Are we doing enough to enhance attendance to aftercare? Service users' evaluation of a group relapse prevention programme for alcohol dependence

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Abstract

Purpose – *The purpose of this paper was to evaluate and improve the quality of the aftercare services we provide for alcohol dependence. This presentation discusses the patient satisfaction of the Relapse Prevention Group.*

Design/methodology/approach – *This was a prospective service users' satisfaction survey of those who attended the relapse prevention group programme at the Community Drug and Alcohol Team for the first 11 months of programme implementation.*

Findings – *In all, 33 out of 36 people participated in the evaluation. The overall results were positive for the whole programme and people felt that the programme helped them in their recovery.*

Originality/value – *Monitoring of service users' satisfaction with aftercare services could provide insight into the barriers compromising engagement.*

Keywords *Alcohol, Prevention, Evaluation, Relapse, Service, Depedence*

Paper type *Research paper*

Introduction

Alcohol use disorders are an escalating problem in the UK. Where medical intervention may be required, NICE CG115 (2011) guidelines advice against rushed detoxifications for clients dependent on alcohol and emphasize the importance of planning the detoxification along with aftercare to follow. In terms of relapse prevention, NICE recommend delivery of psychosocial interventions in combination with offering pharmacological interventions to help people maintain abstinence in the long term (NICE CG115, 2011). Relapse prevention is a process which begins immediately after treatment for alcohol use and continues even if a lapse should occur; this concept provides a broader conceptual framework for intervention.

Relapse Prevention interventions based on cognitive behaviour therapy (CBT), put emphasis on regaining control over the decision-making process involved in resisting or lapsing into alcohol use, through highlighting strategies to prevent or limit relapse episodes. Key components of these interventions include identifying high-risk situations, reducing positive expectancies and developing negative expectancies from drinking, developing self-efficacy and coping skills, and finally, developing overall lifestyle changes compatible with an abstinent way of living (Marlatt and Donovan, 2005; Monti *et al.*, 1989).

Based on the above theoretical model, we run weekly evening group treatment programme for relapse prevention. Primary requirement is that the client should be abstinent from the illicit

substances and alcohol. This group is run by two trained professionals and has eight themed sessions: process of change, high-risk situations, coping with cravings, thinking skills, assertive training and self-esteem, coping with anxiety and depression, lifestyle balance and problem solving and goal setting.

Methods

We conducted a survey to evaluate service users' satisfaction following completion of this programme or immediately after dropping out, in order to understand better any reasons linked with poor compliance and dropping out. We collected data from all clients attended the programme for the first 11 months from 1 July 2013 to 31 May 2014. The feedback form was designed in consultation with all team members and included eight questions. Five of those were closed and rated on a scale of 1-5 ("poor"-"excellent") and three questions were open inviting service users to elaborate on their views. Questions and responses are discussed below.

Results

The total number of people attended this programme during this period was 36. We received responses from 33 people, with five of those been anonymous. Below we discuss in detail responses to individual questions:

1. "Overall how you rate the relapse prevention group": 20 people rated the programme 5, seven rated 4 and six as 3.
2. "Please tell us what session you found most useful and why": six people found the sessions on "High Risk Situations" and "coping with cravings" the most useful. The rest could not distinguish any particular session and found all of them very useful.
3. "Please tell us what session you found least useful and why": one person found the "process of change" session least useful with no particular reason mentioned. None of the other responses pointed out any least useful session.
4. "Did you feel the facilitators delivered the group appropriately? if not please state where we can improve on the relapse prevention group": there was an overall positive feedback. Some examples are as follows: "brilliant and one of the best ever"; "Professional, caring, respectful and supportive"; "enjoyable sessions"; "facilitators spoke with clarity"; "I would like to repeat the sessions".
5. "Did you feel that the group was supportive": 20 out of 33 found the group very supportive and scored 5 points, seven scored 4 points and six scored 3 points.
6. "Did you feel that your opinions were valued by the group": we had only ten responses for this question, with seven of them scored as 5 and rest three scored as 4.
7. "Do you feel that the group has helped you in your recovery": 21 people felt that that the group has been of a great help and scored 5, four people scored 4, seven scored 3 and one person scored 2.
8. "If there is anything you would like to say about the relapse prevention group please feel free to add any comments or suggestions below, this helps us to improve the group and grow on the strengths of the group". Two people made suggestions about the content of the sessions such as: "more information on lifestyle balance and how to achieve this would be useful" and "keep the boundaries in the group". Several people made comments about practical barriers related with poor attendance or dropping out such as: "inconvenient bus timings", "provide coffee", "had to look after children", "relapsed due to relationship and family difficulties", "difficulties because of work timings, went to AA instead", "difficult to attend due to shift work". People who scored closed questions low made comments about their own commitment to abstinence, such as "was not prepared for abstinence and I should start the APG (abstinence preparation group) instead"; "didn't wanted to be abstinent, but wanted to control drinking".

Discussion

The overall view of clients who attended the relapse prevention programme was very positive. Overall, clients felt their views were valued and that the programme had assisted them in developing the skills and knowledge to maintaining abstinence from alcohol. In particular, the sessions on identifying and managing high-risk situations and cravings were found more beneficial. It may be useful to consider how we can make the group accessible to those with work or family commitments, even though holding evening groups was considered the least restrictive option. It may be necessary to adapt the group programme material for use by keyworkers on a one-to-one basis.

It can be noted that two of the six people that dropped-out of the programme had ongoing relationship difficulties, which was said to have contributed to their disengagement. Situations involving another person or group of people (interpersonal high-risk situations), in particular interpersonal conflict, for example an argument with another family member, can result in a range of negative emotions. If a person does not yet have sufficient behavioural or cognitive coping strategies, which they feel able to use in such interpersonal situations, can precipitate a lapse or relapse back into alcohol use. It may therefore be useful to consider including a session specifically looking at interpersonal relationships and the application of coping strategies during interpersonal conflicts.

Conclusion

Monitoring of service users' satisfaction of an aftercare programme could identify existing barriers affecting people's engagement and could provide solutions.

References

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