Effectiveness of a Transitional Care Program for Reducing Alcohol Consumption and Readmissions Led by an Advanced Practice Nurse: A Quasi-Experimental Study

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Abstract: Alcohol use disorder significantly increases morbidity and hospital utilization in Thailand. Coordinated, patient-centered transitional care bridges hospital and home settings to reduce post-discharge readmissions. This quasi-experimental study aimed to evaluate the effectiveness of a transitional care program in reducing alcohol consumption and hospital readmissions in people with alcohol use disorder, led by a nurse practitioner. Eighty-six people with alcohol use disorder were purposively recruited and randomly allocated to either the intervention (n = 43) or the comparison group (n = 43). The comparison group received only usual care, while the intervention group received the transitional care program in addition to usual care, which included hospital-based education, behavioral skills training, and post-discharge nurse consultations. Data were collected using a Demographic Data Sheet, the Time Line Follow Back, and a Hospital Readmission Record Form. A mixed-design analysis of variance was used to compare outcomes for alcohol consumption (heavy drinking days and abstinent days) and hospital readmissions, both within and between groups at baseline, 28 days, and 90 days post-discharge.

At 28- and 90-day post-discharge, the intervention group showed a significant decrease in heavy drinking days and an increase in abstinent days compared with the comparison group. Additionally, hospital readmissions at both time points were significantly reduced in the intervention group. These findings support the effectiveness of the advanced practice nurse-led program in reducing alcohol consumption and hospital readmissions among individuals with alcohol use disorder. Therefore, nurses, particularly those with advanced practice competencies, should consider integrating this program into routine hospital care to reduce alcohol consumption among this population. However, rigorous testing in other settings with larger sample sizes is recommended.

Keywords: Advanced practice nurse, Alcohol consumption, Alcohol use disorder, Readmission, Transitional care program

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Introduction

Alcohol dependence (AD) is a critical public health challenge characterized by high morbidity and frequent hospital readmissions.[1] In Thailand, documented cases reached 190,505 in 2022, followed by 136,215 in 2023 and 141,256 in 2024.[2] These figures underscore a persistent strain on healthcare resources, highlighting the urgent need for effective post-discharge management.[3] As

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a profound psychiatric disorder, AD often manifests through symptoms such as hallucinations, illusions, aggression, and disorientation. These behaviors place an immense burden on patients, their families, social networks, and the broader healthcare system. Notably, cognitive impairment affects up to 82% of individuals with AD.[4] This impairment frequently results in poor treatment adherence—including missed appointments and medication non-compliance—which directly contributes to elevated rates of relapse and readmission. Furthermore, AD is a primary driver of domestic instability and violence, particularly against women and children. Beyond the domestic sphere, individuals with AD frequently struggle to maintain steady employment, as the condition severely impairs overall work productivity.[5]

The transitional care program (TCP) has been identified as a vital intervention strategy that provides coordinated, patient-centered care to reduce alcohol consumption and prevent hospital readmissions during the high-risk transition from hospital to community.[3] However, effectively delivering such complex, multi-component interventions requires nurses with advanced clinical competencies,[6] including motivational interviewing (MI), behavioral skills training, and comprehensive case management—capabilities inherent to advanced practice nurses (APNs).[7-8]

Despite global evidence supporting the efficacy of TCPs, research on AD in the Thai healthcare context remains limited, particularly regarding the use of APNs to manage these complex cases.[9,10] Thus, this study aimed to develop and evaluate the effectiveness of an APN-led TCP designed to reduce alcohol consumption and readmission rates.

Conceptual Framework and Literature Review

Transitional care is the process of moving patients from a hospital to their homes or to other healthcare settings. It includes services that ensure continuity of care and help prevent adverse outcomes in vulnerable populations. Transitional care is often described as a comprehensive model led by APNs,[11] with coordination and continuity as essential components.[12]

The conceptual framework guiding this study centers on the TCP as a multi-component intervention designed to support individuals with AD during the high-risk discharge-to-community transition. This framework comprises two core strategies: 1) pre-discharge strategies, which involve structured education and behavioral skills training. Key components include craving management, refusal skills for resisting social pressure to drink, medication self-management, effective communication with healthcare providers, and the recognition of early warning signs of relapse; 2) post-discharge strategies, which consist of telephone-based consultations aimed at providing ongoing psychosocial support and goal-directed behavioral guidance.[3,13]

The leadership of APNs in complex, multi-component care programs has gained significant recognition across diverse patient populations. APNs possess advanced clinical competencies that extend beyond those of registered nurses, encompassing independent clinical decision-making, patient education, care coordination, and integration of evidence-based practice. APN-led interventions have been shown to consistently improve patient outcomes, reduce healthcare utilization, and enhance the quality of care across various clinical settings.[14] A meta-analysis of randomized controlled trials further reported that APN-led care significantly reduces healthcare costs while improving both quality of care and patient well-being.[15] Additionally, APN competencies in chronic disease management have demonstrated significantly improved hypertension control compared to standard care.[16] In psychiatric and substance use contexts, APNs are uniquely qualified to lead TCPs. Their expertise in MI, behavioral change counseling, and holistic, patient-centered care is essential for delivering effective transitional support to persons with addictive disorders (PADs).[7,8]

System-level transitional care strategies have also demonstrated efficacy in improving outcomes for

individuals with substance use disorders.[3] Extended post-discharge support, particularly through structured telephone-based counseling, has been associated with significant gains in clinic attendance and medication compliance, alongside a decrease in days of excessive alcohol use.[17] Collectively, these findings indicate that sustained involvement through structured transitional care is a primary driver of substantial behavioral modification that persists well beyond the initial treatment phases.[3,6,17]

Low-threshold, patient-centered transitional clinics have demonstrated notable success in engaging high-risk populations who often struggle with traditional therapy models,[18] largely due to their flexibility and reduced barriers to access for marginalized groups.[19] Moreover, some social determinants of health, including transportation, community participation and housing stability, act as essential moderators of TCP effectiveness and must be systematically incorporated into intervention design to prevent clinical gains from being undermined by environmental instability.[19]

In the Thai and Southeast Asian contexts, the cultural adaptation of TCP frameworks is essential. Thailand's healthcare system faces distinctive challenges, including a limited specialist workforce, resource constraints in rural settings, and deeply embedded sociocultural norms surrounding alcohol use.[20] Family involvement is a culturally salient factor that has been shown to enhance motivation, treatment adherence, and relapse prevention.[1,21] Social norms and family dynamics significantly influence treatment engagement and recovery in Asian communities.[21] Aligning evidence-based care with local infrastructure and sociocultural factors remains a key priority in Thailand's healthcare system.[22]

These contextual considerations directly informed the design of the current APN-led TCP. This program integrated APN-directed development and supervision, active family participation, behavioral skills training tailored to Thai sociocultural norms, culturally specific education, and guidance on community resources to address the unique challenges faced by PADs in northern Thailand.

Study Aim and Hypothesis

This study evaluated whether an APN-led TCP could reduce alcohol consumption and hospital readmission rates among individuals with AD. Specifically, the study sought to determine whether the APN-led TCP reduces heavy-drinking days and increases abstinent days at 28 and 90 days post-discharge, and whether it decreases hospital readmissions compared with usual care.

Rationale for Follow-up Intervals

The 28-day time point was selected to capture early post-discharge outcomes during the most vulnerable period for relapse, as evidence indicates that the risk of alcohol recurrence and rehospitalization is highest within the first month following discharge.[3] While some studies utilize a 30-day follow-up, a 28-day interval was chosen to align with the scheduled week-four telephone consultation. This synchronization allowed the outcome assessment to coincide with the intervention's final structured contact point. The 90-day time point was established to evaluate sustained behavioral changes beyond the immediate transition period, consistent with recommended TCP follow-up protocols and the critical window during which patients remain at high risk for relapse.[6]

We hypothesized that PADs receiving the APN-led TCP would report lower alcohol consumption, with fewer heavy drinking days and more abstinent days, and would have fewer hospital readmissions at 28 and 90 days post-discharge compared to those receiving usual care.

Methods

Design: The study employed a quasi-experimental, two-group design with three measurement points. Reporting adhered to the Transparent Reporting of Evaluations with Non-randomized Designs (TREND) statement.

Sample and Setting: The target population was adults diagnosed with AD according to DSM-IV-TR criteria who were admitted to inpatient psychiatric departments (IPD) of a psychiatric hospital in Chiang

Mai, Thailand. Although DSM-5 has been adopted internationally, the DSM-IV-TR diagnostic criteria were used in this study because they remained the standard diagnostic framework at the study hospital during the data collection period (January-April 2024). Eligible participants were recruited through purposive sampling, with screening coordinated as part of the outpatient department (OPD) admission workflow. Inclusion criteria were 1) aged 18-59 years, 2) absence of alcohol-withdrawal symptoms, defined as a Clinical Institute Withdrawal Assessment for Alcohol Revised Version (CIWA-AR) score ≤ 7,[24] 3) residing with at least one relative, 4) ability to communicate in Thai, 5) willingness to participate in all study procedures, and 6) had a relative willing to provide consent to participate. Exclusion criteria were 1) severe cognitive or physical comorbidities that precluded participation and 2) cognitive impairment, defined as a Montreal Cognitive Assessment (MoCA) score ≤ 17 out of 30.[25] To minimize allocation bias, two research assistants (RAs) not involved in clinical care in the OPD or IPD conducted eligibility screening and collected baseline alcohol consumption data. The primary investigator (PI) randomly allocated participants to either the intervention or comparison group using a simple randomization technique (lottery method) to minimize selection bias. Group assignments were concealed in sealed, opaque envelopes delivered by the RA to the responsible IPD nurse; participants were not informed of their allocation. Recruitment and allocation continued between January and April 2024 until the required sample size was reached (**Figure 1**).

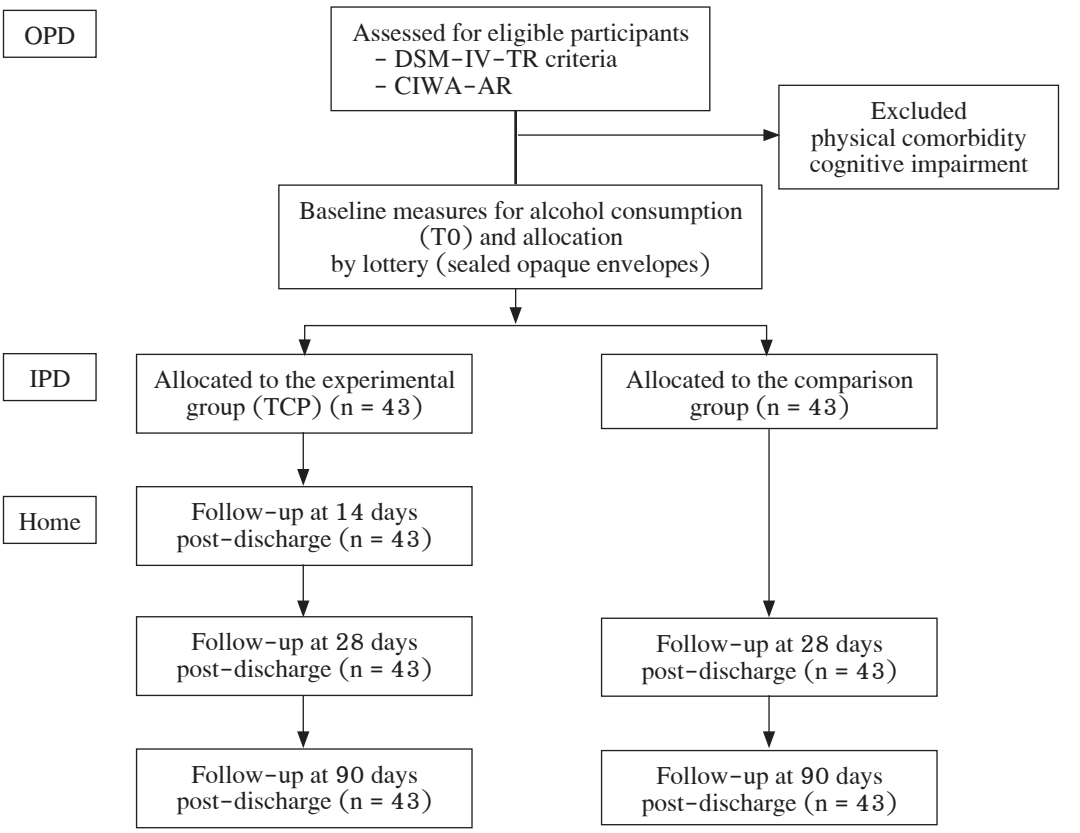


Figure 1. Flowchart of participant recruitment

Sample Size Determination: Using G*Power 3.1.9.7 for a mixed-design, repeated measures analysis of variance (ANOVA), we specified power = 0.95, $\alpha = 0.05$, effect size $f = 0.185$ (derived from a pilot study of 33 PADs), two groups, and three measurements. The minimum required sample was 78 participants. Allowing for 10% attrition, the final target sample size was 86 (43 per group).

Ethical Considerations: The protocol was approved by the Human Ethics Committee of the Department of Mental Health, Ministry of Public Health (Approval No. DMH.IRB.COA 006/2566 from 03/13/2566 to 03/12/2567) and authorized by the hospital administrative committee. Participants and their relatives received comprehensive information regarding study procedures, potential risks and benefits, safeguards for confidentiality and anonymity, voluntary participation, and the right to withdraw from the study, without penalty, at any time. Each participant and one relative gave written informed consent.

Research Instruments: This study employed outcome assessment tools and TCP intervention materials, as detailed below.

Outcome assessment tools

A demographic data sheet: This form captured sex, age, marital status, educational attainment, occupation, and alcohol use characteristics (type and frequency).

The Timeline Follow-Back (TLFB) Assessment: The TLFB was originally developed by Sobell and Sobell[28] and subsequently translated into Thai.[23] This instrument assesses daily alcohol consumption across the 90-day post-discharge period through a calendar-based recall method, yielding heavy drinking days (number of days with ≥ 5 standard drinks for men or ≥ 4 for women) and abstinent days (number of days without alcohol), computed as simple counts; lower heavy drinking days and higher abstinent days indicate improvement. The TLFB is widely recognized as a gold-standard measure demonstrating high test-retest reliability (r = 0.79–0.94) and concurrent validity with collateral reports and biochemical measures across diverse clinical populations.[28,33]

A hospital readmission record form: This form was used to capture all-cause psychiatric readmissions within 28- and 90-day post-discharge. Data were extracted from the electronic medical records (EMRs) by the PI.

The TCP Intervention Program: The TCP was developed through the first six phases of a structured research and development process, incorporating a needs assessment of PADs with prior readmissions, their relatives, and healthcare providers, as well as the transition theory framework. The PI, in her capacity as an APN, led the development of the program, coordinated expert review, supervised the delivery of interventions by ward nurses, and provided clinical oversight throughout the study period. It comprised two core components delivered by nurses (**Appendix, Table A1**): 1) Hospital-based education and behavioral skills training for PADs and relatives: five face-to-face sessions for PADs (45–60 minutes each) addressing AD education, medication importance and self-management, recognition of early-warning signs, and behavioral skills training comprising coping skills for craving management, refusal skills for resisting social pressure to drink, medication self-management skills, and communication skills for interacting effectively with healthcare providers; and two face-to-face sessions for relatives (45–60 minutes each), one on the first visiting day and one on discharge day, focused on AD disease and treatment, a home care plan reinforcing medication support and symptom monitoring, and guidance for self-mental health care; 2) Post-discharge consultation for PADs—two telephone follow-ups at weeks 2 and 4 (25–30 minutes each) emphasizing medication self-management, monitoring of early warning signs, reinforcement of refusal and coping skills, and goal-directed behavior change. The program underwent expert review by a physician, an APN, and three psychiatric nurses and was revised based on expert feedback and pilot testing with 33 PADs.

A personal health record (health booklet): This portable self-management tool includes: 1) medication records (name, dose, schedule, and adverse effects) with self-care reminders; 2) a health-symptom diary with weekly coping methods; 3) daily drinking-behavior records; 4) follow-up appointment schedules; and 5) concise educational pages on AD signs and symptoms, early-warning signs, relapse-prevention strategies, medication management, communication strategies for interacting with healthcare providers, and a directory of community resources and insurance/eligibility contacts.

Usual Care consisted of standard discharge counseling focusing on alcohol-use behavior change and education about AD, medication prescription, and basic instructions, and scheduled outpatient follow-up appointments per hospital protocol. Both the intervention and comparison groups received usual care, with the intervention group additionally receiving the TCP.

Data Collection: Data were collected by the PI, two RAs, and seven trained nurses working across two psychiatric wards. Following IRB approval, the PI provided a one-day training for RAs covering study workflow, eligibility screening, and informed consent procedures, research ethics, data collection, and data security. After the TCP manual and health booklet were finalized, the PI, in her role as APN, delivered a separate one-day workshop for ward nurses, covering the study aims and procedures, ethical considerations, TCP session delivery, use of the TCP manual and booklet, and data protection. At the OPD, RAs screened eligible patients and relatives, obtained written informed consent, and administered baseline TLFB assessments. At the same time, the PI coordinated allocation by lottery to the intervention or comparison group. Allocation concealment was maintained using sealed, opaque envelopes; the implementing nurse received the envelope from the RA, introduced themselves to the participant, and then delivered either the TCP in addition to usual care (intervention) or usual care only (comparison) accordingly. In the intervention arm, nurses scheduled five face-to-face sessions with each participant and two sessions with a designated relative during admission, followed by telephone consultations at weeks 2 and 4 post-discharge. The comparison arm received routine discharge counseling focusing on alcohol-use behavior change and education about AD only, without additional structured sessions, behavioral skills training, or telephone follow-ups. At 28 and 90 days post-discharge, nurses administered the TLFB to assess alcohol consumption, and the PI abstracted hospital readmission outcomes from the EMRs.

Data Analysis: Statistical analyses were performed using IBM SPSS Statistics, version 29.0.1. Means with standard deviations (SD) and proportions were used to summarize participants' characteristics and outcomes. Between-group differences at baseline were examined using independent-samples t-tests for continuous variables and chi-square or Fisher's exact tests for categorical variables. To evaluate the effect of the TCP on alcohol consumption over time, a mixed-design ANOVA was specified with time (baseline, 28 days, and 90 days) as the within-subjects factor and group (intervention vs. comparison) as the between-subjects factor. Before inference, statistical assumptions were evaluated, including normality of residuals (Shapiro-Wilk), homogeneity of variances (Levene), and sphericity (Mauchly); only the sphericity assumption for heavy drinking was violated ($W = 0.471$, $p < 0.01$). Therefore, Greenhouse-Geisser corrections were applied to the within-subject degrees of freedom. Bonferroni adjustments were applied to post hoc tests for between-group and within-group comparisons, with statistical significance set at $p < 0.05$ (two-tailed), and effect sizes were reported as partial eta squared (η^2).

Results

As shown in **Table 1**, the groups were broadly comparable across most demographic characteristics. Most participants in both the intervention and comparison groups were male, married, employed as general workers, and commonly consumed rice

whiskey. However, statistically significant between-group differences were observed in age, educational level, and drinking frequency. Participants in the intervention group were, on average, younger, more likely to have a secondary education, and reported more frequent weekly alcohol use than those in the comparison group.

Table 1. Demographic and drinking characteristics of participants (n = 86)

Variables	Comparison group (n = 43)		Intervention group (n = 43)		p-value
	n	%	n	%	
Age (years)					0.023[a]
Range	29-65		25-69		
Mean (SD)	46.3 (10.18)		41.0 (11.21)		
Gender					0.433[b]
Male	38	88.4	41	95.3	
Female	5	11.6	2	4.7	
Marital status					0.057[c]
Single	16	37.2	14	32.6	
Married	22	51.2	15	34.9	
Separated/divorced/widowed	5	11.6	14	32.6	
Education					0.004[c]
Not study	0	0	4	9.3	
Primary school	18	41.9	6	14.0	
Secondary school	16	37.2	27	62.8	
Certificate/Diploma	9	20.9	6	14.0	
Occupation					0.612[c]
Unemployed	10	23.3	8	18.6	
Farmer	7	16.3	11	25.6	
Government or company employee	3	7.0	3	7.0	
General employee	19	44.2	14	32.6	
Self-employed	4	9.3	7	16.3	
Type of liquor[d]					
Rice whisky	30	69.8	28	65.1	0.645[c]
Moonshine	5	11.6	11	25.6	0.096[c]
Rum	5	11.6	3	7.0	0.713[b]
Beer	3	7.0	4	9.3	1.000[b]
Weekly drinking frequency (days)					
Range	2-7		2-7		0.005[a]
Mean (SD)	4.7 (1.90)		5.8 (1.69)		

Note. [a] independent t-test; [b] Fisher's exact test; [c] Pearson's χ^2 test; [d] Multiple responses permitted

Alcohol consumption behaviors

Alcohol consumption behavior was examined in terms of heavy drinking and abstinent days. Analysis of variance results revealed significant effects of time and group, as well as a time × group interaction, with large effect sizes for both outcomes (**Table 2**); therefore, simple effects of the time × group interaction were tested. At baseline, there were no significant differences in heavy drinking or abstinent days between the intervention and comparison groups. Still, statistically significant between-group differences emerged at 28 and 90 days post-discharge (**Table 3**). When examining changes across time within each group, marked reductions from baseline were observed in heavy drinking in both groups; however, the intervention group demonstrated approximately double the reduction by 28 and 90 days (15.1 and 15.8 days per month, both $p < 0.01$) relative to the comparison group (8.3 and 7.8 days per month, both $p < 0.01$). However, no further change from 28 to 90 days was observed within either group. For abstinent days, the intervention group demonstrated a significant increase from baseline at both 28 and 90 days post-discharge (13.9 and 15.2 days per month, respectively; both $p < 0.01$). In contrast, corresponding changes in the comparison group were not statistically significant (**Table 4**). Taken together, these findings indicate that the APN-led TCP produced clinically meaningful improvements in alcohol consumption behaviors that were sustained through 90 days post-discharge. However, the observed baseline differences between groups should be considered when interpreting these results.

Table 2. Mixed ANOVA results for group and time effects

Variable	df	SS	MS	F	p-value	η^2
Heavy drinking						
Between subjects						
Group	1	760.655	760.655	18.024	< 0.001	0.177
Error	84	3544.915	42.201			
Within subjects[a]						
Time	1.308	7963.124	6.089.031	226.072	< 0.001	0.729
Time x Group	1.308	811.403	620.442	23.036	< 0.001	0.215
Error	109.854	2958.806	26.934			
Abstinent days						
Between subjects						
Group	1	3273.492	3273.492	90.568	< 0.001	0.519
Error	84	3036.093	36.144			
Within subjects						
Time	2	3887.256	1943.628	91.390	< 0.001	0.521
Time x Group	2	2377.147	1188.574	55.887	< 0.001	0.400
Error	168	3572.930	21.267			

Note. [a]Green-house-Geisser; SS = sum of squares; df = degree of freedom; MS = mean square; η^2 = partial Eta squared

Table 3. Between-group comparisons of alcohol consumption at each time point

Timepoint	M_{diff}	SE	p-value	95% CI for difference	
				Lower	Upper
Heavy drinking					
Comparison vs Intervention					
Baseline	-1.535	1.188	0.200	-3.897	0.827
28 days post-discharge	5.326	1.055	< 0.001	3.228	7.423
90 days post-discharge	6.512	1.038	< 0.001	4.447	8.576
Abstinent days					
Comparison vs Intervention					
Baseline	1.372	0.259	0.259	-1.029	3.773
28 days post-discharge	-10.302	0.000	< 0.001	-12.236	-8.369
90 days post-discharge	-12.442	0.000	< 0.001	-14.671	-10.213

Note. M_{diff} = mean difference; SE = standard error; CI = confidence interval

Table 4. Pairwise comparison of mean differences of alcohol consumption behaviors between each pair of time within the intervention and comparison groups

Time	M_{diff}	SE	p-value	95% CI for difference	
				Lower	Upper
Heavy drinking					
Comparison					
Baseline vs Day 28	8.302	1.081	< 0.001	5.661	10.944
Baseline vs Day 90	7.814	1.030	< 0.001	5.297	10.331
Day 28 vs Day 90	-0.488	0.476	0.923	-1.651	0.674
Intervention					
Baseline vs Day 28	15.163	1.081	< 0.001	12.521	17.804
Baseline vs Day 90	15.860	1.030	< 0.001	13.343	18.378
Day 28 vs Day 90	0.698	0.476	0.439	-0.465	1.860
Abstinent days					
Comparison					
Baseline vs Day 28	-2.302	1.045	0.091	-4.855	0.250
Baseline vs Day 90	-1.419	1.062	0.556	-4.014	1.176
Day 28 vs Day 90	0.884	0.864	0.929	-1.228	2.995
Intervention					
Baseline vs Day 28	-13.977	1.045	< 0.001	-16.529	-11.424
Baseline vs Day 90	-15.233	1.062	< 0.001	-17.828	-12.637
Day 28 vs Day 90	-1.256	0.864	0.450	-3.367	0.856

Note. M_{diff} = mean difference; SE = standard error; CI = confidence interval

Hospital readmission

Comparison of hospital readmissions between groups revealed that the intervention group had significantly lower readmission rates than the comparison group at both time points (**Table 5**). Specifically, 7.0% and 4.7% of participants in the intervention group were readmitted within 28 days and 90 days, respectively, compared with 23.3% and 20.9% in the comparison group (28 days: $\chi^2 = 4.440$, $p < 0.05$; 90 days: $\chi^2 = 5.108$, $p < 0.05$). These results demonstrate that the APN-led TCP was associated with a substantially lower risk of rehospitalization compared with usual care alone, with the intervention group showing approximately a three-fold reduction in readmission rates at both time points.

Table 5. Hospital readmission rates at 28- and 90-days post-discharge

Outcome	Comparison group n (%)	Intervention group n (%)	χ^2	p-value
Readmission at 28 days	10 (23.3%)	3 (7.0%)	4.440	< 0.05
Readmission at 90 days	9 (20.9%)	2 (4.7%)	5.108	< 0.05

Discussion

This study shows that an APN-led TCP significantly reduced alcohol consumption and hospital readmissions among individuals with AD in a Thai psychiatric inpatient setting. These results add to the evidence supporting nurse-led transitional care for managing substance use disorders. Conducting follow-up at 28 and 90 days is consistent with established guidelines and underscores the importance of early outpatient care in reducing relapse and rehospitalization.[3,6]

Notably, the two groups differed significantly at baseline in age, educational level, and weekly drinking frequency. The intervention group was younger, had higher educational attainment, and reported more frequent alcohol use, all of which may have amplified treatment responsiveness. Younger age and higher education have been associated with greater engagement in behavioral interventions and stronger self-efficacy for change.[34] Conversely, higher baseline drinking frequency in the intervention group suggests greater initial severity, which may paradoxically have increased the magnitude of observed reduction. Future studies should employ stratified randomization to ensure group equivalence and reduce the risk of confounding.[33]

The intervention group demonstrated approximately double the reduction in heavy drinking days compared with the comparison group at both 28 days (15.1 vs. 8.3 days/month) and 90 days (15.8 vs. 7.8 days/month). These magnitudes of reduction are consistent with, and in some respects exceed, those reported in prior TCP studies targeting substance use disorders. A systematic review reported that structured transitional care reduced post-discharge alcohol relapse rates by supporting continuity between hospital and community settings.[26] Psychosocial interventions that use MI and behavioral skills training have significantly reduced drinking frequency and severity,[13] supporting the behavioral mechanisms behind this program's effectiveness. Evidence also indicates that brief, structured behavioral interventions during hospitalization, combined with post-discharge follow-up, are more effective than single-contact approaches for sustaining alcohol reduction.[36]

The intervention group showed a significant increase in abstinent days (13.9 days/month at 28 days and 15.2 days/month at 90 days), whereas the comparison group showed no significant change. This suggests that structured elements of the TCP, such as craving management, refusal skills training, and telephone-based post-discharge consultation, were

central to sustaining behavioral change. Structured telephone counseling after discharge has been linked to better medication adherence and fewer excessive drinking days.[15] This supports the outcomes observed in this study. The absence of further change between 28 and 90 days in the intervention group indicates that behavioral gains occurred early and were maintained. This is consistent with evidence that early TCP contact helps consolidate recovery behaviors during the highest-risk post-discharge period.[3,6] The plateau may also reflect a ceiling effect within the 90 days, suggesting the need for longer follow-up in future research.[37]

The competencies of APNs were central to the quality and coherence of the TCP. APN-led programs have consistently outperformed standard care in complex clinical scenarios requiring individualized assessment, motivational engagement, and care coordination.[7,8] In the present study, the PI's APN role encompassed program development, nurse training, expert coordination, and clinical supervision—functions that extended beyond the typical registered nurse scope and likely contributed to the structured integrity and responsiveness of the intervention. This aligns with evidence that APN leadership enhances intervention fidelity and patient-centered responsiveness across diverse clinical populations.[22,23] A recent quasi-experimental study of an APN-led program in Thailand reported significant improvements in patient outcomes due to APN oversight and structured protocol delivery,[22] further supporting the present findings within Thai APN research. Systematic reviews also show that nurse-led transitional care interventions reduce readmission rates and improve self-management for patients discharged from acute care hospitals,[6] highlighting the value of APN competencies in this model.

The approximately three-fold reduction in hospital readmission rates observed in the intervention group (7.0% vs. 23.3% at 28 days; 4.7% vs. 20.9% at 90 days) is clinically and economically significant. These findings align with evidence that TCPs effectively address the revolving door phenomenon prevalent among patients with chronic substance use disorders.[3,26,27] A quasi-experimental study of transitional care for high-risk discharged patients found significant reductions in 30-day readmissions and emergency department visits,[10] findings that align with ours. Structured post-discharge follow-up is also linked to lower rehospitalization rates among individuals with alcohol use disorder,[27] highlighting the value of early outpatient contact in preventing relapse-driven readmissions. Additionally, implementing care transition teams reduces hospital readmissions and improves patient outcomes,[18] supporting the adoption of APN-led TCP in psychiatric settings.

This study introduces important cultural nuance to TCP research, which has predominantly been conducted in Western contexts. The inclusion of relatives in both pre-discharge education sessions and discharge-day planning meaningfully enhanced the social support available to participants following discharge. Family involvement was associated with improved motivation, greater treatment adherence, and reduced relapse, reflecting Thai sociocultural values in which family obligation and collective well-being are central to recovery.[9] This finding aligns with evidence that social norms and family dynamics influence treatment engagement and recovery in Asian communities,[21] highlighting the need for culturally tailored interventions. In Thai communities, where stigma around alcohol use disorder persists, family-mediated support can be a key protective factor against relapse and social pressure to resume drinking.[20] Cultural adaptation of evidence-based interventions has been identified as essential to their effectiveness in Asian healthcare contexts,[38] and the present program's integration of Thai-specific behavioral norms, family roles, and community resources represents a meaningful methodological contribution to the regional literature.

Behavioral skills training—including craving management, alcohol refusal skills, medication self-management, and communication strategies with

healthcare providers—effectively reinforces the post-discharge strategies delivered through telephone consultations.[3,13] These competencies align with the motivational and behavioral expertise characteristic of APNs and likely contributed to the sustained improvements observed at 90 days.[7,8] Using a portable personal health record as a self-management tool may have enhanced skill application between structured contact points. This supports evidence that patient-held records and self-monitoring tools improve adherence and self-efficacy in managing chronic conditions.[39]

While the intervention requires trained personnel and structured resources, which may be scarce in low-resource settings, the notable reduction in readmission rates suggests strong potential for long-term cost savings. The cost-effectiveness of APN-led TCPs for alcohol use disorder has not been formally evaluated in Thailand. Economic analyses are needed to determine whether reduced readmission rates justify the program's investment.[40] Evidence from similar transitional care programs indicates that reduced rehospitalization and emergency department use can offset implementation costs over time,[10] supporting broader adoption of APN-led TCPs in Thai psychiatric settings. This study demonstrates that TCPs are effective across diverse cultural settings; however, adapting them to local cultural and family contexts is essential, particularly in Thailand.[6,7]

Policymakers should invest in APN education, regulation, and institutional support to establish sustainable, evidence-based TCPs for individuals with AD. APN roles in psychiatric care remain underdeveloped in Asian healthcare systems,[17] and this study offers empirical support for formally integrating APN-led programs into standard psychiatric care.

Limitations and Future Study

Several limitations should be considered. First, the quasi-experimental design precludes causal inference.[32] Future research should incorporate full randomization and blinding. Second, baseline differences in age, education, and drinking frequency may have influenced the results. Stratified randomization is recommended in subsequent studies to ensure group equivalence.[33] Third, selection and allocation biases may persist due to the quasi-experimental design and purposive sampling, which limit generalizability.[34] Fourth, the exclusion of individuals with cognitive impairment further restricts generalizability and may overestimate intervention effects relative to real-world PAD populations. Fifth, reliance on self-reported alcohol use (TLFB) introduces potential bias and underreporting.[35] Future studies should incorporate objective biomarkers to improve assessment accuracy. Sixth, the 90-day follow-up period may not capture long-term effects, as relapse can occur beyond this timeframe. An extended follow-up is necessary to evaluate sustained outcomes. Finally, conducting the study at a single hospital in northern Thailand restricts generalizability. Future research should evaluate the APN-led transitional care program in diverse regions and healthcare settings. Future research should employ a 6 to 12-month follow-up period to more accurately assess long-term outcomes, as relapse may occur beyond shorter intervals.[3,17] Additionally, studies should compare APN-led and RN-led programs to determine the specific contributions of APN leadership in transitional care.

Conclusions and Implications for Nursing Practice

The findings of this study show that an APN-led TCP effectively reduced alcohol consumption and hospital readmissions among individuals with AD in Thailand. These results underscore the vital role of APNs in connecting hospital detoxification with community recovery and in potentially lowering the economic burden of repeated hospitalizations.

Integrating culturally tailored, family-centered transitional care into psychiatric practice can significantly

improve outcomes for this population. Prioritizing family support and tailoring interventions to patients' cultural backgrounds enhances engagement and supports sustained recovery. This approach is especially important in Thai and Southeast Asian contexts, where family involvement is central to recovery.

APNs are essential for implementing transitional care programs for individuals with AD due to their expertise in leadership, behavioral skills training, MI, and care coordination. Registered nurses should receive advanced training to improve the quality of care and patient outcomes. Healthcare organizations should formally support APN leadership within psychiatric teams.

Policymakers should invest in APN education, regulation, and institutional support to ensure the development of sustainable, evidence-based transitional care programs. Family involvement must be incorporated into care planning and training, especially in Thai and Southeast Asian contexts, to support recovery and prevent relapse. Economic evaluations are needed to assess whether reduced readmission rates justify investment in these programs.

Evaluating telehealth-based follow-up is recommended to improve scalability in underserved regions. Direct comparisons between APN-led and registered nurse-led programs will inform workforce planning and intervention development. Broader implementation of APN-led transitional care, supported by policy and workforce initiatives, can improve patient outcomes and reduce burdens on healthcare systems serving individuals with AD.

Author Contributions

Conceptualization, Method, and design: J.R., C.P., S.S.
Data collection, Drafting the manuscript: J.R., C.P.
Data analysis and interpretation: S.S.
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Appendix

Table A1. Content of the transitional care program (TCP)

Schedule	Objectives	Activities
Week 1 of admission Session 1-2 for PADs	1. To build rapport 2. To enhance understanding of AD 3. To strengthen knowledge of prescribed medications and side effects management	**Session 1 (45-60 min.)** 1. Establish a therapeutic alliance and orient the TCP (aims and process) 2. Assess perceptions of participants' diagnosis, causes, and AD impacts 3. Provide knowledge of AD, causes, impacts, treatment, and relapse preventing self-care 4. Invite questions and clarify misconceptions **Session 2 (45-60 min.)** 1. Assess understanding of the current medication regimen and home use practices 2. Explore experiences with medication side effects and coping 3. Provide information on medication uses for alcohol withdrawal, antipsychotics, and antidepressants, including side effect management 4. Discuss benefits/risks of adherence and consequences of nonadherence 5. Co-create practical strategies to support daily adherence
Session 1 for relatives	To increase understanding of AD and build skills to recognize and manage early warning signs of relapse	**Session 1 (45-60 min.)** 1. Establish rapport; Introduce the TCP (aims, process, and evaluation) 2. Assess perceptions regarding AD 3. Provide knowledge of AD, causes, impacts, treatment, and relapse preventing 4. Invite questions and clarify misconceptions 5. Summarize key points and schedule the subsequent session
Week 2 of admission Session 3-4 for PADs	1. To increase knowledge of relapse warning signs 2. To promote capacity of relapse management 3. To enhance motivation to change drinking behavior	**Session 3 (45-60 min.)** 1. Explore experiences with warning signs and responses 2. Provide knowledge of common early warning signs and relapse signs management 3. Promote strategies for responding to relapse warning signs **Session 4 (45-60 min.)** 1. Determine stage of change and deliver stage-matched counseling 2. Practice refusal/relapse-prevention skills; reinforce self-efficacy

Table A1. Content of the transitional care program (TCP) (Cont.)

Schedule	Objectives	Activities
Day before Discharge date Session 5 for PADs	1. To raise awareness of the importance of attending scheduled follow-ups 2. To strengthen skills for communicating health information to health care providers and using a health booklet	**Session 5 (45-60 min.)** 1. Explore prior experiences and barriers to attending appointments 2. Discuss benefits of adherence and the physicians' treatment plan 3. Discuss preferred strategies for communicating health information with providers 4. Demonstrate health booklet documentation methods, and review the alcohol-reduction plan
Discharge date Session 2 for relatives	1. To strengthen knowledge and skills for relapse prevention 2. To promote one's own mental health observation and caring	**Session 1 (45-60 min.)** 1. Review core knowledge from the first session 2. Provide practical strategies for daily monitoring and medication support 3. Explore mental health needs and teach appropriate self-care practices.
2nd and 4th week post-discharge	To provide consultation on medication use, management of relapse warning signs, and drinking behavior changes	**Telephone follow-ups (25-30 min.)** 1. Assess current medication use, health status, and progress toward drinking behavioral goals 2. Offer tailored guidance and problem-solving; reinforce skills and update the behavior change

Note. **PAD** = patients with alcohol dependence; AD = alcohol dependence; min = minutes

ประสิทธิผลของโปรแกรมการดูแลในระยะเปลี่ยนผ่านโดยพยาบาลผู้ปฏิบัติการขั้นสูงเพื่อลดการบริโภคแอลกอฮอล์และการกลับมารักษาซ้ำในโรงพยาบาล : การศึกษากึ่งทดลอง

จารุณี รัศมีสุวิวัฒน์ ชุลีพร ภู่โสภา เสาวลักษณ์ เศรษฐีกุล*

บทคัดย่อ : ภาวะติดสุราส่งผลต่อการเพิ่มความเจ็บป่วยและการใช้บริการของโรงพยาบาลในประเทศไทยอย่างมีนัยสำคัญ การให้การดูแลในระยะเปลี่ยนผ่านโดยพยาบาลผู้ปฏิบัติการขั้นสูงเป็นการประสานการดูแลที่เน้นผู้ป่วยเป็นศูนย์กลางเพื่อเชื่อมต่อการดูแลระหว่างที่ผู้ป่วยรักษาตัวในโรงพยาบาลและกลับไปอยู่บ้านสามารถลดการกลับมารักษาซ้ำหลังจำหน่าย การศึกษากึ่งทดลองนี้มีวัตถุประสงค์เพื่อประเมินประสิทธิผลของการให้โปรแกรมการดูแลในระยะเปลี่ยนผ่านโดยพยาบาลผู้ปฏิบัติการขั้นสูงในการลดการบริโภคแอลกอฮอล์และการกลับมารักษาซ้ำในโรงพยาบาลในผู้ป่วยที่มีภาวะติดสุรา ผู้ป่วยที่เข้ารับการรักษาที่โรงพยาบาลจิตเวช ในจังหวัดเชียงใหม่ ประเทศไทย จำนวน 86 คน ได้รับการสุ่มเข้ากลุ่มเปรียบเทียบหรือกลุ่มทดลอง กลุ่มเปรียบเทียบได้รับดูแลแบบปกติในขณะที่กลุ่มทดลองได้รับการดูแลตามโปรแกรมการดูแลในระยะเปลี่ยนผ่าน ซึ่งประกอบด้วยการให้ความรู้ การฝึกทักษะ และการให้คำปรึกษาหลังการจำหน่ายโดยพยาบาล เก็บข้อมูลโดยใช้แบบบันทึกข้อมูลส่วนบุคคล ปฏิทินบันทึกการดื่มสุรา และแบบบันทึกการกลับมารักษาซ้ำในโรงพยาบาล การวิเคราะห์ความแปรปรวนแบบผสมถูกนำมาใช้เพื่อเปรียบเทียบผลลัพธ์ด้านการบริโภคแอลกอฮอล์ (จำนวนวันดื่มหนักและจำนวนวันหยุดดื่ม) และการกลับมารักษาซ้ำ ทั้งภายในกลุ่มและระหว่างกลุ่ม ณ เวลาเริ่มต้น 28 วัน และ 90 วันหลังจากออกโรงพยาบาล

ผลการศึกษาพบว่า ในระยะ 28 และ 90 วันหลังจากออกโรงพยาบาล กลุ่มทดลองมีจำนวนวันดื่มหนักลดลงและจำนวนวันหยุดดื่มเพิ่มขึ้นมากกว่ากลุ่มเปรียบเทียบอย่างมีนัยสำคัญทางสถิติ นอกจากนี้ การกลับมารักษาซ้ำในโรงพยาบาลภายในทั้งสองช่วงเวลาก็ลดลงอย่างมีนัยสำคัญในกลุ่มทดลอง ข้อค้นพบเหล่านี้แสดงให้เห็นถึงประสิทธิผลของโปรแกรมในการลดการบริโภคแอลกอฮอล์และการกลับมารักษาซ้ำในผู้ที่มีภาวะติดสุรา ดังนั้น พยาบาลผู้ปฏิบัติการขั้นสูงควรพิจารณาการบูรณาการโปรแกรมนี้ในกระบวนการดูแลตามปกติของโรงพยาบาลเพื่อช่วยลดการบริโภคแอลกอฮอล์ในประชากรกลุ่มนี้ อย่างไรก็ตาม ควรมีการทดสอบโปรแกรมนี้อย่างเข้มงวดในบริบทอื่นและด้วยกลุ่มตัวอย่างที่มีขนาดใหญ่เพื่อประเมินผลลัพธ์ต่อไป

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