occupational Balance
- Relapse Prevention
- Self-Reflection

CONNECTION TO MOHO:

This session is connected to MOHO as it promotes skill development in self-awareness of client's internal and external factors to determine effective resources to support recovery that is unique to them. The session focuses on utilizing the client's interests and values to connect with resources or other individuals to create a strong support system that enhances occupational performance and well-being. The session also focuses on the client's habits and routines to improve time management skills in order to manage participation or utilization of the resources.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"Body Scan for Stress Relief "

10 minute guided meditation

https://drive.google.com/file/d/1oXepdUJdWq5IFgI2CCAxIuKU0AifP2mz/view?usp=sharing

Occupation-focused Activity

SOCIAL AND COMMUNITY OUTREACH

Each community offers various resources that are extremely beneficial to an individual in recovery for SUDs and mental health. There are many different self-help groups, recovery events, recovery environments, and sponsors that can be an asset to utilize in a time of need. For this session, you will obtain information for any resources in your area or region that you would like to join or attend. While you are searching for resources, note the time and purposes for each. Be sure to indicate alternative times and locations. For example, Alcoholics Anonymous meetings may be held at a certain time in a public space, but there are virtual meetings held every hour that anyone can join online.

Once you have made a list of several different resources, select your top 3. Plan to attend at least one group/meeting each week and contact an organization for more information.

Once you have completed the resource list, complete the guided journal section to conclude the session.

COMMUNITY RESOURCES

Create a list of community resources offered in your area as well as provide the contact information. For each entry, indicate the type of resource (i.e. AA = Self-help group, NAMI = national mental health organization).

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

COMMUNITY RESOURCES

(CONTINUED)

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Name		*Type*	
Email		*Phone*	
Address			
Notes			

Journal Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CONCLUDE YOUR SESSION

When you are attending the self-help groups/meetings, it will be helpful to select a sponsor to guide you in your recovery journey.

For this journey entry, reflect on what an ideal sponsor is like for you.

- What are you looking for in a sponsor?
- How or what does this individual offer that will be beneficial to you on your recovery journey?

EIGHTH INTERVENTION: RELAPSE PREVENTION PLAN

FOCAL POINTS

SUPPORTS/ BARRIERS SESSION ADDRESSES

- Self-Awareness, trigger management, emotional and self-regulation, coping strategies, occupational balance, boundary setting, communication and collaboration, logistics and problem solving, and stress and anxiety management
- The use of problem-solving and decision making skills to develop an effective and unique prevention plan while using self-reflection to determine areas or circumstances of concern

TARGET GOALS/ OBJECTIVES

- Mindfulness
- Self-Awareness and Reflection
- Trigger/Trauma Management
- Personal and Interpersonal Effectiveness
- Communication
- Emotional Regulation
- Problem-Solving
- Decision-Making
- Relapse Prevention

CONNECTION TO MOHO:

·This session is connected to MOHO as it promotes skill development as the client applies strategies to associate their current state of self, behaviors or patterns, and motives within various contexts and environments to support recovery and prevent the use of substances. This session focuses on the client utilizing self-reflective skills to identify their typical areas of concern or performance, personal causation, and habituation in regard to specific triggers or traumatic circumstances. This session also focuses on how to implement these skills in various environments as well as incorporating other individuals to support recovery.

Guided Meditation

Read the provided guided meditation to the client to enter into a relaxing and meditative state in order to prepare for the occupation-focused activity of the session. The guided meditations can be retrieved from: https://mindfulnessexercises.com/free-guided-meditation-scripts/

"One Breath at a Time"

10 minute guided meditation

https://drive.google.com/file/d/14aGl0N2nXNJ8dUcIAHxRblhwNGCQlGmi/view?usp=sharing

Occupation-focused Activity

RELAPSE PREVENTION PLAN

The establishment of a prevention plan is essential to reduce the risk or likelihood or relapse. Use the prevention plan template below to identify the most influential factors that may cause or trigger a response or desire to use substances. Once you have identified the triggers and warning signs, utilize the form to create a plan in case you are every in need of external assistance or a visual aid to help you prevent relapse.

Once you have created a relapse prevention plan, discuss the plan with your therapist, family, sponsor, etc. to enhance accountability and awareness of how to provide the best assistance in your time of need.

For more information or a for a more extensive prevention plan, refer to the resources provided to you.

Once you have completed the resource list, complete the guided journal section to conclude the session.

RELAPSE PREVENTION PLAN

Using the prompts below, fill out your own relapse prevention plan. Identifying your tendencies, triggers, and effective coping strategies will help prevent relapse when you find yourself in a time of need. Try to ensure that this plan is always up-to-date with current information.

Review plan with your support system and give them copies of updated plans

What are your triggers?

What are your relapse warning signs.

What are some things that you can do when you are in need (coping strategies)?

RELAPSE PREVENTION PLAN

What are some places, people, or situations that can distract you?

_____

_____

_____

_____

_____

Who is in your personal support system that can provide assistance when you are in need?

_____ _____

_____ _____

_____ _____

_____ _____

Name & Phone Number

What are the reasons why you want to stay sober?

_____

_____

_____

_____

Other Relapse Prevention Resources

Relapse Prevention Workbook
(Hedges, 2012)

https://www.solanocounty.com/civicax/filebank/blobdload.aspx?blobid=14403

How to Create a Successful Relapse Prevention Plan
(The Recovery Village, 2022)

https://www.therecoveryvillage.com/treatment-program/aftercare/relapse-prevention-plan/

Relapse Prevention Plan
(Jewell, 2019)

https://www.flcourts.org/content/download/732700/file/RELAPSE%20PLAN%20Example%20Brittaney%20and%20Emily.pdf

Journal Guiding Questions

USE THE QUESTIONS BELOW TO GUIDE YOU AS YOU CONCLUDE YOUR SESSION

1. DO YOU THINK THIS PLAN WILL BE HELPFUL WHEN YOU ARE AT A TIME OF NEED?
2. DO YOU SEE YOURSELF UTILIZING THIS IN THE FUTURE?
3. HOW DO YOU FEEL ABOUT YOUR RELAPSE PREVENTION PLAN?

Re-Evaluation and Discharge

The final step in the OT process is re-evaluation. Although this is the final step of the OT process, it is considered to be a re-occurring step throughout treatment as the practitioner should be continuously re-evaluating and reviewing the intervention plan in order to apply best-practice for the client (AOTA, 2020). The re-evaluation phase of the OT process consists of the OT practitioner re-analyzing the client's occupational performance, reviewing the targeted outcomes, and identifying the next plan of action (Boyt-Schell & Gillen, 2019). This step is crucial in determining the effectiveness of the interventions implemented to either continue, redirect, modify, or cease the established treatment plan (AOTA, 2020).

The final therapy session, or final re-evaluation and discharge, can be completed by either formally or informally re-evaluating the client. A formal re-evaluation consists of re-administering the assessment tools utilized during the client's evaluation session in order to compare occupational performance, whereas an informal re-evaluation is based on the client's subjective response to their therapeutic progress and occupational performance (Boyt Schell & Gillen, 2019). By re-assessing the client using the previous assessments tools, practitioners are able to more accurately examine a client's progress from therapeutic intervention (Boyt Schell & Gillen, 2019). Once the practitioner has analyzed the results or responses of the re-evaluation, they are able to provide a decision to either continue or discontinue services (AOTA, 2020).

Since OT practice in community mental health and SUD treatment is considered an "Emerging Practice," there are various approaches to documentation or therapeutic intervention that are considered appropriate. Presently, there is a lack of structure and clinical guidance for OT practitioners when working with clients with SUDs as practitioners do not have a consistent guideline or protocol to follow in this setting (Boyt Schell & Gillen, 2019). Instead, OT practitioners are advised to develop treatment plans and documentation methods that are consistent with AOTA's general guidelines for OT practice due to the lack of structure or format in the emerging practice setting (Boyt Schell & Gillen, 2019). See Figure 4.6 for a sample Discharge Summary.

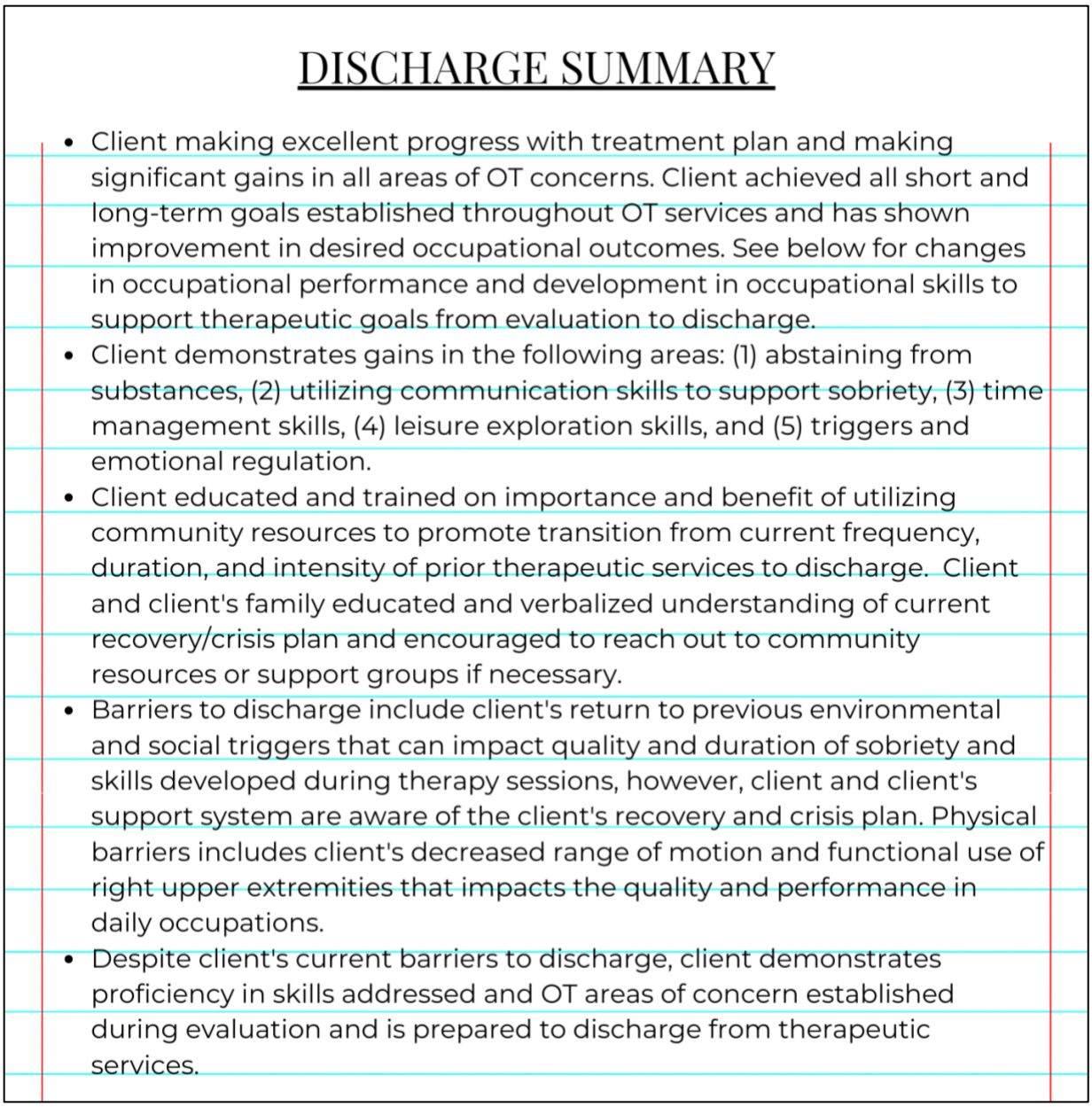


Figure 4.6. Discharge Summary. Figure created using the information from the client Case Study in Appendix A, Occupational Therapy Practice Framework – 4 (AOTA, 2020), and Willard and Spackman's Occupational Therapy (Boyt Schell & Gillen, 2019).

CHAPTER 5: RESOURCES

This chapter will consist of various resources pertaining to the levels of care, types of self-help or support groups, and other community resources available. The appendices provided in this chapter include a client case study that was utilized in prior chapters (*Chapter 4: The Occupational Therapy Process*) as reference tools to apply concepts and assessments in the evaluation, intervention, and re-evaluation/discharge processes for a client with mental health and SUD.

The material provided in this chapter is an overview of general community resources for individuals with mental health and SUDs. The resources or information included is not limited to nor all-inclusive of the materials or types of support groups that are available or accessible to a specific community or region. For more information on the specific resources available to a specific community, visit the governmental authorized webpage or database for Substance Abuse and Mental Health Services Administration (SAMHSA) for more information.

Levels of Care

The various levels of care for SUD and co-occurring disorder treatment, as shown in Table 6.1, differ based on duration, intensity, and modalities utilized for best-fit treatment through evidence-based practice (Center for Substance Abuse Treatment, 2006). The professional or clinical team at each setting or level of care varies due to the purpose and clinical needs of the population. For example, the need for continuous nursing supervision at Levels S and I is not necessary, whereas Levels III and IV require this form of care and medical supervision based on the needs of the client population.

Although the levels of care are typically utilized as a continuum, they are not necessarily required to occur in order or subsequently. Instead, the determination of which level a client will begin at, proceed to, or discharge from is client-based and dependent on the specific client case in order to implement best-practice. For example, a client may begin at any level and either (a) proceed to lower levels as the intensity and modalities of their treatment plan progresses, (b) transfer to a higher level of care if deemed necessary, or (c) discharge once goals are met and client has completed their treatment plan. These tiers or levels are referred to as an entry point/level, step-down level, or a step-up level (Center for Substance Abuse Treatment, 2006).

Level	*Type of Care*
IV	Involuntary Inpatient
III	Voluntary Inpatient/Residential
IIa	Partial Hospitalization Program
IIb	Intensive Outpatient Program
I	Supported Outpatient Program
I	General Outpatient Program
S	Early Intervention Program

Figure 5.1. Levels of Care. This table was created using content from *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (Center for Substance Abuse Treatment, 2006).

However, clients at Levels III and IV will typically be referred to a continuation of therapeutic services at lower levels following discharge to ease the transition from a residential facility to another living environment such as their own home or a transitional living facility (Center for Substance Abuse Treatment, 2006).

Self-Help Groups

There are many types of self-help groups and resources available to individuals with mental health and SUDs. The 12-Step Programs are the most common type of self-help group available. The 12-Step programs or groups, also known as fellowships, consist of various types of self-help groups for multiple different circumstances or behaviors that coincide with the core 12-step principles or recovery model (Alcoholics Anonymous World Services, 1989; Donovan, et al., 2013; Galanter, 2014). The principles of 12-Steps are utilized in each of the fellowships as it is the guiding foundation on the process to sobriety and recovery (Galanter, 2014). See Table 6.2 for examples of 12-Step groups and table 6.3 for the 12-Steps. The list of 12-step support groups provided in Table 6.2 is not "all-inclusive list" as there are over 250 fellowships that follow the 12-Step format (Laudet, 2008). These fellowships or groups offer support in different communities based on substance use, compulsive behaviors, or families of individuals with addiction that can be attended virtually or in-person (Laudet, 2008).

There is no "right" or "correct" path, program, or process that supports an individual's journey to recovery. Each individual is unique and what works for one, may not work for another. Although the 12-Step programs are the most popular, there are several alternative processes and self-help groups to benefit individuals in the recovery process. A few of these alternative self-help groups include SMART Recovery, Women for Sobriety, Refuge Recovery, and Recovery Dharma or Buddhist 12-Steps (Beck, et al., 2017).

Other Community Resources

Other resources or groups that support sobriety or recovery may include public events or community avocations. These events, services, or activities may include fitness groups or classes, book clubs, art and music clubs, or public spaces that provide a safe and sober place for individuals in recovery. For example, there are many public areas, such as restaurants or sober lounges, that offer a space for individuals in recovery that promotes an environment that is substance free to increase an individual's participation in social or dining settings without the temptation to relapse. Specific community resources that may be available are dependent upon one's specific region. To find out more, visit the SAMSHA's Office of Recovery webpage to discover more recovery support tools and resources.

Twelve-Step Programs/Support Groups		
Substance-Specific:		
Alcoholics Anonymous (AA)	Cocaine Anonymous (CA)	Crystal Meth Anonymous (CMA)
Dual Diagnosis Anonymous (DDA)	Heroin Anonymous (HA)	Marijuana Anonymous (MA)
Narcotics Anonymous (NA)	Nicotine Anonymous (NicA)	Pills Anonymous
Others:		
Clutterers Anonymous (CLA)	Co-Dependents Anonymous (CoDa)	Co-Sex Addicts Anonymous (COSA or COSLAA)
Debtors Anonymous (DA)	Emotions Anonymous (EA)	Food Addicts Anonymous (FAA)
Gamblers Anonymous (GA)	Overeaters Anonymous (OA)	Self-Mutilators/Harmers Anonymous
Spenders Anonymous	Trauma Anonymous	Workaholics Anonymous
For Families:		
Adult Children of Alcoholics (ACA)	Al-Anon/Alateen	Co-Anon
Families Anonymous	Gam-Anon/Gam-A-Teen	Nar-Anon

Figure 5.2 Twelve-Step Programs. This table was created using content from *Alcoholics Anonymous and other 12-step programs for alcohol use disorder* (Kelly, et al., 2020) and *12-step interventions and mutual support programs for substance use disorders: An Overview* (Donovan, et al., 2013).

The Twelve Steps		
1	Powerlessness	"We admit we were powerless over addiction – our lives had become unmanageable."
2	Hope/Higher Power	"Came to believe that a Power greater than ourselves could restore us to sanity."
3	Surrender	"Made a decision To turn our will in our lives over to the care of God, as we understood Him."
4	Inventory	"Made a searching and fearless moral inventory of ourselves"
5	Confession	"Admitted to God, to ourselves, into other human being the exact nature of our wrongs."
6	Readiness	"We are entirely ready to have God remove all these defects of character."
7	Asked God	"Humbly asked Him to remove our shortcomings"
8	Amends List	"Made a list of all persons we had harmed and became willing to make amends to them all."
9	Make Amends	"Made direct amends to such people wherever possible, except when to do so would injure them or others."
10	Continue Inventory	"Continue to take personal inventory and when we were wrong promptly admitted it."
11	Keep Contact	"Sought through prayer And meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out."
12	Help Others	"Having had a spiritual awakening as the result of these steps, we tried to carry this message to other addicts, and practice these principles of in all our affairs."

Figure 5.3 The Twelve Steps. This table was created using content from *Twelve Steps and Twelve Traditions* (Alcoholics Anonymous World Services, 1989, pp 21-125) and *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment* (Center for Substance Abuse Treatment, 2006).

Appendix A: Case Study

Name: Allen Carlson

Age: 32 years old

Sex: Male

Ethnicity: White

Early Life:

Allen is the oldest of four children and has three younger sisters (ages 31, 26, and 22). His biological father left him, his mother, and younger sister when was two years old, and he met his step-father when he was 5 years old. Throughout his childhood, his step-father was abusive and would often be debilitated due to intoxication. He died of an overdose when Allen was 10 years old, and Allen was the one that found him.

His mother is considered to have "dry drunk syndrome" as she has been sober for years, but has not addressed the behaviors, emotions, or patterns that led to nor those associated with her substance use. Since his mother was a single mother and was constantly working, Allen was forced to fill the parental role for him and his sisters. He has always been protective of his mother and younger sisters but abandoned the role of a protective brother/parental figure when he turned 16 and his sister, 15, assumed the role instead.

He did not enjoy school and was often in trouble due to misbehavior or lack of academic participation. He spent most of his time with a group of peers that fostered his misbehavior and introduced him to alcohol, marijuana, and other substances.

His maternal grandparents have been his most supportive and stabilizing relationship throughout his life, but he had difficulty maintaining a connection with them as they moved in a different state when he was 14. They call often and allow the kids to visit once a year but are not as involved as they were priorly. He and his sisters were raised religious due to the influence from their grandparents, but often became disengaged when they moved away. When he was 18, he was kicked out of his house by his mother due to behavioral issues and her concern regarding his influence on his younger sisters. He moved in with his fiancé, Samantha, and married soon after.

Current Life:

He lives in a large city in an apartment with two of his work friends. He and wife are separated and have been for 8 months when she found out she was pregnant. They separated as she felt Allen was not prepared for fatherhood due to his substance use and preferred that he spent time on himself prior to the birth of their child. He was homeless during the first 2 months of their separation when his substance use was at its worst. During this time, his wife discussed filing for divorce, which motivated him to get a job, place to live, and seek treatment for his substance use.

He works in construction and his typical work schedule is Monday through Friday from 7 a.m. to 5 p.m. He has been employed for approximately 6 months, which makes this job the longest he has been able to maintain. In the past, he has worked several side jobs for cash in order to live. He is trying to work on his recovery for his wife and his soon-to-be-born son but is often using due to the lack of supervision/regulation and peer use while at work. He formerly enjoyed reading, art, music, visiting with his best friend, and playing video games, but lost interest due to lack of time and energy.

His typical routine consists of waking up at 5:30 a.m., getting ready for work by 6:45 a.m., working at a job site or project until 5 p.m., and heading home to drink and watch television or stopping at a gas station to pick up a case or two of beer before going home. He is currently receiving court-ordered therapy services through his work/employer due to a supervisor’s report that he was severely intoxicated on site and had fallen and injured his right shoulder. Allen understands that he should want to seek treatment for his substance use for his wife and son but feels as though his substance habits or behaviors are not an issue.

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