BEHAVIOURAL THESIS

Development of Relapse Prevention Pamphlet for a Non-Medical Detox Centre

By:

Heather Wates

A thesis submitted to the School of Community Services

in partial fulfillment of the requirements for

the degree of

Bachelor of Applied Arts in Behavioural Psychology

St. Lawrence College

Kingston, Ontario

Canada.

Date: January 4, 2013.
DEDICATION

This thesis is dedicated to the participants and volunteers of a relapse prevention group run at the Hotel Dieu Hospital Detox Centre. Your drive to always move forward and improve gives hope to many.
ABSTRACT

Alcohol dependence is a serious health concern that affects not only the lives of the alcohol dependents but those around them as well as the social services system. Relapse prevention programs offer effective techniques for maintaining sobriety and avoiding relapse through preventative techniques, support, and resilience. However, many individuals who are dependant on alcohol are not fully aware of what relapse prevention is or how it works. By developing a pamphlet which outlines basic information and techniques in an easy to read, interactive way, educational information and support can be provided to alcohol dependents and those who assist them at a low cost. This thesis focuses on the development of the pamphlet and not the evaluation as an objective evaluation could not be performed due to issues with time. Informal, subjective feedback was provided by the supervisor and the clients of a local Relapse Prevention Group on the perceived effectiveness.
ACKNOWLEDGEMENTS

Thank you to the clients, participants and volunteers of the Hotel Dieu Hospital Detox Centre; this project would not have been possible without you. To my on site placement supervisor, C.Karremans, and the staff of Hotel Dieu Hospital Detox Centre, thank you for your ongoing support and feedback throughout this thesis; your knowledge and support has been invaluable to me. Finally, thank you to my college supervisor Dr. Serran and to my second reader Dr. Hal Cain. This thesis would not be what it is without your direction and guidance.
# TABLE OF CONTENTS

DEDICATION ......................................................................................................................... ii
ABSTRACT ............................................................................................................................... iii
ACKNOWLEDGEMENTS ........................................................................................................ iv
TABLE OF CONTENTS ............................................................................................................ v

## CHAPTER

I. INTRODUCTION ................................................................................................................. 1

II. LITERATURE REVIEW ..................................................................................................... 2
   Alcohol Dependence ........................................................................................................... 2
   Relapse Prevention ............................................................................................................. 2
   Treatment Literature ......................................................................................................... 3
   Review of Studies on Relapse Prevention ......................................................................... 3
   Use of Pamphlets as Tools in Patient Education ............................................................... 5

III. METHODOLOGY ............................................................................................................. 6
   Description of Setting and Agency Services ................................................................. 6
   Informed Consent Procedures ........................................................................................ 6
   Participants ....................................................................................................................... 7
   Facilitators ....................................................................................................................... 7
   Pre-Test Likert Scale (06/11/2012) ................................................................................. 7
   Development of Pamphlet ............................................................................................... 7
   Post-Test Likert Scale (29/11/2012) ............................................................................... 8
   Evaluation ....................................................................................................................... 8

IV. RESULTS ....................................................................................................................... 9
   Final Product ................................................................................................................... 9
   Feedback ......................................................................................................................... 9
   Changes to Pamphlet ...................................................................................................... 10

V. CONCLUSION/DISCUSSION .......................................................................................... 11
   Thesis Summary ............................................................................................................ 11
   Strengths ....................................................................................................................... 11
   Limitations and Challenges ......................................................................................... 11
   Multi-level Challenges to Service Implementation Report .......................................... 12
   Contribution to the Behavioural Psychology Field ....................................................... 12
   Recommendations for Future Research ...................................................................... 13

VI. References .................................................................................................................. 14

VII. Appendices .................................................................................................................. 16
   A. Relapse Prevention Model ........................................................................................ 16
   B. Example Likert Scale Pre-Test ............................................................................... 17
   C. Example Likert Scale Post-Test ............................................................................... 18
   D. Confidentiality and Assent Notice .......................................................................... 19
   E. ACHESS Outline ....................................................................................................... 20
   F. Pre-Test Likert Scale Raw Data ............................................................................... 21
   G. Median and Mode ...................................................................................................... 22
   H. Frequency of Responses in Pre-Test Likert Scale .................................................. 23
   I. Pamphlet Side One ..................................................................................................... 24
<table>
<thead>
<tr>
<th></th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>J</td>
<td>Pamphlet Side Two</td>
<td>25</td>
</tr>
<tr>
<td>K</td>
<td>On site supervisor feedback</td>
<td>26</td>
</tr>
<tr>
<td>L</td>
<td>Volunteer Chair of Relapse Prevention Group Feedback</td>
<td>27</td>
</tr>
<tr>
<td>M</td>
<td>Post-Test Likert Scale Raw Data</td>
<td>28</td>
</tr>
<tr>
<td>N</td>
<td>Post-Test Median and Mode</td>
<td>29</td>
</tr>
<tr>
<td>O</td>
<td>Frequency of Responses in Post-Test Likert Scale</td>
<td>30</td>
</tr>
</tbody>
</table>
CHAPTER I. INTRODUCTION

Alcohol dependence is a serious health concern that can deeply affect the lives of the individuals, their family members and the community. When an individual decides to start recovery the first step he or she must take is detoxification, which can be a frustrating and difficult experience. Many individuals who experience alcohol dependence may have already tried other forms of treatment and could not successfully maintain sobriety. All treatment plans have some limitations. For example, some interventions are not effective as they attract only specific populations, such as those who are religious or who are ready for complete abstinence (Tatarsky & Marlatt, 2010). Introducing the relapse prevention model as a life-long treatment possibility provides an attractive alternative and supplement to other types of addiction programs (see Appendix A). Relapse prevention can assist in preventing high-risk situations and avoiding relapse. It can be implemented as early as detox and be used continuously throughout treatment and recovery. By using the relapse prevention model, alcohol dependent clients can learn to identify triggers, barriers, high risk situations and warning signs as well as discover and identify preventative factors. They can do this with very little assistance from others and on any type of budget.

The information in the package will include an understanding of alcohol dependence, understanding how to cope with triggers and risky-situations and will provide the centre with a new resource that can be used in the future. Alcohol dependents may struggle their whole lives with addiction. Relapse prevention can be used years after abstinence has been maintained even if they fall back to old habits. The package was developed specifically for those with alcohol dependence with the hope that future students may develop a relapse prevention package for those with other addictions.

There was no information available at the detox centre or at the relapse prevention group for those who wanted to know more about relapse prevention. In fact although attendance at the relapse prevention group is mandatory for those at the detox center, clients often do not receive explanations of specific concepts relevant to relapse prevention. Another challenge with respect to this domain is the fact that the group is open-ended and a completely different clientele could be present from week to week. This is another reason that an information pamphlet would be helpful; clients who only attend one group session will be able to have a hard copy of concrete and specific information for their use.

The purpose of the current project is to develop an educational relapse prevention package with concrete information for clients to review on an ongoing basis. It is expected that by using this package, clients will be able to continue to make use of specific relapse prevention skills once they leave the detox center and enter other agencies. They will then be better prepared for possible lapses and relapses in the future.
CHAPTER II. LITERATURE REVIEW

The literature review was conducted using the EBSCO host database available through the St. Lawrence College Library. Specifically PsycINFO and PsycARTICLES were chosen. Search terms included relapse prevention, alcohol dependence, addiction, relapse, detox, information packages, pamphlets and meta-analysis.

Alcohol Dependence

There are many different categories of alcohol consumers including heavy drinkers, alcohol abusers and alcohol dependents. Of these consumers alcohol dependents are considered one of the most complicated. Alcohol dependence is defined as a loss of restraint over drinking in spite of negative results; the DSM–IV-TR states that in order to be diagnosed with alcohol dependence, one must display three of the following over a 12 month period: tolerance, withdrawal, use to avoid withdrawal or the symptoms associated with it, loss of control over drinking, continued use in spite of efforts to curtail it, neglect of other activities, and continued use undeterred by the problems it causes (Tomberg, 2010). The difference between alcohol abuse and alcohol dependence is subtle but is important to distinguish. According to Tomberg (2010) alcohol abuse is similar to alcohol dependence but without the extensive negative consequences. At the point of undergoing detox most clients will have had some negative consequences and will therefore most likely fall under the category of alcohol dependent.

Alcohol dependence has been identified by the World Health Organization as a serious public health concern not just in Canada but worldwide (Witkiewitz, Marlatt, & Walker, 2005). It affects countries, societies, families and the individual; therefore it is critical that we provide effective support and intervention.

Relapse Prevention

When an individual decides to begin an alcohol free or limited life it is a very important decision as the first stage of recovery (detox) and can be one of the most daunting and frightening. Many may fear whether they will be able to achieve and maintain an alcohol free or limited life and wonder if they will relapse. Relapse is a serious setback in an alcohol dependents recovery. By returning to the previous negative behaviours the alcohol dependent loses confidence in his or her recovery and puts him or her in a risky situation in regards to their health, social life, work and many other critical life areas. In many instances, the individual might be in a situation which could trigger a relapse without his or her awareness, unless he or she has developed relapse prevention skills. According to Witkiewitz and Marlatt (2004), “relapse prevention (RP) is a cognitive-behavioral approach with the goal of identifying and preventing high-risk situations for relapse” (p. 403). Relapse prevention is an important intervention because it can help identify possible obstacles to recovery as well as triggers in an attempt to avoid and be prepared for possible relapses. There are many treatments available to alcohol dependent individuals but Tatarsky and Marlatt (2010) assert that traditional treatments appeal to and totally assist a minute number of hard to reach alcohol dependents. Therefore relapse prevention can be seen as a possible alternative to traditional treatment and in fact can be very effective for individuals who are alcohol dependent (Witkiewitz & Marlatt, 2004). Vieten, Astin, Buscemi and Galloway (2010) state that central to relapse prevention is the labeling of alcohol related prompts and situations which may trigger relapse. According to Witkiewitz,
Marlatt and Walker (2005) relapse-prevention should be seen as a possible alternative because it “could provide more effective long term improvement as opposed to other treatments which offer only short term improvements” (p. 214).

**Treatment Literature**

Research has shown that at least 60% of individuals will have at least one lapse or single drinking episode within the first year post treatment (Witkiewitz, 2011). This means that we should approach lapses and relapses not as the exception but the rule. Given that a lapse or relapse will most likely occur eventually the best way to address this is to prepare for it and to remove value judgments about the individual. Relapse prevention seeks to reduce the harming effects of a relapse but does not require complete abstinence to be effective (Marlatt & Tatarsky, 2010). This reduces significant pressure to be overconfident; something that is known as a proximal risk factor for relapse along with craving and perceived stress (Witkiewitz, 2011). Acceptance based strategies are integral to the success of the client (Vieten, Astin, Busceni & Galloway, 2010). Relapse prevention puts the control back into the addicts’ hands while still maintaining support of the individual (Kallman, Sjoberg & Wennberg, 2003).

When comparing harm reduction treatments such as relapse prevention in alcoholics to other treatments, such as abstinence based approaches, Logan and Marlatt (2010) assert that harm reduction can be a better option for specific clientele. Logan and Marlatt (2010) suggest that treatments should be individualized to the client and if a client comes from a background of resistance to change then relapse prevention could open up the doors of communication and rapport building without sobriety being a prerequisite. If your client is not capable of abstinence now then abstinence based treatments are not the best approach and may in fact push him or her away (Logan & Marlatt, 2010). Bowen et al. (2009) also state that when compared to 12 step programs there is empirical support to show that relapse prevention techniques show high efficacy and should be considered an alternative. They also state that attrition rates in relapse prevention groups were lower than in treatment as usual groups (Bowen et al., 2009). Support has also been shown for the combination of relapse prevention and cognitive behavioural therapy and the belief that relapse prevention should be part of a multi component approach (Breslin, Zack & McMain, 2002).

Information packages were previously used to assist in the transfer of information specifically in phobias. An example from the National Phobics Society contains definitions on relapses and phobias, the relationship between them as well as what to do if anxiety cannot be managed alone. They incorporate relapse prevention techniques as well as red flags, triggers and barriers specific to phobias (National Phobics Society, 2010). According to Witkiewitz and Marlatt (2004), relapse prevention has been shown to also be effective with depression, obesity, schizophrenia, Bipolar disorder and many others making it a universal approach that can be applied especially to alcohol dependents.

**Review of Studies on Relapse Prevention**

In a Chinese study of relapse prevention in heroin addicts, relapse prevention group therapy was used to assist 100 heroin dependent males (Min, Xu, Hanhui, Ding, Yi & Mingyuan, 2011). Two intervention groups were used: a Relapse Prevention (RP) intervention which utilized 20 group therapy sessions based on Marlatt’s RP cognitive behavioural derived
techniques; and, the comparison group from a Drug Rehabilitation Centre (LDRC) which used a closed setting with didactic drug education and moral and legal education classes and strict rules. Although there was a small dropout rate in both groups as some participants could not be located for follow up, improvements were identified at follow up. Scores on the Self-Rating Anxiety Scale (SAS) (Zung, 1971) decreased indicating lower anxiety in the relapse prevention group while the self-esteem scale (SES) (Rosenberg, 1965) and self-efficacy scale (SE) (Qian, 1985) saw significant improvements in the RP group compared to the LDRC group. Of the 23 participants who had clean urine tests the RP group had the highest percent with 44.4% while the LDRC group had only 18.9%. On the addiction severity index (ASI) the RP group had generally more improved scores and reported less drug use after intervention then the LDRC group. No improvements were seen on the Beck Depression Inventory (BDI) indicating depression must be addressed as a separate issue. Detractions from this study included the small all-male sample size, short follow up time and the fact that after care support was not integrated into the RP group (Min et al., 2011).

Preliminary findings indicate support for an acceptance-based relapse prevention intervention used for alcohol dependents (Vieten, Astin, Buscemi & Galloway, 2010). In this study an Acceptance-Based Coping for Relapse Prevention (ABCRP) intervention was used with 33 individuals. Ten of these individuals failed to complete the program defined as a less than 50% attendance rate. Eight two hour group sessions were implemented which covered five main topics: introduction to the concept of mindfulness, attitudinal foundations of mindfulness, cultivation of willingness to experience rather than avoid, gaining familiarity with observing “self” and gaining more objectivity in regard to the individual’s mental processes. Pre and post data was collected which indicated changes in favour of this approach. These included craving with a decrease of 32%, positive affect with an increase of 20% and a decrease of negative affect by 32%. Emotional reactivity also had a decrease of 17% as well as perceived stress with a decrease of 23%. Mindfulness was increased by 21% and psychological well-being was increased 15%.

Studies also support the use of mobile technology as an effective medium for relapse prevention techniques (Gustafson, Shaw, Isham, Baker, Boyle & Levy, 2011). Through the use of relapse prevention and Alcohol Comprehensive Health Enhancement Support System (ACHESS), those in recovery from alcohol dependence show some improvement. ACHESS uses smart phones and is aimed at those with a grade 6 reading level. In order to decide what to incorporate in the ACHESS individuals and families dealing with alcohol dependence were surveyed and the top issues reported that needed addressing were: understanding what addiction is, knowing how to stop a relapse, being prepared for reentry into society, obtaining individualized treatment, finding motivation to stay in treatment, choosing a successful treatment, improving ability to resist temptations, knowing things that make individuals vulnerable to relapse and knowing warning signs of an oncoming relapse. In the application to alcoholism, the three major constructs chosen were: coping competence, social support and autonomous motivation. Using technology to address these issues allows those in recovery to access assistance at any time especially with the including of a “panic button” in the application which uses Global Positioning System (GPS) and triggers alerts to key supports such as a treatment agency they may be connected with, an Alcoholics Anonymous (AA) support member, counselor, family or friend who can come and assist the individual. This GPS is also used to
track when someone at high risk is approaching an area where they may traditionally seek alcohol. At this point they may be contacted by supports. Information would be tailored to the individuals' reported issues; daily alerts and check in would be used to stay in contact. Mini assessments would also be used to assess where the individual is at in terms of relapse. This is only a brief summary of the application; please see Appendix E for a full outline of the ACHESS smart phone application. This study is on-going and it is expected to be successful in assisting those recovering from alcohol dependence. Some limitations may be access to smart phones and what factors may moderate the success of ACHESS such as motivation to change.

In treating opioid abusers who suffer from chronic pain, relapse prevention and pain management becomes an integral part of recovery (Compton, 2011). Compton (2011) hypothesized that identifying abuse and reframing failure to succeed in treatment as relapse can assist in keeping clients in treatment longer and can help the patient maintain sobriety through sanctioned use of opioids. Through regular monitoring, assessment and development of relapse “contracts” early in treatment can assist in individuals being prepared for relapse. This allows the individuals to continue to access the services necessary without being removed from treatment.

In a meta-analysis on the efficacy of relapse prevention, one group of researchers found that relapse prevention had the highest treatment effect when evaluated with pre and posttests (Irvin, Bowers, Dunn & Wang, 1999). RP was deemed successful in improving psychosocial functioning. Efficacy for RP depended on several moderators. It was found to have the highest efficacy and was most reliable in alcohol treatment. Effect sizes were generally similar despite various modalities in treatment of alcohol. The research also indicated that RP may work well in treatment for alcohol in combination with some drug therapy. Overall this study supported RP in its efficacy in decreasing substance use.

Use of Pamphlets as Tools in Patient Education

In the current age of technology there are many ways in which to distribute educational material to participants. Educational pamphlets have been used, and are still used, extensively to administer educational information and assist clients with decision making in a non-invasive, non-patronizing way. According to Liira (2011) decision aids such as pamphlets can be effective in informing clients of treatment options and understanding the risks and responsibilities of the client. They can also reduce the stress level and anxiety of the individual as they are occupied and feel better informed (Liira, 2011). When developing information pamphlets it is important to take into account several factors including education levels, culture, socio-economic status and family history in order for the pamphlet to be effective and be attractive to the target audience.

Therefore understanding and listening to the clients you work with and what they like is very important (Garcia, Chismark, Mosby & Day, 2010). This is further supported in the literature by the fact that many psycho-education materials have been shown to be above the comprehension of the target audience and that the average person in the United States reads at about a grade 8 level and therefore information pamphlets should reflect this with no words/jargon above a high school level (Adkins, Elkins & Singh, 2011). Studies also support the use of pamphlets to encourage further treatment options as those who receive pamphlets are more likely to explore treatment options relevant to the information that they are provided (Paul, Redman & Sanson-Fisher, 2003). These same authors also state that in order to create a cost effective pamphlet strategies for behavior change must be incorporated (Paul, Redman & Sanson-Fisher, 2004).
CHAPTER III. METHODOLOGY

An information pamphlet on relapse prevention was developed for client and agency use. It is based on pertinent facts about relapse prevention identified by staff, volunteers and the literature. Detailed below is a description of the setting and information on the preparation of the pamphlet.

Description of Setting and Agency Services

The non-medical detox centre offers support to those wishing to detox off any type of substance, assuming they meet the screening criteria. As it is, all non-medical detox clients must receive clearance from a doctor if they have any serious health concerns that require medical attention. Individuals with mental health concerns can be admitted and those who state suicidal ideations are asked to give a verbal contract that they will not attempt suicide during their stay at detox. Staff work closely with other clients throughout their withdrawal at the detox and if there are medical issues, that are beyond the scope of detox staff, clients are referred to a local hospital. A variety of in-house services are offered including one on one counseling, grief and loss support, relapse prevention group and referrals to short-term and long-term treatment dependent on the client and the location most convenient for them. Unfortunately a more detailed description could not be given due to reasons of confidentiality.

The Relapse Prevention Group (RPG) is held in the non-medical detox centre in a meeting room specifically used for groups. Relapse prevention is an open group so anyone who wishes to can attend including those who are not current clients of the detox centre. Participants in relapse prevention groups must be 16 years or older and may be any gender and background which creates a diverse and dynamic environment for the group. RPG is run entirely by volunteers and is mandatory for clients of the detox centre as long as they are able to attend. Clients whose withdrawal symptoms are too severe to attend may defer attendance until they are healthy enough to attend. The group is run Tuesdays and Thursdays from 11 a.m. to 12 p.m.. At the beginning of each group the ground rules are laid out and participants are given the opportunity to discuss what they are doing to stay clean and sober; and, to discuss relapse prevention techniques. The focus is on a solution and not the problem.

For the purposes of this thesis, the information pamphlet was developed specifically for clients participating in the relapse prevention group; and, current clients were asked to provide their opinions on the content and design of this pamphlet.

Informed Consent Procedures

Verbal consent was given by the onsite supervisor to initiate the collection of information through Likert scales for the purpose of development and evaluation of the pamphlet. Verbal consent was also given by the volunteers who run the relapse prevention meeting in which data was collected. At the beginning of collection of information, in each phase, the participants were provided a form outlining confidentiality and the right to opt out of participation (see Appendix D). Participants were informed that the information will be used to develop the pamphlet and they were advised of the benefits and risks of participating. Opportunities were available to address any issues and concerns in an ethical and compassionate manner. Participants provided either verbal consent or refusal to participate. Participants who chose not to participate were not
Participants

Participants who completed the pre-development Likert scale were 10 individuals self-identified as alcohol dependent, four of whom also struggled with drug addiction. They were 16 years or older and at various stages of recovery. Participants of the post-development Likert scale were five individuals self-identified as alcohol dependent entirely unrelated from the first group. It is unknown whether any of these also identified as drug dependent as most left that item blank on the post-test. All participants who were residents of the detox centre were required to have medical clearance; others attended the relapse prevention group but resided outside of the detox centre. Participants in the post-development Likert scale group varied as it is completely confidential and there is no way to compare pre- and post-development scores of specific individuals. Participants were predominantly male. It was not possible to obtain detailed demographic data due to confidentiality and consent issues.

Facilitators

The pamphlet was designed to be distributed by detox centre and volunteers of relapse prevention group. Detox staff (who are primarily Behavioural Science Technicians) are responsible for assisting clients through withdrawal and provide resources and some counselling when necessary. The pamphlet could be used by detox staff to provide clients with a specific resource. When assisting those going through withdrawal, staff would be able to use the pamphlet as another resource. Volunteers are responsible for facilitating the relapse prevention group and providing a safe environment where participants can share and discuss information. The education of the volunteer facilitators is unknown. Relapse prevention group facilitators could be able to use the pamphlet as an introductory material available to those who are commencing the program and with participants who may not want to talk in front of a large audience.

Pre-Development Likert Scale (06/11/12)

The Likert scale was created by the pamphlet developer and approved by the onsite supervisor and college supervisor. The scale was developed following discussions with the onsite supervisor; items that she identified as meaningful and relevant were incorporated. Ten individuals consented to participate in this phase. Four of these individuals identified as attending RPG for both alcohol and drug problems. The feedback was put into tables showing median and mode and charted in a bar graph (see Appendices G and H).

Development of Pamphlet

A pre-development Likert scale was given to 10 participants of the RPG to elicit their opinion on relevant content. The 5 point Likert Scale contains 12 questions (see Appendix B) addressing the relevance of the following issues for the pamphlet: knowledge and level of understanding of relapse prevention, self-efficacy, and esthetic preferences. Client responses are outlined in Appendix F, G and H. Based on this data the pamphlet was developed. As seen in question seven which states “I know a lot about relapse prevention” on the pre-development Likert scale (see Appendix F), there is a large variance in knowledge levels of relapse prevention. Although six individuals either agreed or mostly agreed that they know a lot about RP two stated they neither agreed nor disagreed and two stated they disagreed that they knew a
lot about relapse prevention. Question 5 indicated that if presented with a pamphlet most participants would keep it. Questions 1 and 2 also had high agreement rates indicating the importance of understanding the causes of alcohol dependence, relapse prevention and of making the pamphlet as interactive as possible. Based on these responses, information was chosen and incorporated in a fun and interesting manner. Fun and interesting ideas were collected through conversations with the onsite supervisor and the clients verbal suggestions as well as the creativity of the developer. Information chosen was adapted from articles in the literature review section. The lay out itself was adapted from a free brochure template download from the Office website ("Microsoft office templates," 2013).

**Post Development Likert Scale (29/11/2012)**

Following the creation of the pamphlet, a post-development Likert scale was administered to evaluate satisfaction with the pamphlet. If satisfaction was deemed to be low the pamphlet would be reevaluated for possible changes. The post-development Likert scale was given to clients during relapse prevention group in the same format as the pre-development Likert scale and is outlined in Appendix C. It is a 10 question scale evaluating how valuable and effective the pamphlet is seen to be and whether participants feel they will keep it for future use. Five participants completed the scale.

**Evaluation**

The pamphlet could not be objectively evaluated due to time constraints. Therefore the Post-development Likert scale was completed for social feedback from clients and verbal input from the onsite supervisor was taken into account. In retrospect, a readability tool such as the Readability Assessment Instrument (RAIN) could have been used to assess the readability of the pamphlet.
CHAPTER IV. RESULTS

Final Product

The final product was a relapse prevention information pamphlet prototype applicable to those coping with alcohol dependence issues (see Appendices I and J). The pamphlet focuses on relapse prevention techniques, identifying barriers, identifying red flags to recovery, developing preventative techniques; and, removing blame and guilt from relapse and improving general knowledge of relapse prevention. It also provides information on local resources in the Kingston community relevant to those coping with addictions. These domains were chosen through discussion with the supervisor and through the use of a pre-and post-pamphlet development Likert scale as well as a literature review about topics related to relapse prevention. It was designed not only for use in the detox centre but also for community organizations and others who work with substance abuse issues such as HIV/AIDS workers, advocates, and street outreach teams. Generally, the pamphlet content was well received by those who evaluated it.

Feedback

The pamphlet was reviewed and evaluated by the supervisor, the volunteer chair of the relapse prevention group, and by participants of the relapse prevention group. It was initially reviewed by the first two individuals before release to the larger group in order to ensure its appropriateness for the relapse prevention group. Reviewers were told it was open feedback and they did not receive guidance in answering. The following is a summary of the feedback provided.

On Site Supervisor Feedback

The onsite supervisor filled out a general feedback sheet (outlined in Appendix K) asking what she liked about the pamphlet and what she would like to see changed. According to the supervisor she enjoyed the colours, graphics, questions as an introduction and brief descriptions and explanations. She requested some minor editing and was uncertain whether the quality of print could be maintained in the future. The identified errors were edited and an updated version was given to the supervisor with the appropriate changes. This version of the pamphlet can be edited by the supervisor as changes will need to be made in the future as new information becomes available.

Volunteer Chair of Relapse Prevention Group Feedback

The volunteer chair of relapse prevention also completed a brief question sheet (see Appendix L). What he liked about it was it was short enough for those in detox, the addresses/phone numbers; lay out, preventative strategies and the examples. He offered no suggestions for changes.

Post-Development Likert Scale

In the post-development Likert scale (outlined and graphed in Appendices M, N and O) all participants found it easy to understand and informative. Most thought the pamphlet applied to their situation and that they would keep it. One person did not find the pamphlet fun and interactive however most either did or did not have strong feelings either way. One person also said the pamphlet did not contain everything he wanted it to but the majority said it did. Most believed the pamphlet was an appropriate length and most said they would use relapse prevention techniques in the future. Based on this feedback, although the pamphlet has its
limitations, it was considered potentially beneficial to most people open to learning about relapse prevention. Results may have been affected by the group setting, the level of education, and wanting to please. As Likert scales are a form of assessment that is easily influenced by internal and external factors, the value of the information is difficult to assess. In the future a more efficient and direct form of assessment could be developed and used to evaluate the pamphlet.

Changes to Pamphlet

Based on the feedback from those who evaluated the pamphlet, some changes were made. Changes to the pamphlet included the removal of the Hotel Dieu Hospital name and logo also some corrections were made to out of date phone numbers and typos were addressed. As the supervisor evaluated the pamphlet initially, these items were corrected before the pamphlet was dispensed to anyone else. Most of these changes were clerical in nature and no changes were made to the central information or exercises. One option to address the future quality of the pamphlet was the suggestion of printing it in black and white. The supervisor believed this was a possible alternative that would minimize the cost of continuing to print the pamphlet. Removing the colour would be a considerable change as the pamphlets colour and images were part of making it as appealing as possible. This change from colour to black and white may affect the value of the pamphlet to the community. A number of colour versions were left with the supervisor for future dispersion at no cost to the centre.
CHAPTER V. DISCUSSION

Thesis Summary
The goal of the thesis was to develop a relapse prevention resource for the detox centre and community to utilize that may be used at any stage of change and treatment readiness. By focusing on preventative interactive techniques, those who use the pamphlet will be able to engage in their treatment no matter where they are. They may use it independently while still having community resource information available. Relapse prevention was chosen as the best focus for the pamphlet as the literature supports this type of harm reduction approach. Also it does not require complete abstinence. Complete abstinence was identified in the literature as difficult to maintain and may in fact act as a deterrent to wanting to learn about support options. It was identified, at the time of this thesis, that there was no information package or means of sharing information on relapse prevention readily available for participants of the detox centre if they requested it. A pamphlet was chosen as the mode for sharing information as it is small, easily accessible and many copies may be made at little expense. Although clients who are alcohol dependent are the focus, not necessarily all clients who attend the detox center would be considered alcohol dependent. Based on the nature of the client population and agency, it is not possible to specify exactly whether the client would in fact meet a diagnosis of alcohol dependence; that said, all of the clients who experience problems with alcohol could potentially benefit from the information available in the package.

Strengths
The strengths of this pamphlet are that it concisely and succinctly summarizes basic information on relapse prevention in regards to alcohol dependence while also being interactive and engaging. It also may improve the clients' understanding of relapse prevention and improve their relapse prevention skills. It can also assist them when coping with a relapse, or a possible relapse, and provide them with a valuable resource that could connect with someone who could provide support. It is an educational tool that can be used to engage clients in proactively thinking about relapse prevention as a possible treatment supplement.

Limitations/Challenges
There are several identified limitations of this project. For one, all information collected was informal and given to interpretation. This means that depending on who was reading the information they could have drawn different conclusions. Furthermore a true and objective assessment could not be completed and therefore the full value of the pamphlet to the detox centre, the relapse prevention group, and the clients could not be evaluated. The fact that Likert scales were used is also a complication as there are inherent problems with central tendency where participants avoid extremes. Also some participants may answer the way they believe the person giving the scale wants them too. There is deficient validity and it could be difficult to reproduce the results with any accuracy. Given also that the Likert scale was developed by the student and never tested prior it is difficult to say whether or not it identified what was truly important to those who participated. A further issue was that statistical analysis could be performed on the data and it excluded complete abstinence as a form of assistance something which many people who attend relapse prevention put a high focus on. An additional issue is the small number of participants and the fact that not all were only alcohol dependents but identified as struggling with drug dependence. Finally the same number of people could not participate in both pre and post groups and there was no way to track participants across pre and post tests.
Multi-level Challenges to Service Implementation

Working with individuals with addictions in a non-medical detox centre, there are many challenges to come across that could fit into the client, program, organizational and societal levels. It should be noted though that although it may be challenging working with this population it is also rewarding. As much as you assist them, you will also learn from them.

Client Level. Working within the addictions community offers many challenges on the client level; mostly involving the fact that each client is unique and his or her experience with addiction and feelings going through detox is unique. Thus, it becomes important to encourage appropriate expression of thoughts and feelings while also balancing your responsibility and duties. Remembering to treat each client as an individual who may come from any type of background is important. So is remembering to validate clients without enabling them.

Program Level. All programs currently at the detox centre are run by volunteers and are structured differently depending on the personal approach of the particular facilitator. Providing consistency and detailed program planning then becomes complicated if there are multiple people with loose role responsibilities and no clear definition of what is to happen. Furthermore, information becomes outdated quickly without someone available and responsible for keeping it up to date. Ultimately, given the nature of the detox centre as a non-permanent residence with clients staying varying lengths of time, it is difficult to develop programs that are effective and not redundant for some while still accessing those harder to reach individuals.

Organizational Level. In a non-medical detox centre it is hard to assist those going through withdrawal who may need more support. Policy indicates that if a client is injured or ill in some way they are sent to the hospital. Detox staff are not prepared to deal with serious behavioural issues either and the FCMH crisis team is called if there is a serious issue. If the behavior issue is threatening in some way, the client will most likely be removed by security or staff before the client’s behavior can be addressed. Not having doctors and nurses immediately available means you sometimes have to make judgment calls and are not able to deescalate situations while keeping the client at detox as often as you would like.

Societal Level. The societal issues with this population are overwhelming. Those coping with addictions are often stigmatized and rejected by society. By reaching out to this population and creating an environment of support, some stigma can be removed. Furthermore pathways to communicating about the roots of addiction issues can be researched and addressed. A multi-level approach needs to be taken to address discrepancies in societal attitudes and the perceptions of those coping with addictions.

Contribution to Behavioural Psychology Field

Part of the behavioural psychology field is providing information in a fast paced work environment with clients who come from a variety of backgrounds and support teams. By creating a thesis based on the development of a pamphlet on relapse prevention and alcohol dependence, the community has one more way to reach out to those who may need it. Sharing basic information with people in the field and those coping with addiction allows the door to be opened for those who wish to know more about relapse prevention and how it can help them.
while also providing numbers for support and techniques they can use individually.

**Recommendations for Future Research**

It is recommended that future students develop a pamphlet with a focus on other forms of addiction such as drug dependence or gambling using the current pamphlet as a base. It is also recommended that future research takes a more thorough approach to evaluating the effectiveness of this pamphlet and whether it has content validity.

**Word Count: 6,141**
References


APPENDIX A: Relapse Prevention Model
APPENDIX B: Likert Scale Pre-Pamphlet Development

What substance do you attend relapse prevention for? Please Circle: Alcohol, Drugs, Other

Please answer the following to the best of your ability. Circle only one of the following options per test question. If you have any questions or concerns ask the test distributor.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neither Agree Nor Disagree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Understanding what causes alcohol dependence and relapses is important to me. 1 2 3 4 5

Fun and interactive experiences are important to me. 1 2 3 4 5

I like to be presented with a lot of information at once. 1 2 3 4 5

I would like to be able to identify barriers to success in treatment early. 1 2 3 4 5

If presented with an information package I like I will keep it for further use. 1 2 3 4 5

I like when information is easy to understand. 1 2 3 4 5

I know a lot about relapse prevention. 1 2 3 4 5

I would like to know what to do if a relapse occurs so I can be prepared. 1 2 3 4 5

I know what red flags and warning signs come before a relapse. 1 2 3 4 5

I feel a package on alcohol dependence and relapse prevention would be informative and helpful. 1 2 3 4 5

When I recognize a red flag do I have a list of alternative actions? 1 2 3 4 5

Do I feel safe in the relapse prevention group and that my information is accurate and will be kept confidential 1 2 3 4 5

APPENDIX C: Likert Scale Post-Pamphlet Development
Please answer the following to the best of your ability. Circle only one of the following options per test question. If you have any questions or concerns ask the test distributor.

<table>
<thead>
<tr>
<th>Agree</th>
<th>Somewhat Agree</th>
<th>Neither Agree Nor Disagree</th>
<th>Somewhat Disagree</th>
<th>Disagree</th>
</tr>
</thead>
</table>

1. The package was informative and easy to understand. 1 2 3 4 5

I could apply the information to my own situation. 1 2 3 4 5

There were not enough exercises. 1 2 3 4 5

I know what barriers, red flags and triggers are. 1 2 3 4 5

I will keep this package on relapse prevention for further use. 1 2 3 4 5

The package was fun and interactive. 1 2 3 4 5

The package contained everything I would have liked it to contain. 1 2 3 4 5

I feel better prepared and confident about my recovery. 1 2 3 4 5

The package was too long. 1 2 3 4 5

I will use relapse prevention techniques in the future. 1 2 3 4 5

**APPENDIX D: Confidentiality and Assent Notice**
Confidentiality and Assent to Participate
As participants of the Relapse Prevention Group (although clients who are alcohol dependent are the focus, not necessarily) and clients of the detox centre you are asked to volunteer your participation in the development and assessment of a Relapse Prevention Pamphlet to be used by the detox centre and RPG to share information and open the door to conversation about relapse prevention. Your participation in this project is completely voluntary and no services or access to the detox centre will be barred if you choose not to participate. Information collected is entirely confidential and will be used only for the purposes of understanding what is important to participants of RPG in regards to basic information on relapse prevention. It will not be shared with any outside parties and once data has been analyzed will be shredded. Participants may opt out at any time. Your assent to participate in this project will be assumed if you fill out the Likert scale (the evaluation sheet). The benefits of participating in this project are that a valuable tool will be developed for RPG and that your knowledge of relapse prevention may be expanded. A con of participation is that thinking about relapse could possibly trigger one. If you have any questions or concerns it is important that you raise them. These will be addressed by the facilitator. If you wish to pull the facilitator aside privately to talk about concerns this is also encouraged.
APPENDIX E: ACHESS Outline

Setup, Check-in, Triage & Feedback, and Panic Button inform which ACHESS services an individual is offered, and when the user is given the option to receive them. The ACHESS interface is designed to query the patient with respect to their intrinsic goals and provide options in a manner consistent with the principles of motivational interviewing which should enhance autonomous motivations.
## APPENDIX F: Pre-Development Likert Scale Raw Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Consumer Category</th>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
<th>Question 4</th>
<th>Question 5</th>
<th>Question 6</th>
<th>Question 7</th>
<th>Question 8</th>
<th>Question 9</th>
<th>Question 10</th>
<th>Question 11</th>
<th>Question 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Alcohol</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Alcohol</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>10</td>
<td>Alcohol and Drug</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix G: Median and Mode

<table>
<thead>
<tr>
<th>Question</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 3</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Question 4</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Question 8</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 9</td>
<td>4.5</td>
<td>5</td>
</tr>
<tr>
<td>Question 10</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 11</td>
<td>4.5</td>
<td>5</td>
</tr>
<tr>
<td>Question 12</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix H: Frequency of Responses in Pre-Test Likert Scale

Frequency of Responses in Pre-Test Likert Scale

- Disagree
- Somewhat Disagree
- Neither Agree nor Disagree
- Somewhat Agree
- Agree
Appendix I: Pamphlet Side One

*Some images and design have been excluded as permission was not granted to publish the materials.
Appendix J: Pamphlet Side Two

Identifying barriers to recovery and alternative actions...

What behaviours do you engage in that are unhelpful? (Ex. Excessive drinking, risky/dangerous behaviour, etc.)

Is there an appropriate, healthy alternative to these behaviours? (Ex. Call a sponsor, visit family, go on a hike)

What thoughts do you engage in that are unhelpful? (Ex. "Life is boring and will never get better")

What thoughts can you replace the negative thoughts with that are constructive and appropriate? (Ex. "I am a good person and I have friends who love and support me")

What is a relapse?
A relapse occurs when an individual returns to drinking behaviours after a period of willing abstinence.

What is relapse prevention?
Relapse prevention is a cognitive-behavioural approach that focuses on identifying goals, strategies, high-risk, trigger situations. Relapse prevention techniques can be used for life no matter how much time soberly the individual has had.

IMPORTANT! Don’t be discouraged if you do relapse. Evaluate why it happened and recommit to recovery.

Preventative strategies to use when dealing with situations/feelings that may trigger you to drink:

1. Talking about how you feel with someone you trust
2. Progressive muscle relaxation and deep breathing techniques
3. Exercise
4. Having your day planned out in advance
5. Positive self-talk
6. Avoiding situations or people which may trigger drinking
7. Rewarding yourself with appropriate gifts for good behaviour
8. Attending group or individual counselling

List five triggers that may cause you to drink:

1) ...
2) ...
3) ...
4) ...
5) ...

List five alternative behaviours to drinking:

1) ...
2) ...
3) ...
4) ...
5) ...
Appendix K: On site supervisor feedback

What do you like about the pamphlet?

- Colour
- Graphics
- Questions as an introduction
- Brief description and explanation of what relapse and what prevention is

What are your suggested changes?

- Couple of typos and wrong phone numbers
- Because it is printed in colour we probably cannot maintain the quality of the pamphlet due to cost, I will check however to see if there is a way to duplicate the excellent attraction quality of the pamphlet

Many thanks to Heather for your work and contribution to the centre
Appendix L: Volunteer Chair of Relapse Prevention Group Feedback

What do you like about the pamphlet?

- Everything!
- The addresses and phone numbers
- The preventative strategies
- The examples
- The layout
- The colours

What are your suggested changes?

- None, great job!
### Appendix M: Post-Development Likert Scale Raw Data

<table>
<thead>
<tr>
<th>Participant</th>
<th>Question 1</th>
<th>Question 2</th>
<th>Question 3</th>
<th>Question 4</th>
<th>Question 5</th>
<th>Question 6</th>
<th>Question 7</th>
<th>Question 8</th>
<th>Question 9</th>
<th>Question 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix N: Post-Development Likert Scale Median and Mode

<table>
<thead>
<tr>
<th>Question</th>
<th>Median</th>
<th>Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 2</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Question 3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Question 4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Question 5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Question 6</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Question 7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Question 8</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Question 9</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Question 10</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix O: Post-Development Likert Scale Frequency of Responses Bar Graph

Frequency of Responses in Post-Test Likert Scale

- Disagree
- Somewhat Disagree
- Neither Agree nor Disagree
- Somewhat Agree
- Agree