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Occupation-Based Interventions for Clients with Chemical Addiction Issues

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Occupation-Based Interventions for Clients with Chemical Addiction Issues

by

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This Scholarly Project Paper, submitted by Amanda Sylling, MOTS and Alyson Wilhelmi, MOTS in partial fulfillment of the requirement for the Degree of Master’s of Occupational Therapy from the University of North Dakota, has been read by the Faculty Advisor under whom the work has been done and is hereby approved.

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ABSTRACT

Based on data from an extensive literature review and survey methodology, a product was developed to assist occupational therapists (O.T.'s) in providing individualized occupation-based interventions for clients dealing with substance abuse/dependence. Although the value of occupation-based interventions focusing on occupational performance and function has been established (Law, 2002), the literature suggests that O.T.'s working in substance abuse treatment environments generally provide group-based intervention consisting primarily of preparatory activities (Rychtarik et al., 2000). Because substance abuse often becomes a primary occupation for individuals with substance abuse issues (Stoffel & Moyers, 2004), it is imperative that O.T.'s address and support healthy occupational performance which will, in turn, support sobriety and healthy occupational functioning. Through the survey respondents and literature review, important areas of occupation identified as under-utilized for clients in therapy settings included financial management, health management and maintenance, and social participation (Stoffel & Moyers).

The product created is guided by the Model of Human Occupation (MOHO) (Stoffel, 1994; Forsyth & Keilhofner, 2003) and provides a resource for the O.T. to explore the dimensions of volition, habituation, performance capacity, and the environment in relation to how these factors influence occupational participation. The product includes a questionnaire, summary form, and intervention protocol for the occupational areas of financial management, health management and maintenance, and
social participation. In addition, two case studies were developed to demonstrate the
product's usage. The product provides an example for application to group settings as
well as one-on-one sessions. It is recommended that a pilot study be conducted on this
product, and that further development of the product include other areas of occupation.
CHAPTER I
INTRODUCTION

Within the complex and diverse area of addiction treatment, an occupational therapist’s (O.T.’s) role in substance abuse/dependence has been misunderstood and vague. With this in mind, it is our goal throughout this scholarly project to define an O.T.’s role by assisting in the development of occupation-based interventions through the implementation of detailed questionnaires and summary forms that may be utilized when treating individuals who have substance abuse/dependence. It is noted that occupation-based interventions are those which encompass purposeful activities within the client’s relevant contexts to reach prioritized client goals (American Journal of Occupational Therapy, 2002).

The term addiction has been consistently used to encompass a whole gamete of other more scientific terms such as substance abuse and substance dependence (Sadock & Sadock, 2004). There are many types of addiction that can be found in today’s society; yet, they are not as well known as addictions to alcohol and drugs. The literature that is available on this topic focuses mainly on alcohol related problems; therefore, the information presented throughout this project will focus on alcohol as the drug of choice (Substance Abuse and Mental Health Services Administration, 2006). In America alone, 15 million individuals have alcohol dependence making it the number one drug problem in the country today (US No Drugs, 2005).
Occupations have a prominent role in developing an individual’s sense of self. Since occupations define who we are and what we value, this sense of self can be diminished when substance abuse/dependence becomes the primary occupation in which all others tend to revolve around in the form of unhealthy routines and habits (Stoffel & Moyers, 2005). Therefore, occupation-based activities have proven to be one of the most effective methods of improving occupational performance (Thomas & Nelson, 2000).

The literature review will define and clarify categories of substance abuse/dependence and associated terms, treatment considerations and information, and O.T.’s role in treatment. The available literature in support of O.T. involvement in substance abuse/dependence treatment, especially client-centered, holistic, and occupation-based principles will be discussed. The Model of Human Occupation (MOHO) will be utilized to support the treatment of clients with addictions and the relationship between occupational performance and function.

An understanding of what substance abuse/dependence is and how it affects occupational functioning, provides a foundation for development of a protocol for occupation-based interventions based on comprehensive questionnaires and summary forms outlining three pertinent areas of occupation. The three areas of occupation derived from the literature and survey responses from practicing O.T. clinicians include financial management, health management and maintenance, and social participation.

Collaborating with the client to identify occupational areas of need occurs via the implementation of the detailed questionnaires and summary forms that guide the O.T.’s individual and/or group interventions for clients with substance abuse/dependence. The remaining chapters will include an extensive literature review on the topic, the
methodology employed in developing the product, the "Occupation-Based Interventions for Clients with Chemical Addiction Issues" product, the executive summary, appendix, and references. Through the proceeding chapters, a strong case will be built for the implementation of occupation-based interventions for clients dealing with alcohol abuse/dependence. O.T.'s role will be presented as highly necessary within formal intervention treatment settings due to the specialty of occupations in client-centered practice.
CHAPTER II
REVIEW OF LITERATURE

There are 22 million Americans who have issues related to addiction (Stoffel & Moyers, 2004). Addiction is a term that encompasses a wide range of diagnoses now recognized throughout today’s society. This word is also commonly used in reference to the behavior as well as the neurobiological nature of the disease (Roberts & Koob, 1997). Examining the behavioral aspect, addiction is described as the domination of substance abuse/use patterns over a person’s life involving maladaptive behavior patterns (McDowell & Spitz, 1999). From a neurobiological standpoint, addiction entails common neurochemical and neuroanatomical substances which are present in specific brain structures dealing with pleasure and reward (Sadock & Sadock, 2004). Together, these two components of addiction make these diagnoses complex. Since alcohol is the most widely used drug with over 400,000 people presenting for only alcohol treatment and nearly 320,000 people with alcohol and a secondary drug in 2004, substance abuse and substance dependence with the drug of choice being alcohol will be the primary focus of this scholarly project (Substance Abuse and Mental Health Services Administration, 2006).

Definitions and Terms

Substance abuse is defined as the presence of at least one symptom that reveals that the use of a substance has intervened in an individual’s life (Sadock & Sadock, 2004). Substance abuse differs from substance dependence in a sense that withdrawal
and tolerance are absent in substance abuse (Stoffel & Moyers, 2005). To confirm the diagnosis of substance abuse, one or more criteria must be met within a 12 month period. The criteria include the frequent use of a substance that results in the failure to perform major life roles, repeated use of a substance that places an individual in a physically hazardous situation, legal issues arise due to the use of a substance, and difficulty with social and interpersonal problems (Sadock & Sadock). Substance abuse is excessive and harmful, but it is not as severe as substance dependence (Riley, Ramsey, & Cara, 1998).

Stoffel and Moyers (2005) assert that substance dependence is defined as a behavior that is maladaptive and leads to significant distress or impairment that is evident by three or more criteria that occur at any time throughout a 12 month time frame. The criteria that support the diagnosis of substance dependence include withdrawal, tolerance, and the consumption of larger amounts over a longer period of time than intended. The individual desires to reduce the amount of substance consumed with unsuccessful attempts. It is noted that a large amount of time is spent in those activities in which the individual may attain the substance of his/her choice, resulting in the limited amount of time spent in occupational, recreational, and social activities. The individual continues to use the substance even though he/she is knowledgeable that his/her physical or psychological problems are due to the substance being utilized (Sadock & Sadock, 2004).

It was not until 1967 that the International Classification of Diseases Eighth Edition (ICD-8) first classified substance related problems (Gordis, 2006). In addition, the Diagnostic and Statistical Manual of Mental Disorders-Third Edition (DSM-III) was the first edition to differentiate between substance use and substance dependence disorders in 1980. Before this, the Diagnostic and Statistical Manual of Mental
Disorders-First Edition (DSM-I) outlined that addiction was believed to be a subset of personality disorders, homosexuality, and neuroses. Finally, in the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV), the criteria were revised and now decipher between specific diagnoses.

In addition to substance abuse and substance dependence, there are multiple other diagnoses to consider under Alcohol-Related Disorders according to the DSM-IV-TR. Alcohol-induced disorders, alcohol intoxicification, alcohol withdrawal, and alcohol-induced persisting dementia are just a few of the examples to be cognizant of in regards to alcohol being the drug of choice (Sadock & Sadock, 2004).

Terms to be knowledgeable about in regards to substance abuse/dependence include tolerance, withdrawal, and craving. Tolerance has been achieved when an individual seeks a need to consume larger amounts of a substance to reach intoxicification. This term may also be used to describe a diminished effect when an individual continues to utilize the same amount of a substance. Withdrawal is referred to as a substance-specific syndrome that may occur once heavy amounts of a substance that have been consumed for an extended period of time are no longer utilized (Reed, 2001). Craving involves an irresistible urge to resume the use of the substance (Moyers & Stoffel, 2001).

Approximately 10% of women and 20% of men have met the criteria to be diagnosed with alcohol abuse throughout their lifetime in the United States (U.S.), and 3-5% of women and 10% of men have met the criteria to be diagnosed with alcohol dependence (Sadock & Sadock, 2004). Caucasians have the highest rate of alcohol use at 56%. Hispanics and African Americans do have similar rates taking the breakdown of ethnicity in the U.S. into consideration. Socially, binge drinking is more prevalent in
men since they are more likely to be classified as heavy drinkers. Increased education was discovered to correlate with higher alcohol usage. Despite this finding, alcohol-related disorders can be found amongst all socioeconomic classes (Sadock & Sadock).

There are four categories, excluding alcohol abuse and alcohol dependence, which define drinking patterns of alcohol use for women and men: moderate, at-risk, hazardous, and harmful (Sadock & Sadock, 2004). Moderate drinking is 1 drink per day for women and persons over 65 years old and 2 drinks for men. At-risk drinking for women involves drinking more than 7 drinks per week and 3 or more drinks per occasion; 14 drinks per week or more than 4 drinks per occasion for men are the numbers to taking into consideration when assessing someone’s drinking patterns. Hazardous drinking puts a person in jeopardy for adverse alcohol consequences; harmful drinking occurs when the alcohol use causes physical or psychological harm. It is important to be cognizant of these categories as clients may not be fully aware of their dangerous patterns of usage.

The effects on the brain from substance abuse/dependence include biochemistry, behavioral effects, and sleep effects. When discussing biochemistry, it is vital to note that people are no longer engaging in occupations that they previously enjoyed because the satisfaction that is achieved through the use of alcohol is superior (Vereen, 2006). Those behavioral effects that exist from alcohol abuse/dependence include impaired voluntary motor actions, disruption in judgment, and individual emotional behavior (Sadock & Sadock, 2004). People who utilize substances may also suffer from sleep effects which result in sleep hygiene deficits. This may affect the individual’s performance in everyday occupations as well as fulfilling major life roles. Physiological
effects may also arise due to substance abuse/dependence: liver damage, poor dietary habits, and other medical illnesses (Stoffel & Moyers, 2005).

Models of Practice

The models used to describe the etiology of substance abuse/dependence are reflective of society’s beliefs during various time periods in history. The psychological model deems that unfulfilled individual needs and psychological conflicts are precursors to substance abuse/dependence (Stoffel & Moyers, 2005). This model asserts that the influence of a dysfunctional family results in internal, unconscious conflicts within the individual, leading to a destructive usage pattern with substances. Within this model, the individual is thought to substitute alcohol for the perceived regulation of feelings and coping skills (Riley et al., 1998).

The sociocultural model tends to place the etiology of this disease within the cultural, spiritual, and social contexts of a person. Within this model, environmental factors in childhood incline children to abuse/depend on alcohol in the future (Fisher & Harrison, 2000). In addition, social conditions such as economic status, educational level, and prevalent cultures influence alcohol use in terms of availability and behavioral norms (Riley et al., 1998).

Supporters of the cognitive-behavioral model rally behind the vital social and interpersonal factors of the abuse/dependence on substances. Proponents of this model assert that cognitions about the substance predetermine the abusing/dependence behavior (Stoffel & Moyers, 2005). This model affirms that using behaviors are learned; therefore, they can be unlearned (Riley et al., 1998). To actively pursue sobriety, one must
understand the behavioral consequences of continued alcohol use, the warning signs of relapse, and the impact of the environment.

The medical model firmly states that substance abuse/dependence is a disease. In accordance with this view, Donald Vereen from the National Institute on Drug Abuse stated, "Addiction is a disease of the brain" (2006). He also stated that it is a developmental disease which involves multiple factors of a biological and environmental nature. This model views the disease as "chronic, progressive, incurable, but treatable" (Riley et al., 1998, p. 239).

The biopsychosocial model of substance abuse/dependence is comprehensive in that psychological, social, cognitive, biological, developmental, and environmental factors are incorporated into a single model (Fisher & Harrison, 2000). The biopsychosocial model views alcohol abuse/dependence as a disease that negatively impacts self-cares, finances, work, health/wellness, and relationships (Riley et al., 1998). Ward (2003) asserts that isolating a single cause of substance abuse/dependence is unfeasible, thereby supporting the multifaceted approach suggested by the biopsychosocial model. A combination of models or one that incorporates many models into one is likely considered more representative of the etiology of the disease.

Cycle/Stage of Change

The cycle of change proposed by Prochaska and DiClemente in the 1980s describes an addictive cycle of behavior which starts with societal norms and as well as the desire to satisfy unmet needs (Bryant-Jefferies, 2001). It may be a valuable resource for use by therapists in that it provides insight into the motivational level of the client in treatment. The cycle begins by the individual consciously or unconsciously planning
activities in which he/she can use the substance. Due to the addictive nature of alcohol on some persons, the individual becomes so preoccupied with using the substance of his/her choice that the day(s) completely revolve(s) around engaging in this behavior. People who realize that the use of alcohol has led to a problem generally want to change. Yet, there likely are phases that need to be completed before the change actually occurs. These phases are referred to as the cycle of change or the stages of change and include five to six phases: pre-contemplation, contemplation, preparation/determination, action, and maintenance, as well as relapse (Stoffel & Moyers, 2005; Moyers & Stoffel, 2001).

The pre-contemplation phase involves not actually realizing that one has a problem, despite the fact that he/she is able to relate to a negative consequence that came about because of using the substance. In contrast, the contemplation phase is when an individual is aware of the pros and cons of using a substance but is apathetic in regards to change. When a person decides that change is necessary and is planning and taking into account alternatives to initiate the change process, he/she has entered the preparation/determination phase. One enters into the action phase when he/she is learning new behaviors that focus on sobriety; however, these behaviors are easily broken at this point in time. The final stage is the maintenance phase; this is when the behaviors that are newly learned are integrated into one’s routines and habits for a long-standing period of time. In this case, the person is readily pursuing and experiencing sobriety (Stoffel & Moyers, 2005). Relapses are commonly experienced so this phase is included in that positive change can still occur as the cycle repeats itself after a relapse (Moyers & Stoffel, 2001).
An occupational therapy (O.T.) practitioner following this cycle of change is applying what is known as the transtheoretical model of behavior change (Stoffel & Moyers, 2005). The cycle of change can assist clinicians in determining where the individual is in the change process and what treatment approach is going to be most beneficial for the client. It is also important to keep in mind that relapse may occur and that it too is a part of the process of developing a better and healthier lifestyle. Through the cycle of change, the individual is given all of his/her choices and allowed to make the informed decision to change habits. Any decision that is made should be realistic and owned by the client so that he/she is motivated to achieve individual goals. O'Toole, Pollini, Ford, and Bigelow (2006) conclude that individuals who have intrinsic motivation to participate in treatment are more likely to successfully complete the program. Although relapse may be evident in any of these cycles, its presence is not indicative of failure. Rather, it is reflective of a change process that might lead to a better and healthier life.

Other key points to consider when assisting clients in completing the five phases of change are that upon completion of treatment, he/she may need a longer period of support than initially intended, and some adjustments may need to be made to the plan (Bryant-Jefferies, 2001). McKay (2005) emphasizes the importance of remaining in contact with one’s clients and maintaining the therapeutic relationship to ensure a better outcome over a longer period of time. This notion mirrors a comprehensive treatment that continues past inpatient or outpatient care (formal intervention programs) and includes aftercare or self-help groups (informal intervention programs).
Formal Interventions

Formal intervention programs for alcohol abuse/dependence fall into the following treatment categories: therapeutic community, inpatient, residential, partial hospitalization, day treatment, intensive outpatient, and outpatient (Fisher & Harrison, 2000). Skills and strategies to abstain from abusing/depending on alcohol are learned throughout the services provided to the client in these treatment settings (Moyers & Stoffel, 2001).

Therapeutic communities are treatment settings that are highly structured, closely monitored, and strictly regulated for those individuals with severe substance abuse/dependence (Ward, 2003). Vidjak (2003) asserted that this rigorous long-term treatment may last around two years. Within this holistic rehabilitative community individuals live, work, attend meetings, receive counseling, enjoy recreation, and develop coping skills to abstain from substances (McDowell & Spitz, 1999). While this treatment is considered the most intense, it has produced the greatest number of abstinent participants in a study comparing it with medicine and inpatient therapy (Vidjak, 2003). It also offers a systematic approach to rehabilitation by focusing on changing negative thinking, feeling, and behaving (Inciardi & McElrath, 1998). In other words, this is a holistic treatment which engages the client in occupation-based, real-life scenarios, and it has proven itself to be effective via establishing a substance-free lifestyle.

Often inpatient and residential treatment are terms that are used interchangeably, depending on whether the setting is a hospital or community/residence. Hospital inpatient treatment has been associated with its management of withdrawal symptoms and detoxification (McDowell & Spitz, 1999). Due to the high costs associated with
inpatient care, this form of treatment tends to be a stepping stone to other formal interventions which may be associated with the hospital. A typical inpatient treatment setting may include a 28-day program consisting of activity therapy, group therapy, lectures, and family group sessions (Rychtarik et al., 2000). Specific group intervention topics include problem-solving, assertiveness, anger management, negative thinking, motivational counseling, relapse prevention, and aftercare participation. Inpatient treatment was found to be most helpful for those clients with severe substance abuse/dependence and/or low cognitive functioning. Inpatient and residential treatments are expensive and do tend to pull the clients from their natural contexts; however, community outings and weekend passes are common (Fisher & Harrison, 2000).

Partial hospitalization programs are associated with hospitals or are a component of community mental health programs offering both group and individual treatment interventions (Scheinholtz, 2001). Maintaining the client in their natural context during treatment is the goal of partial hospitalization and day treatment programs (Fisher & Harrison, 2000). In contrast, day treatment programs are more community-based with flexible attendance while still offering structured activities for clients (Scheinholtz).

There is discrepancy in how professionals choose to differentiate between day programs and intensive outpatient treatment facilities. Kaskutas, Witbrodt, and French (2004) identify day hospital treatment as an intensive outpatient service. Sabonis-Chafee and Hussey (1998), in contrast, describe a day treatment program as a program where structured activities are provided for clients who need daytime supervision. Rychtarik et al. (2000), identify the number of treatment days (20 versus 8) as the primary difference between intensive outpatient and outpatient treatments. Fisher and Harrison (2000) also
described time difference in treatment duration as distinguishing treatment settings (3-4 evenings per week for 2-4 hours for intensive outpatient versus 1-2 evenings per week for 1-2 hours for outpatient). These types of outpatient settings are ideal for clients who do not require more complex treatment due to their diagnosis (substance abuse versus substance dependence) and/or have major role responsibilities outside of treatment which would cause restrictions for them.

The importance of matching treatment to the client’s stage of change is exemplified in the notion of the “least restrictive environment” for the client (Fisher & Harrison, 2000, p. 137). Motivation, desire to take action in regards to substance abuse/dependence, social supports, environments, prior treatments, and associated costs are all factors to take into consideration when partaking in a formal intervention treatment program. Kaskutas et al. (2004) believe a good quality community-based program is comparable in cost and client outcomes versus day hospital treatment for clients with chemical dependence. In addition, a wide continuum of services including “group, individual, and family programming; employee assistance programs; and support and self-help programs” are considered vital for client success (Moyers & Stoffel, 2001, p. 333).

Informal Interventions

Informal interventions (i.e., aftercare) or self-help groups provide a means of support and encouragement for individuals with substance abuse/dependence issues (Moyers & Stoffel, 2001). Continuing care via aftercare participation (which also may be considered a formal intervention program due to the involvement of a professional) produced client outcomes such as increased abstinence from substances, fewer problems
related to abusing/depending on substances, and lower arrest rates (Schaefer, Ingudomnukul, Harris, & Cronkite, 2005). Since the choice to attend self-help groups may often be voluntary, social reinforcement is recommended due to the inexpensive, simple, yet, meaningful incentive it provides the client (Lash, Burden, Monteleone, & Lehmann, 2004).

There are several examples of informal treatment that are available for individuals with substance abuse/dependence. Alcoholics Anonymous (AA) was formed in 1935 by Bill Wilson and Bob Smith, who were two individuals both recovering from substance abuse/dependence (Fisher & Harrison, 2000). This self-help group is based on the power of spirituality in achieving sobriety. Through sponsorship, peer support, and a commitment to the program and a “Higher Power”, AA currently assists over two million people worldwide achieve long-term sobriety (Alcoholics Anonymous World Services, 2006). AA programs focus on the recovery process through the help one receives from others and gives to others (Ward, 2003). Social participation within the community, with peers, and subsequent family members is strengthened due to the emphasis on connecting with others who are also recovering from substance abuse/dependence.

AA programs are commonly incorporated into most treatment programs whether it is required attendance or highly recommended throughout and/or after completing a formal treatment. It is reiterated that affiliation with AA throughout one’s lifetime is essential to continued abstinence from alcohol (Stoffel & Moyers, 2005). There is a positive correlation between participating regularly in a self-help group(s) and sustaining abstinence (Vederhus and Kristensen, 2006). In addition to maintaining sobriety through
AA participation, staying sober is associated with “meaningful occupations that promote spirituality and one’s connectedness to the world” (Moyers & Stoffel, 2001, p. 335)

In addition to AA, other support groups have developed throughout the last twenty to thirty years which have addressed different approaches to sustained treatment. Rational Recovery (RR) is one such self-help group that is based on the construction of rational cognitive thoughts for sobriety from Albert Ellis’s work on Rational Emotive Therapy. Irrational beliefs that foster addictive behaviors are identified and changed in regards to emotions and behaviors associated with recovery (Fisher & Harrison, 2000). Cognitions and subsequent behaviors are central to this type of self-help group (Alessandri, Cara, & MacRae, 2005). RR groups do have contact with a professional mental health advisor, and the group supports the presupposition that drinking in moderation may be possible for some individuals (Moyers & Stoffel, 2001).

The Women for Sobriety (WFS) program is based on a holistic approach in recovery by addressing health, nutrition, abstinence from other addictions, and self-esteem for women (Fisher & Harrison, 2000). This program encompasses the notion that women experience alcohol intake differently than men (Moyers & Stoffel, 2001). Women are fostered to believe that they do not need alcohol to cope with life’s stressors.

In addition to these groups, Secular Organization for Sobriety/Save Our Selves (SOS), developed by James Christopher, endeavors to help people recover from alcohol/drug use who do not have an interest in the spirituality aspect involved in AA (Fisher & Harrison, 2000). While each of these groups has the goal of sustained abstinence from substance abuse/dependence with the decrease of inpatient and
outpatient treatment days, different objectives and concepts about recovering are highlighted throughout each self-help group.

Built into treatment slowly from the 1970s to the present day, the emphasis on family involvement is expanding. The conception of Al-Anon in 1954 and Alateen in 1975 highlight the impact abusing/depending on substances has on the family structure (Fisher & Harrison, 2000). Based on the dates these programs were established, people who were familiar with the dysfunction that is rendered from individuals with substance abuse/dependence were ahead of society’s understanding and acceptance of etiological models that emphasized sociocultural considerations.

History of Occupational Therapy

While none of the five founders were specifically involved in the treatment of clients with substance abuse/dependence, the work of Eleanor Clarke Slagle provides a foundation for the role of O.T. in addiction treatment. The roots of the O.T. profession are focused on the mental health aspect, in comparison to the current 3.5% of O.T.’s who are involved in psychosocial practice (American Occupational Therapy Association [AOTA], 2003). Slagle developed the idea of “habit training” while at Phipps Clinic in the 1920s. According to Barker Schwartz (2003), this method was utilized as an effective treatment for clients with severely disordered habits.

One of the first published articles on O.T.’s actual role in treatment of clients with substance abuse/dependence came from the American Journal of Occupational Therapy in the early 1950s. While it is likely that O.T.’s were sporadically practicing in this area prior to this date, societal events were defining O.T.’s role as being more associated with the medical model. This was due to the impact World War II had on the profession with
many practitioners become reconstruction aids within the realm of physical rehabilitation (Barker Schwartz, 2003).

Even in this early literature, O.T.’s stance on substance abuse/dependence was that it was “a disease rather than a social disgrace” (Hossack, 1952, p. 282). It was during this time that substance abuse/dependence was identified as a viable service area by Hossack, who described a program that assisted clients in developing and/or re-integrating activities and social connections back into their life once they attained sobriety. This program also emphasized the importance of having a balance between work life and leisure activities. These intervention ideas are still evident today, in that a healthy balance of occupations is thought of as being especially valuable in community-based programs for clients and in working with families of clients with substance abuse/dependence (Stoffel & Moyers, 2005).

In the 1950s, it was the O.T.’s role to assist each client on an individual basis and to take into consideration the many factors that may contribute to the client’s selection of interests and activities (Hossack, 1952). Factors considered at that time included financial status, previous experiences with leisure activities, and the amount of time spent at work. Leisure exploration was embraced as possessing a vital role in maintaining abstinence. This concept continues to be important in present day treatment programs as time once spent using a substance will now need to be filled with a satisfying leisure activity (Ward, 2003). Encouraging the client to partake in leisure activities and to support his/her choices continues to be the role of the O.T.

Hossack (1952) also mentions the importance of remaining in contact with the clients once they complete treatment. This statement is in harmony with the assertion of
greater functional outcomes and increased abstinence for clients who engage in continuing care after treatment (Schaefer et al., 2005).

It was noted that a majority of the clients were not interested in the media that they were presented with, and those that utilized it saw it as a source of diversion (Hossack, 1952). In addition, daily relaxation groups proved to be effective and helpful for those who participated in them. Individual treatment was considered more effective than group treatment at this time, and very little is published after this point in regards to O.T.’s role in substance abuse/dependence treatment.

During the 1960s and 1970s the federal government began to take an active role in regards to treatment for people with substance abuse/dependence problems by establishing available grants and treatment programs. A reduction in drug and alcohol use also occurred during this time as the government took a more active role in establishing laws dealing with alcohol as well (McDowell & Spitz, 1999). In response to these happenings, AOTA focused seriously on lobbying for the profession’s visibility in the area of substance abuse/dependence (Sabonis-Chafee & Hussey, 1998).

The Comprehensive Drug Abuse and Control Act of 1970 created a policy on controlled substances which encompassed most of the drug control legislation by the federal government since the early nineteenth century (Inciardi & McElrath, 1998). Out of this, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was born and comprehensive treatment for individuals was presented to the public as a treatable disorder (Institute of Medicine, 1990). Research studies were implemented throughout this period to advocate for the provision of treatment for individuals with substance abuse/dependence. Early intervention programs, occupational alcohol programs, and
drinking driver education programs were some of the emerging elements of treatment provided at this time (Institute of Medicine). It is noted that the psychological and sociocultural models of substance abuse/dependence etiology were influencing the advances made in treatment provision.

Value of Therapeutic Activities

It was not until 1990 that the term “occupation” was introduced in O.T. treatment in the area of addiction. Clarey and Felstead (1990) present the term “occupation” as the “goal directed use of time, energy, interest, and attention” (p. 85). Occupations were identified as vital to health maintenance and the process of rehabilitation. These authors believe that the uniqueness of O.T. was in the use of activity throughout treatment, and they cited the use of activities as a therapeutic agent by ancient Greeks, Chinese, and Egyptians, illustrating the benefits of exercise, play, and work on individuals’ physical and mental health.

A feature that has been proven to be consistent, both in the past and present addiction settings for O.T., is the concept of utilizing activity to improve one’s ability in occupation mastery and to aid in the adjustment and function of an individual (Clarey & Felstead, 1990). It was noted that O.T.’s understand that activities are vital to life by incorporating learning/growth and reaching intrinsic satisfaction via participation. Activities also focus on engagement, competence, self-esteem, and efficiency. They allow clients to express their thoughts and feelings, and that is why it is so vital to incorporate such activities, not only in treatment but also in assessment. These authors noted that activities assist clients in making lifestyle changes in order to increase their chance of sobriety.
Occupation-based activities have proven to be one of the most effective methods of improving occupational performance (Thomas & Nelson, 2000). Using occupations is a means of empowering clients while also fostering meaningful roles and relationships (Gutman, McCreedy, & Heisler, 2000). It is the use of occupations in treatment for clients that makes the profession unique in comparison to other disciples (Thomas & Nelson). In her Eleanor Clarke Slagle Lecture, Hasselkus (2006) reiterates this uniqueness in the notion that O.T.’s are able to assist clients in not only the visible occupations they encounter but the invisible ones as well. Great importance and meaning can be central to a plethora of different occupations- complex or simple-, each dependent on the individual’s wants and desires.

O.T.’s today are still implementing both individual and group interventions in substance abuse/dependence treatment and are gradually moving toward implementing more occupation-based interventions. The Occupational Therapy Practice Framework (AOTA, 2002) describes the purpose of occupation-based activities as those that allow for actual engagement in meaningful occupations matching the client’s contexts and goals. To reiterate the uniqueness of O.T., “Contemporary occupational therapy emphasizes occupational engagement. Clients seek occupational therapy because they need help engaging in their valued occupations” (Crepeau, Cohn, & Schell, 2003, p. 29). In summary, O.T. implements important occupations within relevant client environments and understands the necessity of engagement in occupations via interventions (Law, 2002).

Occupation-based activities are utilized because of their versatility, not only in the aspect that they can be adapted and graded to meet the clients’ needs, but they can be
used in various individual and group settings (Clarey & Felstead, 1990). Research
gleamed from John, Veltrup, Driessen, Wetterling, and Dilling (2003) is in favor of group
treatment for clients versus individual sessions. Group treatment has the advantage of
helping people who abuse/dependent on substances realize that they are not alone, in
addition to working on social participation (Ward, 2003). Even though group treatment
is the primary approach for treatment programs, individualized treatment goals can still
be achieved and incorporated into group treatment (Fisher & Harrison, 2000). This
information is vital in designing a product which has the capability to always incorporate
the individual client, yet, be flexible enough for group treatment to occur.

Model of Human Occupation (MOHO)

The Model of Human Occupation (MOHO) offers a theoretical framework for
considering the application of occupation to treatment progress for individuals with
substance abuse/dependence issues (Stoffel, 1994). The volition subsystem emphasizes
reflection on motivation/personal causation, values, interests, and beliefs and how they
relate to the use of substances. What people choose to spend time doing each day are
decisions called activity and occupational choices (Forsyth & Kielhofner, 2003). These
choices are governed by thoughts and feelings about such activities and occupations;
effectiveness (personal causation), importance (values), and enjoyableness (interests) all
pertain to thoughts and feelings synthesized from experiences. Based on these
experiences, one will choose to engage in such activities and occupations again.

Habituation, the second subsystem, organizes habitual behaviors that shape daily
routines (Forsyth & Kielhofner, 2003). The habituated occupations within people’s lives
are based on meaningful formulated habits and roles. It is noted that any changes
encountered in habits and roles subsequently beget changes in the other subsystems as well.

The third subsystem of MOHO is termed "performance capacity," which is based on physical, emotional, and cognitive skills (Forsyth & Kielhofner, 2003). The subjective experience of performance in these areas exemplifies a blending of mind and body for the person (Kielhofner, Forsyth, & Barrett, 2003).

The physical and social environments (contexts) are also considered vital within MOHO due to the impact they can have on values, interests, personal causation, roles, habits, and performance capacities (Forsyth & Kielhofner, 2003). The physical environment consists of various settings and relevant objects; groups of people and their associated occupational forms, which are defined as anything that can be performed in a social context (Kielhofner et al., 2003).

People may choose to engage in the behavior of using substances for several reasons. Initially, consuming may assist the individual feeling a sense of belonging. Since 90% of United States citizens throughout their lifetime will drink alcohol, the culture of consuming substances is generally considered acceptable (McDowell & Spitz, 1999). Using substances can also fulfill unmet needs and give the person a means to have fun, relax, escape, and sleep (Stoffel & Moyers, 2005). It becomes an enjoyable occupation that is of importance and possesses value for the individual.

Consuming substances is a habit that is easily developed in today's society, and these habits can quickly become part of the routine of abusing/depending on alcohol (Bryant-Jefferies, 2001). Since the occupation of abusing/depending on substances is organized into specific habit patterns and routines, the individual's sense of self and
subsequent values, interests, and beliefs may embody this same notion (Stoffel & Moyers, 2005). Due to the addictive nature of alcohol for some individuals, the automatic habit of having a drink becomes a repeated experience in which time is typically spent (Forsyth & Kielhofner, 2003). The roles possessed by clients are negatively impacted with substance abuse/dependence. Since roles shape personal identity, clients with substance abuse/dependence may not be satisfied when in the action phase of change due to their ineffectiveness in previously enjoyed occupations. Clients who are in the pre-contemplation phase may be satisfied within their roles because they are enjoying the occupation of abusing/depending and do not realize they are not engaging in occupations once enjoyed.

Pain and loneliness associated with traumatic memories may contribute to the use of substances, along with the masking of one’s true self and life responsibilities from choices made (Riley et al., 1998). Deficits in problem-solving, time management, and cognitive skills may undermine a client’s performance capacity in daily activities (Stoffel, 1994). Occupation alienation, which occurs when the client cuts off all occupations that do not involving abusing/depending on substances, decreases occupational performance in previously enjoyed occupations (Stoffel & Moyers, 2005).

For the client with substance abuse/dependence issues, contexts such as social groups and occupational forms can either support or discourage healthy occupational participation (Forsyth & Kielhofner, 2003). Social groups can both support an individual in the continued abuse/dependence such as a peer group at the local bar or support an individual in seeking treatment such as a concerned family member or fellow church member. The influence of the family in regards to substance abuse/dependence should be
considered while providing services (Stoffel, 1994). It is important to take into consideration the influence of cultural norms on the acceptance of substance abuse/dependence (drinking) as a normative occupational form (Forsyth & Kielhofner).

Stoffel and Moyers (2005) suggest that substance abuse/dependence can be regarded as an occupation in and of itself. The related activities and tasks that are involved include the following: obtaining money, purchasing the substance, eradicating barriers to using, and defending the supply from others. The person may also create situations for using, develop relationships with people who also use, and spend time using. These activities and tasks may be meaningful to the individual since they are a part of structured roles, habits, and routines and fulfill unmet needs to shape the person’s identity over time.

MOHO can be helpful to the process of examining the impact of substance abuse/dependence on occupational roles and implementing O.T. to support recovery (Stoffel & Moyers, 2005). Stoffel (1994) discusses the unique aspects and perspectives that O.T.’s are able to provide clients who have substance abuse issues due to the emphasis that is placed on functioning within occupations. O.T.’s role in helping clients develop daily routines to replace previous habits and routines revolving around the use of substances is a vital concept. O.T. practitioners focus on the client’s overall life and modify contexts that support the engagement in occupational performance (Moyers & Stoffel, 2001). While there continues to be a limited amount of literature and research on O.T.’s role in treatment for clients with substance abuse/dependence, the Occupational Therapy Practice Framework (AOTA, 2002) is a viable resource for formulating occupation-based treatment in all areas of occupation.
Areas of Occupation within Individualized Developed Product

The areas of occupation addressed in substance abuse/dependence treatment include instrumental activities of daily living (IADL’s), work, leisure, and social participation (Ward, 2003). The occupation of work has been addressed in O.T. since Hossack’s (1952) emphasis on the balance between both work life and leisure. Throughout the 1990’s, O.T.’s were continuing to have involvement with the occupation of work with clients (Stoffel & Moyers, 2004). The compensated work therapy (CWT) program, developed by the Department of Veterans Affairs, involves participants in a routine of attending work, the role or worker, and the associated development of useful habits to experience fewer alcohol problems (Kashner et al., 2002). While this occupation can be highly important to clients in treatment, referrals to vocational services, training agencies, or continued aftercare participation can more importantly connect the client to these additional services and develop skills for work (Ward, 2003).

Leisure is another area of occupation which has been addressed in O.T. treatment since the 1950s. Once a client no longer is abusing/depending on substances, there is time for enjoyable leisure (Ward, 2003). Assessments such as the Leisure Activities Finder, Leisure Boredom Scale, Leisure Competence Measure, Leisure Diagnostic Battery, and Leisure Satisfaction Scale exist to assist the O.T. in developing interventions for the client. In addition to O.T., recreation therapists also tend to focus their interventions on restoring enjoyable leisure.

Taking into consideration the comprehensive treatment already available for the occupations of work and leisure, IADL’s and social participation stand out as areas of need in regards to occupation-based intervention resources. Specifically, financial
management was highly requested as an intervention by clients with substance abuse/dependence (Ward, 2003). Money management, nutrition, and physical fitness have also been identified as occupations that could be addressed by O.T. (Bruce & Borg, 2002). Financial management and health management and maintenance are highly dependent on the development of habits, routines and roles that support performance, and yet, these areas are often overpowered by the addictive nature of substance usage (Ward, 2003). The occupation of physical fitness can be a positive impetus to foster healthy habits for sobriety (Bruce & Borg).

Substance abuse/dependence tends to negatively impact social participation in that the client is alienating family and/or friends who do not approve of the substance abuse/dependence and seeking out people who support their “using” occupation (Stoffel & Moyers, 2005). The Occupational Therapy Practice Framework (AOTA, 2002) defines the social participation that occurs with the individual and the community and/or family as “successful interaction[s]”; for the family it also relates this information to “desired familial roles” (p. 621). Clients who abuse/depend on substances are often lonely, socially isolated, and have difficulty meeting the social demands of roles previously engaged in and enjoyed (Ward, 2003). The individual’s social participation can be positively influenced, however, if the client is engaged in self-help groups and has strong relationships with family and/or friends (Moyers & Stoffel, 2001).

Financial management, health management and maintenance, and social participation are all areas of occupation that can be addressed by O.T.’s who work with clients who have substance abuse/dependence. These three areas are consistently evident in the literature as areas of need, and all can be supported through use of MOHO and
cognitive-behavioral treatment. O.T.'s are primarily involved in providing treatment for substance abuse. They promote function in occupational performance through individually planned interventions offered through group and individual methods (Scheinholtz, 2001).

The available literature and existing resources already focus on the plethora of preparatory and purposeful interventions that O.T.'s can incorporate into treatment such as role playing, improving coping skills, problem-solving, assertiveness training, anger management, and self-esteem (AOTA, 2002; Ward, 2003; Stoffel & Moyers, 2004). Given that most of the previously mentioned interventions are provided in a group format, the challenge remains to provide occupation-based interventions in both individual and group treatment situations. Tailoring occupation-based interventions to clients whether in groups or individually takes time on behalf of the therapist and careful consideration of the values, habits, routines, and performance capacity of each individual, as well as the context in which their occupations occur.

A product has been developed that will assist clients in identifying what they want to work on in treatment based on the analysis of their volition, habituation, performance capacity, and relevant environments (Bruce & Borg, 2002; Forsyth & Kielhofner, 2003). The product designed will be able to accomplish this in a time managed way that encompasses the whole person. It lays out how to provide specific occupation-based treatment in the occupational areas of financial management, health management and maintenance, and social participation for clients through the thorough examination of MOHO principles for a holistic treatment experience for clients with substance abuse/dependence.
This product will support both direct treatment models and the role of the O.T. as an educator-facilitator (Bruce & Borg, 2002). This product will be especially valuable for individuals with substance abuse/dependence who are in the action phase of change and have the cognitive capacity and educational background to participate fully in the collaborative assessment and intervention planning proposed (Sadock & Sadock, 2004; Bryant-Jefferies, 2001). Nevertheless, when the O.T. is an educator-facilitator, as described under the cognitive-behavioral frame of reference, self-directed learning can occur on behalf of the client (Bruce & Borg). Therefore, successful and healthy occupational engagement can once again be achieved by clients with substance abuse/dependence.
CHAPTER III

METHODOLOGY

Despite the advances in treatment for clients who have substance abuse/dependence, there is a dearth of research and support for the role of occupational therapy (O.T.) in the area of addiction. The profession’s literature emphasizes the value of occupation-based treatment (Crepeau, Cohn, & Schell, 2003). However, preparatory and purposeful interventions tend to predominate treatment for clients with substance abuse/dependence (AOTA, 2002; Ward, 2003; Stoffel & Moyers, 2004). The product was designed to be occupation-based to support best practice for O.T. in addiction settings.

Based on the literature and survey data for treatment for individuals with substance abuse/dependence the occupational areas addressed include financial management, health management and maintenance, and social participation. The literature is in support of occupation-based interventions in these areas due to the unique occupation-based services that O.T.’s can provide, especially in the area of instrumental activities of daily living (Ward, 2003; Bruce & Borg, 2002). Financial management was specifically identified in the literature as a major need of clients who are dealing with substance abuse/dependence (Ward, 2003).

To support the literature, a survey based on the Occupational Therapy Practice Framework and cover letter were devised to obtain input from practicing clinicians in regards to the areas of occupation addressed and not addressed in substance abuse/dependence.
abuse/dependence treatment. The responses indicated that health management and maintenance and social participation are two of the most challenging areas to address due to the time constraints and lack of available information. By developing this product, a perceived need in addressing substance abuse/dependence issues is being met.

The Model of Human Occupation (MOHO) provides a format for developing occupational forms shaped by the three subsystems (volition, habituation, and performance capacity) as well as the environments. The developed product aims to assist O.T. practitioners in providing occupation-based treatment to clients with substance abuse/dependence through detailed questionnaires designed to elicit client-centered responses. The information gathered from the questionnaires can be collaboratively summarized by utilizing the concise summary forms provided for each occupation addressed with the client present. This information produced a product clearly driven by MOHO principles.

From the completed summary form(s), occupation-based individual and/or group interventions can be implemented by utilizing the provided protocols. The literature suggests that both group and individual intervention sessions are incorporated into various treatment settings (Clarey & Felstead, 1990; Fisher & Harrison, 2000). Two case studies, Jim and Paula, are employed throughout the product to gain an understanding of how this process is carried out in a simulated treatment setting with clients. This product was designed to assist clinicians in implementing both individualized group and one-on-one sessions depending on the clients’ needs and the facility.

By constructing the product around MOHO, there is no doubt that occupation-based interventions can be the end result of incorporating this product into various formal
intervention treatment settings. Upon utilizing this client-centered and occupation-based product with clients who have occupational struggles due to substance abuse/dependence, successful community reintegration can be achieved. This project supports O.T.'s role in alcohol abuse/dependence treatment as unique and vital for successful occupational performance through healthy routines, skills, and environments. This product exemplifies that O.T. does have an exclusive niche in addiction treatment.
Occupation-Based Interventions for Clients with Chemical Addiction Issues

A Structured Guide in Financial Management, Health Management and Maintenance, & Social Participation

Amanda Sylling, MOTS
&
Alyson Wilhelmi, MOTS
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Introduction

Substance abuse/dependence is a widely recognized disorder which is only going to grow exponentially. As occupational therapists (O.T.'s) you have the ability to assist individuals in maintaining sobriety by the implementation of occupations that are both meaningful and context specific for the client. Based on this assertion, occupation-based interventions for individuals with substance abuse/dependence are vital to incorporate into treatment settings. Incorporating such interventions will assist individuals in achieving success in prioritized occupations for re-integration into the community upon discharge.

Financial Management, Health Management and Maintenance, and Social Participation are three areas of occupation included in this product that are thoroughly addressed via the Model of Human Occupation (MOHO). In the current literature, these identified occupations were acknowledged as lacking in terms of occupation-based interventions. Through the design of MOHO concerning these three areas, a product that is truly unique to occupational therapy was developed.

Within this product, you will find detailed questionnaires, summary forms, and intervention procedures to utilize with clients in regards to therapy for these identified areas of occupation. Two case studies concerning Jim and Paula are presented to assist you in methodologically utilizing the suitable questionnaires and summary forms for each client to obtain the best treatment outcome. You will also discover that occupation-based treatment can be achieved in group or individual measures through utilizing this product.

We sincerely hope you find this product beneficial to both you and your clients!
Section 1

Financial Management Questionnaire, Summary Form, & Intervention Protocol
Financial management
The Financial Management Questionnaire is designed to integrate all of the principles of MOHO to assist occupational therapists (O.T.'s) in gaining a better understanding of his/her client(s) to implement individualized treatment. The questions asked throughout this questionnaire include the clients' Interests/Values, Roles, Performance Capacity, Habits, Social and Physical Environment, and Personal Causation (MOHO principles). The areas that were taken into consideration in regards to financial management tasks including the following: utilizing a checkbook, banking, and budgeting.

The questions found throughout this section are specifically geared toward the clients' spending habits, occupational engagement, client role(s), skills enabling/ hindering the client in occupational engagement, areas of interest for the client, and the value placed on this occupation.

Following the completion of the questionnaire, the O.T. and client will collaboratively fill out the concise summary form that is provided. This will allow the O.T. to identify the areas that need improvement and subsequently develop an occupation-based intervention that is either individual or group focused. To complete the last step of developing an occupation-based intervention according to the gathered data, an intervention protocol is provided to assist the therapist with the planning and implementation of a suitable activity.
Financial Management Questionnaire

Interest/Values
1. Do you engage in financial management tasks (i.e. checkbook, banking, budgeting tasks, etc.)? (please circle one)  Y  N

2. Is financial management something you enjoy doing? (please circle one)  Y  N
   Why or why not? (please explain)

Roles
3. Do you complete all financial management tasks independently? (please circle one)  Y  N
   Why or Why not? (please explain)

4. If not, who assists you? (please check all that apply)
   □ Family member
   □ Friend
   □ Tax advisor
   □ Financial advisor/consultant
   □ Other (please specify)

5. How many times per year do you go to another individual to receive assistance with your finances? (please check the one that applies)
   □ Once per year
   □ Two to five times per year
   □ Six to nine times per year
   □ Ten or more times per year

Performance Capacity
6. What skills do you have that assist you in completing financial management tasks? (please explain)
   □ Paying attention
   □ Choosing materials/items
   □ Using materials/items appropriately
   □ Inquiring information
   □ Initiating tasks
   □ Continuing tasks
   □ Sequencing tasks
7. What skills do you lack that hinder your ability to complete financial management tasks? (please explain)
   - Paying attention
   - Choosing materials/items
   - Using materials/items appropriately
   - Inquiring information
   - Initiating tasks
   - Continuing tasks
   - Sequencing tasks
   - Organizing tasks
   - Storing items away after use
   - Adjusting for changes
   - Articulating needs
   - Asserting needs
   - Asking for information
   - Engaging
   - Expressing self
   - Sharing information
   - Collaborating with others
   - Conforming to social norms
   - Focusing on social actions
   - Relating with others
   - Respecting others

8. Do you have a checking account? (please circle one)  Y  N

9. Do you have a savings account? (please circle one)  Y  N

10. If you do not have a checking and/or savings account, please explain why.
11. If yes, do you have a checkbook? (please circle one)  Y  N

12. How well do you feel you do with balancing a checkbook? (please circle one of the following numbers)

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13. Do you know how to develop a budget? (please circle one)  Y  N

14. Have you ever developed a budget? (please circle one)  Y  N

15. Do you feel it is important to develop a budget?  Y  N
   Why or Why not? (please explain)

16. If you have developed a budget, why did you do so? (please explain)

17. What skills did you use when developing the budget? (please explain)

18. What skills were you lacking throughout the process of developing a budget? (please explain)

19. Did/do you stick to the budget?  Y  N
   Why or Why not? (please explain)

20. If you have a checkbook, how often do you use it? (please check the one that applies)
   □ Once per week
   □ Two to five times per week
   □ Six or more times per week

21. Do you balance your checkbook? (please circle one)  Y  N

22. If you balance your checkbook, how often do you do so? (please check the one that applies)
23. What types of purchases do you make with your checkbook? (please check all that apply)
- Groceries
- Car payment
- Insurance payment
- Utilities (i.e. electricity, telephone, cable, water, etc.)
- Credit card payment
- Rent or house payment
- Alcohol
- Clothing and other necessities
- Miscellaneous purchases
- Other (please specify)

24. How much money do you spend on alcohol in a typical day? (please check the one that applies)
- $10 or less
- $10 - $25
- $25 - $50
- $50 or more

25. How much money do you spend on alcohol in a typical week? (please check the one that applies) *Multiply the number in question 24 by 7 days
- $25 or less
- $25 - $50
- $50 - $100
- $100 or more

26. If you were to add up the amount of money that you spend on alcohol in a typical month, how much would you estimate it amounts to? (please check the one that applies) *Multiply the number in question 25 by 30 days
- $50 or less
- $50 - $100
- $100 - $200
- $200 - $300
- $300 - $400
- $400 - $500
- $500 - $750
- $750 - $1000
- $1000 or more
27. Where do you normally obtain the money that you use to make alcohol purchases? (please explain)

28. Reflecting back on the amount of money spent on purchasing alcohol, how do you think that money could have been better spent? (please explain)

**Physical Environment**

29. Do you keep all of your bills in one place for ease of location? (please circle one) Y N

30. Do you categorize your bills? (please circle one) Y N Why or Why not? (please specify)

31. Do you have a system in place that assists with the organization process? (please circle one) Y N
   • If so, please explain further.

**Social Environment**

32. Do you share your money with another individual? (please circle one) Y N

33. If so, do you feel that you communicate with him/her about the issues related to financial management? (please circle one) Y N Why or Why not? (please explain)

34. Are you currently banking anywhere? (please circle one) Y N
   • If so, where are you banking?

35. How often do you go to the bank? (please check the one that applies)
   □ Never
   □ One to Two times per week
   □ Three to Four times per week
   □ Five to Six times per week

36. How often to deposit or withdraw money? (please check the one that applies)
Never
One to Two times per week
Three to Four times per week
Five to Six times per week

37. Do you engage in online banking? (please circle one) Y N

Personal Causation

38. Overall, how effective do you feel you are at financial management? (please circle one of the following numbers)

1 2 3 4 5 6 7 8 9 10
Poor Well Extremely Well

39. What do you hope to gain from engaging in the occupational intervention of financial management? (please explain)
Financial Management Summary Form

*Occupational Therapist*: Please fill out after collaborating with the client on the Financial Management Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.

- **Interests** identified by client in regards to Financial Management:

- **Value** placed on Financial Management: (please circle one)
  - Not important
  - Somewhat important
  - Important
  - Very important

- **Role** in Financial Management:

- **Performance Capacity** skill strengths:

- **Performance Capacity** skill deficits:

- **Performance Capacity** occupational forms present: (please circle those that apply) Checkbook  Banking  Budgeting  Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply) Checkbook  Banking  Budgeting  Other

- **Habits** supporting engagement in Financial Management:

- **Habits** inhibiting engagement in Financial Management:
- Habits surrounding alcohol abuse/dependence:

- Habits of spending money on alcohol:
  Total Money Spent monthly: _____ Total Money Spent to date: _____

- Physical Environment problems:

- Social Environment problems:

- Personal Causation in regards to effectiveness:

- Personal Causation in regards to intervention plan:
Title of Activity: __________________________

Occupation Addressed: Financial Management

Interests/Values & Personal Causation

Objective(s): (Overall goal(s) to be met)

Social Environment

Group or Individual: (Please Specify)

Physical Environment

Materials Needed: (Throughout intervention)

Space Needed: (Throughout intervention)

Performance Capacity

Skills Addressed: (Relevant performance capacity skill deficits from summary)
(Process)

(Communication/Interaction)

Description of the Activity: (What will take place)

Discussion Questions: (Questions to facilitate discussion)

Adaptations: (Changes made to meet client(s) needs)

Habits

Outcome(s): (Habits established from participating in intervention)
Section 2

Health Management and Maintenance Questionnaire, Summary Form, & Intervention Protocol
Health Management & Maintenance
Introduction

The Health Management and Maintenance Questionnaire is designed to integrate all of the principles of MOHO to assist occupational therapists (O.T.'s) in gaining a better understanding of his/her client(s) to implement individualized treatment. The questions asked throughout this questionnaire include the clients' Interests/Values, Roles, Performance Capacity, Habits, Social and Physical Environment, and Personal Causation (MOHO principles). The areas that were taken into consideration in regards to health management and maintenance tasks include the following: physical fitness/ exercise, nutrition, and medication management.

The questions found throughout this section are specifically geared toward the clients' physical fitness/nutrition/medication habits, occupational engagement, client role(s), skills enabling/ hindering the client in occupational engagement, areas of interest for the client, and the value placed on this occupation.

Following the completion of the questionnaire, the O.T. and client will collaboratively fill out the concise summary form that is provided. This will allow the O.T. to identify the areas that need improvement and subsequently develop an occupation-based intervention that is either individual or group focused. To complete the last step of developing an occupation-based intervention according to the gathered data, an intervention protocol is provided to assist the therapist with the planning and implementation of a suitable activity.
Health Management & Maintenance Questionnaire

Interests/Values

1. How would you rate your health today? (please check one)
   - Poor
   - Fair
   - Good
   - Very good
   - Excellent

2. Is managing and maintaining your health something you enjoy doing? (please circle one)  Y  N
   Why or why not? (please explain)

3. What type(s) of physical activity(s) would you like to engage in on a regular basis? (please list)

4. What area(s) of nutrition would you like to learn more about? (please specify)

Roles

5. What roles are negatively impacted by your lack of engagement in health management and maintenance? (please check all that apply)
   - Spouse
   - Parent
   - Caregiver
   - Employee
   - Coworker
   - Friend
   - Home maintainer
   - Other (please specify)

6. How are the above identified roles affected by your lack of positive engagement in health management and maintenance? (please explain)
7. Who is responsible for the health management and maintenance of people in your household? (i.e. children who need medication, etc.) (please check all that apply)
   - Yourself
   - Spouse or significant other
   - Family member
   - No one
   - Other (please specify)

8. Who prepares the meals for your household? (please check all that apply)
   - Yourself
   - Spouse or significant other
   - Family member
   - No one
   - Other (please specify)

9. If you are not taking care of your health, would close family, friends, or co-workers bring it to your attention? (please circle one) Y N

**Performance Capacity**

10. How well do you feel you take care of your mind, brain, and body overall? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor  Well  Extremely Well

11. When you engage in physical activity, how well do you feel you perform? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor  Well  Extremely Well

12. How well do you feel you prepare nutritious meals? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor  Well  Extremely Well

13. What skills do you have that assist you in completing health management and maintenance tasks? (please check all that apply)
   - Pacing
   - Paying attention
   - Choosing materials/items
   - Inquiring information
   - Initiating tasks
Organizing tasks
Adjusting for changes
Gazing at others
Asserting needs
Asking for information
Engaging
Expressing self
Collaborating with others
Conforming to social norms
Focusing on social actions
Relating with others
Respecting others

14. What skills do you lack that hinder your ability to complete health management and maintenance tasks? (please explain)
- Pacing
- Paying attention
- Choosing materials/items
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Gazing at others
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others

Habits

15. What type(s) of activity(s) do you engage in on a regular basis? (please check all that apply)
- Vigorous activity(s) (i.e. running)
- Moderate activity(s) (i.e. vacuuming)
- Climbing one or more flight of stairs
- Walking one block or more
- Completing morning routine (i.e. showering, dressing, etc.)
- Other (please specify)

16. How many days per week do you engage in vigorous to moderate physical activity? (please check the one that applies)
17. How many servings of fruits and vegetables do you eat in a typical day? (please check the one that applies)
   □ None
   □ One serving
   □ Two to Three servings
   □ Four to Five servings
   □ Six to Seven servings
   □ Eight or more servings

18. How many glasses of water do you drink in a typical day? (please check the one that applies)
   □ None
   □ One glass
   □ Two to Three glasses
   □ Four to Five glasses
   □ Six to Seven glasses
   □ Eight or more glasses

19. How many glasses of milk do you drink in a typical day? (please check the one that applies)
   □ None
   □ One glass
   □ Two glasses
   □ Three glasses
   □ Four or more glasses

20. How much caffeine do you consume in a typical day? (please check the one that applies)
   □ None
   □ One can/cup
   □ Two to Three cans/cups
   □ Four to Five cans/cups
   □ Six or more cans/cups

21. Do you smoke? (please circle one)  Y  N

22. Do you or have you used other forms of drugs besides alcohol, nicotine, or caffeine? (please circle one)  Y  N

23. How much alcohol do you consume in a typical day? (please check the one that applies)
24. Do you currently take any medications? (please circle one) Y N

25. What medications are you currently taking, and how often do you take them? (please list)

26. What side effects from medication, if any, are you experiencing? (please list)

27. Do you take your medications as prescribed? (please circle one) Y N

28. What do you hope to gain by engaging in health management and maintenance occupations? (please explain)

**Physical Environment**

29. Where do you engage in meal consumption? (please check all that apply)
   - At home
   - In the car
   - Restaurants
   - Friend/Family's house
   - Community events
   - At work
   - Other (please specify)

30. Where do you engage in alcohol consumption? (please check all that apply)
   - At home
   - In the car
   - Restaurants
   - Bar/Club
31. Where do you store your alcohol supply? (please check all that apply)
   □ Refrigerator
   □ Liquor cabinet/private bar
   □ Basement
   □ Vehicle
   □ Closet
   □ Bedroom
   □ Garage/Outdoors
   □ At work
   □ Friend/Family’s house
   □ I don’t store alcohol
   □ I buy and consume immediately
   □ Other (please specify)

32. Where do you engage in physical activity? (please check all that apply)
   □ At home
   □ Community Center
   □ Private Gym
   □ Outdoors
   □ At work
   □ Other (please specify)

33. What types of equipment do you use when engaging in physical activity? (please check all that apply)
   □ None
   □ Free weights
   □ Weight machines
   □ Treadmill or other equipment
   □ Small equipment (i.e. medicine ball, resistive bands, etc.)
   □ Everyday items (i.e. can of soup, stairs, etc.)
   □ Workout videos (i.e. yoga, kickboxing, etc.)
   □ Other (please specify)

Social Environment

34. With whom do you consume meals? (please check all that apply)
   □ Independently
   □ With a friend(s)
   □ Family member(s)
   □ Spouse or significant other
35. With whom do you consume alcohol? (please check all that apply)
   □ Independently
   □ With a friend(s)
   □ Family member(s)
   □ Spouse or significant other
   □ Group of people
   □ Co-worker(s)
   □ Other (please specify)

36. With whom do you participate in physical activity? (please check all that apply)
   □ Independently
   □ With a friend(s)
   □ Family member(s)
   □ Spouse or significant other
   □ Group of people
   □ Other (please specify)

37. What motivates you to be physically active? (please explain)

38. What motivates you to eat healthy? (please explain)

39. If you smoke or use other forms of drugs (i.e. alcohol, nicotine, caffeine, etc.), how does this use impact your performance in health management and maintenance? (please explain)

40. Why, if at all, do you feel it is important to take your medications as prescribed? (please explain)
Health Management and Maintenance Summary Form

*Occupational Therapist: Please fill out after collaborating with the client on the Health Management and Maintenance Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.*

- **Interests** identified by client in regards to Health Management and Maintenance:

- **Value** placed on Health Management and Maintenance: (please circle one)
  - Not important
  - Somewhat important
  - Important
  - Very important

- **Role** in Health Management and Maintenance:

- **Performance Capacity** skill strengths:

- **Performance Capacity** skill deficits:

- **Performance Capacity** occupational forms present: (please circle those that apply)
  - Physical activity/fitness
  - Nutrition
  - Medication
  - Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply)
  - Physical activity/fitness
  - Nutrition
  - Medication
  - Other

- **Habits** supporting engagement in Health Management and Maintenance:
• Habits inhibiting engagement in Health Management and Maintenance:

• Habits surrounding alcohol abuse/dependence:

• Physical Environment problems:

• Social Environment problems:

• Personal Causation in regards to effectiveness:

• Personal Causation in regards to intervention plan:
Title of Activity: __________________________

Occupation Addressed: Health Management and Maintenance

Interests/Values & Personal Causation
Objective(s): (Overall goal(s) to be met)

Social Environment
Group or Individual: (Please Specify)

Physical Environment
Materials Needed: (Throughout intervention)

Space Needed: (Throughout intervention)

Performance Capacity
Skills Addressed: (Relevant performance capacity skill deficits from summary)
(Process)
(Communication/Interaction)

Description of the Activity: (What will take place)

Discussion Questions: (Questions to facilitate discussion)

Adaptations: (Changes made to meet client(s) needs)

Habits
Outcome(s): (Habits established from participating in intervention)
Section 3

Social Participation Questionnaire, Summary Form, & Intervention Protocol
Social Participation
Introduction

The *Social Participation Questionnaire* is designed to integrate all of the principles of MOHO to assist occupational therapists (O.T.'s) in gaining a better understanding of his/her client(s) to implement individualized treatment. The questions asked throughout this questionnaire include the clients' Interests/Values, Roles, Performance Capacity, Habits, Social and Physical Environment, and Personal Causation (MOHO principles). The areas that were taken into consideration in regards to social participation include the following: family, peer/friend, and community relationships.

The questions found throughout this section are specifically geared toward the clients' social habits, occupational engagement, client role(s), skills enabling/hindering the client in occupational engagement, areas of interest for the client, and the value placed on this occupation.

Following the completion of the questionnaire, the O.T. and client will collaboratively fill out the concise summary form that is provided. This will allow the O.T. to identify the areas that need improvement and subsequently develop an occupation-based intervention that is either individual or group focused. To complete the last step of developing an occupation-based intervention according to the gathered data, an intervention protocol is provided to assist the therapist with the planning and implementation of a suitable activity.
Social Participation Questionnaire

Interests/Values
1. Do you enjoy being around other people? (please circle one)  Y  N
   Why or Why not? (please explain)

2. What do you enjoy doing with other people? (please explain)

3. What barriers currently exist that inhibit you from engaging in enjoyable social participation? (please explain)

Roles
4. What roles are negatively impacted by your current engagement in social participation? (please check all that apply)
   □ Spouse
   □ Parent
   □ Caregiver
   □ Employee
   □ Coworker
   □ Friend
   □ Home maintainer
   □ Other (please specify)

5. If you are not participating in your usual healthy social activities, would close family, friends, or co-workers bring it to your attention? (please circle one)  Y  N

6. What roles do you have within your community, if any? (i.e. school board member, church participant, etc.) (please list)

7. How are these identified roles in question 6 impacted by alcohol use? (please explain)
Performance Capacity

8. What skills do you have that are strengths to you in social participation? (please check all that apply)
   - Paying attention
   - Inquiring information
   - Initiating tasks
   - Organizing tasks
   - Adjusting for changes
   - Contacting others
   - Gazing at others
   - Gesturing
   - Asserting needs
   - Asking for information
   - Engaging
   - Expressing self
   - Sharing information
   - Speaking to others
   - Sustaining conversations
   - Collaborating with others
   - Conforming to social norms
   - Focusing on social actions
   - Relating with others
   - Respecting others

9. What skills do you lack that hinder your ability to engage in social participation? (please check all that apply)
   - Paying attention
   - Inquiring information
   - Initiating tasks
   - Organizing tasks
   - Adjusting for changes
   - Contacting others
   - Gazing at others
   - Gesturing
   - Asserting needs
   - Asking for information
   - Engaging
   - Expressing self
   - Sharing information
   - Speaking to others
   - Sustaining conversations
   - Collaborating with others
   - Conforming to social norms
   - Focusing on social actions
   - Relating with others
   - Respecting others
Habits

10. During a typical day, how many hours do you spend interacting with other people? (please check the one that applies)

- None
- One hour
- Two to Three hours
- Four to Five hours
- Six to Seven hours
- Eight to Nine hours
- Ten or more hours

11. What types of activities do you participate in with other people? (please explain)

12. How many times per week do you go out with family and/or friends? (please check the one that applies)

- None
- One time per week
- Two to Three times per week
- Three to Four times per week
- Five or more times per week

13. Where do you go with family and/or friends? (please check all that apply)

- Movie Theatre
- Restaurant
- Bar/Club
- Shopping
- Concert(s)
- Community or Church Events
- Vacation
- Other (please specify)

Physical Environment

14. Do you live by yourself? (please circle one) Y N

15. If not, who do you live with? (please check all that apply)

- Spouse or significant other
- Children
- Parent
- Friend
- Other family members (please specify)
- Other (please specify)
16. Do you have any pets within your household? (please circle one)
Y  N

17. If so, what types of pets do you have? (please check all that apply)
☐ Dog
☐ Cat
☐ Bird
☐ Fish
☐ Horse
☐ Reptile
☐ Other (please specify)

18. Do you have access to the internet? (please circle one) Y  N

19. How do you use the internet to connect with people or groups?
(please check all that apply)
☐ Email
☐ Chat rooms
☐ Instant messenger
☐ Subscribing to periodic group emails
☐ Purchasing items
☐ Other (please specify)

20. What bar(s) do you typically drink at with others? (please list)

Social Environment

21. How many close friends do you have? (please check one)
☐ None
☐ One
☐ Two to Three
☐ Four to Five
☐ Six or more

22. Do you feel uncomfortable in large groups? (please circle one)
Y  N
Why or Why not? (please explain)

23. How much time in a typical week is spent drinking socially with others? (please check one that applies)
☐ None
☐ One day per week
24. Which people in your life support your drinking? (please list)

25. Which people in your life support your desire to seek treatment and become sober? (please list)

26. Please describe the social environment(s) which trigger you to drink in high, intoxicating amounts.

Personal Causation

27. Do you feel that you have a hard time initiating a conversation? (please circle one) Y N

28. If so, why? (please explain)

29. How well do you feel you can sustain a conversation? (please circle one of the following)

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30. Do you feel that the majority of time with others is spent when consuming alcohol? (please circle one) Y N

31. Do you feel it is easier to talk with others when you are consuming alcohol or under the influence? (please circle one) Y N
Why or Why not? (please explain)

32. What would you like to learn more about regarding social participation? (please explain)
Social Participation Summary Form

Occupational Therapist: Please fill out after collaborating with the client on the Social Participation Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.

- **Interests** identified by client in regards to Social Participation:

- **Value** placed on Social Participation: (please circle one)
  - Not important
  - Somewhat important
  - Important
  - Very important

- **Role** in Social Participation:

- **Performance Capacity** skill strengths:

- **Performance Capacity** skill deficits:

- **Performance Capacity** occupational forms present: (please circle those that apply)
  - Family
  - Library
  - Shopping
  - Restaurant
  - Community Events
  - Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply)
  - Family
  - Library
  - Shopping
  - Restaurant
  - Community Events
  - Other

- **Habits** supporting engagement in Social Participation:

- **Habits** inhibiting engagement in Social Participation:
• Habits surrounding alcohol abuse/dependence:

• Physical Environment problems:

• Social Environment supports:

• Social Environment problems/triggers:

• Personal Causation in regards to effectiveness:

• Personal Causation in regards to intervention plan:
Title of Activity: ____________________________

**Occupation Addressed:** Financial Management

**Interests/Values & Personal Causation**

**Objective(s):** (Overall goal(s) to be met)

**Social Environment**

**Group or Individual:** (Please Specify)

**Physical Environment**

**Materials Needed:** (Throughout intervention)

**Space Needed:** (Throughout intervention)

**Performance Capacity**

**Skills Addressed:** (Relevant performance capacity skill deficits from summary)

(Process)

(Communication/Interaction)

**Description of the Activity:** (What will take place)

**Discussion Questions:** (Questions to facilitate discussion)

**Adaptations:** (Changes made to meet client(s) needs)

**Habits**

**Outcome(s):** (Habits established from participating in intervention)
Section 4

Jim's Case Study, Completed Questionnaires, Summary Forms, & Interventions
Case Study #1

Jim

Jim is 37 year-old Caucasian male who is receiving treatment in a partial hospitalization program for his alcohol dependence. Jim is divorced and currently resides with his mother and ten year-old son in his mother's home which is a two-story house in a rural community. Jim stated that he graduated from high school and then attended a technical school for an additional year. His most recent occupation was working at a heating and air company but is currently unemployed.

Jim's current drug of choice is alcohol, but it was noted that he has utilized other types of drugs in the past. Jim also mentioned that he has a gambling addiction and is a smoker. Jim voluntarily referred himself for treatment this time, but he has been in treatment a total of 18 times in the past. Prior to admission, Jim sated that he had been steadily consuming alcohol for the past six months.

Jim feels that he is experiencing a lot of problems when it comes to his instrumental activities of daily living (IADL's). He stated that he has difficulty with financial management, child rearing, and home management and maintenance. Jim is having difficulty with financial management due to his unemployment and gambling addiction. Home management and maintenance is posed as a problem due to Jim being dependent on his mother to complete all of the tasks related to home management and maintenance.

Jim's support system consists of his mother and son; however, he feels that social interaction with others is an area of concern. He stated that he has difficulty with relationships, and this is an area that he would like to improve upon. Jim enjoys fishing, spending time with his son, and being outdoors.
Financial Management Questionnaire

Interest/Values
1. Do you engage in financial management tasks (i.e. checkbook, banking, budgeting tasks, etc.)? (please circle one) Y N

2. Is financial management something you enjoy doing? (please circle one) Y N
   Why or why not? (please explain)
   No, I do not enjoy doing financial management tasks; however, I know that it is important to do them.

Roles
3. Do you complete all financial management tasks independently? (please circle one) Y N
   Why or Why not? (please explain)
   Because it is hard to do and keep track of everything that I need to

4. If not, who assists you? (please check all that apply)
   □ Family member
   □ Friend
   □ Tax advisor
   □ Financial advisor/consultant
   □ Other (please specify)

5. How many times per year do you go to another individual to receive assistance with your finances? (please check the one that applies)
   □ Once per year
   □ Two to five times per year
   □ Six to nine times per year
   □ Ten or more times per year

Performance Capacity
6. What skills do you have that assist you in completing financial management tasks? (please explain)
   □ Paying attention
   □ Choosing materials/items
   □ Using materials/items appropriately
   □ Inquiring information
   □ Initiating tasks
   □ Continuing tasks
7. What skills do you lack that hinder your ability to complete financial management tasks? (please explain)
- Paying attention
- Choosing materials/items
- Using materials/items appropriately
- Inquiring information
- Initiating tasks
- Continuing tasks
- Sequencing tasks
- Organizing tasks
- Storing items away after use
- Adjusting for changes
- Articulating needs
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Sharing information
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others

8. Do you have a checking account? (please circle one)  Y  N

9. Do you have a savings account? (please circle one)  Y  N

10. If you do not have a checking and/or savings account, please explain why.
I do not have a savings account because I don’t have enough money to put into it.

11. If yes, do you have a checkbook? (please circle one)   Y   N
   But I rarely use it.

12. How well do you feel you do with balancing a checkbook? (please circle one of the following numbers)
   
   1 2 3 4 5 6 7 8 9 10
   Poor        Well        Extremely Well

13. Do you know how to develop a budget? (please circle one)   Y   N

14. Have you ever developed a budget? (please circle one)   Y   N

15. Do you feel it is important to develop a budget?   Y   N
   Why or Why not? (please explain)
   So you know how much money you have to spend on things

16. If you have developed a budget, why did you do so? (please explain)
   I have not developed a budget before.

17. What skills did you use when developing the budget? (please explain)
   N/A

18. What skills were you lacking throughout the process of developing a budget? (please explain)
   N/A

   Habits

19. Did/do you stick to the budget?   Y   N
   Why or Why not? (please explain)

20. If you have a checkbook, how often do you use it? (please check the one that applies)
   □   Once per week
   □   Two to five times per week
   □   Six or more times per week

21. Do you balance your checkbook? (please circle one)   Y   N

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22. If you balance your checkbook, how often do you do so? (please check the one that applies)
   □ Once per week
   □ Two times per week
   □ Three times per week
   □ Every day

23. What types of purchases do you make with your checkbook? (please check all that apply)
   □ Groceries
   □ Car payment
   □ Insurance payment
   □ Utilities (i.e. electricity, telephone, cable, water, etc.)
   □ Credit card payment
   □ Rent or house payment
   □ Alcohol
   □ Clothing and other necessities
   □ Miscellaneous purchases
   □ Other (please specify)

24. How much money do you spend on alcohol in a typical day? (please check the one that applies)
   □ $10 or less
   □ $10 - $25
   □ $25 - $50
   □ $50 or more

25. How much money do you spend on alcohol in a typical week? (please check the one that applies) *Multiply the number in question 24 by 7 days
   □ $25 or less
   □ $25 - $50
   □ $50 - $100
   □ $100 or more

26. If you were to add up the amount of money that you spend on alcohol in a typical month, how much would you estimate it amounts to? (please check the one that applies) *Multiply the number in question 25 by 30 days
   □ $50 or less
   □ $50 - $100
   □ $100 - $200
   □ $200 - $300
   □ $300 - $400
   □ $400 - $500
   □ $500 - $750
27. Where do you normally obtain the money that you use to make alcohol purchases? (please explain)
From my job

28. Reflecting back on the amount of money spent on purchasing alcohol, how do you think that money could have been better spent? (please explain)
I could use it to buy my son the things that he needs or to help my mom with the groceries.

29. Do you keep all of your bills in one place for ease of location? (please circle one) Y N

30. Do you categorize your bills? (please circle one) Y N
Why or Why not? (please specify)
I don’t have enough time or patience

31. Do you have a system in place that assists with the organization process? (please circle one) Y N
• If so, please explain further.

32. Do you share your money with another individual? (please circle one) Y N

33. If so, do you feel that you communicate with him/her about the issues related to financial management? (please circle one) Y N
Why or Why not? (please explain)

34. Are you currently banking anywhere? (please circle one) Y N
• If so, where are you banking?
Western Local State Bank

35. How often do you go to the bank? (please check the one that applies)
□ Never
□ One to Two times per week
36. How often to deposit or withdraw money? (please check the one that applies)

☐ Never
☐ One to Two times per week
☐ Three to Four times per week
☐ Five to Six times per week

37. Do you engage in online banking? (please circle one)  Y   N

Personal Causation

38. Overall, how effective do you feel you are at financial management? (please circle one of the following numbers)

1  2  3  4  5  6  7  8  9  10  
Poor  Well  Extremely Well

39. What do you hope to gain from engaging in the occupational intervention of financial management? (please explain)
How to manage my checkbook, maybe some budgeting, and doing banking things
Jim’s Financial Management Summary Form

*Occupational Therapist:* Please fill out after collaborating with the client on the Financial Management Questionnaire. *After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.*

- *Interests* identified by client in regards to Financial Management:
  Managing a checkbook; budgeting and banking tasks

- *Value* placed on Financial Management: (please circle one)
  Not important  Somewhat important  Important  Very important

- *Role* in Financial Management:
  Seeking assistance from others; Does not do banking or budgeting but has a desire to engage in these tasks

- *Performance Capacity* skill strengths:
  Choosing materials/item; Using materials/items appropriately; Organizing tasks; Articulating needs; Asserting needs; Asking for information; Collaborating with others; Respecting others

- *Performance Capacity* skill deficits:
  Paying attention; Inquiring information; Initiating tasks; Continuing tasks; Sequencing tasks; Storing items away after use; Adjusting for changes; Engaging; Expressing self; Sharing information; Conforming to social norms; Focusing on social actions; Relating with others

- *Performance Capacity* occupational forms present: (please circle those that apply) Checkbook  Banking  Budgeting

- *Performance Capacity* occupational forms to be addressed via interventions: (please circle those that apply) Checkbook  Banking  Budgeting  Other

- *Habits* supporting engagement in Financial Management:
  Prior experience utilizing a checkbook

- *Habits* inhibiting engagement in Financial Management:
  Poor financial management skills; Living with his mother

- *Habits* surrounding alcohol abuse/dependence:
Excessive spending on alcohol: Gambling; Smoking

- **Habits of spending money on alcohol:**
  Spends $25-$50 per day; Spends $100 or more per week

  Total Money Spent monthly: $400-$500 Total Money Spent to date: $96,000

- **Physical Environment problems:**
  Has difficulty with organizing, categorizing, and filing bills

- **Social Environment problems:**
  Does not engage in banking tasks

- **Personal Causation in regards to effectiveness:**
  Poorly (2). Client wants to develop organizational skills in regards to banking, checkbook use, and minimal budgeting.

- **Personal Causation in regards to intervention plan:**
  Plan is to engage the client in checkbook management and banking tasks for organization and effectiveness.
Occupation Addressed: Financial Management

Objective(s): The client will demonstrate the ability to independently organize his financial statements, withdraw and deposit money, and pay bills.

Group or Individual: Individual

Materials Needed: Client's financial statements, file folder, checkbook, withdrawal/deposit slips, pens, calculator, whiteout, stapler, client's bills

Space Needed: Table, chairs, access to vehicle, adequate lighting

Skills Addressed: Paying attention; Inquiring information; Initiating tasks; Continuing tasks; Sequencing tasks; Storing items away after use; Adjusting for changes; Engaging; Expressing self; Sharing information; Conforming to social norms; Focusing on social actions; Relating with others

Description of the Activity:
- Client and Therapist will sort financial statements and bills and group them accordingly in the labeled file folder.
- Client will practice filling out withdrawal and deposit slips before going to the bank to actually withdraw and/or deposit money.
- Client will pay bills with checkbook and correctly document and balance his checkbook log.

Discussion Questions:
- How can organizing your finances help you maintain sobriety?
- How will this intervention benefit you in the future?

Adaptations:
- This intervention may take place over the course of more than one treatment session.
- This intervention can be done in a group session involving more feedback solicited from participants.

Outcome(s): The client will report using the new banking system including organizing financial statements, being able to withdraw or deposit money when necessary for non-alcohol purchases, and paying bills on-time.
Social Participation Questionnaire

Interests/Values
1. Do you enjoy being around other people? (please circle one)  Y  N
   Why or Why not? (please explain)
   Because I think that I get along with others and I like talking to other people.

2. What do you enjoy doing with other people? (please explain)
   Talking with them and doing fun things

3. What barriers currently exist that inhibit you from engaging in enjoyable social participation? (please explain)
   My using of alcohol

Roles
4. What roles are negatively impacted by your current engagement in social participation? (please check all that apply)
   □ Spouse
   □ Parent
   □ Caregiver
   □ Employee
   □ Coworker
   □ Friend
   □ Home maintainer
   □ Other (please specify)

5. If you are not participating in your usual healthy social activities, would close family, friends, or co-workers bring it to your attention? (please circle one)  Y  N

6. What roles do you have within your community, if any? (i.e. school board member, church participant, etc.) (please list)
   None

7. How are these identified roles in question 6 impacted by alcohol use? (please explain)
   N/A
Performance Capacity

8. What skills do you have that are strengths to you in social participation? (please check all that apply)
- Paying attention
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Contacting others
- Gazing at others
- Gesturing
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Sharing information
- Speaking to others
- Sustaining conversations
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others

9. What skills do you lack that hinder your ability to engage in social participation? (please check all that apply)
- Paying attention
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Contacting others
- Gazing at others
- Gesturing
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Sharing information
- Speaking to others
- Sustaining conversations
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others
Habits

10. During a typical day, how many hours do you spend interacting with other people? (please check the one that applies)
   - None
   - One hour
   - Two to Three hours
   - Four to Five hours
   - Six to Seven hours
   - Eight to Nine hours
   - Ten or more hours

11. What types of activities do you participate in with other people? (please explain)
    Going fishing, being outside, spending time with my son, drinking

12. How many times per week do you go out with family and/or friends? (please check the one that applies)
    - None
    - One time per week
    - Two to Three times per week
    - Three to Four times per week
    - Five or more times per week

13. Where do you go with family and/or friends? (please check all that apply)
    - Movie Theatre
    - Restaurant
    - Bar/Club
    - Shopping
    - Concert(s)
    - Community or Church Events
    - Vacation
    - Other (please specify)

Physical Environment

14. Do you live by yourself? (please circle one)  Y  N

15. If not, who do you live with? (please check all that apply)
    - Spouse or significant other
    - Children
    - Parent
    - Friend
    - Other family members (please specify)
    - Other (please specify)
16. Do you have any pets within your household? (please circle one)
   Y  N

17. If so, what types of pets do you have? (please check all that apply)
   □ Dog
   □ Cat
   □ Bird
   □ Fish
   □ Horse
   □ Reptile
   □ Other (please specify)

18. Do you have access to the internet? (please circle one)  Y  N

19. How do you use the internet to connect with people or groups?
   (please check all that apply)
   □ Email
   □ Chat rooms
   □ Instant messenger
   □ Subscribing to periodic group emails
   □ Purchasing items
   □ Other (please specify)

20. What bar(s) do you typically drink at with others? (please list)
   Local bar and in the nearby town

Social Environment

21. How many close friends do you have? (please check one)
   □ None
   □ One
   □ Two to Three
   □ Four to Five
   □ Six or more

22. Do you feel uncomfortable in large groups? (please circle one)
   Y  N
   Why or Why not? (please explain)
   Because I feel stupid and nervous, and I don’t know what to say. I do not feel uncomfortable though when I am drinking.

23. How much time in a typical week is spent drinking socially with others? (please check one that applies)
   □ None
☐ One day per week
☐ Two to Three days per week
☐ Four to Five days per week
☐ Six to Seven days per week

24. Which people in your life support your drinking? (please list)
   My friends

25. Which people in your life support your desire to seek treatment and become sober? (please list)
   My mother and son

26. Please describe the social environment(s) which trigger you to drink in high, intoxicating amounts.
   Being around others who drink, the bar, or being at friends' house

Personal Causation

27. Do you feel that you have a hard time initiating a conversation? (please circle one)  Y  N

28. If so, why? (please explain)
   Well, I guess it depends on who I am with. Some people I just don't know what to say.

29. How well do you feel you can sustain a conversation? (please circle one of the following)

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30. Do you feel that the majority of time with others is spent when consuming alcohol? (please circle one)  Y  N

31. Do you feel it is easier to talk with others when you are consuming alcohol or under the influence? (please circle one)  Y  N
   Why or Why not? (please explain)
   Because they don't really know what I am saying or care what I have to say. It is all fun when I am out drinking with my buddies. We are just looking to have a good time.
32. What would you like to learn more about regarding social participation? (please explain)
How to start and maintain conversation with someone that I feel uncomfortable around and how to talk with my son without sounding stupid and being drunk.
Jim’s Social Participation Summary Form

Occupational Therapist: Please fill out after collaborating with the client on the Social Participation Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.

- **Interests** identified by client in regards to Social Participation:
  Spending time with son; meeting new people who are not involved with alcohol

- **Value** placed on Social Participation: (please circle one)
  Not important  Somewhat important  Important  Very important

- **Role** in Social Participation:
  Parent; Employee; Co-worker; Friend

- **Performance Capacity** skill strengths:
  Inquiring information; Initiating tasks; Contacting others; Gazing at others; Engaging; Sharing information; Speaking to others; Relating with others; and Respecting others

- **Performance Capacity** skill deficits:
  Paying attention; Organizing tasks; Adjusting for changes; Gesturing; Asserting needs; Asking for information; Expressing self; Sustaining conversations; Collaborating with others; Conforming to social norms; Focusing on social actions

- **Performance Capacity** occupational forms present: (please circle those that apply)
  Family  Library  Shopping  Restaurant  Community Events  Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply)
  Family  Library  Shopping  Restaurant  Community Events  Other

- **Habits** supporting engagement in Social Participation:
  Spends four to five hours around others; goes out with other people five or more times per week; Enjoys being outdoors; spending time with his son

- **Habits** inhibiting engagement in Social Participation:
  Going out with friends six to seven times per week; Going to bar; Drinking

- **Habits** surrounding alcohol abuse/dependence:
Goes to bar with friends and/or family; smokes; drinks at friend's house; goes out to local bar six to seven times per week

- **Physical Environment problems:**
  Lives with his mother; Goes out to bar

---

- **Social Environment supports:**
  His mother and son; Has one close friend

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- **Social Environment problems/trigger:**
  Being around others who consume alcohol; Going to a restaurant that serves alcohol; Going to a bar

- **Personal Causation in regards to effectiveness:**
  Poor social skills (3) Client wants to feel comfortable and confident when talking to others.

- **Personal Causation in regards to intervention plan:**
  Plan is to enable the client to interact with new people, talk to his son without being under the influence, and initiate/sustain a conversation with others when not using alcohol.
Baseball Outing

**Occupation Addressed:** Social Participation

**Interests/Values & Personal Causation**

**Objective(s):** The client will spend time with his son by attending a baseball game. He will engage in conversation in addition to focusing on the game and others in the social environment.

**Social Environment**

**Group or Individual:** Individual  *Outside of treatment setting*

**Physical Environment**

**Materials Needed:** Game schedule, pen, paper, highlighter, map, phone book/contact information, phone, journal

**Space Needed:** Table, chairs, white board, adequate lighting

**Performance Capacity**

**Skills Addressed:** Adjusting for changes; Gesturing; Asserting needs; Asking for information; Expressing self; Sustaining conversations; Collaborating with others; Conforming to social norms; Focusing on social actions

**Description of the Activity:**

- Client will select and plan an outing with his son taking into consideration all the contexts involved.
- Client and Therapist will develop achievable objectives for the outing.
- Client will report in his journal and process the experience with the Therapist at the next session.

**Discussion Questions:**

- How did this outing change the relationship with your son?
- What did you struggle with during the outing?
- What other types of outings will you engage in with your son?

**Adaptations:**

- This intervention may include the therapist in an observing role.
- This intervention can be done in a group session with other clients.

**Habits**

**Outcome(s):** The client will report anticipated outings with his son in which meaningful conversations are sustained. The client will engage in social participation while sober.
Section 5

Paula's Case Study, Completed Questionnaires, Summary Forms, & Interventions
Case Study #2

Paula

Paula is a 32 year-old Native American female who is receiving treatment in a partial hospitalization program for her alcohol dependence. For the last two months, Paula and her daughter have been living in a two bedroom apartment with Paula’s mother. Though she did not graduate from high school, Paula received her general education degree (GED). She has worked many different jobs including an aerobics instructor, telemarketer, and grocery cashier. Currently, she is unemployed but desires to either go to college or obtain employment upon discharge.

For the past 20 years, Paula has smoked and is currently smoking half a pack per day. Alcohol is her primary drug of choice, even though she has also used a plethora of other drugs since she was in her teens. She also uses caffeine quite heavily as evidenced by her habit of drinking pop and coffee daily. Paula has received counseling for her alcohol dependence in the past and reports this experience as “positive.”

Most of her IADL’s are affected at this time: community mobility due to no personal vehicle, financial management due to minimal money, health management and maintenance (i.e. exercising/nutrition), and the seemingly stressful living situation at her mother’s house. She possesses the desire to get back into physical fitness activities and eating healthy. She wants to feel healthy again by having more energy, exercising, and eating well.

Paula does not have a strong support system but does have a few good friends who do not use. She has an AA sponsor who she meets for coffee with occasionally. She enjoys volunteering, being outdoors, listening to music, and spending time with her daughter. Yet, when she is heavily using alcohol or experiencing a craving, Paula does not like to get out and engage in social activities.
Health Management & Maintenance Questionnaire

Interests/Values

1. How would you rate your health today? (please check one)
   □ Poor
   □ Fair
   □ Good
   □ Very good
   □ Excellent

2. Is managing and maintaining your health something you enjoy doing? (please circle one) Y N
   Why or why not? (please explain)
   I have always enjoyed physical activity. Some of my favorite jobs involved getting into and being in shape. I would like to feel more energetic.

3. What type(s) of physical activity(s) would you like to engage in on a regular basis? (please list)
   Lifting weights, biking, playing outdoors with my daughter, aerobics, meditation

4. What area(s) of nutrition would you like to learn more about? (please specify)
   Water intake, carbohydrates, protein for becoming more muscular

Roles

5. What roles are negatively impacted by your lack of engagement in health management and maintenance? (please check all that apply)
   □ Spouse
   □ Parent
   □ Caregiver
   □ Employee
   □ Coworker
   □ Friend
   □ Home maintainer
   □ Other (please specify)

6. How are the above identified roles affected by your lack of positive engagement in health management and maintenance? (please explain)
I don’t have energy to play with my daughter or to help out my mother in the house. I wouldn’t be able to hold a job right now because I don’t feel healthy.

7. Who is responsible for the health management and maintenance of people in your household? (i.e. children who need medication, etc.) (please check all that apply)
   - Yourself
   - Spouse or significant other
   - Family member (my mother)
   - No one
   - Other (please specify)

8. Who prepares the meals for your household? (please check all that apply)
   - Yourself
   - Spouse or significant other
   - Family member (my mother)
   - No one
   - Other (please specify)

9. If you are not taking care of your health, would close family, friends, or co-workers bring it to your attention? (please circle one) Y N

Performance Capacity

10. How well do you feel you take care of your mind, brain, and body overall? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor Well Extremely Well

11. When you engage in physical activity, how well do you feel you perform? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor Well Extremely Well

12. How well do you feel you prepare nutritious meals? (please circle one of the following numbers)

   1 2 3 4 5 6 7 8 9 10
   Poor Well Extremely Well

13. What skills do you have that assist you in completing health management and maintenance tasks? (please check all that apply)
   - Pacing
Paying attention
Choosing materials/items
Inquiring information
Initiating tasks
Organizing tasks
Adjusting for changes
Gazing at others
Asserting needs
Asking for information
Engaging
Expressing self
Collaborating with others
Conforming to social norms
Focusing on social actions
Relating with others
Respecting others

14. What skills do you lack that hinder your ability to complete health management and maintenance tasks? (please explain)
- Pacing
- Paying attention
- Choosing materials/items
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Gazing at others
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others

Habits

15. What type(s) of activity(s) do you engage in on a regular basis? (please check all that apply)
- Vigorous activity(s) (i.e. running)
- Moderate activity(s) (i.e. vacuuming)
- Climbing one or more flight of stairs
- Walking one block or more
- Completing morning routine (i.e. showering, dressing, etc.)
- Other (please specify)
16. How many days per week do you engage in vigorous to moderate physical activity? (please check the one that applies)
   □ None
   □ One day per week
   □ Two to Three days per week
   □ Four to Five days per week
   □ Six to Seven days per week

17. How many servings of fruits and vegetables do you eat in a typical day? (please check the one that applies)
   □ None
   □ One serving
   □ Two to Three servings
   □ Four to Five servings
   □ Six to Seven servings
   □ Eight or more servings

18. How many glasses of water do you drink in a typical day? (please check the one that applies)
   □ None
   □ One glass
   □ Two to Three glasses
   □ Four to Five glasses
   □ Six to Seven glasses
   □ Eight or more glasses

19. How many glasses of milk do you drink in a typical day? (please check the one that applies)
   □ None
   □ One glass
   □ Two glasses
   □ Three glasses
   □ Four or more glasses

20. How much caffeine do you consume in a typical day? (please check the one that applies)
   □ None
   □ One can/cup
   □ Two to Three cans/cups
   □ Four to Five cans/cups
   □ Six or more cans/cups

21. Do you smoke? (please circle one)  Y  N

22. Do you or have you used other forms of drugs besides alcohol, nicotine, or caffeine? (please circle one)  Y  N
23. How much alcohol do you consume in a typical day? (please check the one that applies)
   - One can/bottle
   - Two to five cans/bottles
   - Five to ten cans/bottles
   - Ten to fifteen cans/bottles
   - Fifteen to twenty cans/bottles
   - Twenty to twenty-five cans/bottles
   - Twenty-five to thirty cans/bottles
   - Thirty or more cans/bottles

24. Do you currently take any medications? (please circle one)  Y  N

25. What medications are you currently taking, and how often do you take them? (please list)
   - Remeron 15 mg 1 oral @ bedtime
   - Lexapro 10 mg 2 oral daily
   - Revia 50 mg 1 oral everyday at suppertime

26. What side effects from medication, if any, are you experiencing? (please list)
   - Nausea, sleepiness

27. Do you take your medications as prescribed? (please circle one)  Y  N

28. What do you hope to gain by engaging in health management and maintenance occupations? (please explain)
   - I want to be in shape and feel healthy. If I'm not drinking, I will start feeling better. Then I will be able to find a job and have more time with my daughter.

29. Where do you engage in meal consumption? (please check all that apply)
   - At home
   - In the car
   - Restaurants
   - Friend/Family's house
   - Community events
   - At work
   - Other (please specify)

30. Where do you engage in alcohol consumption? (please check all that apply)
31. Where do you store your alcohol supply? (please check all that apply)
- Refrigerator
- Liquor cabinet/private bar
- Basement
- Vehicle
- Closet
- Bedroom
- Garage/Outdoors
- At work
- Friend/Family's house
- I don't store alcohol
- I buy and consume immediately
- Other (please specify)

32. Where do you engage in physical activity? (please check all that apply)
- At home
- Community Center
- Private Gym
- Outdoors
- At work
- Other (please specify)

33. What types of equipment do you use when engaging in physical activity? (please check all that apply)
- None
- Free weights
- Weight machines
- Treadmill or other equipment
- Small equipment (i.e. medicine ball, resistive bands, etc.)
- Everyday items (i.e. can of soup, stairs, etc.)
- Workout videos (i.e. yoga, kickboxing, etc.)
- Other (please specify)

Social Environment

34. With whom do you consume meals? (please check all that apply)
35. With whom do you consume alcohol? (please check all that apply)
- Independently
- With a friend(s)
- Family member(s)
- Spouse or significant other
- Group of people
- Co-worker(s)
- Other (please specify)

36. With whom do you participate in physical activity? (please check all that apply)
- Independently
- With a friend(s)
- Family member(s)
- Spouse or significant other
- Group of people
- Other (please specify)

**Personal Causation**

37. What motivates you to be physically active? (please explain)
I like having energy and spending time outdoors with my daughter. I want to be more active.

38. What motivates you to eat healthy? (please explain)
I could eat healthier, and I think I will once I become sober. I think healthy meals are tasty and good for you.

39. If you smoke or use other forms of drugs (i.e. alcohol, nicotine, caffeine, etc.), how does this use impact your performance in health management and maintenance? (please explain)
Drinking causes me to have a hangover, and then I just lay in bed the whole next day and want to just drink again. Caffeine wakes me up, but then I shake a lot. I guess I don’t feel very healthy when I do those things.

40. Why, if at all, do you feel it is important to take your medications as prescribed? (please explain)
It keeps me stable and feeling better. If the psychiatrist prescribed it, then I trust him. But I know that I must tell him about my side effects, too. He
will then adjust my dosages or tell me that therapy will help me feel healthier.
Paula’s Health Management and Maintenance
Summary Form

Occupational Therapist: Please fill out after collaborating with the client on the Health Management and Maintenance Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.

- **Interests** identified by client in regards to Health Management and Maintenance:
  Lifting weights, biking, playing outdoors with daughter, aerobics, meditation
  Water intake, carbohydrates, protein for muscle building

- **Value** placed on Health Management and Maintenance: (please circle one)
  Not important  Somewhat important  Important  Very important

- **Role** in Health Management and Maintenance:
  Caretaker for daughter; Assists mother in home management/maintenance;
  Parent, Employer, and Home maintainer roles are diminished currently

- **Performance Capacity** skill strengths:
  Choosing materials/items; Inquiring information; Adjusting for changes; Asking for information; Conforming to social norms; Respecting others

- **Performance Capacity** skill deficits:
  Paying attention; Initiating tasks; Organizing tasks; Gazing at others; Asserting needs; Engaging; Focusing on social actions; Relating with others

- **Performance Capacity** occupational forms present: (please circle those that apply) Physical activity/fitness  Nutrition  Medication  Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply) Physical activity/fitness  Nutrition  Medication  Other

- **Habits** supporting engagement in Health Management and Maintenance:
  Light exercise engagement; Moderate engagement once per week; Some fruit/vegetable and milk intake; Taking Medications as prescribed
• **Habits inhibiting engagement in Health Management and Maintenance:**
  Lack of consistent vigorous/moderate exercise; Water intake at 1 glass per day; Fruit/vegetable servings under recommended 5 to 9 daily servings; Milk servings under recommended 3 daily servings

• **Habits surrounding alcohol abuse/dependence:**
  Drinking 10-15 drinks per sitting; Smoking ½ pack per day; Drug use; Caffeine daily intake at 6 or more servings

• **Physical Environment problems:**
  Drinking at friend's house and local bars; Stores alcohol in basement, her closet, and at friend's house

• **Social Environment problems:**
  Consumes alcohol independently, with a friend, or in groups of people

• **Personal Causation in regards to effectiveness:**
  Client wants to feel healthier and incorporate physical activity and nutrition into her daily routine. She does not like the person she is when hung-over.

• **Personal Causation in regards to intervention plan:**
  Plan is to address physical fitness and nutrition with the client in regards to her specified areas of interest in health management and maintenance.
**Nutrition Know-All**

**Occupation Addressed:** Health Management and Maintenance

**Interests/Values & Personal Causation**

**Objective(s):** The client will demonstrate the ability to independently plan and shop for a healthy meal centered on the educational principles of the food pyramid.

**Social Environment**

**Group or Individual:** Individual

**Physical Environment**

**Materials Needed:** Client's planner, shopping list, pocket-size food pyramid chart, selected recipe card, pen, pencil, calculator (optional)

**Space Needed:** Table, chairs, white board, access to vehicle, adequate lighting

**Performance Capacity**

**Skills Addressed:** Paying attention; Initiating tasks; Organizing tasks; Gazing at others; Asserting needs; Engaging; Focusing on social actions

**Description of the Activity:**
- Client and Therapist obtain educational information on nutrition in regards to the food pyramid.
- Client will plan a meal based on a selected recipe which employs principles of the food pyramid.
- Client will formulate a grocery list and buy these items at the local store.

**Discussion Questions:**
- How will this intervention assist you in becoming healthier and sober?
- How will this intervention positively impact your family and friends?
- How will you incorporate this intervention into your daily life?

**Adaptations:**
- This intervention may take place over the course of more than one treatment session.
- This intervention can be done in a group session where clients plan a healthy meal together or involve their families in the process.

**Habits**

**Outcome(s):** The client will report implementation of healthier eating habits based on the food pyramid which will carry over into meal planning that she may begin assisting her mother with.
Social Participation Questionnaire

Interests/Values

1. Do you enjoy being around other people? (please circle one)  Y  N

   Why or Why not? (please explain)
   Spending time with my daughter is great, but my mother and I butt heads a lot. I enjoy time with friends, but the ones that drink and use drugs are not good influences. I need to find people to hang out with who don’t use.

2. What do you enjoy doing with other people? (please explain)
   I like to play outdoors with my daughter or take her to the movies. I used to enjoy drinking and smoking with some of my former friends, but I want to be sober instead. I would really like to be more social and meet fun people.

Roles

3. What roles are negatively impacted by your current engagement in social participation? (please check all that apply)
   □ Spouse (I want to date)
   □ Parent
   □ Caregiver
   □ Employee
   □ Coworker
   □ Friend
   □ Home maintainer
   □ Other (please specify) Daughter

4. If you are not participating in your usual healthy social activities, would close family, friends, or co-workers bring it to your attention? (please circle one)  Y  N

5. What roles do you have within your community, if any? (i.e. school board member, church participant, etc.) (please list)
   I am a member of the local Catholic church, but I don’t go there on a regular basis. I have volunteered at the elementary school carnival. I attend AA.
6. How are these identified roles in question 6 impacted by alcohol use? (please explain)
I don't go to church because I am embarrassed by my alcohol and drug use. I wasn't able to attend parent/teacher conferences this past year since I was hung-over. I don't want to participate in community events when using alcohol.

Performance Capacity

7. What skills do you have that are strengths to you in social participation? (please check all that apply)
- Paying attention
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Contacting others
- Gazing at others
- Gesturing
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Sharing information
- Speaking to others
- Sustaining conversations
- Collaborating with others
- Conforming to social norms
- Focusing on social actions
- Relating with others
- Respecting others

8. What skills do you lack that hinder your ability to engage in social participation? (please check all that apply)
- Paying attention
- Inquiring information
- Initiating tasks
- Organizing tasks
- Adjusting for changes
- Contacting others
- Gazing at others
- Gesturing
- Asserting needs
- Asking for information
- Engaging
- Expressing self
- Sharing information
Speaking to others
Sustaining conversations
Collaborating with others
Conforming to social norms
Focusing on social actions
Relating with others
Respecting others

Habits

9. During a typical day, how many hours do you spend interacting with other people? (please check the one that applies)
- None
- One hour
- Two to Three hours
- Four to Five hours
- Six to Seven hours
- Eight to Nine hours
- Ten or more hours

10. What types of activities do you participate in with other people? (please explain)
I go to the park with my daughter, help my mother with dinner, and go to AA meetings. I also like to spend time with friends at the bar.

11. How many times per week do you go out with family and/or friends? (please check the one that applies)
- None
- One time per week
- Two to Three times per week
- Three to Four times per week
- Five or more times per week

12. Where do you go with family and/or friends? (please check all that apply)
- Movie Theatre
- Restaurant
- Bar/Club
- Shopping
- Concert(s)
- Community or Church Events
- Vacation
- Other (please specify) Outdoor activities

Physical Environment

13. Do you live by yourself? (please circle one)  Y  N
14. If not, who do you live with? (please check all that apply)
   - Spouse or significant other
   - Children
   - Parent
   - Friend
   - Other family members (please specify)
   - Other (please specify)

15. Do you have any pets within your household? (please circle one)
   - Y
   - N

16. If so, what types of pets do you have? (please check all that apply)
   - Dog
   - Cat
   - Bird
   - Fish
   - Horse
   - Reptile
   - Other (please specify)

17. Do you have access to the internet? (please circle one)
   - Y
   - N

18. How do you use the internet to connect with people or groups?
    (please check all that apply)
    - Email
    - Chat rooms
    - Instant messenger
    - Subscribing to periodic group emails
    - Purchasing items
    - Other (please specify)

19. What bar(s) do you typically drink at with others? (please list)
    I drink at all the local bars.

20. How many close friends do you have? (please check one)
    - None
    - One
    - Two to Three
    - Four to Five
    - Six or more

21. Do you feel uncomfortable in large groups? (please circle one)
    - Y
    - N
    Why or Why not? (please explain)
I will be uncomfortable going out to bars and restaurants where drinking is present. I am dreading telling my friends about treatment. I think I'm claustrophobic because I don't like people in my space.

22. How much time in a typical week is spent drinking socially with others? (please check one that applies)
   □ None
   □ One day per week
   □ Two to Three days per week
   □ Four to Five days per week
   □ Six to Seven days per week

23. Which people in your life support your drinking? (please list)
    My friends Kathy and Dane drink with me, and I spend a lot of time at their house. There is a big group of people who hang out at the local bars often, and I feel comfortable drinking around them.

24. Which people in your life support your desire to seek treatment and become sober? (please list)
    My daughter wants me to be sober, and my mother has been on my case about my drinking for years. I guess my sponsor does and so do some friends at church.

25. Please describe the social environment(s) which trigger you to drink in high, intoxicating amounts.
    Being in a group where everyone is drinking gets me to drink the first drink. After I've had a few, I prefer to be in a smaller group of people. That is when I drink until I pass out and am hung-over the next day.

26. Do you feel that you have a hard time initiating a conversation? (please circle one) Y N

27. If so, why? (please explain)
    I get nervous around men even though I'd like to date again. I can be shy. Alcohol gets me to be more social.

28. How well do you feel you can sustain a conversation? (please circle one of the following)

   1   2   3   4   5   6   7   8   9   10
   Poor  Good  Well  Very Well  Extremely Well

29. Do you feel that the majority of time with others is spent when consuming alcohol? (please circle one) Y N
30. Do you feel it is easier to talk with others when you are consuming alcohol or under the influence? (please circle one)  Y  N
   Why or Why not? (please explain)
   I feel happier at first, and then I can talk to people without being so self-conscious. If everyone else is drinking, I am more at ease.

31. What would you like to learn more about regarding social participation? (please explain)
   I want to find places to spend time that don't trigger me to drink. I do want to hang out with my friends and in the community, but I know I can't drink with them anymore. I have to be confident in myself to still be social without alcohol.
Paula’s Social Participation Summary Form

Occupational Therapist: Please fill out after collaborating with the client on the Social Participation Questionnaire. After completing this summary form with the client present, the information gathered will be synthesized for intervention planning with occupational forms in mind.

- **Interests** identified by client in regards to Social Participation:
  Meeting new people who don’t use alcohol or drugs; Volunteering at daughter’s school; Spending time with daughter in new environments

- **Value** placed on Social Participation: (please circle one)
  Not important Somewhat important Important Very important

- **Role** in Social Participation:
  Member of local Catholic church; AA attendee; Has volunteered at daughter’s school carnival; Wants to date again

- **Performance Capacity** skill strengths:
  Inquiring information; Gesturing; Asking for information; Expressing self; Sustaining conversations; Relating with others; Respecting others

- **Performance Capacity** skill deficits:
  Paying attention; Organizing tasks; Contacting others; Gazing at others; Asserting needs; Sharing information; Speaking to others; Conforming to social norms; Focusing on social actions

- **Performance Capacity** occupational forms present: (please circle those that apply) Family Library Shopping Restaurant Community Events Other

- **Performance Capacity** occupational forms to be addressed via interventions: (please circle those that apply) Family Library Shopping Restaurant Community Events Other

- **Habits** supporting engagement in Social Participation:
  Spends time with daughter; Assists mother in home management/maintenance; Present at some community and church events

- **Habits** inhibiting engagement in Social Participation:
  3 to 4 nights spent out each week with friends; Isolates self when not drinking with friends or spending time with daughter
• **Habits surrounding alcohol abuse/dependence:**
  Drinks at the local bars with friends 3 to 4 nights per week; Drinks at her friend's house; Smokes ½ pack per day

• **Physical Environment problems:**
  Drinks at all the local bars; Local bars are some of the few places to socialize with others her age in the community

• **Social Environment supports:**
  Lives with daughter and mother who support sobriety; Has a pet cat and fish; Friends at church and AA support sobriety

• **Social Environment problems/triggers:**
  Close friends drink; Most people her age in the community drink at the local bars; Feels she must be drinking to be confident, fit in, and communicate with others

• **Personal Causation in regards to effectiveness:**
  Client wants to not use alcohol and drugs but still spend time in the community socializing with others. She does not want to rely on substances to meet others because she realizes that she cannot control her drinking once she starts.

• **Personal Causation in regards to intervention plan:**
  Plan is to address social participation in regards to finding new activities to engage in within her community and making different friends. She will be coping with triggers to use when around others who are using substances.
Knitting

**Occupation Addressed:** Social Participation

**Interests/Values & Personal Causation**

**Objective(s):** The client will learn how to knit by engaging in a free beginner’s class at the local fabric store. She will also be interacting with other women in the class.

**Social Environment**

**Group or Individual:** Group *Meeting individual client needs

**Physical Environment**

**Materials Needed:** Phone book, phone, pen, paper, map, yarn, knitting needles

**Space Needed:** Table, chairs, access to vehicle, adequate lighting

**Performance Capacity**

**Skills Addressed:** Paying attention; Organizing tasks; Contacting others; Gazing at others; Asserting needs; Sharing information; Speaking to others; Conforming to social norms; Focusing on social actions

**Description of the Activity:**
- Client will contact the fabric store to obtain information on knitting class.
- Client and Therapist will establish achievable objectives to be completed for therapy purposes throughout the class.
- Client will engage in the knitting class and report back to others in the treatment facility about the experience.

**Discussion Questions:**
- What types of new people did you meet?
- What did you enjoy the most during the class?
- How can this activity take the place of time spent focused on alcohol?

**Adaptations:**
- This intervention may be done without the therapist present at the class.
- This intervention can be done individually if the therapist is knowledgeable on how to knit.
- A group of clients can partake in the class together as an intervention.

**Habits**

**Outcome(s):** The client will report making at least one new social contact. The client will continue knitting and teach her daughter as well.
Section 6

Social Participation Group Intervention
Library Learning

**Occupation Addressed:** Social Participation

**Interests/Values & Personal Causation**

**Objective(s):** The clients will demonstrate the ability to interact with other people while gaining information on a topic of their choosing from the media available at the library.

**Social Environment**

**Group or Individual:** Group

**Physical Environment**

**Materials Needed:** Library card, pens, pencils, paper

**Space Needed:** Table, chairs, access to vehicle, computer, media (i.e. books, magazines, etc.), step stool, adequate lighting

**Performance Capacity**

**Skills Addressed:** Paying attention; Organizing tasks; Adjusting for changes; Contacting others; Gazing at others; Gesturing; Asserting needs; Asking for information; Expressing self; Sharlng information; Speaking to others; Sustaining conversations; Collaborating with others; Conforming to social norms; Focusing on social actions

**Description of the Activity:**

- Clients will establish achievable objectives to be completed in regards to obtaining information for therapy purposes.
- Clients will engage in conversation with others at the library.
- Clients will report back to others in the treatment facility about what they learned while at the library.

**Discussion Questions:**

- Why will you go to the library again?
- Based on what you researched at the library, what aspects can be used to take the place of alcohol usage?

**Adaptations:**

- This intervention can be done individually based on client needs.
- This intervention may also take place at a book store.

**Habits**

**Outcome(s):** The clients will report the utilization of the library services in the future. The clients will continue to go to social establishments on a regular basis.

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CHAPTER V

SUMMARY

As a result of the literature findings, a product was developed based on Model of Human Occupation (MOHO) principles that address occupation-based interventions for clients with substance abuse/dependence in formal intervention settings. Over 15 million Americans struggle with substance abuse/dependence, making this an enormous health concern within today’s society (US No Drugs, 2006). This problem is not expected to dissipate any time soon, so treatment programs for such clients will tend to grow exponentially.

The development of the product consisted of completing an extensive literature review to determine the areas of occupation that are and are not currently being addressed in regards to substance abuse/dependence. Upon completing the investigation of the literature, a survey and cover letter were designed to gain the perception of practicing clinicians in order to determine the most challenging areas of occupation to address. From the results of the study, the instrumental activities of daily living (IADL’s) selected to be designed for the product included financial management and health management and maintenance, in addition to the occupation of social participation. After examining these identified areas, detailed questionnaires, summary forms, and intervention protocols were developed. The product also includes two case studies, Jim and Paula, that illustrate how to implement this tool to construct individualized occupation-based interventions.

This product only contains the fully developed occupations including the IADL’s
of financial management and health management and maintenance; social participation is the other area of occupation comprehensively addressed in this product. Despite the notion that these three occupations were identified in the literature and survey as being vital to address with individuals struggling with substance abuse/dependence, other areas of occupation may be of similar importance to some clients in treatment. A limitation of this product is that not all occupations, which clients may be struggling with, are included at this point.

In addition, this product has not been formally tested with clients who are dealing with substance abuse/dependence to determine its efficacy. Since it has not been tested, it is unknown at this time whether clients of all cognitive levels have the ability to comprehend the questionnaire information which is asked of them.

The development of additional questionnaires, summary forms, and intervention protocols is recommended for the remaining areas of occupation that can be addressed with this population. A pilot study is recommended to determine the efficacy of the product in an actual clinical setting. This study would support the effectiveness of occupation-based interventions and promote their use with clients who have substance abuse/dependence, and would also address cognitive issues associated with the implementation of this product within an actual clinical setting. Based on the information gathered through the study, modifications to the product could be made to meet client and clinician needs.

Utilizing this product in addition to other MOHO assessments is recommended due to the present narrow focus on only three occupations within the product and the lack of a pilot study. These existing MOHO assessments would be enhanced by the
implementation of the questionnaires and summary forms for individualized, specific treatment. The implementation of outcome measures to determine occupational performance (improvement), role competence, and client satisfaction in regards to the product would be beneficial to determine the effectiveness and usefulness of utilizing occupation-based interventions with clients who have substance abuse/dependence. In addition, outcome measures may lead to the modification of the current product to better suit client and clinician needs.

The product provides occupational therapists (O.T.'s) with the structured resources they need to develop occupation-based treatment for individual and/or group interventions. This product has the adaptability to address the occupations that adolescents engage in since the questionnaire topics are applicable to adolescents as well as adults. Clients with other diagnoses aside from substance abuse/dependence can also fill the questionnaires, but it is noted that any questions which do not apply to them do not need to be answered. Most questions within the questionnaire have adequate space to include other pertinent additional information solicited from the client.

The versatility of this product allows it to be implemented into all types of formal treatment settings. The questionnaires and summary forms can be part of an individual’s treatment session or homework assignment, making this process time effective. Designing the occupation-based interventions require minimal extra time on behalf of the O.T. because the protocols follow the information gathered on the summary form. It is also noted that not all three occupations may need to be addressed with each client; the O.T. has the liberty of selecting only those deemed most important.
The product, Occupation-Based Interventions for Clients with Chemical Addiction Issues, has the inevitable potential to assist a plethora of clients struggling with substance abuse/dependence who have taken the initiative to seek treatment within formal intervention settings. Through the implementation of this comprehensive product which thoroughly addresses pertinent occupations, clients can experience success in meaningful occupations that take place within relevant contexts. The development of healthy occupations is the ultimate objective of this product, thus taking the place of abusing/depending on substances.
APPENDICES
Appendix A

Cover Letter

October 16, 2006

Dear,

Hello, our names are Amanda Sylling and Alyson Wilhelmi, and we are second-year occupational therapy students (OTS) at the University of North Dakota (UND) in Grand Forks. We are contacting you in regards to completing a survey in relation to substance abuse/dependence treatment. We are developing a program for our scholarly project that will assist clinicians in implementing occupation-based interventions for clients with substance abuse/dependence, particularly in the area of instrumental activities of daily living (IADL's). We have developed a survey that will help us to better understand your clientele, what types of interventions you are currently utilizing, and what subtypes under the occupation of IADL’s are the most difficult to address.

The information provided will remain confidential and be viewed by only the students and their advisor working on this project. From the results, we will gain a better understanding of your needs so we can best develop a program that will meet the needs of clinicians practicing in this area. We would appreciate any additional comments or suggestions you may have.

We are emailing this survey directly to you for your convenience. We would like you to fill it out as soon as possible so that we can integrate the results into our project. You have a few options to choose from when completing this survey. You may fill it out accordingly or we may visit via the telephone. If you wish, we could do both; the choice is yours. Just contact one of us and communicate your preferences. If you choose to fill it out over email, please send it back to one of us as soon as possible. If you wish to visit via the telephone, please email one of us and let us know when the best time would be to contact you.

We would like to thank you in advance for your time, cooperation, and thoughts on developing occupation-based interventions for clients who are diagnosed with substance abuse/dependence. We look forward to hearing from you and developing a program that will meet the needs the all clinicians and clients in the occupation of IADL’s.

Sincerely,

Amanda Sylling, OTS
Appendix B

Survey

*Please fill out and return by *Tuesday, October 24th, 2006*. Thank you!! :)*

**Name/Title:**

1. **What client population do you serve?** (Please bold all that apply)
   - ☐ Substance Abuse/Dependence
     - ☐ Alcohol
     - ☐ Amphetamine
     - ☐ Cannabis
     - ☐ Cocaine
     - ☐ Hallucinogens
     - ☐ Inhalants
     - ☐ Opioids
     - ☐ Phencyclidine
     - ☐ Sedative hyponotic or anxiolytic
   - ☐ Dual Diagnosis
   - ☐ Ages 10-20
   - ☐ Ages 21-30
   - ☐ Ages 31-40
   - ☐ Ages 41-50
   - ☐ Ages 51-60
   - ☐ Ages 61+
   - ☐ Other (please specify)

2. **What type of facility are you employed at?**
   - ☐ Inpatient
   - ☐ Outpatient
   - ☐ Partial Hospitalization
   - ☐ Residential
   - ☐ Aftercare Program
   - ☐ Other (please specify)

3. **What model or Frame of Reference is your facility utilizing to guide your practice?** (Please bold the one that applies)
   - ☐ Solution-Focused
   - ☐ Model of Human Occupation
   - ☐ Occupational Adaptation
   - ☐ Ecological Model
4. What types of interventions are you currently utilizing? (please bold all that apply)
   - Individual treatment
   - Group treatment
   - Leisure
   - Vocation/Avocation
   - Crafts
   - Cognitive Behavioral
     - Problem-solving
     - Goal setting
     - Skill building
   - Family Therapy
   - Social Participation
   - Other (please specify)

5. What area(s) of occupation do you address most frequently? (Please bold all that apply)
   - Activities of Daily Living (ADL’s)
   - Instrumental Activities of Daily Living (IADL’s)
   - Work
   - Play Leisure
   - Social Participation
   - Education

6. What areas of occupation are the most difficult to address? (Please bold all that apply)
   - ADL’s
   - IADL’s
   - Work
   - Play Leisure
   - Social Participation
   - Education
   - Why are they the most difficult?? Please describe
7. What type(s) of interventions is your facility currently utilizing that address IADL’s? (Please bold all that apply)
   □ Preparatory- prepare the client to engage in an occupation (i.e. relaxation training)
   □ Purposeful- are goal-directed and eventually lead to the engagement in an occupation, but occur in a therapeutic environment (i.e. practicing a conversation/role play)
   □ Occupation-based- allows clients to work towards their goals and to engage in their occupations in their original context (i.e. go to the grocery store and purchasing the necessary items to prepare a meal)

8. Consider the array of IADL activities located below, which areas are the most difficult to find purposeful and/or occupation-based interventions for? (Please bold all that apply)
   □ Care of others
   □ Care of pets
   □ Child rearing
   □ Communication device use
   □ Community mobility
   □ Financial management
   □ Health management and maintenance
   □ Home establishment and maintenance
   □ Meal preparation
   □ Safety procedures and emergency responses
   □ Shopping
   □ Other (please specify)
   □ Why do you feel they are the most difficult?? Please describe

Please indicate any resources or handbooks that you have utilized and have found beneficial

Comments or suggestions??
REFERENCES


Reed, K. L. (2001). Quick reference to occupational therapy (2nd ed.). Austin, TX: PRO-ED.


Vereen, D., Jr. (2006, October 5). Dean’s Hour: Drug abuse and addiction. Presented at the University of North Dakota, School of Medicine and Health Sciences.
