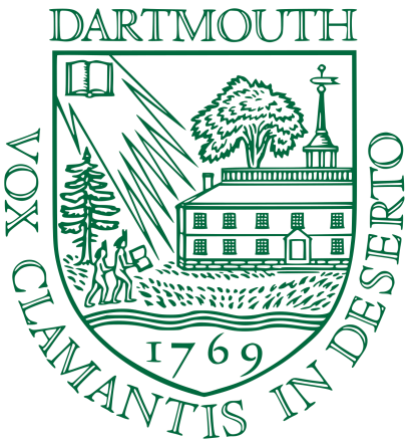
Determining Anchors to Recovery After Headrest's Low Intensity Residential Treatment Program: Identifying Supportive And Challenging Factors



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Determining Anchors to Recovery After Headrest's Low Intensity Residential Treatment Program: Identifying Supportive And Challenging Factors

There is no question that the public health crisis surrounding addiction has reached unmanageable proportions (Saloner et al, 2018). If we can begin to understand the motivations and tools necessary for maintaining recovery, we can begin to codify how to help patients succeed, and learn to track it.

The goals of our community partner are to help those who struggle with addiction and substance use disorders by offering resources such as a 24 hotline, residential treatment, outpatient counseling and vocational training. As a research team, we are striving to help define what sustained recovery looks like and how to track it. As there is support in sociological literature that initiating recovery in an institutional setting does not guarantee sustained recovery maintenance in natural, community environments (White, 2009), we must identify the factors that can help. Our proposal attempts to conceptualize the issues that contribute to sustained recovery. Our partner, Headrest, provides a 24-hour crisis hotline and offers numerous resources to the Upper Valley community including but not limited to outpatient substance use disorder counseling, community outreach and education. Two of Headrest's stand out programs are the Headrest Opportunities for Work vocational program and their Low Intensity Residential Treatment Program. Our attempt to codify the successful work that Headrest has done should further inform their processes and help improve outcomes.

Understanding Addiction Before Recovery

It is important to ground our understanding of recovery in knowledge of what Headrest's clients are recovering from. As we frame the questions that identify the tools that support long term recovery, it is important to understand the source of the client's addiction. There are many

theories about how and why people become addicted and no general consensus about how to best help them. We looked to Saloner et. al (2018) to confirm that drug overdoses are now the leading cause of injury death in the United States. Current data reveals that the overdose crisis affects all demographic groups, informing us about our survey population. The framing of the opioid crisis this way makes our inquiry a sociological one, demanding consideration of the interaction of multiple determinants, including structural factors like poverty and racism, inadequate strategies of pain management, limited data collection and poor access to addiction treatment services (Saloner et. al 2018). This framework supports our project which seeks to include data collection as a way to guide changes to recovery processes (Saloner et. al 2018).

Understanding the overarching social attitudes that Headrests clients are experiencing helps to inform how sensitively we ask them about their reintegration into society or identity change process. Roberts and Chen (2013) detailed how attitudes and policies toward those who abuse drugs have been driven by a sense of moral outrage that has relatively little basis in the medical evidence for the pharmacological harm done. This was crucial to our understanding of the level of sensitivity we will incorporate into the questions.

Robinson and Berridge (2003) suggested that addiction is due to incentive-motivational consequences of drug-induced alterations in brain circuitry. The response of the nervous system compounds difficulties further with drug-induced dysfunction in the prefrontal cortical systems involved in decision making, judgement, emotional regulation, and inhibitory control over behavior. The conclusion therefore is that once an addict's biology has been altered, their bodies are now working against efforts at recovery. Understanding the potential of these limitations must inform how fast certain changes can be expected, informing when and how often the survey is administered.

In the event that Headrest's clients have been or are currently involved in the criminal justice system, we turned to Kaye (2012) to inform our focus on the need for personal development and the role that ownership plays in remaining sober. Clarification of the need for recovery centers to assist in the development of a client's ability to navigate boredom, accept criticism, and help clients create the abilities to execute repetitive tasks informed the formulation of our questions. His study also highlighted the benefit of the development of these skills as an asset to their re-entry back into the workforce. Understanding the special conditions that exist when a client is dealing with being released from prison informed our overall line of questioning that the development of individual agency is key for long term recovery.

Defining Recovery

The definition of recovery is up for debate in both the literature and to those experiencing it, complicating how we understand the outcome of the data collection. Our survey focuses on the ideas discussed in Best et. al (2016), that the importance that recovery constitutes a lived experience of people as they accept and overcome the challenge of substance use disorders. The most recent definition of recovery by SAMHSA imagines recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery levels are determined to be ideal, reachable, or realistic as they pertain to prominent domains of life including relationships, housing, health, employment, self-care, community participation and well-being (Watson, 2012 and Moos, 2007). For our definition we will draw on Watson (2012), Best et. al (2016), and Moos (2007) to define recovery as a voluntarily maintained lifestyle characterized by health, well being, and sustained control over substance use that maximizes wellbeing and active participation in society. We have

formulated our data collection to identify the elements in a client's life which will encompass the items above.

How To Sustain Recovery

In order for us to track sustained recovery, we needed to understand the factors that both encourage and discourage long-term recovery. As we attempted to define these, we sought to anchor our questions in sociological literature. Watson (2012), detailed four elements vital to assisting people with recovery. The first addressed social stresses, which helped us to clarify a client's abilities to cope with sober life, their access to social support, and their mastery of their mental health. The second is an examination of how they are managing to integrate socially (including employment) and the positive and negative influences this has on their recovery. The third is an examination of the social inequalities and mental health disparities that they are experiencing and how this is affecting their sustained recovery. The fourth is an examination of stigmas they feel they are facing (Watson, 2012). Previous research shows that recovering individuals see quality of life to be a more important issue in their recovery than total treatment adherence (Watson, 2012), and we will attempt to understand client's perceptions of how their lives are evolving as we create the survey. Understanding these factors should help Headrest better define the factors that assist clients in maintaining sobriety.

Through a sociological lens, we discovered that a major part of recovery is the transformation of a person's identity from one of "addict" to one of "in recovery." Anderson (1994) guided our thinking as he identifies two varieties: alterations, meaning clients seek a transition between contradicting identities, and second: conversion which includes new meanings of the self that change due to shifts in allegiances and the negation of former identities. Both varieties of identity transformations should be recognized as positive steps to long term change,

and we seek to identify both, but we hypothesize that conversions lead to more stable long term recovery. Our questions will try to identify both.

When identifying resources that best engage clients in recovery, Best et. al (2016) guided our development of questions as they found that larger social networks, frequent contact with recovery oriented social networks, and an increase of people in their social networks who do not use substances, are important in developing recovery values and processes. When we understand the changes in a person's social world that coincide with changes in a socially derived sense of self, we will hopefully understand how recovery occurs. In the formulation of our survey questions, we kept this concept in mind as we quantified the multitude of changes that Headrest's clients are experiencing. Buckingham et. al (2013) reinforced the idea that social support acts as a buffer against stress-related psychological and physical health issues. Social Identity Theory proposes that becoming a member of a group is both emotionally and psychologically relevant for ones individual and group decision-making and behavior (Buckingham et. al, 2013), and this should help us understand how and when the Headrest clients use participation in groups to claim their recovery identity over their addiction identity. This new claim has the potential to increase self-efficacy beliefs and be associated with new behaviors. This means that the adoption of a recovery associated identity alone has the power to convince individuals that they have what it takes to stay clean. The more detailed our understanding of the kinds of social support that contribute to maintaining sobriety, the better Headrest can be in suggesting activities that assist clients in recovery.

Questions to the clients will also delve into the support being offered by family members and the support that these relationships can offer as tools for successful recovery. White (2009) identified that engaging and extracting individuals from existing cultures of addiction at the

earliest possible stages of problem and redevelopment and linking individuals and families to cultures of recovery, was an asset. While it has been noted that professionalizing recovery support can undermine the natural support for recovery that exists within families (White, 2006), we will ask about the support being received from families to assure it remains intact. White identified the efficacy of are 1) working with local recovery role models in collaboration with local recovery community organizations and 2) involving each client's family and kinship network members in the treatment and posttreatment recovery process. We know that the recovery communities including AA and NA, are already facilitated by Headrest as a core part of the recovery processes. We see an opportunity here for Headrest to take an active role in maintaining contact with their client's family network as a vital support team.

Employment also functions as a successful tool to assist in recovery. Through the survey we sought to learn if employment is being maintained and if not, is it being actively sought out. Sherba et. al (2018)'s study on employment and substance abuse informed us that the cause of unemployment is often related to substance abuse disorders. Those with employment found it to be helpful in maintaining sobriety, if triggers to using were managed with counseling assistance. There are challenges when it comes to obtaining employment that can be ameliorated by a facilitator, which Headrest seeks to do. Due to obstacles related to the stability of employment, one of our primary indicators of successful recovery will be inquiries into both employment acquisition and maintenance.

Measuring Sustained Recovery

Two metrics that have been used in past literature to measure or quantify sustained recovery: PROMs and ARC. In Moos (2007) the author details a myriad of questionnaires, rating scales and assessment forms, known as patient reported outcome measures (or PROMs). PROMs

focus on the quality of patients' lives. As we have learned from Watson (2012) clients view recovery from the perspective of quality of life, and therefore PROM's should be the appropriate tool to establish this.

Groshkova et. al (2013) created a scale that assessed addiction recovery capital. Recovery capital is defined as the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery. We are interested in designing a scale fit for Headrest that assesses their clients recovery capital in an effort to understand which aspects of their life support their recovery and which aspects pose threats. Recovery capital has three parts: 1) support from family, kinship and social networks; 2) generalized support from indigenous cultural institutions and 3) specialized support provided by addiction recovery mutual aid groups and professionally directed treatment (White and Roth, 2012). Groshkova et. al (2013) concluded that recovery is predicted more effectively on the basis of individual strengths rather than pathologies. This indicates a need for stronger measures of personal recovery capital for people in long-term recovery. This is a gap in the literature our survey will seek to fill for our target population.

This population is notoriously difficult to access. Data collection via mobile technology is explored as a method in Savic et. al (2013). Smartphone applications were evaluated as a tool and it was found that apps are a useful tool to provide information on recovery, as well as content to enhance motivation, promote social support and to monitor progress. Unfortunately very little information has been gathered about the different types of apps that exist, but the benefits of utilizing mobile technology include convenience and repeated sampling of behavior over time allowed for success. (Cohn and Hunter-Reel, 2011). While there may not yet be

sustained data to support cell phone apps as a way to engage those in recovery, this does appear to be our best option as a tool for communication with our client population.

Summation

The existing literature on recovery reveals that the elements that anchor an individual to their recovery process include lifestyle changes that address both physical and psychological symptoms. The sociological literature frames recovery in terms of identity transitions from one that revolves around drug taking to one that revolves around identity as a recovered person. With this change comes a shift in values and goals and a focus on the importance of community involvement, employment and new self perceptions. For our survey we will attempt to adopt the metric proposed by Moos (2007), and Grashkova et. al (2013), to understand the individual respondents recovery capital. Our attempt combines strategies from multiple sources in the pre-existing literature with a survey that can provide the insights that Headrest can utilize to better understand and improve their program. We know the work Headrest does is crucial as Evans (2012) found that as five or more years of abstinence accumulates, individuals are less likely to use, or be involved in the criminal justice system, and improved their emotional and social functioning. This tells us that the early stages of recovery are crucial in laying the groundwork for long term recovery and the longitudinal study should help to clarify the elements that contribute to extended sobriety.

OUR RESEARCH QUESTION

We took into account all the information provided from the literature above in the creation of a measurement tool to answer Headrest's research question: how can we measure the sustained recovery of our clients after they leave Headrest's Low-Intensity Residential Treatment Program? We structured the survey to measure sustained recovery according to our

conceptualization of it as a voluntarily maintained lifestyle characterized by sustained control over substance use that maximizes wellbeing, health and active societal participation. Our methods, detailed below, were devised to offer insight into our question while focusing on three integral dimensions of recovery established in the literature: employment, social support, and self-perception.

METHODS

In order to best address our research question we developed a quantitative, descriptive study to explore the causal relationships between our independent and dependent variables. Panel studies are most well suited for examining the causal relationship we expect to see. We are striving to determine whether or not Headrest can construct a numeric relationship that will define sustained recovery while identifying the personal and social factors that play into sustained sobriety. We chose a longitudinal panel survey design to meet the needs of Headrest, who requested we measure sustained recovery. A panel study investigates attitude changes using a constant set of people that compares individual's opinions at different times. In comparison, trend studies, while they may repeat survey question as a means to identify change, seek a different pool of respondents each time the survey is offered. This resulting data then shows patterns for a larger population rather than specific ones. Additionally, longitudinal studies ask respondents the same questions multiple times, producing data points that allow for the identification of patterns. The choice of a longitudinal design rather than a cross-sectional one enables the production of data points that creates pictures of relationships and changes within respondents lives. The literature indicates that recovery should be measured as a process and a spectrum, and a longitudinal design caters to this.

As our study moves through the steps of a quantitative study, it is necessary to understand the separate independent and dependent variables involved. Literature has informed us that social support, employment status, and self perception are all more accurate indicators of recovery than abstinence. These three indicators are our dependent variables, as they are the variables being measured and are expected to affect recovery outcomes. Our independent variable is a client's exposure to Headrest, as we are examining if time spent at Headrest has had any effect on the dependent variables. We will be using inductive logic as we are hoping to draw generalized conclusions from the specific responses that we know to be true. From the survey responses we hope to gain an understanding of how all of these variables support or challenge an individual's unique recovery experience.

The mode of data collection that will be used in our study will be a computer-assisted self-administered interviewing questionnaire (CASI). This mode of data collection allows clients of Headrest to receive our survey electronically (via email). This method eliminates the cost of shipping as well as data entry charges making it highly cost effective. Headrest has limited financial resources to commit to this project. This combined with the populations unstable housing situations in the early stages of recovery led us to conclude that this method accounts for both financial limitations and the mobility of our population. Filling out the survey online also allows for respondents to answer in their own private space, on their own time, in a way that protects their privacy and does not inconvenience them.

While we perceive this method to be the most practical for both Headrest and their clients, and will yield the highest response rates, there are some inherent risks that our design presents. One disadvantage is the potential for inaccurate responses to the survey stemming from the pressure and stigma surrounding relapse. Secondly, clients may change phone numbers

without notifying Headrest. We suggest that Headrest minimizes the exclusion of individuals without smartphones by encouraging them to answer the survey when they are at the Headrest facility using their technology. For those whose phone numbers change, Headrest should also initiate contact via the emergency contact provided to the organization. Courtney Hoppe, the Director of Development at Headrest, suggested that client's Facebook profiles are, on occasion, more reliable than phone numbers. Taking this information into account, we suggest that Headrest use their social media platforms to share the survey as well.

Furthermore, our survey does not account for the differences in individual recovery structure preferences. In order to maximize response rates, we created a shorter survey with a limited number of questions. This compromise however, limits the surveys ability to address the comprehensive list of social factors that influence recovery. The longer version of the survey is also not exhaustive. The impact of spirituality and individual recovery structure preferences are not discussed in the long survey due to the fact that the sociological literature puts increased emphasis on social support networks, employment, and self-perception as factors that contribute to sustained recovery. Our questions were informed by the literature we read which also emphasizes the importance of community based support, however we are aware that for more introverted individuals this attempt at understanding their recovery may not align with their preferences. We also are aware that when we ask questions about personal feelings, the answers are deeply subjective, leading to responses that are open to interpretation.

In the selection of CASI, we also considered computer-assisted telephone interviewing (CATI) as well as computer-assisted self-administered interviewing (CAPI). CATI interviewing is advantageous as it offers a low cost option that allows for expedited data collection. Ultimately, we did not choose CATI as we hoped to save Headrest the financial and personnel

resources. Telephone interviewing would require the respondent to step away from their daily life to respond. CAPI interviewing offers a low cost option with lower risks of mistakes (Dixon, 2016). However, this method does not provide the same level of privacy to respondents as the CASI method.

As we moved to the challenge of measuring these variables it was important to have a clear conceptualization of what they were. In the conceptualization of recovery we drew from the literature to develop the previously mentioned definition of recovery as a voluntarily maintained lifestyle characterized by health, well being, and sustained control over substance use that maximizes wellbeing and active participation in society. We believe that a longitudinal panel study that administers surveys upon leaving Headrest's Low Intensity Residential Treatment Program, then three months and six months after they leave, is the most well suited approach to measure sustained recovery while remaining mindful of Headrest's limited resources.

We are proposing a causal relationship between between our independent and dependent variables in that we expect to see that time spent at Headrest resulted in the recognition of the importance of strong social support, stable employment, and positive self perceptions as keys to long term recovery. Our approach utilizes inductive logic, meaning that we are aware a client who reports strong social support, stable employment, and positive self perception may or may not result in positive recovery outcomes. We will perform non-probability sampling through the selection of specific cases. We are recommending a type of purposive sample similar to a census in which the entire population is given access to the survey. We are choosing this method because our target population is such a specified group. Non-probability sampling is appropriate because successfully targets the specific respondents who have previously attended Headrest's program and are transitioning to long term recovery.

Our participants are accessible to us as clients of the Headrest organization. Information regarding the survey (including the consent form and list of resources, see Appendix A and B) will be given to them by Lara Quillia upon leaving Headrest's program. She will explain that Headrest is interested in the things that help or hinder their long term recovery, and this survey is how they hope to codify those factors.

Our guidelines for how Headrest might analyze the resulting data and identify aspects of recovery in which their clients could use more or different support are as follows. The survey data will be divided between three sections: Social Support, Self-Perception, and Employment. In the resulting data, Headrest will be able to see that the higher the numerical values of the client responses (as the responses are coded 0=Not Applicable, 1=Strongly Disagree, 2= Somewhat Disagree, 3= Neutral, 4=Somewhat Agree, 5= Strongly Agree) the higher the strength of each element in supporting the respondent's recovery. Trends should emerge to confirm how the work completed at Headrest paved the way for continued recovery. The open ended question at the end of the survey will need to be analyzed on an individual basis. The purpose of this question is to provide respondents with an opportunity to clarify any *other* aspects of their lives that currently play a major role in supporting their recovery that we were unable to include in the survey. In acknowledging the limitation that the recovery indicators we include are not exhaustive, this question is an opportunity to ameliorate this limitation. Headrest staff will need to read these responses to see if the data offers suggestions for additional questions that could be added to the survey. These potential gaps that may not have been recognized or emphasized by the current literature need to be monitored and used as an indicator that additional treatment considerations potentially be utilized so Headrest increases the efficacy of their work.

Due to the financial constraints of Headrest as a nonprofit organization, we understand that encouraging participation in this study cannot come through incentives. Rather, by informing respondents that their information will continue to help the organization which has helped them and that they are paying it forward to others as discussed in AA, detailed more in depth below.

In an effort to assess the quality of our conceptualization of the variables of interest, we turned to the concepts of reliability and validity. Reliability tries to explain consistency and stability. By administering the same survey to the same population we are able to achieve reliability in alignment with the concept of test-retest reliability which is defined by measuring the same units on separate occasions.

Validity is concerned with what is being measured and if it is an actual reflection of what our survey is seeking to discover, namely if social support networks, employment status, and self-perception affect long term recovery outcomes. We looked to the literature and found there were very few methods that we could look to for an assessment of converging validities. Convergent validation examines the association between different measurement strategies for the same concept (Dixon, 2016). Because of the limited other measurement tools at our disposal in assing validity, our study anchors its validity in the sociologically informed questions that focus on social support, employment, and self perception as indicators of long term recovery success.

We designed two research instruments for Headrest: a 15 question survey that takes approximately five minutes to complete as well as a more in depth, 50 question survey that covers many more factors that the literature has cited as recovery determinants. The longer survey will take approximately 25 minutes to complete. This extended design presents an

opportunity to collect substantial amounts of data from willing participants. However, we are aware that the length could present a barrier to completion. We propose that the short survey and the long survey be sent together to clients in an email on the day that they leave Headrest's program, as well as three months and six months after that date. In the email we suggest explaining that the lengthier survey provides a more in depth understanding of their recovery experience and will offer more information for Headrest, but if they do not have the time, the shorter survey is available to them. In order to time the dissemination of the interviews properly, we recommend the utilization of a tool like Boomerang for Gmail, which allows for emails to be scheduled to be sent at later dates. This intends to alleviate the responsibility of Headrest employees to keep track of the three month intervals upon scheduling the follow ups for the individual clients on the day that they leave the program.

ETHICAL CONSIDERATIONS

As we designed our study, we kept in mind the three principles stated in the Belmont Report, a report detailing principles that must be adhered to in an effort to protect participants in research studies. The three principles are respect for persons, beneficence, and justice.

To ensure respect for persons, Headrest will be responsible for securing consent before participants complete the survey for the first time. They will assure they understand its content, as well as what participation entails before they leave the Low Intensity Residential Program. To ensure beneficence, meaning minimization of risk while maximizing benefits to participants, we have carefully chosen the language of the survey to address the variety of educational levels of the population. We paid particular attention to word choice to carefully to minimize triggering words or phrases.We expect no harm to be experienced by participants, as they will likely be relatively comfortable in responding to a survey pertaining to recovery, as all of the topics

touched on in the survey will have already been discussed during their treatment at Headrest. Prior to leaving the program, participants will sign a consent form (see Appendix A) so they are aware of the risks and will be provided with a comprehensive list of resources (see Appendix B) to help address any unforeseen reactions that may arise. There are also potential ethical implications of the security of electronic data collection methods which will also be outlined on the consent form.

The primary ethical concern of the study is compensation, and if any would be provided as a reward for completing our survey. In our discussion of justice in the study, or the fair distribution of benefits and burdens, it was concluded (in conjunction with Headrest) that no reward will be offered. However, participants will be encouraged to fill out the survey with an explanation of how the results will aid Headrest and it's clients in future recovery efforts. We suspect that clients will be familiar with the "pay it forward" mindset as a common phrase repeated in AA curriculum is "to keep it [sobriety] you have to give it away." We hope that once they understand how their responses will offer Headrest insight into the efficacy of their program, clients will be incentivised to participate.

SIGNIFICANCE AND FEASIBILITY

Headrest does important work for people in recovery but as of now has no way to quantify if their work is helping clients long term. Collecting and understanding the information from a survey can identify if what Headrest is doing is working, and can help them improve the work they do. The collected data should reveal information about the long term experience of recovery and which aspects of their lives —whether it be social support networks, employment, self-perception, or something else—supports and or impedes recovery. If there is a notable difference between how certain elements support an individual's recovery, Headrest can contact

their clients with specific resources which address the aspect(s) of recovery the individual is struggling with. The collection of this data can also help expand the scope of the work they do for their community. For example, data on recovery outcomes can be used to support future grant applications. The data can also be used in promotional materials to help others learn about the Low Intensity Residential Treatment Program. The more data that is collected and the more Headrest understands which factors play the most significant roles in recovery outcomes, the closer they get to addressing factors that help address the crisis. As factors are clarified, researchers in turn can begin to explore the efficacy of those factors, hopefully creating a roadmap to codified services which establish best practices in the recovery industry. While the data should be informative, we are aware that it may have limitations as recovery can differ in both the range of measurable changes and the degree of change within each measured dimension (White and Kurtz, 2006).

It is important to note the inevitability of coverage error in our data collection process. Not only are we are attempting to electronically survey a population that does not necessarily have access to electronic devices, but we are not incentivising them to participate. We predict that the data received will be skewed to those doing well in recovery. From a fundraising and PR perspective, this outcome might be desirable, but in order to obtain a more accurate understanding of what the broadest range of clients is experiencing, we offer the following recommendations. In order to more accurately gauge the recovery experiences of individuals who are struggling, we suggest altering the sampling method and considering a form of compensation that incentivises people to fill out the longer survey. We feel the longer version takes into account a greater number of recovery indicators which would be valuable in a comprehensive understanding of the potential effects that Headrest may have had. It would be

interesting to understand how engagement with Headrest affects recovery outcomes, so perhaps adding questions to the survey that could help compare outcomes across groups of people who have participated in varying types of Headrest interventions. Perhaps a comparison of recovery outcomes for those who completed Headrest's Low Intensity Residential Treatment program versus those who only stayed a short time, engaged with other treatment programs, or never got treatment due to space limitations would provide valuable insight. We understand that Headrest does as much as they can with the limited resources they have, so we wanted to suggest a few additional options to maximize the survey experience and improve data collection for analysis.

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Appendix A: Consent Form

Informed Consent: Headrest Survey

Introduction: You are being asked to take part in a research study. Taking part in research is voluntary.

What does this study involve?
We anticipate collecting data from participants first on the day they leave Headrest's residential treatment program, as well as 3 months, and 6 months after that date. Our hope is to track the recovery of clients as to better inform patient treatment and sustained recovery.

Who is eligible to participate?
You must have participated in, or graduated from Headrest's Low Intensity Residential Treatment Program.

Will you be paid to take part in this study?
Respondents who meet the eligibility criteria listed above and who complete the survey will not receive a form of compensation. However, Headrest would appreciate you taking the time to fill out the survey, as your response will help Headrest tailor their treatment program to maximize efficacy. Teachings of AA encourages us to help others achieve their sobriety. As you will hear many times: "in order to keep it, you have to give it away," and we hope you see the survey as a chance to pay it forward.

What are the options if you do not want to take part in this study?
Participation in this study is completely voluntary, and respondents can pull out at any time. Please note that you will not receive payment if you stop participating before you finish the full study.

Will you benefit from taking part in this study?
Respondents will benefit from taking part in this research as the compensation aids in sustaining recovery and maintaining a supportive community. All data collected will also help inform future addiction treatment models at Headrest.

What are the risks involved with taking part in this study?
Some of the questions or discussion topics may make you feel uncomfortable. You will be given a list of resources we encourage you to contact if you would like to further discuss any issues raised by the surveys.

How will your privacy be protected?
The information collected for this study will be kept secure and confidential. Your name will not be linked to your interview responses in any way, and the data you provide will be accessible only to the researchers.

Whom should you contact about this study?
Lara Quillia,
Email: Lara.Quillia@headrest.org
Phone: (603)-448-4872 ext 154

CONSENT

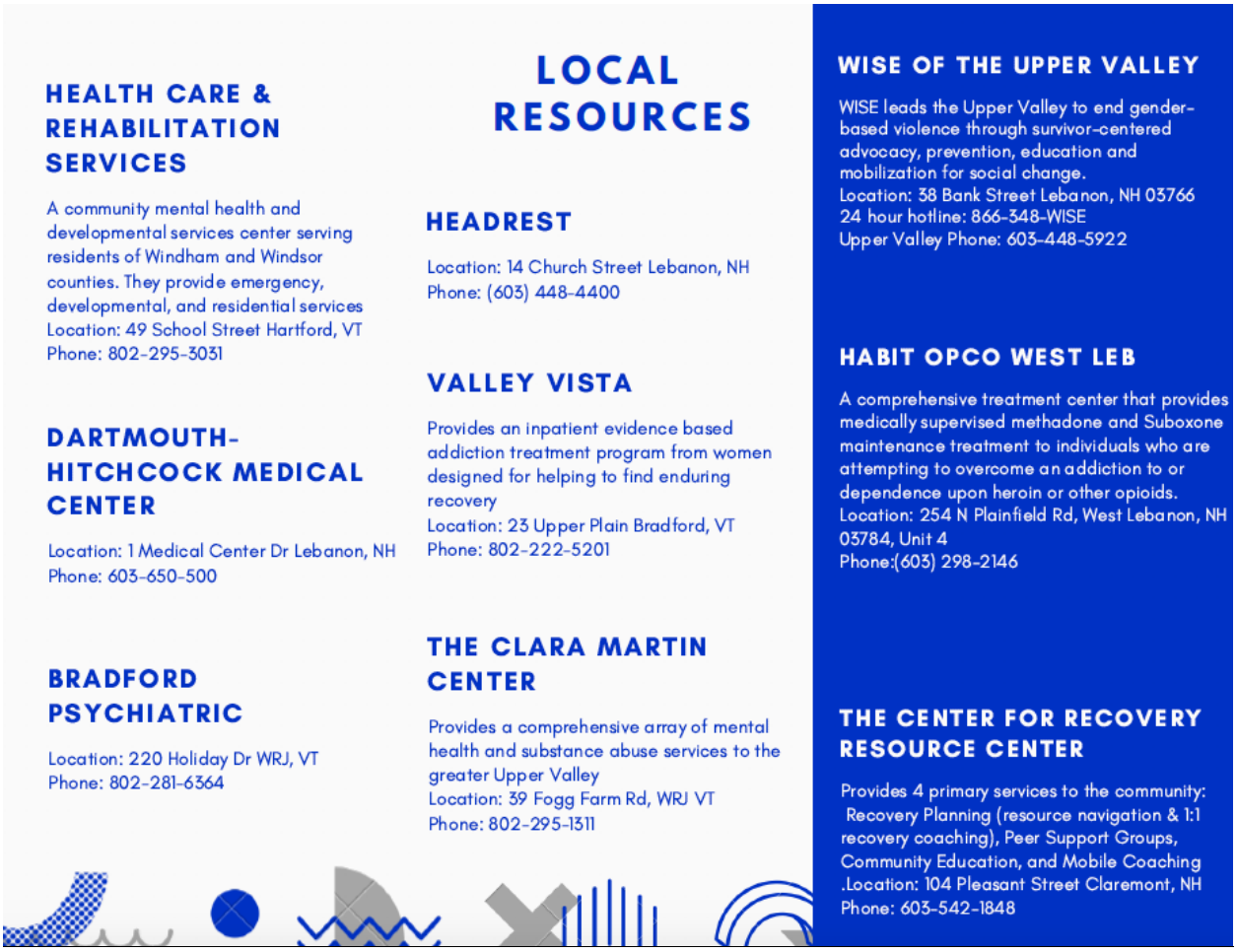
I have read the above information and agree to take part in this study.

Date: _____

Name (Print): _____

Signature: _____

Appendix B: Local Resources



Appendix C1: Short Survey Questions

*Every question will have the following response options: Strongly Disagree (coded as a value of 1), Somewhat Disagree (coded as a value of 2), Neutral(coded as a value of 3), Somewhat Agree (coded as a value of 4), Strongly Agree (coded as a value of 5), and Not Applicable (coded as a value of 0).

Explanation on the opening page of the survey:

We at Headrest are interested in tracking how you, our client, continue to navigate recovery after you leave our Low Intensity Residential Treatment Program. There are many factors that can support and challenge your individual recovery process, and these factors are different for everyone. The questions in this survey will ask you about your who you recieve your social support from, how you see yourself, and your employment status. Ultimately, we hope to learn about what makes your specific recovery experience easier or harder.

Social Support: This section of the survey will ask about where you receive your social support from. Please answer based on what is most accurate to you at this present moment.

1. I have a network of people I can rely on to support my recovery
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
2. I have a special person that I can share my joys and sorrows with
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
3. My social circles have changed a lot since I began my recovery journey
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
4. I engage in activities and events that support my recovery
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral

    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
5. I am routinely attending AA/NA/other support group meetings
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
6. I am still receiving addiction treatment services
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable

Self-Perception: This section of the survey will ask about how your quality of life and how you feel related to housing and food security, physical and mental health, legal issues, self esteem, and your current relationship with substances. Please answer based on what is most accurate to you at this present moment.

1. I have a stable, consistent living situation
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
2. I am not worried about putting food on the table
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
3. I am coping with the stresses in my life
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable

4. I have not had legal issues since leaving Headrest
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
5. I think I am making progress in my recovery
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable

Employment: This section will ask questions about your status of employment and feelings about your ability to fulfill your work responsibilities. Please answer based on what is most accurate to you at this present moment.

1. I have found stable, consistent employment since leaving Headrest's facility
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
2. I am able to support myself from the wage that I earn
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
3. I am able to support my dependables from the wage that I earn
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable
4. I consistently meet my work obligations promptly
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree

    f. Not Applicable
5. I would like more help from Headrest in the job search process
    a. Strongly Disagree
    b. Somewhat Disagree
    c. Neutral
    d. Somewhat Agree
    e. Strongly Agree
    f. Not Applicable

Final Question (optional open response):

1. Is there anything else playing a role in your recovery that you would like to include?

Appendix C2: Long Survey Questions

Explanation on the opening page of the survey:

We at Headrest are interested in tracking how you, our client, continue to navigate recovery after you leave our Low Intensity Residential Treatment Program. There are many factors that can support and challenge your individual recovery process, and these factors are different for everyone. The questions in this survey will ask you about your who you recieve your social support from, how you see yourself, and your employment status. Ultimately, we hope to learn about what makes your specific recovery experience easier or harder.

Social Support: This section of the survey will ask about where you receive your social support from. Please answer based on what is most accurate to you at this present moment.

1. I have a network of people I can rely on to support my recovery
2. I feel comfortable discussing recovery with my family and friends
3. I am satisfied with my involvement with my family
4. I get the emotional help and support I need from my family
5. I get the emotional help and support I need from my friends
6. I have a special person that I can share my joys and sorrows with
7. I engage in activities that I find enjoyable and fulfilling
8. It is important for me to be involved in activities that contribute to my community
9. I feel as though my life has changed a lot since leaving Headrest's Low Intensity Residential Treatment Facility
10. My social circles have changed a lot since I began my recovery journey
11. I do not interact with my drug-using social circle anymore
12. I engage in activities and events that support my recovery

13. I am attending meetings (AA/NA/other)
14. Attending AA/NA/other meetings help with my recovery process

Self-Perception: This section of the survey will ask about how your quality of life and how you feel related to housing and food security, physical and mental health, legal issues, self esteem, and your current relationship with substances. Please answer based on what is most accurate to you at this present moment.

15. I have a stable, consistent living situation
16. I am free of threat or harm when I am at home
17. I feel safe and protected where I live
18. My living space has a positive impact on my recovery journey
19. I am not worried about being unable to feed my family
20. I look after my health and wellbeing
21. I eat regularly and have a balanced diet
22. I sleep well most nights
23. I have enough energy to complete the tasks I set myself
24. I feel physically well enough to work
25. I am actively involved in leisure and sport activities
26. In general I am satisfied with my life
27. I feel optimistic about my future
28. I am coping with the stresses in my life
29. I have not had legal issues since leaving Headrest
30. I have access to resources if legal issues come up
31. I feel confident in my ability to manage my addiction
32. I think I can achieve recovery
33. It is unlikely that I will remain drug free
34. What happens to me in the future mostly depends on me
35. My personal identity does not revolve around drug use or drinking
36. I am making good progress on my recovery journey
37. I am happy with my personal life
38. There are more important things to me in life than using substances
39. I have not used substances since leaving Headrest
40. I feel that I am in control of my substance use
41. I get my motivation to maintain recovery from myself
42. I get my motivation to maintain recovery from others

Employment: This section will ask questions about your status of employment and feelings about your ability to fulfill your work responsibilities. Please answer based on what is most accurate to you at this present moment.

43. I have found stable, consistent employment since leaving Headrest's facility
44. I am able to support myself from the wage that I earn

45. I am able to support my dependables from the wage that I earn
46. I am content with my current employment
47. I feel comfortable dealing with relationships in a professional setting
48. I consistently meet my work obligations promptly
49. I have found Headrest to be helpful in the job process
50. I would like more help from Headrest in the job search process

Final Question (Optional open response)

Is there anything playing a role in your recovery that you would like to include?