Perceptions and Knowledge Around Substance Use Disorders and the Role of Occupational Therapy: A Survey of Clinicians

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ABSTRACT

BACKGROUND: Today’s healthcare system requires practitioners to acquire a level of confidence, knowledge, and personal desire that enables them to treat a growing clientele with substance use disorders (SUDs). Although SUDs impact millions of Americans, there are many barriers to receiving treatment. It is important to understand how occupational therapy (OT) practitioners’ perceptions of working with clients who experience SUDs relate to the knowledge and skills required to identify and provide treatment.

METHOD: Two surveys, the Medical Regard Scale and modified Drug Problems Perceptions Scale, were utilized to analyze participants’ attitudes, perceptions, and knowledge around working with individuals with SUDs. Data was collected from 116 practitioners with a variety of experience, practice settings, and backgrounds in understanding SUDs.

RESULTS: The majority of respondents reported no formal training in treating clients with SUDs (72.4%). In terms of attitudes around working with this population, a fraction reported a preference not to work with patients experiencing SUDs (16.0%) or finding them “irritating” to work with (12.9%), while 62.0% reported they felt especially compassionate toward this population. The majority of respondents felt that insurance plans should cover patients like this to the same degree that they cover patients with other conditions; however, only 48.3% had a clear idea of their responsibilities in helping individuals with SUDs. In regard to knowledge around working with SUDs, just over half of respondents reported a true working knowledge of SUDs and SUDs related problems (53.4%).

CONCLUSION: Occupational therapy practitioners would benefit from additional training, resources, and support related to provision of services to individuals with SUD. In addition, training to continue to reduce stigma within the profession can potentially increase access to care.

KEYWORDS: Occupational therapy and substance use disorders, evaluation, treatment, competence

Background/Literature Review

Substance use disorders (SUDs) remain an ongoing serious public health concern. In 2020, it was estimated that 59.3 million Americans ages 12 and older reported using illicit drugs within the past year. Within the 12 and older population, it is estimated that only 4.2 million individuals received treatment for their SUD within the past year, despite more than 20.4 million Americans struggling with substance use. Provisional data from the National Center for Health Statistics reports 90,722 drug overdose deaths in the U.S. for the 12-month period ending in November 2020. This all-time high reflects an alarming 29% increase from the year prior. These statistics certainly impact the profession of occupational therapy, where clinicians may interact with and treat clients or family members of clients with SUDs or co-occurring diagnoses (COD) in all areas of practice. By nature, occupational therapy is a profession in which services address areas such as everyday life occupations (such as health management, work, leisure, or social participation) and the ability of an individual to successfully engage in their environments. Therefore, occupational therapy can play a key role in the screening, identification, and management of individuals dealing with SUDs. In their study across occupational therapists in West Virginia, Pivont and McCombie found that over 80% of practitioners encountered clients abusing or strongly suspected of abusing opioid substances, suggesting the need for immediate education and training around assessment, treatment, and overdose response protocols.

A literature review provides evidence that negative attitudes and stigma toward individuals with SUDs presents a barrier to the identification and treatment of this prevalent issue. Individuals cited concerns in seeking treatment due to the stigma associated with use or a lack of properly trained and educated healthcare professionals. The attitudes and behaviors that persist within the general population, as well as the structural stigma and bias that exists within healthcare, the criminal justice system, and among employers, leads individuals with SUDs and their loved ones to hide their illness and delay seeking treatment for fear of discrimination and labeling. Moreover, inadequate training, organizational policies, and the perpetuation of negative attitudes and beliefs among health care professionals interferes with prompt identification of at-risk individuals and timely access to effective treatment.
Research indicates that individuals with SUDs should receive interdisciplinary care, including occupational therapy, that is prepared to treat the multi-faceted and complicated nature of SUDs. In occupational therapy, SUDs are most often treated as a co-occurring disorder, leading to a focus primarily on referral for physical, psychological, or social problems secondary to the misuse of substances. Today’s best practice indicates that to properly treat these clients, occupational therapists need to understand current evidence-based practice within their scope and understand and implement a Screening, Brief Intervention, and Referral to Treatment (SBIRT) Model. Unfortunately, in the profession, there is also limited up-to-date research and practice in this area. In Amorelli’s narrative review on occupational therapy interventions for SUDs, only 10 articles met the criteria for further analysis and in Ryan and Boland’s scoping review, an additional 8 were identified. Additionally, occupational therapists are not assessing for SUDs frequently, despite the profession’s ability to be instrumental in the earlier detection and treatment of the disorder. In a study conducted by Thompson, results indicated that the majority (64.8%) of respondents (n = 128) assessed their clients for substance use at less than or equal to 5% of the time. Only 20.3% of the respondents indicated that they assessed clients for substance use routinely (p. 10). Based on this study conducted over 10 years ago, clinicians are not routinely assessing clients for SUDs or do not have full knowledge of the best practice interventions, despite the very brief time it takes to implement the SBIRT model. For example, a typical SBIRT screening tool can take less than 5 minutes to complete and evaluate, once the clinician is comfortable with the process. It is imperative that with the growing SUDs epidemic, clinicians are more aware and active in today’s clinical practice, hence the need for an updated understanding of the current state of practice.

Despite the limited literature, it is clear that occupational therapy assessment and interventions can have a positive impact on the recovery of individuals with SUDs. In their research, Peloquin and Ciro found that women who participated in various themed and meaningful occupational treatment groups perceived their treatment as an important and satisfactory component of their recovery. In their scoping review, Ryan and Boland found that occupational therapy is well-situated to practice SUDs treatment and remains an essential, supportive part of the treatment team. In order to provide this level of care, practitioners need more skilled training and education to reduce the barriers that surround treating individuals with SUDs. In addition to assessment and intervention, occupational therapy can provide a distinct and valuable role on the interdisciplinary team. Occupational therapy practitioners can utilize therapeutic communication and occupational performance skills to facilitate clients with SUDs to advocate for themselves, increase their self-care, and ultimately lead a healthier and more productive lifestyle.

Purpose of the study

This study aims to describe how OT practitioners’ own perceptions around knowledge, confidence, and attitudes regarding SUDs may impact the future care of these clients. The following research questions guided the study and provided a framework for answers to the problem statement.

The overarching research questions are:

1. What are the attitudes and perceptions of OT practitioners around working with individuals with substance use disorders (SUDs)?
2. What is the perception of scope of practice for OTs when working with individuals with SUDs?

Methods

This study utilized survey methodology and exploratory descriptive analysis. The use of an internet-based survey design was chosen for data collection in this study in an effort to survey occupational therapy practitioners from all areas of practice and from regions across the United States. The university Institutional Review Board (IRB) approved the study in Fall 2020. Recruitment included utilization of state professional association websites via the practice corner forum, email listserves, social media platforms such as Facebook and Twitter research-based accounts, and the American Occupational Therapy Association (AOTA) website via the CommnOT public forum. All self-selected participants’ responses were included unless they did not meet the parameters of the sole inclusion criteria of being a practicing occupational therapy clinician or the survey was returned outside of 3 months. Ultimately, 116 participants completed the survey during the open timeframe of October to December 2021 and were included for analysis.

Procedures and survey instruments

For participants enrolled in this study, the purpose of the study, the methods of data collection and all potential risks associated with participation were communicated in writing at the initiation of the survey. Participants were asked to consider “substance use disorder” as any clients they encounter who have, or may be susceptible to, at-risk use of drugs and/or alcohol. Once consent was obtained and demographics acquired, subjects moved on to data collection, utilizing survey instruments via the Qualtrics platform. For the first survey, participants answered questions regarding attitudes and comfort with treating individuals with SUDs, utilizing the Medical Regard Scale. This survey is a scale comprising 11 items scored on a Likert scale from “Strongly Disagree” to “Strongly Agree,” designed to capture biases, emotions, and expectations generated by medical condition descriptors-in this case, SUDs. The second survey assessed the knowledge of treatment and scope of practice. The survey was adapted from the Drug Problems...
Perceptions Questionnaires. It is a scale comprising 11 items scored on a Likers scale from “Strongly Disagree” to “Strongly Agree,” with subscales related to role adequacy, role support, job satisfaction, role-specific self-esteem, and role legitimacy in the treatment of SUDs.

Data analysis

The survey results were analyzed using IBM SPSS Version 25. The data were analyzed using descriptive statistics to answer the research questions.

Results

Participants

The survey was completed by 116 practitioners across the country. Respondents were primarily from acute care and rehab settings, but represented all areas of practice with a majority of 0 to 5 years’ experience. Table 1 provides respondents various characteristics in practice.

Findings for research question 1: Attitudes and perceptions. In terms of attitudes around biases, emotions and expectations of working with this population, the statements were categorized to: (1) desire to work with this population, (2) attitudes and perceptions around “treatability,” and (3) worthiness of medical resources. A fraction reported a preference not to work with patients experiencing SUDs or finding them “irritating” to work with (16.0% and 12.9%, respectively), while 62.0% reported they felt especially compassionate toward this population. In terms of treatability, 63.0% felt comfortable enough to find ways to help individuals with SUDs, and 9.5% who felt there was little they could do to help patients experiencing SUDs. Finally, in the aspect of the perceptions of worthiness to receive resources, 72.4% felt that insurance plans should cover patients like this to the same degree that they cover patients with other conditions, while 2.6% felt treating patients with SUDs is a waste of medical dollars. While the slight majority of respondents had less than 10 years of experience (n = 57), it was of note to share the differences between newer practitioners and those with greater than 10 years of practice (n = 44) in terms of desire to work with these clients. When asked if “working with this population is satisfying,” 50% of the clinicians with greater than 10 years of experience responded with neutrality or disagreement, while 36% of the newer clinicians reported the same. Table 2 provides a full overview of the results of this scale.

Findings for research question 2: Knowledge and scope of practice. When considering knowledge around psychological and physical effects related to SUDs, just over half of respondents reported a true working knowledge of SUDs and SUDs related problems (54.3% and 51.7%, respectively). Additionally, in terms of occupational therapy’s role, 58.6% felt they knew enough about the factors which put people at risk of developing SUDs. In terms of roles and responsibilities, while 48.3% felt they had a clear idea of the role of OT in treating SUDs, 19.8% reported receiving adequate supervision from a more experienced person or having support from colleagues (29.3%). About 44.8% of practitioners reports they are able to work with clients with SUDs as effectively as other clients who do not have SUDs. Overall, 74.1% shared that caring for this population was important to the profession. Table 3 presents an overview of results within this scale.

Table 1. Professional characteristics of respondents (n = 116).

| CHARACTERISTIC                     | TOTAL SAMPLE |
|-----------------------------------|--------------|
| Type of practitioner              |              |
| Occupational therapist            | 114 (98.3)   |
| Occupational therapy assistant    | 2 (1.7)      |
| Practice setting                  |              |
| Acute care                        | 19 (16.4)    |
| Outpatient rehab                  | 18 (15.5)    |
| School system                     | 13 (11.2)    |
| Community practice                | 11 (9.5)     |
| Skilled nursing facility          | 10 (8.6)     |
| Inpatient rehab                   | 10 (8.6)     |
| Academia                           | 10 (8.6)     |
| Home health                        | 7 (6.0)      |
| Early intervention                 | 5 (4.3)      |
| Outpatient pediatrics              | 3 (2.6)      |
| Psychiatric rehab                  | 3 (2.6)      |
| Prefer not to answer               | 7 (6.1)      |
| Clinical experience                |              |
| 0-5                                | 40 (39.6)    |
| 6-10                               | 17 (16.8)    |
| 11-15                              | 11 (10.9)    |
| 16-20                              | 9 (8.9)      |
| 20+                                | 24 (23.8)    |

Prior formal training in SUDs

| Prior formal training in SUDs*  |        |
|---------------------------------|--------|
| Yes                             | 32 (27.6) |
| No                              | 84 (72.4) |

*Prior formal training was defined by examples such as formal coursework on SUDs, certification programs, work-related training/on-the-job training, and/or continuing education courses on the topic.
Participant’s responses generally indicated that while there is an interest and desire to work with and treat individuals with SUDs, the knowledge, support, and comfort level to do so successfully is lacking. The results of this study indicated that less than half of occupational therapy practitioners sampled have a clear idea of their roles and responsibilities in treating individuals with SUDs. While universal screening and brief interventions are best-practice, the statement indicating practitioners can appropriately advise their clients about SUDs indicates most are not routinely assessing and intervening on SUDs.

When further delving into the results, the small portion of mental health practitioners (n = 3) reported the most consistent positive attitudes and confidence in treating clients for SUDs. However, practitioners in all other areas indicated that they have the desire to work with these clients in various ways. Considering 72.4% of respondents reported no previous training in this area, it may simply be that general occupational therapy practitioners require more training to increase confidence and knowledge levels, which in turn, may lead to more therapists incorporating the best practices that are available to them. Of the 32 respondents who had reported previous training, 8 shared they had attending continuing education courses or conferences, 11 indicated they had training in their respective OT academic programs, and 4 shared they received training through their workplace.

There is also still a clear stigma that exists within at least part of the profession around these clients. While a much smaller subsection of respondents indicated discomfort or even “irritation” around working with these clients, 12% to 15% is

| Table 2. Medical Condition Regard Scale for SUDs (n = 116). |
|-------------------------------------------------------------|
| **SUBSCALE AND STATEMENTS** | **AGREEABILITY** |
| | N (%) |
| Desire to work with population |  |
| Working with this population is satisfying | 53 (45.7) |
| I feel especially compassionate toward patients like this | 72 (62.0) |
| Patients like this irritate me | 15 (12.9) |
| I enjoy giving extra time to patients like this | 48 (41.4) |
| I prefer not to work with patients like this | 16 (14.0) |
| Treatability of individuals with SUDs |  |
| There is little I can do to help patients like this | 11 (9.5) |
| Patients like this are particularly difficult for me to work with | 26 (22.4) |
| I can usually find something that helps patients like this feel better | 73 (63.0) |
| Worthiness of medical resources |  |
| Insurance plans should cover patients like this to the same degree that they cover patients with other conditions | 84 (72.4) |
| I wouldn’t mind giving extra time or effort to care for patients like this | 34 (29.3) |
| Treating patients like this is a waste of medical dollars | 3 (2.6) |

| Table 3. Knowledge and skills around treatment of SUDs (n = 116). |
|-------------------------------------------------------------|
| **STATEMENT** | **AGREEABILITY** |
| | N (%) |
| Caring for people with SUDs is an important role of occupational therapists | 86 (74.1) |
| I am interested in the nature of SUDs and the treatment of them | 79 (68.1) |
| I feel I have something to offer clients with SUDs | 76 (65.6) |
| In general, I feel like I can understand individuals with SUDs | 70 (60.3) |
| I feel I know enough about the factors which put people at risk of developing SUDs to carry out my role | 68 (58.6) |
| I feel I know enough about the psychological effects of SUDs to carry out my role in working with individuals with SUDs | 63 (54.3) |
| I feel I have a working knowledge of SUDs and SUDs related problems | 62 (53.4) |
| I feel I know enough about the physical effects of SUDs to carry out my role when working with individuals with SUDs | 60 (51.7) |
| I have a clear idea of my responsibilities in helping individuals with SUDs | 56 (48.3) |
| I can appropriately advise my clients about SUDs and its effects | 54 (46.6) |
| I feel I am able to work with clients with SUDs as effectively as with other clients who do not have SUDs | 52 (44.8) |
| When working with clients who have SUDs I receive adequate on-going support from colleagues | 34 (29.3) |
| I feel the best I can personally offer SUDs is referral to someone else | 33 (28.4) |
| When working with patients who have SUDs I receive adequate supervision from a more experienced person | 23 (19.8) |
| I often feel uncomfortable when I work with individuals with SUDs | 18 (15.5) |

Scale presented in order of agreeability, versus the order in which questions were answered for ease of interpretation.
still too large of a number, considering the current epidemic at hand. In addition, those that desire to work with these patients are often not finding the support from colleagues or supervisors to successfully navigate the complexities associated with treating SUDs. These factors could be associated with the less-than-half of respondents (44.8%) who felt they are able to work with clients with SUDs as effectively as any other population. While not explicitly stated, the concern regarding the potential additional time to spend using screening tools and models such as SBIRT could also be a contributing factor to the lack of use. Ideally, as more practitioners are trained in this area, they will find that utilizing the SBIRT model is an efficient, timely approach for universal screening.

When considering the staggering statistics previously reported from SAMHSA, it is encouraging to see the strong alignment of respondents who consider caring for people with SUDs as an important role of occupational therapy. Bridging the confidence in this desire will be key to the profession. While occupational therapy evidence is still somewhat limited, 1 pivotal study around OT and SUDs discussed the following as evidence-based interventions, which fall within the scope of occupational therapy for SUDs treatment: (1) brief intervention, (2) cognitive-behavioral therapy, (3) motivational strategies, (4) 12-step programs, (5) harm reduction programs, and (6) community reinforcement approaches. Six established interventions were discussed, providing the tools and knowledge to incorporate the developed interventions into their treatment plans. Many of these skill sets are integrated into all aspects of occupational therapy education and care; therefore, even encouraging therapists to utilize these core techniques can help to increase confidence and comfort in this treatment area.

Finally, it is important to note that as we are seeing an upward trend in the profession. In Thompson’s findings with a similar participant set in 2007, 26% of respondents felt SUDs were not in the scope of occupational therapy practice and 30% doubted their ability to treat those dealing with substance misuse. Today, only 9.5% of practitioners reported feeling there was little they could do to address this disease.

Limitations

There are several limitations of this study which must be acknowledged. The data for this study was collected using a sample of convenience through available listservs, social media platforms, and memberships. The respondents may not be representative of all practitioner’s experience with SUDs across the United States. The fact that most respondents were subscribers to the particular listservs could be a possible source of bias. In addition, because some respondents forwarded the invitation to additional colleagues or groups, the researchers had little control over who responded and were unable to calculate a true response rate. Finally, the nature of this particular topic may primarily consist of responders who had a strong interest in the subject.

Implications for practice and future research

Understanding the current status of OT’s knowledge and perceptions around treatment of SUDs is vital for increasing the understanding and behaviors of practitioners to address the needs of this population. Statistically speaking, occupational therapists in all practice settings and across all ages of the lifespan, will likely interact with an individual or family member who is experiencing the undesirable impact of SUDs. Working toward a common goal to effectively treat and provide accessibility to de-stigmatized care for these clients both meet AOTA’s Vision 2025. Findings of this study suggest that continued research and formal education and training may be necessary for occupational therapists to represent their critical role in the solution to this public health crisis.

Author Contributions

AMM: Conceptualization, Methodology, Formal Analysis, Writing-Original Draft. GS: Formal Analysis, Writing-Original Draft. RL: Formal Analysis, Writing-Original Draft.

REFERENCES

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Key Substance Use and Mental Health Indicators in the United States: Results From the 2020 National Survey on Drug Use and Health. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2021.
2. National Center for Health Statistics Center for Disease Control and Prevention. Provisional drug overdose death counts. Center for Disease Control and Prevention. Accessed June 21, 2021. https://www.cdc.gov/nchs/voices/vsdr/drug-overdose-data.htm
3. Pivont E, McComb R. Opioid substance abuse among clients of OTs in West Virginia. Am J Occup Ther. 2020;74(11):102761.
4. Paquette CE, Svyrtsen JL, Pollini RA. Stigma at every turn: health services experiences among people who inject drugs. Int J Drug Policy. 2018;57:104-110.
5. Ashford RD, Brown AM, Curtis B. “Abusing addiction”: our language still isn’t good enough. Alcohol Treat Q. 2019;37:257-272.
6. Dyregrov K, Selseng LB. “Nothing to mourn, he was just a drug addict” – stigma towards people bereaved by drug-related death. Addict Res Theory. 2022;30:5-15.
7. McNeeley J, Kumar PC, Rieckmann T, et al. Barriers and facilitators affecting the implementation of substance use screening in primary care clinics: a qualitative study of patients, providers, and staff. Addict Sci Clin Pract. 2018;13:8-15.
8. van Boekel LC, Brouwers EP, van Wegen J, Garretsen HF. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug Alcohol Depend. 2013;131:23-35.
9. Amorelli CR. Psychosocial occupational therapy interventions for substance-use disorders: a narrative review. Occup Ther Ment Health. 2016;32:167-184.
10. Ryan DA, Boland P. A scoping review of occupational therapy interventions in the treatment of people with substance use disorders. Br J Occup Ther. 2021;49:104-114.
11. Stols D, van Heerden R, van Jaarsveld A, Nel R. Substance abusers’ anger behaviour and sensory processing patterns: an occupational therapy investigation. S Afr J Occup Ther. 2013;43:25-34.
12. Extent JK, Privott C. Understanding therapists’ perceptions of co-occurring substance use disorders using the model of human occupation screening tool. Open J Occup Ther. 2021;9:1-8.
13. Vendetti J, Gmyrek A, Damon D, Singh M, McRee B, Del Boca F. Screening, brief intervention and referral to treatment (SBIRT): implementation barriers, facilitators and model migration. Addiction. 2017;112 Suppl 2:23-33.
14. Thompson K. Occupational therapy and substance use disorders: are practitioners addressing these disorders in practice? *Occup Ther Health Care*. 2007;21:63-77.

15. Hutchison SL, Flanagan JV, Karpov I, et al. Care management intervention to decrease psychiatric and substance use disorder readmissions in Medicaid-enrolled adults. *J Behav Health Serv Res*. 2019;46:533-543.

16. Leppard A, Ramsay M, Duncan A, Malachowski C, Davis JA. Interventions for women with substance abuse issues: a scoping review. *Am J Occup Ther*. 2018;72:7202050301-7202050308.

17. Peloquin SM, Ciro CA. Self-development groups among women in recovery: client perceptions of satisfaction and engagement. *Am J Occup Ther*. 2013;67:82-90.

18. Klein J, Smith R. Using the internet as a vehicle for research. *Am J Occup Ther*. 2002;56:221-223.

19. Christison GW, Haviland MG, Riggs ML. The medical condition regard scale: measuring reactions to diagnoses. *Acad Med*. 2002;77:257-262.

20. Watson H, Maclaren W, Kerr S. Staff attitudes towards working with drug users: development of the Drug Problems Perceptions Questionnaire. *Soc Stud Addict*. 2007;102:206-215.

21. IBM Corp. Released. IBM SPSS Statistics for Windows, Version 25.0. IBM Corp; 2017.

22. Stoffel VC, Moyers PA. An evidence-based and occupational perspective of interventions for persons with substance-use disorders. *Am J Occup Ther*. 2004;58:570-586.

23. American Occupational Therapy Association. Vision 2025. *Am J Occup Ther*. 2017;71:71034200101.