Perceptions of Persons with Alcohol Dependence, Family, and Healthcare Providers towards Causes of Post-Treatment Relapse

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Abstract: This paper reports the qualitative first phase of a participatory action research study to develop a model for preventing alcohol-dependent relapse in a tertiary hospital. The aim of this phase of the study was to explore the perceptions of persons with alcohol dependence, family, and healthcare providers towards causes of post-treatment relapse among those with alcohol dependence. Focus group discussions were conducted with 9 healthcare providers and 8 persons with alcohol dependence who had been readmitted to hospital. Semi-structured interviews were conducted with 16 healthcare providers, 6 persons with alcohol dependence, and 14 members of their families. The data were analyzed using content analysis.

Causes of relapse were categorized as follows; 1) brain dysfunction, 2) dealing with psychological distress, 3) lack of readiness to receive treatment, 4) lack of family support for alcohol cessation, 5) living in drinking environment, 6) inadequate discharge planning assessment, and 7) constraints of resources for preventing alcohol relapse. The findings are useful for healthcare providers to understand regarding the causes of relapse in persons with alcohol dependence, and to help them develop interventions and strategies to minimize alcohol relapse among persons with alcohol dependence.

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Introduction

Nowadays alcohol dependence is viewed as a chronic disease which needs long-term care like other chronic diseases such as diabetes and depression[1]. Previous studies in Western countries revealed that 12-month and lifetime prevalence of alcohol dependence were 3.4% and 13.9%, respectively[2]. In Thailand, a report by National Epidemiological Survey revealed that the prevalence of 12-months' alcohol dependence among the Thai population aged 15-59 years old was 6.65 % in 2008[3].

A critical problem in caring for persons with alcohol dependence (PAD) is relapse after receiving

treatment in both national and international healthcare services. Published studies reported that the relapse rate in PAD within three-months and 12-months following discharge were 32.7-53.3%[4-5] and 47.7-61.8%, respectively[6-7]. In Thailand, the relapse rates for alcohol dependence within 1, 6 and 12 months following discharge from a psychiatric hospital were 16.56%, 32.50, and 50.94, respectively[8]. These rates indicate that the situation of relapse among PAD in Thailand is similar to Western countries.

Relapse in PAD is defined as the return to drinking after completing treatment from a hospital, followed by re-hospitalization within one day or more. [9-10] Relapse in PAD has an impact on the health of the patients themselves, their family, and the socioeconomic and health care systems. At the level of the individual, chronic heavy alcohol consumption leads to disease and even death. Physical comorbidity in PAD includes alcoholic liver and pancreatic diseases, hypertension, diseases of the upper gastrointestinal tract, renal diseases, cellulitis, iron deficiency anemia, fractured neck of femur and peripheral vascular disease[11]. The psychological comorbidities that are most common among PAD are anxiety disorders and depression[12]. The impact of relapse in alcohol dependence on families includes intimate partner violence, domestic violence[13], a high level of interpersonal conflict, parental inadequacy, child abuse and negligence, financial and legal difficulties[14-15]. The impact of relapse in alcohol dependence in the socioeconomic sphere has focused primarily on financial issues, but the consequences of alcohol dependence have marked impacts on the economies of the countries affected. A 2018 study reported total excess costs of €11839 for PAD within six months of discharge from hospital compared with patients without alcohol dependence[16]. In Thailand, a 2016 report revealed that the first ranked of disability adjusted life years lost among Thai males was alcohol dependence[17], and the economic costs of their alcohol consumption was 156,105.4 million baht (US $9,627 million)[15]. The impact of relapse in alcohol dependence on health care system is substantial.

Previous studies have identified causes of post-treatment relapse mainly from the report of PAD using quantitative studies[7,8,9]. Few studies have explored causes of post-treatment relapse from the perspective of PAD[10, 18, 19]. In order to develop a model for preventing alcohol dependent relapse, causes of post-treatment relapse among PAD need to be considered for better understanding of how and why they return to drinking. This paper reports the findings of a qualitative approach employed as part of the needs assessment phase of a participatory action research (PAR) project. Data were collected to explore the perceptions of PAD, their families, and healthcare providers regarding the causes of post- treatment relapse among PAD. The question that this phase of the study pursued was *What are the causes of post-treatment relapse as perceived by PAD, family, and healthcare providers?*

Review of literature

At the present time, the health professionals are facing increasing PAD who need care and treatment in hospital. Importantly, most PAD have post-treatment relapse. The phenomenon of relapse among PAD is multiple cycles, including treatment, abstinence, and relapse[1]. The definition of relapse among PAD in the alcohol treatment field has still semantic ambiguity, with variations noted in the literature. References to relapse in alcohol dependence can be defined in 3 categories, including returning to any drinking alcohol following a period of abstinence[21,22], number of days from treatment start until the first drink and quantity and frequency of alcohol consumption[22], and resumption of alcohol drinking until re-hospitalization[9,10]. Most studies examined the factors related to relapse in PAD based on relapse theories such as social learning or cognitive behavior framework, social factors, neurobiological, and the disease concept[23].

Previous studies have shown that the factors related to relapse in PAD consisted of individual, family, social and healthcare factors. Individual factors include biological, psychological, and spiritual factors. Biological factors encompass age[20,23], gender[23], brain function[23], sleep disturbance[22], and physical health[23], while psychological factors include anxiety[5], depression[25], and suicide[20]. Spiritual factors include life purpose and spirituality[23]. Family factors include marital conflict and being part of a drinking couple[6], while social factors include stressful life events[20,25] such as financial problems, lower changing social environment after receiving treatment[7,20,26], social problems[27], and a culture of heavy drinking[28]. Finally, healthcare factors include infrequent attendance at outpatient treatment programs[7,26] and irregular at outpatient clinic[26]. Most studies used a quantitative approach to identify causes, and primarily collected data from PAD themselves. A few qualitative studies found that psychological distress and perceived benefits of drinking were causes of post-treatment relapse[29].

Study aim

To understand the perceptions of PAD, their families, and healthcare providers towards the causes of post-treatment relapse among PAD.

Methods

Study design

This paper reports the findings of a qualitative approach employed as part of a larger PAR project.

Study setting and participants

A psychiatric hospital in northern Thailand was selected based on the hospital director's approval for participation in the study, the presence of alcohol relapse in the region, and the hospital's capabilities in preventing alcohol-dependent relapse. This site is a 415 bed tertiary hospital. There were five alcohol inpatient units, including three male units and two female units. Four alcohol inpatient units had 25 to 27 beds and one alcohol inpatient unit had 10 beds.

Twenty-five multidisciplinary health care providers, including 5 administrators, 2 psychiatrists, 11 nurses, 2 psychologists, 2 social workers, 2 occupational therapists, and 1 pharmacist, were recruited for focus group discussions (FGDs) and semi-structured interviews, through purposive sampling. Selection criteria were: providers who had experience in preventing relapse for PAD at alcohol units for at least one year, or setting up policy on the prevention of relapse in PAD.

Fourteen PAD were recruited for FGDs and semi-structured interviews through purposive sampling. Selection criteria were: 1) having current rehabilitation; 2) aged 18 years or older; and 3) having had experience of relapse at least once.

Fourteen family members were recruited for semi-structured interviews through purposive sampling. Selection criteria were: 1) aged 18 years or older; and 2) living with PADs during the recruitment period; 3) taking responsibility in caring for PADs for at least one year. All of them volunteered to participate in this study.

The number recruited for each group was based on data saturation

Ethical considerations

This study was approved by the Research Ethics Committee (REC), Faculty of Nursing, Chiang Mai, Thailand (Study code: Full 117-2560), and by the participating hospital. All participants gave both verbal and written informed consent to join in the proposed study. They were told that they could refuse to participate or withdraw at any time without jeopardizing their health care. Before collecting data, participants were asked permission for audio-recording of the sessions. The information related to the participants was kept confidential by using codes instead of real names for tape transcriptions. The documents and tape recordings were kept under lock and key.

Data collection

PAR emphasizes collaboration and participation among people directly affected by a situation in focus in all processes of study. Eight healthcare providers volunteered to be co-researchers, including 7 nurses and 1 psychologist. They were trained by a qualitative research expert about the skills of qualitative data collection such as in-depth interview and focus group discussion. Data were collected by co-researchers from November 2017 to March 2018.

Semi-structured interviews and FGDs were employed to gain both in-depth individual perspectives as well as and collective views on the topic. Selection of participants into FGDs followed the principle of homogeneity of FGDs. Participants in each group had a similar background such as healthcare providers' experience in providing relapse prevention interventions for PAD or number of readmissions among PAD.

Participants were voluntarily recruited by the principal investigator (PI) and the co-researchers at inpatient alcohol wards and outpatient departments. Each FGD were conducted in the meeting room in inpatient alcohol wards and included 4-5 participants, and lasted for approximately 60-90 minutes. Semi-structured interviews were conducted in the meeting room in inpatient alcohol wards and outpatient department. Each interview lasted for approximately 60-90 minutes. Interview guides were used for the FGDs and semi-structured interviews to explore the perceptions of causes of post-treatment relapse among PAD. The main questions were "What are causes of post-treatment relapse among PADs?" and "Why?".

The PI held weekly meetings with co-researchers to reflect on and verify their interviews and FGDs and to discuss as a group how to improve and standardize the data collection process.

The PI also took a role as a facilitator in all processes of data collection by assisting the core working group to define their problems clearly and monitoring and supporting the activities of data collection.

Data analysis

Qualitative data were analyzed following Stringer's method[30]. First, transcripts from FGDs and semi-structured interview were read repeatedly in order to become familiar with the data. Categorizing and coding were undertaken to identify the perceptions of the people involved in the study. The categories and excerpts were identified by the PI and subsequently verified by her advisor. Finally, categories, sub-categories, and key findings were discussed and verified by the research team until consensus was reached.

Rigor and Trustworthiness

To ensure the rigor of the study, the strategies applied followed the principles of trustworthiness recommended by Lincoln and Guba[31]. Credibility was confirmed by "verifying collected data with participants, employing multiple methods of data collection to compare a variety of data sources in order to confirm the accuracy of the finding" [31], including semi-structured interviews and FGDs. The data were obtained from different participants, PAD, family members, and healthcare providers. Dependability was ensured by using an audit trail to clearly explain the data collection process and completely record raw data. Confirmability of analysis was enabled by using the multiple methods of data collection and obtaining the data from different sources, while transferability was achieved through thick description.

Findings

Seven categories emerged from the FDGs and interviews reflecting the participants' perspectives and are described in **Table 1.**

Table 1 Categories and sub-categories arising from the data

Category	Sub-category
1. Brain dysfunction	Brain addiction
	Cognitive impairment
2. Dealing with psychological distress	Encounter with family problem
	Inadequate of economic expense
	Feeling loneliness
3. Lack of readiness to receive treatment	Unaware of drinking consequences
	Not ready to stop drinking
	Reducing fatigue from labor work
4. Lack of family support for alcohol cessation	Misunderstanding about alcohol addiction
	Inadequate knowledge to care at home
	Family drinking at home
5. Living in drinking environment	Peer influence
	Easy access to alcohol in the community
	Drinking is norm in community
6. Inadequate discharge planning assessment	Lack of planning for family involvement
	Lack of investigation the relapse risk
	Insufficient community support
	Disconnection of care within the hospital
	Disconnection of care with the community
7. Constraint of resources for preventing alcohol relapse	Restriction of workforce
	Inadequate equipment for patients' monitoring

Category 1: Brain dysfunction

Brain dysfunction referred to impairment of function of the brain caused by the chronic alcohol consumption among PAD. Brain dysfunction included brain addiction and cognitive impairment. Healthcare providers and PAD perceived that some part of brain was changed by alcohol addiction that led PAD to have a strong desire to drink alcohol all the time. Their mind was obsessed by alcohol and always seeking to drink it.

> *Their minds desire it* (alcohol). *Their brains tell that it's time to drink...thinking about it* (alcohol), *desiring it*(alcohol). (PAD, No.9)

> *For the factors related to the brain, we call it brain addiction...the patients consume alcohol to the extent that can be called addiction. Their brains change, causing alcohol addiction... When returning home, they have craving and tend to relapse.* (Healthcare provider, No. 15)

Moreover, healthcare providers mentioned that cognition function, especially executive function of PAD was damaged by repeatedly returning to drinking of alcohol. Cognitive impairment affected on learning and memory of PAD. They could not get the information provided by healthcare providers during hospital stay. Therefore, they did not know how to stop drinking when they came back home.

> *With cognitive dysfunction, although we provide them with information or implement interventions, no matter how much we give them, they do not think about cessation. They still think that alcohol makes them happy, and see alcohol as beneficial.* (Healthcare provider, No.19)

Category 2: Dealing with psychological distress

Psychological distress meant that the suffering of mental and emotion when faced with and managing stressful situations in daily life, including encounters

with family problems, inadequate of economic expense, and feeling lonely. Most PAD participants stated that stress mostly came from the family, for example, they fought with their wives. They said that no one in the family understood them. They felt hurt. Encountering family problems led them to return to drinking.

> *Stress, family problems... lack of understanding... fighting... hurt feelings...I use alcohol to help me make decisions... Most of the time, I drink because of a fight.* (PAD, No.11)

PAD usually felt lonely because they had broken up with their wives. Some did not have any close friends.

> *Lonely ... My close friends have moved to work in other provinces. To be honest, I don't have any close friends in my life now... Also, I work from home and do not meet anyone, so that's why I feel lonely.* (PADs, No.5)

> *I feel lonely because I have broken up with my wife for five years now. Some Saturdays and Sundays, I pick up my child to stay with me at home. Sometimes I don't want my child to leave. I want my child to be with me. I feel lonely so I drink.* (PAD, No.4)

The family members mentioned that PADs had stress about the financial problem in the family. They could not balance the family expensing and income. Therefore, their family had a lot of debt. It made them stressful and drink alcohol.

> *If he is stressed from the situations with his mistress, he will drink and become like this... His mistress has a lot of debt, so he is stressed.* (Family member No.1)

Category 3: Lack of readiness to receive treatment

This category refers to PAD not having the willingness to obtain alcohol treatment in the hospital as they were unaware of drinking consequences, not ready to stop drinking, and using alcohol to reduce fatigue from their labor work. Most PAD did not realize their drinking behavior as problems and consequences. Therefore, they did not collaborate with the alcohol treatment, including with medication taking, and not attend psychosocial treatments. This led to very early relapse.

> *The patients have no motivation for treatment in the first place. They don't perceive their problems. What we give them, all the treatments, may not work at all because the patients won't take it. They don't realize the consequences. They may not cooperate with the treatment, medication, or therapy. It is useless and the outcome will not be good.* (Healthcare provider, No. 15)

PADs perceived that their parents forced them to be admitted. They thought that they had a good consciousness and did not want to receive treatment in the hospital.

> *That day, I came for my medicine, so I was admitted. Actually I didn't mean to be admitted... I have come here 11 times. I never want to come... If my parents didn't tell me to come, I would never have come. Actually I am in good consciousness. I am not insane. I don't know how to tell you. I didn't plan on coming. For the second time, they forced me to come.* (PAD, No.4)

Some PADs viewed the benefit of drinking that helped them to feel 'breezy' after they had tired from hard work.

> *It's tiring to climb up the longan trees. I am tired so I keep on drinking...like that...It gives me strength. When I feel uncomfortable, I drink and it makes me feel alive.* (PAD, No.6)

Category 4: Lack of family support for alcohol cessation

This meant that PADs did not have assistance from their family to stop drinking due to members misunderstanding about alcohol addiction, inadequate

knowledge to care at home, and family drinking at home. Family members thought that alcohol dependence was not a disease: the PAD could control drinking behavior and stop drinking by themselves or live without drinking.

> *The understanding of relatives... "He is the one who seeks it." Like that. They understand. "He can live without drinking." Like that. They don't understand that it is a disorder.* (Healthcare provider, No.25)

Moreover, healthcare providers and family members perceived that the family did not have the skills to help and support PAD in avoiding drinking such as encouraging them to work, regulating their spending, and finding a job for them. Some family members said that they complained or blamed when patients lapsed to drink following completion treatment.

> *Sometimes I feel upset and am busy working. When I feel upset, I would not talk to him nicely and blame him. I complain about his drinking. I tell him to drink and die. I say what I think. I also feel sorry for what I have said. Sometimes I think if I talk to him nicely, he would get better.* (Family member, No.3)

> *The families of most of the alcohol dependent patients do not understand how to support the patients. Sometimes, the patients can unconsciously drink after they finish the treatment. The relatives would blame the patients. The relatives would repeatedly complain or something like that…so the patients have a relapse.* (Healthcare provider, No.24)

The environment at home also influenced PAD to return to drinking. Some family members drank alcohol at home and invited them to drink with them. A female alcoholic said that she lived in the drinking atmosphere at home. She has saw her parents drinking alcohol since she was in kindergarten.

> My parents drink alcohol...My father drinks, sometimes all day. He pays 20 baht a drink... Since I was in kindergarten, I see my parents drink all the time. (PAD, No. 12)

> *According to the patients, the important factor causing relapse and repeated treatment is the environment at home. They have to drink with their family at home. Their family drinks too.* (Healthcare provider, No. 18)

Category 5: Living in drinking environment

In this category, the alcohol drinking atmosphere in the community had induced the PAD to return to drinking. Peer influence, easy access to alcohol in the community, and drinking norms in the community related to their relapse. PAD participants stated that they had drinking friends. When they met with their friends, they would start the first drink and the result was uncontrolled drinking.

> *I have quit for a long time. When I meet my friends, I may not start drinking right away. But I start drinking after hanging out for a while. After a while, I got carried away... Like* (The name of the 4th participant) *said, I drank Coke and then my friend asked why I wouldn't drink. So, I took a small drink, and that's when I drink again.* (PAD, Nos, 2, 4)

Moreover, accessibility to alcohol in the northern Thailand was easy. People in the community can make local alcohol to drink at home and to sell to the villagers. PAD could find a lot of alcohol stores in the villages and buy to drink anytime.

> *My house is in the northern region. The environment induces drinking... Alcohol can be easily accessed. Alcohol is legal. Although there is a time limit for selling alcohol, it can be accessed easily. Home-made alcohol. It's*

free. There is no limit of selling time. It's sold like a snack. They sell it all the time...When the access is so easy, the patients can get to it easily. (Healthcare provider, No.19)

It can be bought easily. In the morning, you can visit stores and see a lot of it. Five or ten baht. They sell it. It's not so far away. I can get there on a bicycle. I can always find it. People know where it is sold. The store opens early in the morning. The customers would wait to buy it. It will be crowded at around 5 or 6:30. The customers would be there, waiting. We see alcohol everywhere we go. (PAD, Nos.1, 2)

Drinking norm in community was perceived as the one cause of relapse in PADs as well. Healthcare providers and PAD participants stated that alcohol was involved in the Northern Thai festivals and many special occasions such as Songkran Festival, house-warming parties, longan season, and funerals. People thought that if all festivals or special occasions did not have alcohol to drink, they would not have fun. Most PAD drank during these periods and could not control drinking.

It's their tradition, cultures, festivals or something like that. Without drinking, they would not have fun. So, alcohol is involved. When they drink, they have no limits. It's hard to stop, so the patients come back to us. (Healthcare provider, No. 12)

Festivals or something like that, special occasions, house-warming parties, funerals... Most of these occasions take many days. Our patients usually drink during those days. After 3, 5, or 7 days of drinking, they think they will quit but they start to have withdrawal symptoms, making them unable to quit and have relapse. (Healthcare provider, No.21)

Category 6: Inadequate discharge planning assessment

Most healthcare provider participants mentioned that the planning process of alcohol relapse prevention for PADs during admission in the hospital was insufficient, including lack of planning for family involvement, lack of the relapse risk investigation, insufficient community support, disconnection of care within the hospital, and with the community. The participants said that the alcohol relapse prevention systems did not encourage the family into the treatment plan. They did not provide health education regarding alcohol relapse prevention for family members of PAD systematically.

We still lack an explicit system to encourage the relatives' involvement in the care for the patients to prevent alcohol relapse. There is no obvious care system. (Healthcare provider, No.16)

We still don't have the system that requires the caregivers to receive information or education when the patients have finished their rehabilitative treatment and are ready to return home. (Healthcare provider, No.5)

The family members neglected to take care of PAD both at home and in the hospital. They did not visit PAD during their hospital stay and pushed them to be in care of the hospital. On discharge day, they left the PAD to go back home by themselves.

Many times, the relatives don't care, and let the patients go home on their own. They don't come to provide care; they don't care at all. Some relatives push the patients to be the responsibility of the hospital. After coming home, the patients have a relapse...Now, there is still no concrete system that involves the relatives in the care. (Healthcare provider, No.15)

Most of the health providers stated that they did not assess deeply about the relapse risks of alcoholic patients.

We don't investigate deeply... The patients have been discharged. We don't reassess to see whether they have any family problems. Actually, someone who wants to quit...but when they are there, they may have some problems that we don't know about. We never look into it. Finally, the patients have relapse. That's what we're lacking... We don't investigate deeply into each patient. We don't see the actual problems faced by the patients so clearly. (Healthcare provider, No.9)

For the true cause of relapse in patients with mental problems as a result of alcohol, I think it is the fact that we don't investigate the problems faced by each case…we don't examine whether there are other factors that may promote or lead to relapse among patients. (Healthcare provider, No.14)

Moreover, this study found that community interventions for supporting patients in ceasing alcohol were still lacking, even though there were interventions which had been launched in some areas, but those interventions have not been included into alcohol treatment plan. At that time, patients were prepared and developed the relapse preventing skills before discharge from the hospital but they had not found treatments in the community to help them maintain abstinence. Therefore, they could be turned to repeat drinking.

We still lack supportive factors because we still don't have community treatment or any rehabilitation program for community follow-up. There are some pilots in some areas, but we don't really make any serious assessment. There are preliminary assessments such as the project at Monk Dang's temple or something like that... but most of it has not been included in the system. (Healthcare provider, No.10)

After returning home, they used to be able to work with us, but when returning home…there is no supportive system in care in the community... We let the patients return to work in the community... Then, as a result, the patients are readmitted within days. (Healthcare provider, No.22)

Most of the healthcare providers mentioned that providing care for PAD within the hospital was fragmented. Each ward did not connect and share the data related to preventing alcohol relapse of PAD with others. They said that they failed to monitor them after discharge from hospital.

There are OPD data but these data are not interconnected. The staff don't know about it... the systems are not linked to each other...I don't know about anything. It's all fragmented. When the patients are discharged from the OPD, there is no coordination about what still has to be done. We have implemented interventions and what needs to be done after that? The patients have to go home. We make follow-up but there is no coordination. The data about rehabilitation is missing, not found in the file. Or, if it is in the file, someone else added more information to it. I don't know where I can put more information, so I just write it on another piece of paper. Is this the way it should be? (Healthcare provider, No. 6,7,8)

In addition, the transfer system between hospital and community for preventing alcohol relapse among alcohol-dependent patients was disconnected. They could not monitor drinking behavior and follow-up the PAD.

In general, (the patients) *are referred back to their locality, but the systems are not interconnected; there are unclear and insecure referral system. Also, we cannot follow-up with the patients. Next time we know is when the patients have relapsed to alcohol and come back to us.* (Healthcare provider, No. 10)

Category 7: Constraint of resources for preventing alcohol relapse

Most healthcare providers mentioned that preventing alcohol relapse among PADs was not comprehensive due to the restriction of workforce and inadequate equipment for patients' monitoring. They stated that there were many patients in the ward that needed intensive care, while there were too few staff on duty. They prioritized care for critical patients without time to provide psychosocial treatment in ceasing alcohol for PADs.

> *There is insufficient workforce. Sometimes, we lose the ability to do our work fully... With the current workforce, it is not enough to deal with the current number of patients who require treatments from us. There are many patients but fewer staff...so it is hard for us to do it.* (Healthcare provider, No.26)

> *We have limitations due to staff shortage too. When there is insufficient staff, what can we do? For example, in* (name of a ward)*, it is obvious that we have to set aside non-office hours administer treatments and to deal with the patients. During office hours, we mostly deal with critical cases and withdrawal case only... In Jira there are not only patients with alcohol dependence but there are also those patients who just pop up. So, we have to set priority to determine which case is more severe, causing us less time to devote to each case.* (Healthcare provider, No.1,3)

Moreover, healthcare providers stated that the hospital support for monitoring patients after discharge was insufficient. There was only one mobile phone for the 17 wards. They had to queue up to use the phone. Thus, they could monitor only a few cases per day. A lot of patients were not monitored or followed-up upon discharge from the hospital.

> *There are no phones in the wards... Phones have to be borrowed throughout the hospital…Once borrowed, the phone has to be returned by 4 pm... I just borrowed one and now I have to return it. I only called five cases with this phone. They don't provide each ward with a phone. There is one phone for the 17 wards.....After making a phone call, we have to make a note which takes minutes... Speaking of system support, the hospital provides us with little support with the follow-ups... I think the problem lies within the devices for follow-up.* (Healthcare providers, No.6,8)

Discussion

The findings of this study highlights holistic aspects related to relapse among PADs as reported by PADs, family members, and healthcare providers. Existing research mostly presents causes of alcohol at the individual level. This study builds upon previous studies which found that brain dysfunction[23,26], dealing with psychological distress[27,32], and lack of readiness to receive treatment[23] were related to alcohol relapse.

Lack of family support for alcohol cessation is consistent with two studies[33, 34] which indicated that lack of family support was associated with an increase in relapse among PAD. In addition, this study supports previous studies that documented the community drinking culture found in Thai-Isaan context, where drinking occurs in everyday life, social events and traditional rites[35]. Thai men with alcohol addiction perceived that drinking was a necessary part of the work culture and a way to engage with colleagues and to celebrate special occasions[29]. A systematic review in 2014 found that living in a heavy drinking culture was a strong risk factor for relapse[28].

This study identified perceived causes of alcohol relapse among Thai PAD. One cause of post-treatment relapse was identified as inadequate discharge planning

assessment. Healthcare participants mentioned that most PADs had not been assessed for their risk of relapse. Therefore, healthcare providers could not clearly see the actual problems faced by the patients and provide appropriate treatment for the patients both during hospital stay and post-discharge when living in the community. This finding extends previous studies in Thailand which have shown that discharge planning for PAD did not thoroughly assess their relapse risk[36].

Most healthcare participants said that their efforts to prevent alcohol relapse among PADs did not involve family members in treatment because there was no intervention for such families. Family members had not been informed about caring for PADs to help prevent their relapse, nor were they informed about the disease and how to support the patients in maintaining their abstinence. Therefore, some families pushed the patients to be the responsibility of the hospital and could not help PADs avoid drinking. This finding is congruent with previous studies which indicated that the patients were neglected by their family during hospitalization,[29] and that family support was important to improve the recovery process among PADs[37].

In addition, the present study found that treatment in preventing alcohol relapse was fragmented, due to discontinuity of care within the hospital and between the hospital and community. Meanwhile, community support for alcohol cessation was insufficient as well. Continuity of care for PAD is necessary and important to maintain patients in treatment just as it is for other chronic diseases[1]. The one main element of continuity of care is coordination with multidisciplinary and service across settings. Therefore, the lack of coordination care for PADs could result in lower abstinence and retention rates. This finding extends previous a qualitative study in Thailand which revealed that there was not a connection of care between the hospital and community to take care of the patients after discharge from hospital[38]. It is also consistent with a qualitative study in the United States which found that lack of interagency cooperation was a barrier to providing effective substance abuse treatment services[39].

Moreover, inadequate workforce and equipment were crucial obstacles because they prevented monitoring of patients. Healthcare providers could not provide comprehensive relapse prevention interventions, monitor, and follow-up the PAD. This finding extends a previous qualitative study in Thailand which found that the barrier to successful treatment of alcohol addiction was understaffing in alcohol addiction treatment[40]. A similar finding was also reported from a qualitative study which found that urban counselors perceived heavy caseloads and understaffing be the primary barriers to providing effective substance use treatment[39].

Limitations

This study has several limitations. The qualitative approach was conducted by co-researchers whose insider view might create their own bias during data collection and analysis. Furthermore, this study was conducted with the PADs, family, and healthcare providers living in northern Thailand, and therefore was unable to fully capture the cultural diversity across Thailand or to represent a larger population of PADs, family, and healthcare providers.

Conclusions and Implications for Nursing Practice

This study provided fruitful information regarding the perception of the causes of post-treatment relapse in PADs, especially the healthcare service aspect which included inadequate discharge planning and assessment, and constraint of resources for preventing alcohol relapse. The data are sufficiently compelling to use them as pilot work for studies of the effectiveness of the factors identified in preventing relapse in PAD. This research needs to be done before the factors identified are accepted for general application.

The findings could help registered nurses and nurse administrators to develop discharge plans for PAD and to develop effective care interventions for preventing alcohol relapse among PAD. Moreover, findings can inform nurse administrators or hospital administrators to direct hospital policy to support availability of healthcare resources needed to prevent relapse among PAD.

Interventions need to focus on continuity of care for relapse prevention that should be relevant to holistic aspects of post-treatment relapse and interdisciplinary collaborations in hospital setting.

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การรับรู้ของผู้เป็นโรคติดสุรา ครอบครัว และบุคลากรสุขภาพต่อสาเหตุของการกลับเป็นซ้ำของการติดสุรา

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บทคัดย่อ: การศึกษานี้เป็นส่วนหนึ่งของการวิจัยเชิงปฏิบัติการแบบมีส่วนร่วมที่มีวัตถุประสงค์เพื่อพัฒนารูปแบบการป้องกันการกลับเป็นซ้ำของการติดสุราในโรงพยาบาลตติยภูมิ การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาการรับรู้ของผู้เป็นโรคติดสุรา ครอบครัว และบุคลากรสุขภาพต่อสาเหตุของการกลับเป็นซ้ำของการติดสุรา ดำเนินการเก็บรวบรวมข้อมูลโดยใช้วิธีการสนทนากลุ่มในบุคลากรสุขภาพจำนวน 9 ราย และผู้เป็นโรคติดสุราที่กลับมารักษาซ้ำในโรงพยาบาลจำนวน 8 ราย และใช้วิธีการสัมภาษณ์แบบกึ่งโครงสร้างในบุคลากรสุขภาพจำนวน 16 ราย ผู้เป็นโรคติดสุราที่กลับมารักษาซ้ำในโรงพยาบาลจำนวน 6 ราย และสมาชิกครอบครัวของผู้เป็นโรคติดสุราที่กลับมารักษาซ้ำในโรงพยาบาลจำนวน 14 ราย การวิเคราะห์ข้อมูลใช้วิธีการวิเคราะห์เชิงเนื้อหา

ผลการศึกษาเกี่ยวกับสาเหตุของการกลับเป็นซ้ำของการติดสุราตามการรับรู้ของผู้เป็นโรคติดสุรา ครอบครัว และบุคลากรสุขภาพมีดังนี้ 1) ความผิดปกติของสมอง 2) การจัดการกับความทุกข์ด้านจิตใจ 3) ขาดความพร้อมในการเข้ารับการบำบัดรักษา 4) ขาดการสนับสนุนจากครอบครัวในการเลิกสุรา 5) อาศัยอยู่ในสิ่งแวดล้อมที่มีการดื่มสุรา 6) การประเมินเพื่อวางแผนการจำหน่ายไม่เพียงพอ 7) ข้อจำกัดด้านทรัพยากรในการป้องกันการกลับเป็นซ้ำของการติดสุรา ผลการศึกษาครั้งนี้จะเป็นประโยชน์ต่อบุคลากรสุขภาพในการทำความเข้าใจเกี่ยวกับสาเหตุของการกลับเป็นซ้ำของการติดสุราในผู้เป็นโรคติดสุรา และพัฒนาโปรแกรมและกลยุทธ์ในการลดการกลับเป็นซ้ำของการติดสุราในผู้เป็นโรคติดสุรา

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