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Individuals with Substance Use Disorders: Lived Experiences, Perceptions of Daily Life, and Behavioral Health Services

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Individuals with Substance Use Disorders: Lived Experiences, Perceptions of Daily Life, and Behavioral Health Services

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Abstract

There are macro and micro level impacts associated with substance use disorders ranging from significant spending by the United States government at a societal level, to changes in neuroanatomical structures and body functions, as well as psychosocial and functional impacts for the individual. While occupational therapy practitioners are approved behavioral health service providers research indicates there is a lack of understanding regarding the need for and role of occupational therapy for individuals with substance use disorders. This study utilized a phenomenological qualitative design to learn about the lived experiences, as well as the perceptions of daily life and current behavioral health services, of individuals with substance use disorders. Semi-structured interviews were conducted with five participants, recruited through convenience sampling. Results showed participants' lived experiences included a pervasive cycle of drug and/or alcohol use, chronic emotional distress, and varying motivators for sobriety. Participants' daily lives included occupying time with meaningful activity, giving up control, and meeting expectations by fulfilling roles and responsibilities. Most participants lived in the moment and presented with difficulty establishing long-term goals. While participants felt their current behavioral health services were meeting their immediate needs, they expressed a desire for individuality and trust from counselors. Based on these findings, occupational therapy's role may be the provision of client-centered services focusing on long term health and wellness, adaptive habits and use of time, and facilitating planning and achievement of long-term occupational goals in order to foster enhanced success in maintaining sobriety.

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Dedication

This study is dedicated to those individuals living with substance use disorders. I hope the information presented may help support ongoing research to help better serve this community.

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Chapter 1: Introduction

In 2018, over 20 million individuals were impacted by a substance related disorder (National Center for Drug Abuse Statistics, 2019). Substance related disorder is an umbrella term used to describe the use of 10 classes of drugs including, but not limited to alcohol, opioids, and cocaine. This category of diagnoses is sub-divided into substance induced disorders and substance use disorders (American Psychiatric Association [APA], 2013). Substance-induced disorders include intoxication, withdrawal, and substance-induced mental disorders (APA, 2013), while substance use disorders apply to all 10 classes of drugs and typically feature brain alterations due to persistent use (APA, 2013). The more severe presentation of substance use disorders is addiction (APA, 2013).

In 2019, 14 million individuals were diagnosed with an alcohol use disorder and approximately two million individuals were diagnosed with an opioid use disorder (National Center for Drug Abuse Statistics, 2019). Overall, substance use disorders resulted in thousands of deaths per year, with over 88,000 deaths from alcohol related causes and 70,000 deaths from drug overdose (National Institute on Alcohol Abuse and Alcoholism ([NIAAA], 2020; National Institute on Drug Abuse [NIDA] 2020a; U.S. Department of Health and Human Services, 2019).

Societal and the Individual Implications

Economically, addiction to nicotine, alcohol, and illicit drugs may result in upwards of 740 billion dollars spent in the United States (US) related to lost productivity, healthcare costs, and crimes (NIDA, 2020b). The US government allocated 3.8 billion dollars towards substance misuse and co-occurring mental health disorders for the 2019 fiscal year (USASpending.gov, 2019). Future expenditures expected for substance misuse treatment in the year 2020 are expected to increase to 42.1 billion dollars (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). A large majority of the burden of these costs will be placed on private and public payers. Spending on substance use disorders from public sources, including Medicare,

Medicaid, and other federal or state dollars, is anticipated to account for 71% of the total potential 42.1 billion dollars spent annually (SAMHSA, 2014).

High prevalence of use, death, and significant expenditures by the US government signify the importance of addressing substance use disorders on a macro-level. On a micro-level, the individual is significantly impacted by substance use disorders with noted physiological, behavioral, and cognitive impairments (APA, 2013) and long-lasting brain changes (NIDA, 2018a). Substance addiction may make it difficult for individuals to engage in daily activities and fulfill life roles resulting in lost employment, homelessness, and troubled relationships (APA, 2013; Gutman, 2006). Lander, Howsare, & Byrne (2013) stated that children who are addicted to substances may experience differing levels of support from family members influencing their relationship with the substance and their family. Certain individuals also may have a predisposition to substance addiction.

Early neurobiological evidence shows men, whose biological parents are alcoholics, are likely to have a 50% chance of developing addiction to alcohol and are shown to have less sensitivity to alcohol (Cami & Farre, 2003; Gutman, 2006). Further, genetic predispositions such as increased levels of acetaldehyde lead to a decreased likelihood of alcohol misuse (Cami & Farre, 2003); whereas specific gene polymorphisms led to an increased likelihood of alcohol use (Gutman, 2006). A single polymorphism of a specific gene coding opioid receptors was associated with higher chances of heroin use and a specific gene for a dopamine receptor was related to increased chances of developing nicotine, alcohol, opiate, and polysubstance abuse (Cami & Farre, 2003; Gutman, 2006).

Early evidence also states, in addition to genetic predispositions, environmental risk factors may lead to increased chances of substance addiction. NIDA (2003) stated that risk factors for developing substance addiction in children include exposure to aggressive behavior, peer pressure, increased drug availability in the child's environment, and a lack of parental supervision in the home. In more recent research, risk factors contributing to substance use during

adolescence may be related to the significant cognitive development that occurs during this period of life which makes adolescents more vulnerable to stress and risk seeking behaviors (Whitesell, Bachand, Peel, & Brown, 2013). In addition to brain development, adolescents experiencing phenomenon such as strained parent-child relationships; emotional, physical, and sexual abuse; bullying; and peer pressure, are at higher risks for engaging in and developing abuse of substances. Evidence shows increased use of illicit drugs in individuals with a history of physical and sexual abuse (Whitesell et al., 2013).

Pre-existence of mental illness may also impact substance addiction. Early evidence stated certain personality traits like risk taking behavior may increase the likelihood of using addictive drugs (Cami & Farre, 2003). Mental illness such as schizophrenia, bipolar disorder, depression, and attention deficit hyperactivity disorder (ADHD) are related to increased risk of abuse (Cami & Farre, 2003; Whitesell et al., 2013). Research demonstrates a correlation between a diagnosis of ADHD and increased risk of alcohol and nicotine misuse amongst adolescents; adolescents with ADHD are almost three times more likely to develop a substance use disorder (Whitesell et al., 2013).

Physical and psychological effects including but not limited to; distorted vision and hearing; impaired coordination and judgement; changes to the sleep/wake cycle, heart rate, blood pressure, and breathing; and manifestation of violent behaviors may be adverse effects of substance use (NIDA, 2020c). Substance addiction is also associated with medical complications including liver cirrhosis, cancer, and dementia. Early neurobiological evidence states stimulant use (such as cocaine) can lead to cardiac arrhythmias and stroke (Gutman, 2006). On a more anatomical level, prolonged use of drugs and alcohol may result in neuroanatomical and neurobiological changes (Whitesell et al., 2013) and older research explains these changes in great depth. Substance use at an early age may lead to increased dopamine levels which may impact the function of the brains reward system associated with pleasurable behaviors such as eating, drinking, and sex (Cami & Farre, 2003). Prolonged use of substances lowers perceived

pleasure by the reward system, leaving individuals with increased cravings and increased levels of substance use in order to feel the desired effects. This may lead to increased tolerance levels and escalated drug and/or alcohol use. Additionally, periods of abstinence from the substance may increase sensitivity to the substance; if an individual were to reuse, it may cause heightened pleasure and lead to relapse (Cami & Farre, 2003; Gutman, 2006). Structural changes like the strength and size of dopamine neurons' dendrites and soma are decreased with opioid use. Conversely, repetitive use of stimulants like cocaine increases dendritic branches of neurons in the prefrontal cortex (Cami & Farre, 2003). As a result of these synaptic changes in the brain, changes in cognition and motor control may also occur (Cami & Farre, 2003; Cunha, Nicastri, Guerra de Andrade, & Bolla, 2010).

Legislative Action

According to Abraham and colleagues (2017), the Patient Protection and Affordable Care Act (ACA) of 2010 increased access to services for substance use disorders in several ways. The ACA expanded insurance coverage to a greater number of people, including expansions to Medicaid and regulated insurance programs, while also ensuring that existing insurance plans covered screening and intervention services for substance use disorders. The ACA built upon the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and extended benefits for substance use disorders, considered to be equitable to coverage for medical and surgical procedures, to individual health insurance plans in addition to group based coverage (Abraham et al., 2017). The expansion of ACA's coverage aimed to create more community integration programs for individuals with substance use disorders and provide state level opportunities to tackle the needs associated with the growing opioid epidemic (Abraham et al., 2017). The opioid epidemic is a current public health crisis stemming from increased prescription of opioid pain medication leading to misuse and addiction (U.S. Department of Health and Human Services, 2019; Rowe & Breeden, 2018). After the establishment of the ACA, the Comprehensive Addiction and Recovery Act (CARA) of 2016 granted over 180 million dollars per year towards

the opioid epidemic response (SAMHSA, 2020a). Most recently, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, passed in 2018, aimed to strengthen behavioral health services to combat the national opioid epidemic (SAMHSA, 2020a).

Substance Use Disorder Interventions

Treatment models. Several models exist to help explain substance addiction and inform or guide treatment ranging from the moral model, which places an onus of addiction on the individual, to the medical/disease model, which suggests that the individual has no control over addiction as it is genetically based and progressive in nature (Skewes & Gonzalez, 2013). A limitation of the moral model is that it does not consider genetic predispositions, while a limitation of the medical/disease model is that it does not account for those individuals who demonstrate recovery from their addiction. The biopsychosocial model was created as a holistic understanding of addiction. In this model, addiction is the result of the interaction between multiple factors including genetics, psychology, cognition, environment, and culture. Therefore, treatment for addiction should address all of these factors (Skewes & Gonzalez, 2013).

More contemporary models include the Recovery Model and the Transtheoretical Model. The Recovery Model boasts self-management and puts the individual's health in their own hands (Duckworth, 2015; SAMHSA, 2019). This model is not symptom and deficit focused, but rather focused on achieving the individual's goals (Duckworth, 2015). Therefore, an individual may choose to address areas of self-care, home care, and community involvement while still living with addiction (Duckworth, 2015). Lastly, the Transtheoretical Model, a long-standing public health model commonly utilized by social and behavioral sciences to make sense of behavioral changes, presumes that change may occur in a cyclical pattern (Prochaska & Di Clemente, 1982). In order to foster habitual adaptive behaviors individuals must demonstrate intention towards change as well as require adequate self-efficacy skills to maintain change (Prochaska & Di Clemente, 1982). This model is a process rather than a theoretical lens, where individuals go

through stages during their attempt to create change (Prochaska & Di Clemente, 1982). The process is dynamic, and the individual may exit or re-enter at any stage, as well as demonstrate regression (Prochaska & Di Clemente, 1982). In this process, the individual is the most important participant determining their own goals for change, while the provider utilizes active involvement, support, and expertise on how to facilitate change (Prochaska & Di Clemente, 1982). More current sources state that this model consists of specific stages which individuals transition through as they pursue changes in behavior and include precontemplation, contemplation, preparation, action, maintenance, and termination (LaMorte, 2019; Velicer, et al., 2000). The individual typically begins with inaction (pre-contemplation), moves to thinking about a change (contemplation), prepares themselves to make a change (preparation), actively makes modifications to their lifestyle (action), and then attempts to maintain the change (maintenance) (LaMorte, 2019, Velicer, et al., 2000). Termination is the complete cessation of the unwanted behavior (LaMorte, 2019, Velicer, et al., 2000).

Abstinence vs. harm reduction approaches. Treatment for substance use may focus on abstinence which is considered to be a period of time ranging from weeks to years within a person's lifetime of no drug or alcohol use (Mignon, 2015). Therefore, abstinence involves cessation. The 12-Step approach, commonly utilized by social workers and behavioral health professionals, promotes abstinence through a group-based program where individuals begin with an acceptance of addiction as a disease and aspire for spiritual and personal growth (Donovan, Ingalsbe, Benbow, & Daley, 2013). Twelve-step programs are noted to increase peer relationships amongst individuals who are abstinent. Twelve-step programs can be an adjunct to, continuing care from, or a form of ongoing community support with traditional substance use treatment (Donavan et al., 2013). Conversely, treatment may focus on harm-reduction to reduce substance use and related negative secondary consequences to the individual (Mignon, 2015). Components of harm reduction may include methadone treatment services for opioid addiction and needle exchange programs (Mignon, 2015). These programs are believed to decrease drug use, increase

participation in psychotherapy, and assist individuals to return to productive functioning (Mignon, 2015). As this approach focuses on reduction rather than cessation of use, the harm-reduction approach allows treatment providers to support individuals in their recovery process without stigmatization, while also increasing the individuals' motivation to engage in treatment (Mignon, 2015).

Treatment settings and services. Settings for substance use disorders may include residential, inpatient, or outpatient programs (NIDA, 2019). Outpatient programs may include group and/or individual counseling sessions and varying forms of therapy such as: cognitive behavioral therapy, family therapy, motivational interviewing, and/or motivational incentives such as positive reinforcement to encourage abstinence (NIDA, 2019). Inpatient and residential programs are geared for higher need individuals, providing increased structure and care (NIDA, 2019). Additionally, residential programs may include recovery housing which is developed to create smooth transitions for individuals moving from inpatient and other forms of residential services to being active and independent members of the community (NIDA, 2019).

Behavioral health services are specific treatment services that combine psychotherapy and medication to alter thoughts, behaviors, emotions, and how individuals perceive situations (SAMHSA, 2020b). The medication provided is for symptom relief so that individuals may utilize learned therapeutic strategies towards recovery (SAMHSA, 2020b). It is assumed that the combination of these two treatment approaches is the most effective for addressing substance use disorders (SAMHSA, 2020b). Behavioral health services aim to increase life skills and develop coping skills to address stressful and trigger inducing situations (NIDA, 2018b). An example of a behavioral health intervention is cognitive behavioral therapy, which is a psychological treatment focused on changing thought and behavior patterns (American Psychological Association, 2020).

Significance to Occupational Therapy

As previously described, substance use disorders may impact an individual's physical, mental, and social well-being as a result of neurobiological changes to the brain, increased risk of

mental health disorders, and impaired community participation. Individuals challenged by substance use disorders may present with difficulties participating in daily activities such as homecare, education, and work (Mignon, 2015; NIDA, 2020c). Achieving optimal health, well-being, and participation in life activities is within the domain of occupational therapy according to the American Occupational Therapy Association (AOTA) Occupational Therapy Practice Framework: Domain & Process 4th Edition (OTPF-4) (2020a). Some of the occupations or daily activities that fall within the scope of occupational therapy practice are (1) activities of daily living like dressing, bathing, and feeding, (2) instrumental activities of daily living like childcare, driving, community mobility, financial management, and home management, (3) health management, (4) work, and (5) education (AOTA, 2020a). According to AOTA (2020b), occupational therapy addresses individuals' needs and desires to participate in occupations or meaningful activities by utilizing a holistic, health promotion approach (AOTA, 2020a; AOTA, 2020b).

Further, NIDA (2018b) stated substance related treatment should aim to assist individuals in returning to a prior level of function with family, work, and community engagement. This directly aligns within the scope of occupational therapy practice (AOTA, 2014) and leaders in the occupational therapy profession have advocated for a role for occupational therapy services within behavioral health settings (Hutchinson et al., 2019; Stoffel, 2013). Stoffel (2013) issued a call for action encouraging occupational therapy practitioners to explore this emerging area of practice and consider working with individuals with substance use disorders in behavioral health settings. In 2015, occupational therapy practitioners were recognized as key community behavioral health providers and were included on the list of staff for newly developed community behavioral health centers (AOTA, 2015).

In addition to advocacy, occupational therapy research related to addiction and substance use has been growing to include studies exploring individuals' physical and cognitive health (Martin, Smith, Rogers, Wallen, & Boisvert, 2011; Rojo-Mota, Pedrero-Perez, Ruiz-Sanchez De

Leon, & Miangolarra Page, 2014; Sanchez-Camarero et al., 2019; Wasmuth et al., 2015), sensory function (Bar-Shalita, Asayag, Bonneh, & Parush, 2019), occupational participation (Davies & Cameron, 2010; Cruz, 2019; Wasmuth, Pritchard, & Kaneshiro, 2016a), and occupational identities (Martin et al., 2011). Occupational therapy researchers have also explored addiction as an occupation itself (Wasmuth, Crabtree, & Scott, 2014; Wasmuth, et al., 2016b) and have developed measures and protocols (Dietz & Schriber, 2017; Martin et al., 2015) to assist with working with this population.

Occupational therapy practitioners have utilized long-standing occupation-based models to guide research on this topic such as the Model of the Human Occupation (MOHO) by Kielhofner and Posatery Burke (1980). MOHO can be utilized to help understand individuals' behaviors in response to particular phenomena in their occupational lives (Kielhofner, 2008; Kielhofner & Posatery Burke, 1980). Assumptions of the model are that individuals are dynamic open systems, and their ability to participate in occupation is interdependent on factors related to an individual's volition, habituation, performance capacity and the environment (Kielhofner, 2008). MOHO appears frequently within occupational therapy literature related to substance use disorders as a prime theoretical lens that guides both research design and data analysis (Davies & Cameron, 2010; Dietz & Schriber, 2017; Martin, Bliven, & Boisvert, 2008). More recently, occupational therapy practitioners began to utilize the Transtheoretical Model to understand the lived experiences of individuals in recovery from substance use disorders (Sullivan, Macone, Lucey, & Erler, 2020).

Occupational therapy researchers have also focused on the opioid epidemic (Pivont & McCombie, 2020). Rowe and Breeden (2018) authored a continuing education article discussing opioid prescription guidelines for chronic pain management as well as the role for occupational therapy practitioners in addressing the opioid crisis. According to Rowe and Breeden (2018), occupational therapy practitioners are well equipped to work with individuals challenged by the opioid crisis through the use of preventative approaches, education on pain management and the

physiological impacts of prescription misuse, and exploration of self-management techniques for pain. However, a recent state survey of occupational therapy practitioners found that respondents felt they lacked the necessary training and education to address the opioid crisis (Pivont & McCombie, 2020).

Gaps in the literature existed despite a growing body of occupational therapy research focused on substance use disorders. Occupational therapy systematic reviews lacked consensus on the effectiveness of occupation-based interventions, clinical trial-based studies, and a definitive role for occupational therapy (Hutchinson et al., 2019; Rojo-Mota, Pedrero-Perez, & Huertas-Hoyas, 2017a; Wasmuth et al., 2016a). Additionally, there were only a handful of studies in which researchers utilized the first-hand client perspective to inform their work (Hutchinson et al., 2019; Rojo-Mota et al., 2017a; Wasmuth et al., 2016b).

Based on the limitations in existing research, the purpose of this study was to further explore the first-hand experiences of individuals who were challenged by substance use disorders and specifically those who were receiving behavioral health services. Results of this study were intended to expand the occupational therapy body of knowledge about individuals challenged by substance use disorders and to inform occupational therapy practice.

Purpose Statement

Substance use disorders have had a significant impact on both the individual challenged by the disease and on society as a whole. The societal costs associated with substance use continue to increase and the physiological, psychological, and cognitive implications for the individual contributing to loss of life roles and quality of life persist. Emerging occupational therapy research supports the profession's role in the provision of services for individuals challenged by substance use disorders, however, published research has been limited and inconclusive to date (Hutchinson et al., 2019; Rojo-Mota et al., 2017a; Wasmuth et al., 2016a). The purpose of this research was to learn more about the lived experiences of individuals with substance use disorders, their perceptions of daily life, and the behavioral health services they

received. Interviews were used to explore the human experience and learn more about the phenomena of substance addiction. Exploring perceptions of behavioral health services, daily life, the impact substance use may have had on individuals' lives, and any other information, may further inform the role of occupational therapy when working with individuals challenged by substance use disorders.

Research Questions

1. What are the lived experiences of individuals with substance use disorders who are receiving behavioral health services?
2. What are the perceptions of daily life of individuals with substance use disorders who are receiving behavioral health services?
3. What are the perceptions of the behavioral health services received by individuals with substance use disorders?

Definition of Terms

1. *Substance related disorders* is an overarching category of diagnoses within the Diagnostic and Statistical Manual for Mental Disorders V [DSM V], that consists of 10 classes of drugs including but not limited to alcohol, opioids, and cocaine. Substance related disorders are divided into two sub-categories: substance use disorders and substance induced disorders (APA, 2013). This group of diagnoses are given to individuals who demonstrate a pattern of using a substance leading to *clinically significant impairments* cognitively, behaviorally, and physiologically (APA, 2013). Specific criteria must be met in order for an individual to be diagnosed which includes repetitive substance use leading to an inability to fulfill role obligations associated with work, home, or school and cessation or reduction of social, occupational, and recreation activities (APA, 2013). "The overall category of *substance induced disorders* includes substance intoxication, withdrawal, and other substance-induced/medication-induced mental disorders" (APA, 2013, p.485).

2. *Substance use disorders* are a subcategory of substance related disorders which includes all 10 classes of drugs. An individual is diagnosed with a substance use disorder when they continue to use a substance despite related problems (APA, 2013). Individuals diagnosed with substance use disorders experience cognitive, behavioral, and psychological symptoms (APA 2013). Substance use disorders feature brain alterations due to persistent drug use (APA, 2013). Within the DSM, substance use disorders are used to describe all levels of substance use including severe use such as addiction (APA, 2013). Substance use disorders are frequently addressed within occupational therapy and non-occupational therapy literature.
3. *Addiction,* in this study, refers to addiction to a substance such as alcohol or drugs. This study will utilize either *substance addiction* or *addiction* interchangeably. Older evidence states that addiction involves using substances in high amounts over a long period of time and is characterized by the inability to stop or reduce use and by spending a large amount of time on obtaining the substance (Gutman, 2006). This is supported by more recent sources such as NIDA who states, "addiction is defined as a chronic, relapsing disorder characterized by compulsive drug seeking, continued use despite harmful consequences, and long-lasting changes in the brain" (NIDA, 2018a, para. 1).
4. *Sobriety* will be defined as the "state of being sober" (Merriam-Webster, n.d.-a); while *sober* is defined as "not addicted to intoxicating drink" or "not drunk." (Merriam-Webster, n.d.-b)
5. *Substance dependence* also known as physical dependence refers to a state where the body naturally accommodates to the intake of a substance (NIDA, 2018a).
6. *Substance misuse,* also known as *substance abuse,* is incorrectly using a prescribed medication or inability to consume alcohol in moderation. (NIDA, 2018a). Substance misuse and substance abuse will be utilized interchangeably within this paper as sources inconsistently utilize both terms.

7. *Behavioral health treatment services* combine psychotherapy and medication to alter thoughts, behaviors, emotions, and how individuals perceive situations (SAMHSA, 2020b). Medications are used for symptom relief to support the use of learned therapies by individuals during recovery (SAMHSA, 2020b). Behavioral health treatment works to increase life skills, and develop coping skills to address stressful, and trigger inducing situations (NIDA, 2018b).
8. *Metacognition* is defined as "awareness of one's own learning and thinking processes." (Merriam-Webster, n.d.-c).
9. *Occupations* refers to everyday activities individuals find important to their daily life that provide purpose as outlined in the OTPF-4 (AOTA, 2020a). Everyday activities can include eating, showering, personal hygiene, care of others, financial management, meal preparation, sleep, education, work, play, leisure, and social participation, to name a few (AOTA, 2020a).
10. *Occupational performance* refers to an individual choosing to actively engage in activities they value as stated in earlier work by Nelson & Jepson-Thomas (2003). The OTPF-4 (AOTA, 2020a) provides a more updated definition to include the *accomplishment* of a meaningful activity. This study will follow the definition within the OTPF-4 (2020a).
11. *Role competence* is the effective fulfillment of the demands of individuals' roles (AOTA, 2020a).
12. *Occupational deprivation is* the lost ability to engage in meaningful occupations due to the lack of access or circumstances beyond an individual's control, such as racial, systemic, or legislative barriers, which may impact the individual's overall health (Occupational Therapy Australia, 2016; Reitz, 2014).
13. *The Model of Human Occupation* is an occupation-based model that can be used when working with individuals across the lifespan and has been shown to be effective when

working with individuals with chronic conditions (Kielhofner, 2008; Kielfhofner & Posatery Burke, 1980). Assumptions of the model are that individuals are dynamic open systems and their ability to participate in occupation is interdependent on factors related to an individual's volition, habituation, performance capacity and the environment (Kielhofner, 2008).

a. *Volition* refers to an individual's motivation in choosing to do something (Kielhofner, 2008).
b. *Habituation* refers to automatic behavior patterns that are informed by the individual's *habits* (repetitive actions) and *internalized roles* (performance of actions based on societal norms) (Kielhofner, 2008).
c. *Occupational choices* are defined as intentional commitments to perform an action like acquiring a new habit (Kielhofner, 2008).
d. *Performance capacity* refers to the ability to perform an action based on the individual's physical and mental abilities in addition to their own experiences (Kielhofner, 2008).
e. *Environment* refers to the external environment and how it impacts an individual either to support, provide chances, create demand, or restrain actions or behaviors (Kielhofner, 2008).
f. *Occupational participation* is defined in MOHO as an individual's engagement in meaningful activities (Kielhofner, 2008)
g. *Occupational competence* is the level at which individuals are able to participate in meaningful activities (Kielhofner, 2008)
h. *Occupational adaptation* is the ability of individuals to engage in meaningful occupations in changing circumstances as *occupational adaptation* (Kielfhofner, 2008; Forsyth et al., 2014).

Delimitations

This study was limited to recruitment from only two sites within a specific behavioral healthcare agency, both located in one geographical region, and the primary researcher was familiar with the agency from previous employment. This provided ease of access to individuals receiving behavioral health services, ease in disseminating study recruitment information to the population of interest, and ease in scheduling interviews with interested individuals.

Limitations

Several factors limited generalizability of the results of this to the greater public. The participant pool originated from one geographical location, one agency, and one clinical site. The experiences of the participants were unique as they may have shared counselors and attended the same group therapy program. Program policies, structure of the behavioral health program, individuals' socioeconomic status, and their access to substance related services, were factors not addressed by this study's methodology and may have impacted who was able to participate in this study. On-site recruitment was restricted due to confidentiality requirements and may have impacted adequate dissemination of recruitment information. The timing of interviews may have been a limiting factor as participants had scheduled transportation and interviews were completed back-to-back leaving little time for the researcher to reflect between participants. Further, interview questions may not have been worded in a way that enabled participants to fully reflect on the intent of the question being asked. Finally, certainty that participants met the inclusion criteria for this study is limited due to the recruitment process and inaccurate terminology used in the inclusion criteria and may be a limitation of this study.

Chapter 2: Literature Review

The significant impact substance use disorders have on an individual's physiology, emotional processing, social participation, and occupational performance is widely accepted in the literature (Cami & Farre, 2003; Gutman, 2006; Whitesell et al., 2013). The following review summarizes both occupational therapy and non-occupational therapy literature pertaining to substance use disorders and focuses on the following topics: impact on body functions; impact on occupational performance; traditional treatment; and occupational therapy services.

Impact of Substance Use Disorders on Body Functions

According to some studies, prolonged use of addictive substances had negative impacts on specific mental functions like attention and initiation of tasks, and on global mental functions like impulse control. Other studies found sensory functions like pain response, and control of voluntary movement like fine motor skills were impacted due to substance addiction.

Specific mental functions. A quantitative study comparing executive functioning between individuals with dependence to cocaine and those without, utilized a novel neuropsychological assessment in conjunction with known assessments (Cunha et al., 2010). Participants were required to copy movement patterns and the results showed individuals with dependence exhibited lower performance in mental flexibility, conceptualization, and motor programming (Cunha et al., 2010). Similarly, executive functioning was found to be affected in polysubstance users (Hagen et al., 2016). Hagen and colleagues compared individuals with polysubstance misuse and those without by utilizing several measures to test executive function skills such as attention, inhibition, cognitive flexibility, long-term decision making, risk perception, initiation, planning, and organization (Hagen et al., 2016). Individuals with polysubstance use underperformed on the Stroop Test and the BRIEF assessment compared to the control group, suggesting impairments in executive functioning. The study also found that the BRIEF assessment was the most useful in evaluating executive functioning in individuals with substance use disorder (Hagen et al., 2016).

In a second study, researchers examined metacognition between three groups: substance use disorder, schizophrenia, and HIV positive (Wasmuth et al., 2015). Data were collected through semi-structured face to face interviews and measures that assessed self-reflection, understanding of others' thoughts, multiple perspective taking, and use of knowledge to address social and psychological predicaments. Individuals with substance use disorders were found to have decreased scores in comparison to the HIV group on 'metacognitive mastery,' defined as the ability to use metacognitive knowledge to address social or psychological predicaments. These findings suggested that individuals with substance use disorders may have had difficulties in the use of novel learned skills for problem solving (Wasmuth et al., 2015). Other researchers compared performance on the Assessment of Motor and Process Skills (AMPS) amongst individuals with varying demographic variables and severity of drug and/or alcohol addiction (Rojo-Mota et al., 2014). Researchers found that severity of addiction and length of substance misuse impacted motor and process skills which in turn negatively impacted performance of daily activities. These results demonstrated a high negative correlation between AMPS scores to severity of addiction and length of use. Further, 60% had suboptimal AMPS scores and 25% demonstrated significant decline particularly in cognitive performance skills. (Rojo-Mota et al., 2014). Finally, researchers explored the lived experiences of mothers in recovery from long-term substance addiction (Martin et al., 2011). Based on responses, participants were noted to utilize substances as coping mechanisms to escape everyday pressures such as financial, and relationship stress (Martin et al., 2011).

Global mental functions. In their qualitative study, Martin and colleagues explored the lived experiences of mothers in recovery from addiction, researchers found reduced performance capacity as a theme (Martin et al., 2011). That is, during active use, some participants expressed the need for increased amounts of substances to maintain energy and function so that physical withdrawal did not impede participation in activities. Other participants experienced physical

weakness in addition to poor concentration and judgement as a result of being high on a substance (Martin et al., 2011).

Temperament and personality. In the psychology literature, researchers found that impulsivity, exhibited in individuals with cocaine and opioid use, was dependent on whether individuals just used cocaine or whether they had dual use of cocaine and opiates. Those with dual use were more likely to show impulsivity than those solely using cocaine (Rodriguez-Cintas et al., 2016).

Sensory functions. Occupational therapy researchers in Israel explored sensory modulation disorders in individuals with substance use disorder (Bar-Shalita et al., 2019). Researchers compared a substance use disorder group with otherwise healthy individuals. All participants completed measures including sensory responsiveness scales and pain questionnaires, monofilament pin prick tests to assess pain, and a measure exploring averseness to sounds. Participants with a substance use disorder were identified as having a sensory modulation disorder and demonstrated increased averseness to sound however, there were no significant group differences on the monofilament pin prick test assessing pain. This study was novel within the occupational therapy literature in that the researchers assessed sensory based dysfunction stemming from substance use disorders (Bar-Shalita et al., 2019).

Control of voluntary movement. Occupational therapy researchers explored whether there were differences in manual dexterity and fine motor control between individuals with cocaine use and otherwise healthy individuals (Sanchez-Camarero et al., 2019). Researchers conducted observations in addition to administering the Purdue Pegboard Test and the Jebsen-Taylor Hand Function Test to both groups. Researchers found decreased fine motor and dexterity skills bilaterally in individuals with cocaine use in comparison to healthy individuals (Sanchez-Camarero et al., 2019).

Impact on Occupational Performance

In a psychology doctoral dissertation, Cavanaugh (2019) aimed to understand the lived experiences of individuals with substance misuse and comorbid homelessness. The study used semi-structured interviews with 23 male participants currently in recovery from substance misuse and homelessness. Key themes that emerged were participants valued making and maintaining connections for personal and professional growth, autonomy and ability to achieve goals, increased self-worth, and participation in community-based activities (Cavanaugh, 2019). Similar to autonomy, participants in a study by occupational therapy practitioners discussed the importance of self-maintenance (Davies & Cameron, 2010). The study used mixed methods, including semi-structured interviews and the use of the Occupational Self-Assessment measure, to understand the perceptions of those in inpatient detoxification settings on their occupational abilities and priorities for change. The study utilized the Model of Human Occupation (MOHO) as a guiding theoretical framework for their methodology and interpretation of data. Based on the results, individuals in inpatient detoxification wanted to further develop self-maintenance skills and improve their ability to manage self-care, finances, and their homes. Additionally, 41% of the participants in the study identified it was important for them to care for people for whom they are responsible (Davies & Cameron, 2010).

Value of caring for people whom individuals are responsible for was a similar theme in the study by Martin et al. (2011). In this study, themes revealed significant impacts on occupational performance and occupational identity (Martin et al., 2011). Participants expressed time spent using substances took away from essential occupations or impacted how well they performed their roles. Some mothers reported instances of endangering their children as a result of substance use. Others expressed guilt and remorse over their substance use because of the impact on their children. Finally, the role of the physical and social environment impacted substance use. Mothers described friendships with individuals challenged by addiction and

strained spousal relationships acted as both stressors and triggers for substance use (Martin et al., 2011).

In further support of the findings by Davies & Cameron (2010), Cruz (2019) conducted semi-structured interviews with individuals receiving substance use treatment and the results revealed themes associated with leisure exploration and social participation. Participants expressed the desire for adding activity to free time, as well as engaging with peers and others in sobriety meetings in order to abstain from using substances. Additional themes included work and education. Participants expressed interest in finding employment, returning to school, or establishing a meaningful career either during or after completion of their substance related program (Cruz, 2019).

Addiction as an Occupation

While some occupational therapy researchers explored the impact of addiction on occupational performance (Davies & Cameron, 2010; Cruz, 2019; Martin et al., 2011), others sought to understand addiction as an occupation itself (Wasmuth et al., 2014; Wasmuth et al., 2016b). Limited occupational therapy involvement in serving individuals challenged by addiction, high relapse rates, and low retention rates amongst individuals seeking substance related services, prompted researchers to view addiction as a potential occupation. Researchers believed that by viewing addiction as an occupation, it could uncover potential barriers in the recovery process and give meaning to the high relapse and low retention rates. In order to understand whether individuals with substance misuse disorders perceived their substance use as an important occupation in their daily lives, the researchers completed and analyzed semi-structured interviews, developed from a MOHO perspective, with participants from an Alcoholics Anonymous group (Wasmuth et al., 2014). In this study, participants recognized that their addiction contributed to either feelings of social connectedness or isolation, and served as a means of self-expression and identity, coping, and occupation of time. The study also suggested that addiction became increasingly an occupation for those individuals who possessed little to no

alternative occupations. This resulted in individuals seeking purpose, social interaction, and meaning through their addiction (Wasmuth et al., 2014).

In another qualitative study, addiction as an occupation was further explored with veterans with substance use disorders (Wasmuth et al., 2016b). Findings supported those of Wasmuth et al. (2014) in that there was a social component to the initiation and continuation of substance use and self-identification with use. Additionally, participants found their addiction through socialization, and individuals spent more time using when they lacked alternative occupations (Wasmuth et al., 2016b).

Traditional Treatment for Substance Use Disorders

A common abstinence-based program, 12-step, utilized by social workers and behavioral health practitioners, was effective in supporting long-term abstinence and fostering peer support (Donovan et al., 2013). The study used self-report questionnaires in a longitudinal study of individuals receiving substance related treatment to investigate the benefits of 12-step programs (Costello et al., 2019). Twelve-step meetings were found to have effective short-term substance use outcomes with increased duration of abstinence associated with increased involvement in 12-step meetings (Costello et al., 2019).

Though there is some support for the effectiveness of abstinence-based programs (Costello et al., 2019), harm-reduction approaches utilizing motivational interviewing had mixed evidence. According to Agerwala and McCance-Katz (2012), the Screening, Brief Intervention and Referral to Treatment (SBIRT) approach is an evidence-based approach that utilizes motivational interviewing to reduce and prevent substance misuse and dependence. SBRIT was found to be effective in not only reducing costs, but also in decreasing frequency and severity of use, reducing trauma risk, and increasing engagement in substance related treatment (Agerwala & McCance-Katz, 2012). With increased use of this approach in medical settings across the United States, significant improvements in individuals' health, employment, and housing have been reported (Agerwala & McCance-Katz, 2012). However, a limitation of SBRIT, also supported by

SAMSHA (2011) is that most studies pertaining to SBRIT are based on alcohol use and not illicit drug use. Therefore, there is limited evidence to support the effectiveness of SBIRT in treating drug misuse. Additionally, the format of motivational interviewing seems to influence the effectiveness of the approach as well. In a systematic review by Jiang, Wu, & Gao (2017), evidence supported the use of motivational interviewing over the telephone as a strong alternative to individual face-to-face services in the prevention and treatment of substance abuse. The effectiveness of motivational interviewing utilized through text message, the internet, and in group sessions was found to be inconclusive and requires further research (Jiang, Wu, & Gao, 2017).

Abstinence and harm-reduction approaches to substance misuse treatment did not explore the benefits of finding alternate activities to sustain sobriety or reduce use. Twelve-step programs did encourage community engagement and spiritual connection (Donovan et al., 2013) but did not explore direct correlations between alternate activities and abstinence. Psychology based studies have demonstrated the effectiveness of treatment approaches related to finding alternative activities. In an earlier study by Correia, Benson, and Carey (2005), participants with reported alcohol or illicit drug use were divided into one of three groups: (1) substance reduction (2) activity increase (3) no change. The study measured participant alcohol or illicit drug use at baseline and after completion of the 28-day study and recorded the participants self-monitored progress towards their personal goals. Results showed participants had decreased substance use in the ‘substance reduction’ group and ‘activity increase’ group. Participants in the ‘activity increase’ group also demonstrated a decrease in the number of the days spent using a substance and an increase in engagement with exercise and creative activities. This study suggested the importance of finding and participating in non-substance related activities to help reduce substance use behavior (Correia, et al., 2005). In another randomized control trial by Daughters and colleagues (2017), individuals in residential treatment for substance addiction were divided into two groups: a typical treatment group (narcotics/alcohol anonymous groups, 12-step, and

relapse prevention programs) and the life enhancement treatment for substance use (LETS ACT) group. The LETS ACT group received a specialized and novel form of a substance treatment program, based on typical behavioral theories, where individuals were asked to schedule, engage, and record alternative substance-free behaviors or activities. Participants were followed pre- and post-treatment and results showed individuals in the LETS ACT group demonstrated increased abstinence post treatment (Daughters et al., 2017).

Occupational Therapy and Substance Use Disorders

The findings of Correia et al. (2005) and Daughters et al. (2017) are relevant to occupational therapy as they explore the importance of non-substance related activities in achieving and sustaining long term sobriety. Similarly, occupational therapy literature related to substance use disorders has explored the relevance of engaging in occupations. In a systematic review of the occupational therapy literature by Wasmuth, Pritchard, & Kaneshiro (2016a), several areas of occupation were found to be negatively impacted for those with substance use disorders to include work, education, activities of daily living, and instrumental activities of daily living, which were then used as the focus of intervention. Leisure activities and social participation activities, followed by work related programs, were the most commonly used intervention methods by occupational therapy practitioners. The study suggested that including occupation-based interventions could easily be integrated into the daily lives of those with addiction disorders thereby facilitating meaningful engagement in occupation and reducing symptoms of substance misuse (Wasmuth et al., 2016).

In an earlier study that explored occupation-based assessments with individuals challenged by substance use disorders, Martin, Bliven, & Boisvert (2008) hypothesized that including occupational therapy services within treatment programs for substance use disorders would result in increased occupational performance, self-esteem, and quality of life. Over the course of three years, as individuals entered a halfway house, researchers administered outcome measures to include the Occupational Performance History Inventory 2.0 (OPHI-II), the

Rosenberg Self-Esteem Scale (RSES), and Quality of Life Rating scale (QOLR), as well as a second OPHI-II prior to discharge. Of the 57 participants whose data was captured, pre-post test scores were higher on the RSES, QOLR, occupational identity, and competence. While the results did not indicate that occupational therapy services were the sole contributor to increased scores, the study suggested that it was possible that participants benefited from occupational therapy services addressing life skills (Martin et al., 2008).

In addition to the use of occupation-based approaches, the use of SBIRT as a therapeutic approach by occupational therapy practitioners was recently explored (Mitchell, Dillon, Hallber, LeBlanc, & Robnett, 2019). Researchers supported the use of the SBIRT in occupational therapy services for individuals with substance use across settings as it was cost-effective, promoted function, and the motivational interviewing component was effectively used to exchange substance use with health promoting occupations (Mitchell et al., 2019). While the use of SBIRT was supported as a valuable approach for use by occupational therapy practitioners, SBIRT does not directly explore occupational performance.

Occupational performance assessments used in occupational therapy have the potential to identify relevant areas that might not be otherwise identified in typical substance abuse programs. Martin et al. (2015) developed a tool called the Lifestyle History Questionnaire, a self-report measure for understanding the level of occupational dysfunction that may stem from substance misuse. “The instrument addresses the person (e.g., thoughts, feelings), the physical and social environment, and the cultural and temporal context, as well as patterns of behavior (tasks and occupational performance in context)” (Martin et al., 2015, p. 8). This measure was utilized with individuals receiving care for substance use disorders from two residential detoxification centers. The measure was found to be both reliable and valid after testing and may be useful in gathering information related to clients’ occupational histories, performance patterns, strengths, weaknesses, and level of occupational dysfunction from substance misuse (Martin et al., 2015).

Other researchers explored the effectiveness of occupational therapy assessment tools to evaluate an individual's motor and cognitive function; determined by prior research as being negatively impacted by addiction (Cunha et al., 2010; Hagen et al., 2016; Wasmuth et al., 2015). Rojo-Mota, Pedrero-Perez, Heurtas-Hoyas, Merritt, & MacKenzie (2017b) found that the Allen's Cognitive Level Screen-5 (ACLS-5) was an effective assessment tool to assess functional cognition in individuals receiving outpatient addiction treatment in Spain. Rojo-Mota et al. (2014) found that the AMPS may also be a reliable tool to utilize in assessing motor and process skills for individuals with substance related disorder due to the high correlation of AMP scores and substance use severity. Rojo-Mota, Pedrero-Perez, Ruiz-Sanchez de Leon, Llanero-Luque, & Puerta Garcia (2013) also utilized the Montreal Cognitive Assessment (MoCA) in conjunction with the ACLS-5 to determine cognitive functioning of individuals in treatment for substance addictions. Most participants demonstrated a low score on the MoCA in comparison to norms for the general population, those with mild cognitive impairment, and those with dementia. Researchers concluded that the MoCA was a useful cognitive screening tool to use with individuals with substance addiction and may be helpful to use as a basis for referral to neuropsychological and occupational therapy services (Rojo-Mota et al., 2013).

While some researchers explored the effectiveness of motor and cognitive assessment tools (Rojo-Mota et al., 2013; Rojo-Mota et al., 2014) others have explored the use of MOHO assessment tools (Davies & Cameron, 2010; Martin et al., 2008). However, there was little to support or refute the effectiveness of using MOHO as a theoretical framework for assessing and understanding substance use disorders. Recently, occupational therapy students at the University of North Dakota developed a comprehensive program outline using the MOHO as a guide, for use in outpatient behavioral health programs to bridge occupational therapy services with behavioral health services, despite a lack of research establishing its effectiveness (Dietz & Schriber, 2017).

Research supporting the potential effectiveness of occupation-based services for individuals with substance use disorders it is limited, and the overall evidence remains

inconclusive (Dietz & Schriber, 2017; Martin et al., 2008, 2015; Rojo-Mota et al., 2013; Rojo-Mota et al., 2014; Wasmuth et al., 2016a) A recent survey distributed to occupational therapy practitioners currently working in behavioral health settings and those serving in leadership roles in AOTA's Mental Health Special Interest Section revealed that practitioners believed there is still limited evidence to guide the occupational therapy process when working in behavioral health services (Hutchinson et al., 2019). Additionally, despite there being a potential role for occupational therapy in addressing substance use disorders, including opioid use some occupational therapy practitioners feel inadequately educated or trained to work with individuals with substance use disorders (Rowe & Breedan, 2018; Pivont & McCombie, 2020).

Gaps in Literature

Based on this review of the literature, it is apparent that there are multiple aspects of service related to substance use disorders are being explored by occupational therapy researchers, yet systematic reviews reveal inconclusive and limited findings. (Hutchinson et al., 2019; Rojo-Mota et al., 2017a; Wasmuth et al., 2016a). Despite the efforts of occupational therapy researchers to explore the effectiveness of occupation-based theory and assessments for individuals with substance use disorders, there remains limited scientific studies, specifically controlled clinical trials, combining occupation-based theory with direct assessment and intervention. Additionally, there is only low-level evidence to directly support the inclusion of occupational therapy services for treating addiction (Rojo-Mota et al., 2017a). Review of the literature revealed a significant gap in learning about and treating addiction from an occupation-based perspective (Rojo-Mota et al., 2017a).

There is also a lack of understanding as to whether or not there is a need for occupational therapy services within behavioral health settings for individuals with substance use disorders (Hutchinson et al., 2019). Subsequently, there is a press for continued research to create a body of evidence to support occupational therapy services in the behavioral health field (Hutchinson et al., 2019). In a recent study presented at a virtual conference, researchers surveyed and

interviewed individuals with substance use disorders to explore their perceptions of the benefits of including occupation-based services in substance use disorder treatment programs and the potential impact this would have on recovery and relapse prevention (Sullivan et al., 2020). Participants perceived that the benefits would include a positive impact on social support systems, mental health management, and physical health. Despite perceiving a benefit, all participants reported having never received occupational therapy services for substance use disorders (Sullivan et al., 2020).

This study attempted to address gaps in the literature by offering a first-hand perspective of individuals receiving behavioral health services for substance use disorders. A first-hand perspective sought to offer insight into the strengths and needs of individuals experiencing substance use disorders about their lived experiences, daily lives, and behavioral health services. The information from this study may help further inform the existing literature on the role of occupational therapy with individuals with substance use disorders.

Chapter 3: Methods

Research Design

This study was a qualitative phenomenological design informed by a constructivist paradigm which assumes that individuals live a reality that is relative to the experiences they have had individually and socially (Lincoln, Lynham, & Guba, 2011). These realities are self-created, and individuals may have their own realities distinct from others despite similar circumstances (Lincoln et al., 2011). Qualitative studies drawn on a constructivist paradigm focus on how individuals perceive the events that occur within their lives (Teherani, Martimianakis, Stenfors-Hayes, Wadhwa, & Varpio, 2015). Additionally, the phenomenological qualitative design was chosen as it allowed the researcher to focus on the phenomenon (Creswell, 2014) of substance use disorders. Only a handful of studies within the existing occupational therapy literature utilized a phenomenological approach to understanding substance use disorders (Davies & Cameron, 2010; Martin et al., 2011; Wasmuth et al., 2014). Using a phenomenological approach not only helped focus on the particular phenomenon of substance use disorders, it also supported the use of qualitative methods like interviews to collect data related to the human experience (Creswell, 2014).

Two semi-structured interviews were conducted with participants; an initial interview lasting 20 to 45 minutes and a follow up interview lasting about 15 minutes. The semi-structured interview format was beneficial as it did not require standardization (Adams, 2015). Open-ended questions were utilized to explore the totality of the lived experience and how the phenomenon of substance use disorders impacted the participants' lives. This allowed for open, free-flowing dialogue with participants, where the interviewer could tailor the pre-developed questions, as needed. Additionally, a semi-structured interview format provided opportunities to ask probing "how" or "why" questions during the interviews as needed (Adams, 2015). Examples of tailored interview questions included, "what are the most important things to you throughout your day?" and "what would you like to change about your current routine?" Follow-up interviews were

conducted for clarification of content provided during the initial interview. Follow up interview questions were individualized and conducted after a thorough reading of initial interview transcripts. Examples of individualized follow-up questions included, “what are some topics that you would want to be covered in the group?” or “what are your goals and priorities for the future?”

The semi-structured interview questions were developed based on a review of literature and partially informed by the Occupational Performance History Interview II (See Appendix A: Interview Questions). This tool was used as a guide as it included open-ended questions to understand individuals’ daily lives and occupations (Kielhofner et al., 1998), and therefore aligned with the research questions for this study. The use of MOHO and related tools, as a theoretical lens, have been similarly implemented in occupational therapy research pertaining to substance addiction (Davies & Cameron, 2010; Martin et al., 2017).

Researcher Description and Researcher-Participant Relationships

The primary researcher was a novice graduate student researcher, with no significant previous research experience and was previously employed as a case manager at the recruitment site for four years. Despite prior employment at the recruitment site, no relationship existed between the primary researcher and the participants in this study. Additionally, the primary researcher had no direct involvement in the recruitment of participants. The faculty advisor and thesis committee member for this study were both licensed occupational therapists with several years of experience producing scholarly work.

Participant Recruitment

After receiving Ithaca College Institutional Review Board (IRB) approval (#4870) (Appendix B), and a letter of approval from the behavioral healthcare agency serving mental health and substance use disorders in New Jersey, United States of America (Appendix C), an on-site agency supervisor disseminated the recruitment invitation (Appendix D) via an email blast to two sites providing substance treatment programs. The on-site agency supervisor was provided

with blank informed consent forms (Appendix E) to give to any individual who expressed interest in the study. A licensed clinical social worker at one site electronically provided the primary researcher with signed informed consent forms from five individuals who were receiving substance related services through the agency. These participants were informed about the study from their individual counselors.

Inclusion Criteria

In order to participate in the study, individuals were required to; (1) be between 18 and 65 years old (2) have a diagnosis of a substance abuse disorder (3) be receiving psychotherapy or group therapy for substance use in the last 6 months (4) not currently homeless or in prison (5) not have a history of self-harm or harm of others and (6) not have a diagnosis of severe mental illness. Individuals were excluded from this study if any of the above inclusion criteria was not met.

Data Collection and Recording Data Transformation

Despite recruiting at two different clinical sites, all initial interviews were completed at one clinical site, were face-to-face, and occurred during the Intensive Outpatient Program (IOP) group time of all participants. Three individuals who had previously consented to participate did not show for their scheduled interviews. An intensive outpatient group counselor informed current on-site group members about the study and three new individuals participated after reading and signing informed consent forms. A total of five participants engaged in consecutive semi-structured interviews. Only two participants took part in follow up interviews despite all five participants voluntarily providing their phone numbers during the initial interview process. The three participants without follow up interviews were unresponsive to calls attempting to schedule. The total time for the interviews (initial and follow-up) ranged between 20 and 50 minutes. Individuals were compensated with 25-dollar Visa gift cards for participation in initial interview. TEMI (2020) transcription software was used to transcribe the recorded audio files verbatim and all identifying information was removed (TEMI, 2020). TEMI transcriptions were

cross referenced with original audio files to ensure accuracy. Handwritten notes were taken during all interviews and all collected data was marked with first and last initials to correspond with each participant for referencing and to prevent errors during the data analysis process.

Analysis

The primary researcher and faculty advisor separately conducted independent initial descriptive coding for each transcription. The phenomenological approach allowed the research team to make notes and form initial codes (Creswell & Poth, 2018). The process of reading through transcripts and forming codes was iterative. Concept maps were utilized for assistance throughout the coding process. Codes were grouped together based on similar meaning until themes and subthemes emerged. To ensure research questions were being answered, the primary researcher categorized emergent themes to correspond with the appropriate research question.

Several methods were implemented to establish trustworthiness of the data analysis (Creswell & Poth, 2018). Engaging in reflexivity in order to achieve confirmability was made apparent prior to engaging in the research process. That is, the primary researcher disclosed any preconceived understandings stemming from personal work experience. Second, constant comparison between primary researcher and faculty advisor was implemented for credibility throughout all stages of the coding process. Third, an audit trail was utilized for dependability which includes a compilation of all notes and concept maps leading to the development of the themes. Fourth, to ensure credibility, peer reviewing by the thesis advisor was implemented wherein questions related to the methods, understanding of concepts, and interpretation of data were asked. Fifth, the research committee member served as a third independent reviewer of data for external auditing (Creswell & Poth, 2018).

Chapter 4: Results

Five participants completed the initial interview for this study, all of whom attended the same Intensive Outpatient Program (IOP) at one clinical site of a behavioral healthcare agency in central New Jersey, United States of America. Participants' characteristics varied in sex, age, employment status, and substance use (Table 1) but shared some commonalities. All five participants acknowledged having a form of substance use disorder when they signed the informed consent as it included the inclusion criteria. All participants had children and a form of social or environmental support such as family members, co-workers, community groups, leisure, and/or volunteer activities. All participants had extensive substance use histories as well as some form of involvement in a legal program (e.g., probation, parole, Department of Children and Families) while receiving behavioral healthcare services. Incidentally, while no participant reported any difficulties with body functions, such as cognition or motor skills due to their substance use disorders, tangential speech, delayed understanding, and response to questions were observed in interviews with all participants. It is also important to note, two participants explicitly discussed challenges with mental health in conjunction with substance use.

Data analysis revealed several themes related to the three research questions for this study: (1) What are the lived experiences of individuals with substance use disorders who are receiving behavioral health services? (2) What are the perceptions of daily life of individuals with substance use disorders who are receiving behavioral health services? (3) What are the perceptions of the behavioral health services received by individuals with substance use disorders? Throughout the results, participants will be referred to by their initials to maintain anonymity.

Lived Experiences

Themes that emerged related to the lived experiences of participants included: cycle of use, emotional distress, and motivators for sobriety.

Cycle of use. All five participants spoke about experiencing a cycle of substance use, referring to a pattern of drugs and/or alcohol use, characterized by periods of sobriety and relapse. All participants began using either in childhood to early adulthood for varying reasons ranging from traumatic life events and peer pressure to medicating for pain management. One participant alluded to having a genetic predisposition and experiencing modelling behavior, in that his father was an alcoholic and he wanted to be just like his father. E.B. stated:

> My father was an alcoholic. That's what he did. I followed him. [I] wanted to be like my father. My first time hanging out in the bar was with him in Texas because back then, or even now, he was proud. 'Oh, I can bring my son and send him to the bar, feed him a beer [at] 11 - 12 years old that is cool' [with sarcasm].

Throughout participants' cycle of use, relapse occurred for varying reasons. Similar to reasons for onset of use, some participants succumbed to peer pressure while others presented with difficulty coping with ongoing traumas, pain, life demands, relationships, and lost employment. K.S., A.H., and E.B. identified an extensive history of "use and abuse" spanning decades, while J.F. and M.G. identified having received services multiple times from either the same or different recovery programs. E.B. and K.S. used the terms "vicious cycle" and "spinning wheel" to describe their history of use. A.H stated:

> This is a pivotal moment here because my dad was an alcoholic and I had always stayed away. I never drank, but I never ever would drink to numb a feeling, you know. I socially have a couple, but this was just different. Sure, enough I did, and I got whipped and then I was whipped for a while and it just snowballed from there. I had gotten treatment and I had clean time and relapse and clean time and relapse and clean time throughout.

Emotional distress. All five participants in this study shared sentiments of loss, guilt, and/or remorse throughout their histories of drug and/or alcohol use. Participants experienced loss of privileges, trust from family and peers, relationships with spouses or children, and employment. Two participants spoke of lost independence and subsequent dependency on others

due to revoked driving privileges. M.G. stated, “I lost my license a couple of months back. So, like it would just make me happier to do things on my own time rather than other people’s time.” Meanwhile, J.F. spoke of lost contact with her children due to her substance use history. J.F. stated “None of my other kids do [call her mom]. My six-year-old is with her paternal side and my oldest was adopted. I haven’t seen her since 2010 and not by choice. They shut me and my family out completely.” This loss contributed to J.F.'s guilt over not meeting the requirements of the Department of Child Protection and Permanency (DCPP) to regain custody of her other children, as she did for her son. Guilt is the term to describe the blame placed on oneself over the inability to fulfill responsibilities/roles when necessary. E.B. felt guilty for being a “bad father” and believed this emotion might subside if he maintained sobriety.

Apart from loss and guilt, some participants described remorse which was understood to be the awareness of and regret over life decisions. E.B. stated, “[I] was still doing shit I shouldn’t have been doing,” and wished to erase past actions. K.S. stated:

> I didn't take all the advice, you know, I half assed it. I went to a couple of meetings here and there...I white knuckled it for two years. You get out what you put in, right? You put in nothing you're going to get nothing. I wish I knew [what I know now] back then to take everybody seriously.

Motivators for sobriety. Four participants discussed intrinsic motivators, or internal thoughts or emotions that provided reasons to maintain sobriety. E. B. mentioned that a “fear of relapse” was a motivator in his recovery process when he stated, “thinking about it [relapse] right now scares me. I don’t want to go off the beam.” For two participants, intrinsic motivators related to the desire to maintain their relationships with family members. Additionally, these same two participants along with another described their intrinsic motivation as being related to an enhanced sense of self-worth stating, “it just feels good to be clean and responsible,” and “she [daughter] calls me now and she asks me for help and for guidance.” K.S. was intrinsically motivated by the pride and content expressed by his family members. He stated:

> I'm sober for today, you know what I mean? My family, my daughter means everything to me and she's so proud of where I'm at. And just that alone right there makes my day just knowing that she can go to bed tonight and knowing that I was sober. And if she needed me, I'd be able to be there for her, sober.

E. B. had increased determination for sobriety, despite feelings of low self-worth based on others' opinions of him. He described a conversation that transpired with former colleagues:

> You're talking to me? I'm an alcoholic addict truck driver. So why do you like me? '[Employers stated] because you do your job. You don't complain. People like you.' I never saw myself as that a little bit, but they saw that more. I thought, I've got a lot to live up to.

Some participants were motivated by their responsibilities of caring for family members and/or pets and others were motivated by expectations of employers, legal entities (drug court, probation, Department of Children and Families), and living environments. M.G. shared:

> I live in one of those Oxford houses, like the sober living house. It's kinda just a house where a bunch of people don't do drugs. And if you do then you get kicked out. Every week we have like a business meeting about the money and the rent and the bills and that's it.

Perceptions of Daily Life

Themes that emerged related to the perceptions of daily life for participants included: occupying time, staying connected, giving up control, meeting expectations, and living in the moment versus planning for the future.

Occupying time. All participants described their day-to-day schedules to include everything from program and community involvement to home care responsibilities and provision of family care. A.H. shared:

> I cook all the meals. I have my mom also. I help her as much as she needs. I get her medication, I'm responsible for all of her medications. I am responsible for all of my own

> medications. I help her dress. I make sure she has her meals in her bed, and I sit and spend a lot of time with her, talking with her.

Most participants shared the importance of occupying their time to either avoid relapse, falling into 'old behaviors', or boredom. E.B. stated, "I keep very busy. I mean, I get bored and all I know is to go back and do drinking and drugs...just try to keep busy, surround myself with positive stuff." Meanwhile, K.S. stated:

> I occupy myself with doing normal responsibilities...cutting up the lawn, winterize it, raked the leaves out...first couple of weeks of becoming sober you still don't feel great! I had to force myself [to stay busy] because if you get into that, downtime mood, you always want to stay like that.

Apart from home management K.S. took part in Alcoholics Anonymous (AA), sought volunteer activities such as firefighting, went fishing, and even requested an increase in days with his Intensive Outpatient Group.

Similar sentiments to "downtime mood" were shared by other participants who equated staying productive to decreased boredom and decreased bad days. A.H. stated:

> [in reference to what a good day looks like] Productive. Getting things done, not wanting to stay in my room. A bad day for me is in my bed and not wanting to answer my door, not wanting to answer the phone, doing the absolute minimum that I need to do.

Staying connected. All participants described the importance of staying connected or maintaining strong bonds/associations spiritually, with friends, with family, or with peers challenged by similar circumstances. For E.B. maintaining his bond with "God" correlated with maintaining sobriety. He stated:

> It's church in the morning because that shapes my day.... if I don't let go, let God in in the morning, I'm on this crazy path for today. That for me is my basis right now. That keeps me centered. And good that I found that. Some people might have goldfish they talk to, but I got God that I talk to.

Apart from church, E.B also described the need to care for his dog, attend AA meetings, consistently speak with his mother, and stay in touch with former co-workers.

Similarly, K.S described the importance of and gratitude towards God, in addition to his wife, daughter, and parents, for continued support in his life. For K.S., the support from his family was crucial for survival. K.S. recalled:

> There was just so much emotions and stress that something broke up there [brain]. It's a thought that went through my mind. It was like I was planning it all out and everything [refers to part thoughts of suicide]. You know, luckily my wife and my dad were there.

J.F. also described the importance of the support provided by her grandparents throughout her life, as well as how connected she felt to her son whom she was able to regain custody of. Two additional participants described how their leisure activities center on time spent with family or friends. M.G. spoke of the importance of playing video games as it connected him to his friends and A.H. spoke of how she enjoyed crafting as it allowed her to spend time with her grandchildren.

Giving up control. All five participants', either willingly or due to external pressures, gave up control to allow others to make decisions pertaining to their lives. E.B. willingly handed control over his life to God. He recalled:

> I wouldn't be where I am today if God wasn't involved in my life. I don't force it on anybody, but miracles in my life.... when I let things go and quit trying to control things and just try to pray on it, things go the way it's supposed to... I made a decision to turn my will and my life over to the care of God as I understand it.

K. S. also referred to the control God had over his life. He stated:

> God had different plans for me because you know, if he wanted me, he would've let me hang myself or overdose or whatever the case may be, but he got other plans for me because it gave me the opportunity to sit here and speak to you.

Four participants were required to stop driving and lost the ability to participate in activities on their own time due to revoked privileges and external circumstances beyond their control. J.F. described a level of acceptance over loss of driving privileges. She stated, "[this is] not my entire life...I might have to work around things you know, and it can be navigated." However, she described continued determination to seek the ability to drive again as she wanted to be able to participate in activities that were meaningful to her. M. G. described having to accept sober living house rules, such as following a curfew, however, was determined to regain control over 'doing things on [his] own time.' He continued:

> I can't sleep out because I'm on drug court, or I can't be out as the curfew is nine o'clock. I can't drive. The curfew thing is whatever cause you can at least have somebody come over. But the driving thing...that's important to me. I gotta fix that.

Meeting expectations. All participants described that within their daily lives, they had to meet the expectations associated with fulfilling personal roles and responsibilities. These roles and responsibilities pertained to family members, employers, substance related programs, and legal entities. M.G. described the expectations placed upon him by his sober living home, such as maintaining house duties and meeting curfew. Some found that meeting expectations had positive benefits. K.S. described that putting in the effort to meet expectations of others in his life, boosted his morale. He stated:

> They [counselors] don't fully, open up or, trust or whatever the case, so I'm doing everything [to the] highest of my ability. I want to put [in] that good work. Knowing myself and my God, that I was honest. But everybody believed me, and it was such a great fucking feeling.

Participant J.F. described the importance of fulfilling her roles and responsibilities, however in doing so, created a void in other areas of her life. J.F. spoke of wanting to take care of her medical needs and pursue further education but these took a backseat due to her obligations of caring for her son, her grandparents, and meeting program requirements. She shared:

> At this moment I feel like my responsibilities are taken care of. There are certain things that I still need to take care of, like myself...I need to go to see an ophthalmologist...regular things like OBGYN and stuff like that. And I feel like I'm just kinda lacking on that part. But I'm putting my son first before me because I [have] never done that... Being responsible and showing up...and not being all messed up and being able to concentrate and it will be responsible to do that... and help my grandparents out too as much as I can...It's tough right now, if I wanted to go back to school, it's hard, I have to work, I have to support myself and my child...It's not about what I want, it's about what he needs.

A similar sentiment was shared by M.G. who stated that the demanding schedule associated with substance related programs and meeting expectations of his sober living environment kept him from pursuing other goals.

Living in the moment versus planning for the future. Some participants spoke of living in the moment as they had difficulty reflecting on future plans. When prompted about what else she wanted to do in her life A.H stated, "I don't know. I never gave it any thought." A.H. also presented with difficulty reflecting on personal interests, taking increased time to describe any leisure activities she participated in. On the other hand, planning for the future elicited apprehension for E.B., who much preferred living in the moment. He shared:

> I'm just scared. Everything's a good routine, you know what I mean? One thing at a time. I've got a lot going on in the last month...whatever happens is going to happen next. That's the way I can do that today. I mean, that's the only way I'm surviving.

Of the five participants, M.G., was the only who was able to reflect on future plans but noted a busy schedule was a barrier in taking action towards his goals. He stated, "Yeah, soon as I get out of the IOP and my time frees up. I'm going to go to a cosmetology school and become a barber." J.F. described short-term goals for the future but had less concrete plans. She stated:

> I know my short-term goal right now is to get my license back this month. Save money, get a car, be independent. Eventually, you know, once I get transportation, I could maybe go find another job. Or, obviously get off drug court. Just to be able to support myself and my kid.

J.F. described the importance of taking care of her child and complying with program and legal requirements as barriers to taking action towards her goals.

Perceptions of Current Behavioral Health Services

Themes that emerged related to participants' perceptions of current behavioral health services included: meeting immediate needs and trust versus individuality.

Meeting immediate needs. All participants discussed that their current program met their current social and support needs. For some participants their current program provided written updates of compliance for legal entities. Participants stated they simply had to ask, and they would be provided with the needed resource or have their need/request met so long as it was "reasonable." M.G. shared, "Even when I need so-and-so to write me a letter for court and they do that, that's my needs being met. Like anything that I can really ask for that is reasonable." If a participant's need was not fulfilled, the onus was on the participant, as A.H. described:

> If it [the program] didn't suit a need it was because I wasn't putting out there what I needed [advocating for herself] or wasn't taking part [being involved fully in the program], you know, but services have always been there. It's just me.

One participant described the current program to be a place to seek social support and discuss ongoing problems in his life. He recalled the support his counselors, group members, and probation officer showed him after a false negative drug screen stating, "Everybody [was] like you got this, we support you, we believe in you. That was good, because for the past five years you have people always like 'I don't care about your problems or we don't believe you.'

Only M.G. reflected on the limitations of the services he received. He wished for his current group program to include scenario-based discussions to provide members the opportunity

to critically think and reflect on the repercussions of potential relapses. He shared, “If [someone] were to relapse today what would the next three months be like in his family life, his work life, social life, and his own life.”

Trust and individuality. One sentiment shared by most participants was the lack of trust and/or individuality they experienced throughout various treatment programs that they had participated in. J.F. described how she would be faulted or lumped together with other group members who may have broken rules or engaged in substance use at the primary treatment agency. She stated:

> Something that happened the other night, people weren't listening or [were] talking...and it's always everyone. It's not always everyone. Half of the people in the classroom were vaping [according to group leaders]. No, we weren't. That stigma as ‘everyone’ is not everyone. Pinpoint the people that actually did it. Why do I have to suffer, because that person can't follow the rules?

M.G. described a similar sentiment at his sober living home. He stated, “if one person falls out, it could affect somebody else.”

Meanwhile, K.S. explained the value of trust from peers and clinicians at his program and its impact on his self-worth. He shared:

> My mind is still trying to get back from using in the last five years and then this hits you [referring to a false positive on a drug test]. For once you're being honest and yet nobody believes in you. But then once I found out everybody was believing me...I was in a good mood... And like she [counselor] was the first one that believed me right off the bat.

Chapter 5: Discussion

This study aimed to understand the lived experiences and perceptions of daily life and behavioral health services of individuals with substance use disorders currently receiving behavioral health treatment. Thematic analysis revealed several themes related to each of the research questions.

Lived Experiences

Participants in this study described a history of a cycle of use, emotional distress, and varying motivators for sobriety over time. All participants experienced a cycle of drug and/or alcohol use often beginning in childhood and spanning several months to years; biological and contextual factors influenced onset and relapse episodes. Throughout each participant's cycles of use, intrinsic or extrinsic motivators influenced sobriety. Participants described multiple episodes of care with either the same or different substance misuse programs. Participants lived with an ongoing expectation of potential relapse that could derail their recovery and subsequently create ongoing emotional distress and fear. These results suggest that there is a significant gap between current behavioral health services for substance use disorders and an individual's ability to maintain long-term sobriety. It may be important for individuals with substance use disorders to receive more consistent and effective healthcare interventions that go beyond meeting their immediate support and social needs. Additionally, participants experienced significant emotional distress related to their cycle of substance use, expressing sentiments of loss, guilt, and remorse associated with their level of independence, employment, relationships, and other life decisions. These results support the research of Martin et al. (2011) who found mothers in recovery from drug and/or alcohol addiction expressed guilt and/or remorse over their inadequate handling of responsibilities pertaining to their children. It is possible these sentiments pertaining to past actions or inactions impact decisions in the present.

Perceptions of Daily Life

Participants in this study reflected on the importance of occupying time, staying connected, giving up control, meeting expectations, and living in the moment or planning for the future. All participants verbalized the importance of occupying their time and staying busy. For some participants occupying their time by engaging in activities in their communities, homes, or virtually was important to prevent boredom. Some participants spent their days connecting with family and friends, while others connected spiritually. For others, the fear of relapse contributed to a need to occupy time by engaging in activities to assure sobriety. The theme of 'occupying time' was also found by Cruz (2019) and Wasmuth et al. (2016b). Cruz (2019) found that 'leisure exploration and participation' was the result of the participants' desire to fill their time with substance-free activities to prevent relapse. Similarly, Wasmuth and colleagues (2016b) identified that participants sought out 'other occupations' to avert addictive behaviors. The consistent theme of 'occupying time' found in this study and prior research offers insight into the importance of engaging in meaningful occupations as a means to support recovery and mitigate boredom and subsequent relapse.

The theme of 'staying connected' in this study was also a common theme in both occupational therapy and psychology literature (Cruz, 2019; Cavanaugh, 2019). Cruz (2019) described 'social participation' to include a desire to engage with family members or the community. Cavanaugh (2019) found individuals in recovery from homelessness and substance misuse valued making and maintaining social connections post recovery for multiple reasons ranging from increased self-image from being connected to a more 'responsible' group of peers to fostering connections and networks for potential job opportunities. In this study, participants placed value on spiritual relationships or relationships with family, friends, peers, and community members. All participants occupied their time with some form of social connection, and some took part in leisure activities which connected them to a friend or family member. Social connection was a key component of occupying time as relationships with other individuals

outside of the treatment program were prioritized. The results of this study support that of Cavanaugh (2019), in that it may be reasonable to assume that social connections are valuable to the recovery process.

Participants described either willingly, or due to external circumstances, giving up control over their lives. Two participants described handing control over to God. It is relevant to note, that both participants were actively engaged in Alcoholics Anonymous, a 12-Step program with a strong spiritual focus (Donovan et al., 2013). The spiritual aspect of the 12-Step Program may explain the readiness to hand over control of life decisions to God as demonstrated by the two participants in this study. Giving up control due to external circumstances beyond participants' control resulted in forms of lost independence such as driving, which led to an inability to participate in occupations on their own time. One participant was more vocal about their determination to regain lost driving privileges, while some participants demonstrated a level of acceptance over their circumstances; this may be a result of an increased need to comply with what was expected of them.

Participants described the importance of ‘meeting expectations’ of other people, treatment programs, living environments, and legal entities. For some participants, meeting expectations contributed to an enhanced sense of self-worth or *self-concept* (AOTA, 2020a). For others, meeting expectations signified role competence (AOTA, 2020a). A similar result by Davies & Cameron (2010) was found in that participants placed an importance on fulfilment of responsibilities. Participants in this study acknowledged experiencing a loss of relationships and roles during periods of active substance use. It may be that participants now placed a greater value on their relationships after becoming sober and therefore had increased motivation to meet the expectations associated with their relationships. This is supported by Lander and colleagues (2013) who explained that obligation towards family may be the result of the typical toll that substance use disorders have on familial relationships.

Other participants experienced, to some degree, occupational deprivation. Occupational deprivation was noted by two participants who described not having time to engage in all desired occupations such as preventative healthcare or further education due to their substance program requirements and other role responsibilities. Busy schedules, complying with loss of privileges and independence, meeting the requirements associated with treatment programs and legal entities, and prioritizing certain roles and responsibilities, resulted in these participants placing little importance on self. Decreased focus on self may explain why some participants had difficulty establishing future oriented goals. In this study, some participants were able to loosely formulate long-term goals for themselves while others never gave it a thought. The participants who described not having time to engage in health maintenance or pursue further education, were noted to have only vague plans for the future. In both cases, participants stated that the responsibilities and demands placed upon them were keeping them from moving forward and accessing all desired occupations.

Perceptions of Current Behavioral Health Services

Finally, all participants perceived that the services they were receiving from their current treatment program were meeting their immediate support and social needs, especially when they experienced feelings of trust and individuality from their treatment providers. All participants described satisfaction with their services in that they met their needs associated with fulfilling legal and program requirements. One participant noted that the onus was on the participants themselves if they perceived that their needs were not being met; emphasizing that if individuals were willing to ask for what they needed, they would receive it. It is interesting to note that participants in this study were not able to identify any other outstanding treatment needs they might have beyond the need for immediate support and socialization.

These results may be explained by two possibilities. First, all participants came from the same program and group, and shared counselors. This may have impacted the quality and diversity of services they have received thus far. Second, since no participant reported receiving

occupational therapy services, they may not recognize the occupational needs they have that fall within the scope of occupational therapy and that are missing from their current care. Only one participant was able to reflect on something he would want to change about the behavioral health services he was receiving, which was related to scenario-based education. Additionally, while most participants expressed satisfaction with their behavioral health services, some participants discussed a perceived lack of trust and individuality from counselors which may speak to a lack of client-centered care. Client-centered services that focus on facilitating optimum occupational performance, health management and maintenance, and long-term goal setting and achievement may be potential roles for occupational therapy practitioners when working with individuals with substance use disorders.

Model of Human Occupation

Many of the themes identified in this study can be understood through the lens of the MOHO, similar to previous research on substance use disorders (Cruz, 2019; Davies & Cameron, 2010; Dietz & Schriber, 2017; Wasmuth et al., 2014). In this study, participants' lives were shaped by a pervasive cycle of drug and/or alcohol use impacting their occupational lives. This cycle of use included periods of sobriety and relapse, dependent on participants' volition, including intrinsic/extrinsic motivators, occupational choices, and the influence of environmental triggers and supports. Participants' occupational choices related to their social and spiritual engagement, occupying their time with adaptive activities, and fulfilling roles and responsibilities. Level of control over the circumstances in their life may have also impacted participants' volitions. Participants described their daily routines to include a focus on role fulfillment (such as caring for family members and completing household chores), adjustment to lost driving privileges and lost ability to determine their own schedules, and compliance with legal entities and current substance treatment programs. Habituation from a previous lifestyle to a new lifestyle required participants to create adjustments and adapt to the changes that have occurred in their lives due to their cycles of use.

As the MOHO is person-centered (Kielhofner, 2008), it may be useful in addressing the potential areas of need identified in this study. First, MOHO enables occupational therapy practitioners to view each person as an individual, not part of the collective (Forsyth et al., 2014; Kielfhofner, 2008;). Second, this model explores occupational adaptation which is notably difficult for participants who provided examples of occupational deprivation and loss of independence. Third, this model offers the development of measurable goal setting to support engagement in desired occupation and to create change (Forsyth et al., 2014; Kielfhofner, 2008). MOHO explores change, perceiving that change occurs both internally and externally in the individuals' environment (Cole & Tufano, 2008). If an individual chooses to engage in new behaviors, adequate practice and incorporation of feedback from the environment may allow for new behaviors to become more habitual (Cole & Tufano, 2008). This aligns with the findings of Correia et al. (2005) and Daughters et al. (2017) who found individuals' persistent engagement with non-substance use activities, such as leisure activities led to changes which resulted in increased abstinence (Correia et al, 2005). Therefore, MOHO may be a useful theoretical lens when working with individuals with substance use disorders to develop new occupational choices, involving non-substance related behaviors. Finally, though none of the participants in this study indicated any changes in performance capacity, participants displayed tangential speech and slowed response to questions during the interview process. Previous studies indicate that cognition and motor skills are impacted by substance addiction (Rojo-Mota et al., 2013; Rojo-Mota et al., 2014). Given the pervasive cycle of substance use noted by participants, it is likely that cognitive and motor skills were impacted, however, these were not specifically assessed in this study. Since impaired performance capacity negatively influences occupational performance in individuals with substance use disorders (Rojo-Mota et al., 2014) assessing client factors and performance skills would be a relevant role for occupational therapy within traditional substance treatment programs.

Transtheoretical Model (Stages of Change)

Given the chronic and cyclical nature of substance addiction (NIDA, 2018a), it may be beneficial to use the TTM in conjunction with occupation-based models, such as MOHO, to help understand the lives of individuals with substance use disorders and guide services. In this study, participants described their own experiences starting with 'precontemplation' and progressing to the 'action' stage of change. Whether voluntarily or mandated, all participants in this study were receiving behavioral health services and subsequently, were in the action stage of change. Participants were in the process of actively making behavioral and lifestyle adaptations in response to the recovery program and legal requirements and creating a lifestyle free from drug and/or alcohol use. Participants identified short-term goals to support maintenance of their sobriety but had difficulty establishing long term goals and plans, which could negatively impact ongoing 'maintenance' of sobriety and engagement in meaningful and adaptive occupations. Prochaska & Di Clemente (1982) discussed the importance of self-efficacy when attempting behavior change. Therefore, individuals may require a strong sense of self-efficacy to ensure long-term maintenance of sobriety especially given participants' experiences with multiple episodes of relapse and remission.

Implications for Occupational Therapy

This study was unique because it explored perceptions of current behavioral health services and the lived experiences and daily lives of individuals with substance use disorders. While the themes found in this study were similar to that of previous occupational therapy studies, such as Cavanaugh, (2019), Cruz, (2019), Davies & Cameron, (2010), and Wasmuth et al. (2016b), unique themes pertaining to daily life and perceptions of current behavioral health services were also revealed. This supports the role of occupational therapy practitioners as part of the interdisciplinary team providing services to individuals with substance use disorders.

Participants identified several areas of occupation that they valued, including relationships with family and friends, spirituality, community, work, home maintenance, and care

of family members. During periods of active substance use, participants lost relationships, work, and described guilt and remorse over decisions and inadequate fulfillment of roles and responsibilities. Additionally, participants described the impact of lack of trust being an unwanted result of active drug and/or alcohol use that impacted relationships with counselors, group members, family members, and on personal self-worth. During sobriety, participants demonstrated the ability to engage in occupations that met the demands of various roles but noted difficulty in participating in other areas of desired occupations such as health management, education, and work. As sobriety plays an important role in the lives of this group of participants, an opportunity for occupational therapy may be to assist individuals in maintaining long-term sobriety and engagement in current and new meaningful occupations.

Maintenance is a stage of change within the TTM, a model beginning to be adopted by occupational therapy practitioners as the profession moves towards an active role in health promotion and prevention in emerging areas of practice (Morris & Jenkins, 2018; Rietz, 2014). Therefore, in addition to the use of occupation-based models, occupational therapy practitioners may embrace existing health promotion models, like the TTM, as a basis for understanding health behavior change in individuals with substance use disorders. Utilizing the TTM, occupational therapy practitioners may be able to support an individual at any stage of change as needed. For example, occupational therapy practitioners may support social participation and exploration of leisure activities as participants identified a desire to stay occupied to prevent relapse and boredom.

In this study, participants presented with tangential speech and delayed understanding and response to interview questions. Therefore, a potential role for occupational therapy practitioners is to address cognitive changes in individuals with substance use disorders. Further, participants could not identify other treatment needs beyond the social and immediate support provided by their current behavioral health program. Yet, participants described receiving treatment for their substance use disorders multiple times and with several different

agencies suggesting that there may be gaps in traditional services impacting long term sobriety. Participants may not be aware of any other potential treatment needs they may have beyond the services provided by their current treatment program. A distinct value of occupational therapy within behavioral health services may be the assessment and treatment of impairments in performance skills and client factors (AOTA, 2020a) that may negatively impact successful occupational performance.

Finally, participants in this study noted difficulty in developing long-term goals and most participants appeared to "live in the moment," with only a few participants being able to conceive of future plans. Some participants noted future plans but seemed to be consumed by current commitments and roles, depriving them opportunities to engage in new and/or meaningful occupations. A role for occupational therapy practitioners in working with individuals challenged with substance use disorders is to assist in establishing client-centered long term goals using occupation-based models and frameworks which appears to be missing in behavioral health services. Given that the use of occupation to promote the health of an individual is within the occupational therapy scope of practice (AOTA, 2014), occupational therapy practitioners may focus on health promotion, maintenance, and prevention to support long term sobriety. Cumulatively, these areas of support provided by occupational therapy practitioners may assist individuals with substance use disorders to lead more meaningful and productive lives.

Study Limitations

Results of this study may have been impacted by the recruitment process and variables during the interview process. First, the participant pool may share program related experiences, as they all came from one agency clinical site and IOP group, which may have impacted diversity of responses related to perceptions of current behavioral health program; participants may present with biases towards their program group or program counselor. Second, this study did not account for program policies, structures, or the individuals' socioeconomic status and their access to substance related services. This may have impacted who was able to participate in the study and

results may only represent a specific population demographic. Third, as the researcher could not verify whether or not participants accurately met the inclusion criteria for this study, the intended participant pool may not be accurately represented impacting the trustworthiness of the results. Fourth, contextual factors like environment, time, and structure of the behavioral health program may have impacted participant responses. Interviews were conducted during evening hours when most participants had scheduled transportation to return home. This could have impacted the depth of participant responses as they may have been eager to make their transportation on time. Further, participants were scheduled for back-to-back interviews leaving little time for the researcher to reflect on data and ask immediate follow-up questions. Additionally, only two individuals responded for follow-up interviews potentially limiting the richness and accuracy of the data. Fifth, because this research included participants solely from an outpatient setting, the results cannot speak to the experiences of individuals with substance use disorders receiving different levels of care as they may present with different needs. Sixth, the types of questions asked during the interview process may have limited the depth of answers provided by participants, especially pertaining to perception of current behavioral health services. For example, participants were not asked questions regarding their understanding of occupational therapy services or their motor and cognitive functional abilities. . Therefore, they may not have been able to reflect upon potential treatment needs and gaps within current behavioral health services.

Chapter 6: Summary, Conclusions, & Future Research

Substance use disorders result in thousands of deaths per year in the United States. Individuals challenged by substance addiction may face significant physical, psychological, and social impairments impacting participation in daily life activities. The pervasive impact of substance addiction on the individual aligns with the holistic client-centered approach used in occupational therapy. Occupational therapy practitioners are already working with individuals challenged by substance use disorders, conditions diagnosed to include the spectrum of use (APA, 2013). Occupational therapy studies have explored the impact of addiction on individuals' physical and cognitive health (Martin et al., 2011; Rojo-Mota et al., 2014; Sanchez-Camarero et al., 2019; Wasmuth et al., 2015), sensory function (Bar-Shalita et al., 2019), participation in occupation (Cruz, 2019; Davies & Cameron, 2010; Wasmuth et al., 2016b), and occupational identities (Martin et al., 2011). Occupational therapy studies have also explored addiction as an occupation (Wasmuth et al., 2014; Wasmuth et al., 2016b), the opioid epidemic (Pivont & McCombie, 2020), and have developed measures and protocols (Dietz & Schriber, 2017; Martin et al., 2015) to assist in working with this population. Yet, the results of systematic reviews indicate that there is inconclusive evidence supporting occupational therapy's role when working with individuals with substance use disorders (Hutchinson et al., 2019; Rojo-Mota et al., 2017a; Wasmuth et al., 2016a).

The purpose of this study was to explore the impact that substance use disorders have on individuals' lives and their perceptions of daily life and current behavioral health services. In doing so, this study aimed to add to the existing occupational therapy literature and potentially further help in identifying a role for occupational therapy when working with individuals with substance use disorders. Based on the views of participants in this study, substance use disorders created a pervasive cycle of drug and/or alcohol use which impacted role fulfillment, participation in occupations, and self-concept. In their daily lives, participants utilized social participation, leisure activities, spirituality, and/or community engagement as a means of occupying their time

out of fear of potential relapse or due to boredom. Given the results of this study, potential roles for occupational therapy with this population include providing client-centered care to aid in planning and achieving long-term occupational goals, fostering health and wellness, addressing potential client factors and performance skills that may be impacting occupational performance, facilitating enhanced self-worth and self-efficacy, and creating adaptive habits and appropriate use of time to foster enhanced success in maintaining sobriety.

Conclusions of the Present Study

1. Substance use disorders may create a pervasive cycle of use impacting individuals' participation in daily occupations, emotional health, and self-concept.
2. Individuals living with substance use disorders may value occupying time and social connection out of fear of relapse and/or boredom.
3. Individuals with substance use disorders may live with altered levels of control over their lives and life decisions and seem to strive to meet the expectations of others sometimes creating occupational deprivation in their own lives.
4. Individuals with substance use disorders may have challenges with developing long-term goals, establishing their own individuality, and trusting others.
5. Individuals with substance use disorders may perceive that behavioral health services are effective in meeting their treatment needs; however, may lack insight into unmet treatment needs and additional available services, such as occupational therapy.
6. Potential roles for occupational therapy when working with individuals with substance use disorders may be utilizing occupation-based theories and public health models to create client-centered treatment plans to assist individuals with engaging in self-care, establishing occupational identity, facilitating long-term goals, and maintaining sobriety, as desired.

Recommendations for Future Research

As a result of the significant impact substance addiction has on individuals and society and how the occupational therapy profession aligns well with the needs of the population, the following are recommendations for future occupational therapy studies:

1. Explore perspectives of individuals across all levels of care and settings to gain a greater understanding of the varied needs of individuals with varying levels of function receiving treatment for substance use disorders.
2. Create similar studies exploring the lived experiences and perceptions of daily life and current behavioral health services of individuals with substance use disorders across multiple settings, geographical locations, and with a diverse participant group further supported by quantitative studies to enable greater generalization of results.
3. Explore the effectiveness of occupation-based occupational therapy services with individuals actively receiving treatment for substance use disorders.
4. Explore the provision of occupational therapy services with individuals challenged by substance use disorders to address potential impacts of substance use on client factors and performance skills.

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Table 1

Participant Characteristics

Participant	Sex	Age	Employment Status	Primary Substance (s)
E.B.	Male	49	Currently unemployed	Alcohol
K.S.	Male	41	Seasonally employed	Heroin/ Opiates
J.F.	Female	32	Employed Part-time	Alcohol, Cocaine, Heroin
M.G.	Male	23	Employed Part-time	Unknown
A.H.	Female	47	Currently unemployed	Alcohol, Cocaine, Heroin/Opiates

**Note: All participant characteristics are based on self-reports during initial interviews.*

Appendix A: Interview Questions

1. Tell me about yourself.
    a. Are you currently working or in school?
        i. If so, can you tell me about some of the jobs you have held in the past or jobs that you may currently be doing.
        ii. If so, can you tell me about your studies?
    b. Are you responsible for the care of children, a partner, or another individual in your life? Can you tell me about that?
        i. How well do you feel you handle the responsibilities associated with your current jobs/studies/family life? Can you give me some examples?
        ii. Has your ability to handle your responsibilities related to work/studies/family changed over time? If so, how? Can you give me an example?
2. Is there anything else that you do in your life that takes up a lot of your time and energy How important is this to you? Why or why not?
3. Describe your ability to complete these activities?
4. How would you describe your friendships? Can you give me an example?
5. How satisfied are you with your social network? Why or why not?
6. Tell me about your home/living situation.
    a. Do you live with anyone?
    b. How satisfied are you with your home/living situation? Why/why not?
    c. What kind of responsibilities do you have within your home?
    d. How satisfied are you with your ability to complete your responsibilities at home? Why/why not?
    e. Does your living situation support your ability to do your day-to-day activities? Why or why not? Can you give me an example?
7. Tell me about what a typical day looks like for you? or Can you describe a typical day. What do you do on a day-to-day basis?
    a. Are weekends any different from weekdays? Give me an example?
    b. Can you describe what a good day is for you?
        i. What makes it good day for you?
    c. Can you describe what a bad day for you would be?
        i. What makes it a bad day for you?
    d. Are you satisfied with your current daily routine? Why/why not?

e. What are the most important things in your daily routine?
f. Are you able to complete the things that are most important to you? Why or why not?
g. Is there anything that you would like to change about your current routine? Why/why not?

8. Tell me about some of the activities you engage in (hobbies, projects?)
    a. Do you enjoy these activities? What is it about these activities that you enjoy?
    b. Are you able complete these activities as often as you would like? Why or why not?
    c. Are there things you would like to do that you currently aren't able to? What is about these activities that makes you want to do them? How come you currently are not able to do them? Can you give me an example?
9. Do you get to do the things that are really important to you?
    a. If yes: What are some of the things that are really important to you?
    b. If No: Can you tell me about those things you don't get to do? What are things you can't do? Why do you feel you can't do them?
10. Is there anything that interferes with the things you want to do?
    a. Do you feel substance use impacts any of the activities you need to, want, or would like to engage in? If yes, please explain and provide examples.
11. Tell me about the services you are currently receiving for your substance abuse. What are your experiences related to these services?
12. How satisfied are you with the services that you are receiving? Please explain.
    a. Do you feel that the current services you are receiving, address all your needs?
        i. In what way does your current services meet/not meet your needs? Can you provide examples?
13. Is there any other information you would like to share?

Example of follow up interview questions during the second interview:

I would like to review the information that you shared with me during out last interview. Based on our conversation, it is my understanding that… does that sound correct?

1. Now that you have had time to reflect on our last interview, based on your responses at that time is there any additional information that you thought of that you feel would be important for me to know?
2. Has there been any change to the information you provided? If so, please describe.
3. Is there any other information you would like to share with me at this time?

Appendix B: IRB Approval Letter

Ithaca College IRB — *Approval Notification*

To: Roshni Patel
From: Warren Calderone
Subject: Protocol #85
Date: 11/26/2019

ITHACA COLLEGE
Sponsored Research

Re: [IRBID]Individuals with Substance Abuse: Perceptions of Daily Life and Behavioral Therapy Services

Thank you for submitting your proposal to the Institutional Review Board for Human Subjects Research (IRB). You are authorized to begin your project. This approval is issued under the Ithaca College's OHRP Federal-wide Assurance #00004870 and will remain in effect for a period of one year from the date of authorization.

Please add the IRB approval number (IRB [IRBID]) to ALL recruitment and consent materials.

The approval of your study is valid through 11/25/2020, by which time you must submit an annual report either closing the protocol or requesting permission to continue the protocol for another year. Please submit your report by **10/28/2020** so that the IRB has time to review and approve your report if you wish to continue it for another year. The project can be extended up to three years.

Please note that if there are any adverse events resulting from this research, they must be submitted through Axiom.

Sincerely,

Warren J. Calderone

Warren Calderone
Director of Corporate, Foundation Relations, and Sponsored Research
Institutional Review Board for Human Subjects Research

953 Danby Road, Ithaca, NY 14850, (607) 274-1206
www.ithaca.edu/sponsored-research
ithaca.edu

Appendix C: Site Approval Letter

ITHACA COLLEGE
School of Health Sciences and Human Performance
Department of Occupational Therapy

Dear [redacted] (Vice President of Clinical Operations)

I am a graduate student in the occupational therapy department at Ithaca College, Ithaca, NY and am completing my individual thesis as part of the requirement for my Master of Occupational Therapy. As we discussed previously, I am conducting a research study on the perceptions of individuals with substance abuse who are currently receiving individual or group treatment about their daily lives and their experiences with substance abuse services. The purpose of my study is to learn more about the potential role for occupational therapy when working with individuals with substance abuse disorders.

Nature of the Study:

For this study, I am looking to recruit 4 to 5 individuals to participate in 2 semi-structured non-consecutive interviews for a total interview time of approximately 1 hour. The first interview would be approximately 45 minutes in length. The second interview will be approximately 15-20 minutes in length used to ensure the information obtained in the first interview is accurate and to allow the participants an opportunity to fill in any information that may be missing. Interview questions will address participants' perceptions of their daily life, the impact that their drug use may have on their daily life, and current substance abuse services.

Recruitment:

The inclusion criteria for participation in my study is: 1. ages 18 and 65 years 2. Individuals must have been receiving a form of psychotherapy or group therapy for substance use in the last 6 months of treatment. 3. No current status of homelessness or incarceration. 4. Must have a primary clinical diagnosis of a substance abuse disorder. 5. No history of self-harm or harm of others. 6. No existing diagnosis of severe mental illness. As we previously discussed, I am asking for assistance in disseminating the invitation to participate in this study to individuals who are receiving services at your facility. The invitation will include my name and contact information so that if someone is interested in participating in this study, they can reach out to me directly. Additionally, I will plan to have blank copies of informed consent forms at the front desk at designated [redacted] locations for individuals interested in the study, to sign. Please note that [redacted] employees will not be a part of the study, nor will they be required to carry out any tasks related to the study.

Location:

To provide familiarity of location for the participants, and to ensure privacy of information, I would like to complete the interviews in person at [redacted] locations in a closed office setting during regular business hours. If there is a scheduling conflict between researcher and participant, the interviews would, alternatively, be conducted by telephone or video conference.

Please sign below indicating that you affirm the following:

a) Understand the purpose/nature of this study and,
b) Understand and agree to disseminate the invitation to participate in the study to individuals who are currently receiving services at [redacted] and
c) Understand and agree that the researcher may conduct the interviews on site at the designated locations.

Please sign your name below.

x [redacted]

[redacted]

Vice President of Clinical Operations

x

Roshni Patel

Occupational Therapy Student Researcher

953 Danby Road • Ithaca, NY 14850 • (607) 274-1975 • (607) 274-3055 fax

ithaca.edu

Appendix D: Email/Phone Recruitment Statements

Email to Supervisor of Addiction Recovery Program:

Hi [Name of Clinical Site Supervisor]

I am asking for assistance in disseminating the following information about the study as an invitation to participate to individuals who are receiving services at your facility. The information to disseminate is attached.

Thank you again for the opportunity.

Sincerely,

Roshni Patel
Master's in Occupational Therapy Student
Ithaca College
Ithaca, NY

(Recruitment statement)

Hello,

I am conducting a research study about the experiences of people with substance abuse disorders who are currently receiving individual or group therapy.

I am looking for 4 to 5 people to participate in 2 interviews for a total time of about 1 hour. The first interview will be about 45 minutes long. The second interview will be about 15-20 minutes long

To participate you must meet the following:

1. Be between 18 and 65 years old
2. Have a diagnosis of a substance abuse disorder.
3. Be receiving psychotherapy or group therapy for substance use in the last 6 months
4. Are currently not homeless or in prison.
5. Not have a history of self-harm or harm of others.
6. Not have a diagnosis of severe mental illness.

During the interview, I will ask you questions related to your daily life such as taking care of yourself, taking care of your home, work, family, social life, involvement in the community, how drug use may affect your daily life, and your current substance abuse services.

People who participate in the full study will be given a 25-dollar visa gift card (15$ visa gift card for the first interview; and 10$ visa gift card for the second interview). You will receive gift cards for the study whether you complete both interview or not.

You may refuse to answer any questions or stop the interview at any time without consequences. Any information provided in the interview will be confidential between the researcher and the faculty advisor.

If you want to participate you will have to sign an **Informed Consent Form**. The informed consent form is a form explaining the study in more detail and is needed so that it is in writing that we have your permission to participate in the study.

There will be informed consent forms at the front desk of either [Location Name]. You may come in to either one of the locations and sign a form if you are interested. After signing, place the form in the pre-stamped envelope provided and return through the US Mail. If not signed, we can't schedule the interview.

If you want informed consent forms emailed to you or have any other questions, please contact me at the number or email below.

My Name: Roshni Patel
Email Address:
Phone Number:

Appendix E: Informed Consent

Title of Study: Individuals with Substance Abuse: Perceptions of Daily Life and Behavioral Therapy Services.
Principal Investigator: Roshni Patel, OTS. Ithaca College.
Faculty Advisor Shannon L. Scott, OTD OTR/L. Assistant Professor Ithaca College

Invitation to Participate in a Research Study
You are invited to participate in a research study consisting of 2 interviews, conducted by the principal researcher: Roshni Patel, to learn about experiences related to your day-to-day activities, the impact that your substance abuse disorder may have on these activities and your views about the services you are currently getting for your substance abuse. To participate you must:

1. Be between 18 and 65 years old
2. Have a diagnosis of a substance abuse disorder.
3. Be receiving psychotherapy or group therapy for substance use in the last 6 months
4. Are currently not homeless or in prison.
5. Not have a history of self-harm or harm of others.
6. Not have a diagnosis of severe mental illness.

Participating in this study is voluntary and you may stop at any time with no consequences.

Important Information about this Research Study
Purpose of the study: To learn about your daily life such as how you take care of yourself, take care of your home, work, family, participating socially, involvement in the community, how drug use may affect your daily life, and your current substance abuse services. The information provided in this study may help us learn more about occupational therapy services for people diagnosed with a substance abuse disorder.

If you choose to participate, you will be asked to sign this consent form, and schedule appointments for two face to face interviews taking place at either [Location Names]. If face to face interviews are more difficult to do, phone and/or video interviews may be arranged.

You will be provided with a 15-dollar visa gift card for participating in the first interview and a 10-dollar visa gift card for participating in the second interview for a total of 25 dollars. The total time for participating is approximately 1 hour.

Potential Risks and discomforts associated with this research
Reflecting on your personal experiences related to drug use, health issues, family/social relationships, employment
status, home care, and quality of life may contribute to emotional stress.

Direct benefits to the participants
There is no direct benefit to your participation in this study. But thinking about your everyday tasks and drug use may help you find areas for change or growth.

Please read this entire form and ask questions before deciding whether you would like to participate in this research study.

1. Purpose of the Study

Substance abuse can cause challenges in everyday tasks like social life, work, and managing your finances. Drug addiction may result in loss of employment, stable housing, and social supports. Occupational therapy (OT) can help support long-term recovery by looking at roles, habits, routines, and providing people with information to help them restructure their lives to be more meaningful and fulfilling. The purpose of this research is to learn about the first-hand experience of people with substance abuse disorders.

2. Benefits of the Study

There is no direct benefit to you by participating in this study. But you may benefit from the conversation, and from reflecting on areas of strength and needs with everyday activities. This study will benefit the researcher because it will meet requirements to graduate. The study may benefit the research community to learn more about the study topic.

3. What You Will Be Asked to Do

You will be asked to sign an informed consent form and participate in two interviews. The first interview will be about 45 minutes. The second interview will be about 15 minutes. During the interview you will be asked to answer questions related to your daily life, community involvement, and opinions related to your current participation in psychotherapy/group therapy.

You are unable to participate in this study if:

1. You are below the age of 18 and over the age 65.
2. You have been in psychotherapy or group therapy for substance abuse less than 6 month
3. You are currently homeless or in prison
4. You have a history of self-harm or harm of others.
5. You have a severe mental illness.

4. Withdrawal from the Study

If you feel you no longer wish to participate in this study, you may stop at any moment. During participation in this study, you may refuse to answer questions if you wish, without question. If you stop participating or refuse to answer questions during the interview process, you will still be provided with the gift card total fixed for each interview. The researcher will proceed in examining the information you provide willingly.

5. Risks

Because the study is asking you to think about personal strengths and weakness, drug use, health issues, family/social relationships, employment status, home care, and quality of life, there may be a risk if you participate. If you feel discomfort, or emotional stress during any part of participating in this study, please inform the researcher immediately. After participating in the study, if you feel any discomfort, emotional stress, thoughts of suicide, self-harm, or harm of others, please seek advice from your therapist or physician. Below are free resources to assist you if required:

1. National Suicide Prevention Hotline Phone Number: 1-800-273-8255
2. [First hospital name, address, phone number]
3. [Second hospital name, address, phone number]

6. How the Data will be Maintained in Confidence

Please be aware, any information you provide during the interview will be confidential. Any identifying information such as your name, gender, will not be included in the study project.

Your participation in the study will only be known to the primary researcher (Roshni). Any papers and recordings associated with the study will be kept in a locked cabinet and password-protected computer and then destroyed after 3 years. Access to records related to the study will only be available to the primary researcher and faculty advisor.

Use of information beyond this study
Identifying information may be removed and used for future research without additional informed consent from the participant.

7. Compensation for Injury
While this study will have minimal risk to you, if you suffer an injury that requires any treatment or hospitalization because of the study, the cost for such care will be charged to you. If you have insurance, you may bill your insurance company. You will be responsible to pay all costs not covered by your insurance. Ithaca College will not pay for any care, lost wages, or provide other financial compensation.

8. If You Would Like More Information about the Study
Prior to, during, and after completion of this study, if you would like to learn more please feel free to contact the researcher: Roshni Patel [email] or my Faculty Advisor Shannon L. Scott [email] You may also contact the IRB below if you have any further questions or concerns with the information provided below:

Ithaca College IRB
Peggy Ryan Williams Center
953 Danby Road
Ithaca, NY 14850
irb@ithaca.edu
(607) 274-3113

I have read the above and I understand its contents. I agree to participate in the study. I acknowledge that I am 18 years of age or older, and I meet the inclusion criteria of this study.

_____
Print or Type Name

_____ _____
Signature Date

I give my permission to be audiotaped.

_____ _____
Signature Date