The Relapse Prevention Plan: Views and preferences of clients with a substance use disorder and their significant others

- a qualitative approach

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ABSTRACT

Title: The Relapse Prevention Plan: views and preferences of clients with a SUD and their significant others.

Background: As part of Relapse Prevention, a relapse prevention plan (RPP) is made, aiming to enable the client with a substance use disorder (SUD) to plan how to prevent or manage high-risk situations for relapse. Both the client and the significant other have a role in the RPP. In practice however, clients' use of the RPP is seemingly limited as well as the involvement of significant others.

Aim: To describe the views and preferences of clients with a SUD and their significant others (1) regarding the RPP and (2) regarding the role of the significant other within the RPP.

Method: A generic qualitative approach. Semi-structured interviews, using an interview guide based on existing literature, were conducted among a sample of clients (N=8) with a SUD and their significant others (N=4). A thematic analysis was done, according to the model of Braun and Clark.

Results: Three themes were derived from the data; insight, independence and availability. Clients' views regarding gaining insight in how to prevent relapse by means of the RPP were contrasting. All participants described that the client had the most important role in preventing relapse. The primary role of significant others was to be available.

Conclusion and implications: The structure and shape of the RPP is not as helpful as it is designed to be in preventing relapse. The current implicit role of significant others could be more active. The results can be used to evaluate the current structure and shape of the RPP and the role of the significant other within it, taking into account the clients' perceived and the significant others' experienced burden.

Keywords and MeSH terms: Substance use disorder, SUD, Relapse Prevention, Relapse Prevention Plan, Significant other.

SAMENVATTING

Titel: Het signaleringsplan: denkbeelden en voorkeuren van cliënten met verslavingsproblematiek en hun naasten.

Achtergrond: Cliënten met verslavingsproblematiek maken tijdens de behandeling een signaleringsplan als onderdeel van Terugvalpreventie. D.m.v. dit plan bereid de cliënt zich voor op situaties waarin het risico op een terugval groot is. Zowel de cliënt als de naasten hebben een rol in het signaleringsplan. In de praktijk blijkt echter dat cliënten het signaleringsplan weinig gebruiken en dat naasten weinig betrokken worden. Hierdoor lijkt het terugvalpreventieplan niet effectief in het voorkomen van een terugval in middelengebruik.

Doel: Het beschrijven van de denkbeelden en voorkeuren van cliënten met een verslaving en hun naasten met betrekking tot (1) het signaleringsplan en (2) de rol van de belangrijke naasten in het signaleringsplan.

Methode: Een beschrijvend, algemeen kwalitatief design. Data is verzameld d.m.v. semigestructureerde interviews met cliënten (N=8) en belangrijke naasten (N=4), aan de hand van een interview guide, gebaseerd op bestaande literatuur. Een thematische analyse is uitgevoerd, a.d.h.v. het model van Braun en Clarke.

Resultaten: Geïdentificeerde thema's zijn Inzicht, Zelfstandigheid en Beschikbaarheid. Cliënten beschreven tegenstrijdige denkbeelden m.b.t. het verkrijgen van inzicht in hoe een terugval te voorkomen door middel van het signaleringsplan. Zowel cliënten als naasten waren van mening dat de cliënt zelf de belangrijkste rol en verantwoordelijkheid heeft in het voorkomen van een terugval. Beide partijen omschreven beschikbaarheid als een belangrijke rol van de naaste.

Conclusie en implicaties: De structuur en vorm van het signaleringsplan lijken voor cliënten niet zo helpend als gedacht. Naasten zouden een actievere rol en betrokkenheid kunnen hebben in terugvalpreventie. De resultaten kunnen worden gebruikt om het huidige signaleringsplan en de betrokkenheid van naasten te evalueren, rekening houdend met de door cliënten gedachte belasting van de naaste en de daadwerkelijk door naasten ervaren belasting.

Trefwoorden: Verslaving, Stoornis in het gebruik van middelen, Terugvalpreventie, Signaleringsplan, Naasten.

INTRODUCTION AND RATIONALE

Among the adult population of the Netherlands substance use disorders (SUD) are a large problem, 2.2 percent (%) suffers from an alcohol use disorder and 2.0 percent (%) are addicted to other substances such as cannabis, cocaine and heroin.[1]

SUD is defined as a chronic psychiatric disorder, characterized by patterns of occasional relapse into substance use, despite of negative consequences.[2,3] Clients with SUD can experience problems regarding several life areas.[2] According to the fifth version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), symptoms of a SUD include difficulty with controlling substance use and physical, psychological, social or interpersonal problems related to substance use.[4,5] Furthermore, clients with a SUD often experience difficulties in relationships with significant others. Research shows that partners of clients with a SUD experience psychological and physical problems and a decrease in quality of life.[2]

In the Netherlands, the treatment of a SUD mainly consists of psychosocial interventions such as Motivational Interviewing (MI), Cognitive Behavioural Therapy (CBT) and Relapse Prevention (RP)[6] and is primarily focussed on helping the client to achieve positive behavioural change, i.e. abstinence or prevent relapse into the pattern of (problematic) substance use[7]. Apart from this focus on prevention, the aim is to support the clients' social, clinical, functional and personal recovery.[8] Despite different treatment options, research has shown that approximately only 31% of clients achieve posttreatment and/or clinically significant abstinence.[7] Within the process leading to relapse, three different terms are distinguished; lapse, relapse and prolapse. When a client is attempting to change (problematic) addictive behaviour, the possibility for an initial setback (or lapse) is high. A lapse can result in the client returning to a pattern of (problematic) addictive behaviour (relapse), or continuing the attempt of positive behavioural change (prolapse).[9]

RP is often part of SUD treatment programs in the Netherlands and has been proved to be effective in preventing relapse.[9–11] It is based on the cognitive-behavioural model of relapse, which focuses on high-risk situations for relapse and views relapse as a complex and dynamic process, influenced by stable and temporary factors.[11] RP focuses on addressing the problem of relapse, identifying high-risk situations and (early) warning signs in behaviour, emotions, thoughts and physical perception and developing techniques to avoid or manage these situations.[7,9,10] As part of RP the client formulates a Relapse Prevention Plan (RPP) together with the healthcare professional.[12,13] The RPP aims to enable the client to anticipate on high-risk situations and plan how to prevent or manage them, by describing (early) warning signs and strategies that can be executed by the client or their significant other(s) within different phases in the process leading to relapse.[10,14]

In a qualitative study, among clients with schizophrenia, their families and healthcare professionals, van Meijel et al. (2002) found that the construction of a symptom recognition plan, comparable to the RPP, helped the client to better understand the causes and effects of their behavior. Furthermore, the plan served as a guideline for healthcare professionals and family members how to support the client in a (impending) crisis.[15] Moreover, van Meijel et al. (2006) tested an symptom recognition protocol by means of an RCT and found that the risk of relapse decreased by 52%.[16]

The social network of the client has an important role within relapse prevention and the RPP. Studies show that a good social support system can enhance the clients' chances of coping effectively in high-risk situations, and therefor prevent relapse.[10] Moreover, the clients' chances of recovery from a SUD improve when people within the clients social network reach out to the client and/or stay in contact with them.[17] Additionally, clients who report higher levels of emotional support were more likely to remain abstinent three months post treatment.[18] Furthermore, research into community-based approaches, such as the Community Reinforcement Approach (CRA), which contains elements of RP, shows the importance of involving the clients' significant others (people who are close and significant to the client, such as family and friends) in the recovery process whenever possible.[19,20] Moreover, CRA emphasises the importance of enabling the client to experience that a sober lifestyle is more rewarding than a life controlled by substance use, through for example positive social or occupational experiences.[20]

In practice however, the clients' use of the RPP and the involvement of the significant other within the RPP are seemingly limited, resulting in a lack of effectively preventing relapse by means of the RPP. Apart from studies regarding the RPP within mental healthcare, specifically patients with schizophrenia[15,16,21], an exploration of the literature showed no available research regarding the RPP in SUD treatment and the role of the significant other within the RPP. The current study therefore focuses on describing the views and preferences of clients with a SUD and their significant others regarding the RPP and the role of the significant other within the RPP, aiming to develop recommendations for practice.

RESEARCH QUESTION

(1) ‘What are the views and preferences of clients with a substance use disorder and their significant others regarding the Relapse Prevention Plan, as part of SUD treatment?’

(2) ‘What are the views and preferences of clients with substance use disorder and their significant others regarding the role of the significant other within the Relapse Prevention Plan, as part of SUD treatment?’

METHOD

Design

A descriptive qualitative design was used, to enable a thorough exploration and rich description of the views and preferences of clients and their significant others, from their individual perspective.[22,23] A generic approach to this design was chosen, because of the generic nature of the research objectives, which fit none of the more established qualitative methodologies.[23]

Population and domain

The sample was drawn from the population of clients with a SUD and their significant others. Both clients and significant others were included, enabling representation of both perspectives. The study was conducted on two inpatient wards, part of an organization specialized in addiction mental healthcare. Care provided on the wards consisted of diagnostical and treatment interventions, focussed on SUD. At the first ward, clients were forcibly admitted, in agreement with the Dutch 'special admissions to psychiatric hospitals' Act.[24] At the second ward, clients received voluntary SUD treatment on a judicial basis. On both wards, the RPP is used as part of RP.

Procedures

Sampling

To ensure the collection of information-rich data, a purposeful sample[25,26] of clients, who are admitted to an inpatient care facility, specialised in SUD treatment, and their significant others, was established using in- and exclusion criteria. Clients were eligible for participation when they (1) are diagnosed with a SUD, according to the DSM-5, (2) can name at least one significant other, eligible for participation, (3) are familiar with the RPP, (4) experienced a relapse into substance use within the last two years and (5) are capable of reading and speaking Dutch. Clients were excluded from participation in the study when they (1) were detoxing from substance use, according to the treating physician, (2) suffered from an active psychotic episode, according to the treating physician, (3) recently displayed suicidal behaviours or thoughts, according to the electronic client file (ECF) and (4) recently displayed physical or excessive verbal violence in the last four weeks, according to the ECF.

Significant others were eligible for participation in the study when they (1) are significant to the client with SUD, (2) have witnessed the clients' relapse process, (3) are capable of reading and speaking Dutch. Significant others were excluded from the study when they were diagnosed with a SUD, according to the DSM-5.

Recruitment started in February of 2018. The treating physicians of the wards determined the eligibility of admitted clients, together with the researcher (AW).

Clients eligible for participation (N = 14) were approached face-to-face, given a short introduction to the research and received a participant information letter as part of an informed consent procedure. Clients were asked to give informed consent for participation and for the researcher contacting their significant other for participation. In cases where the client declined consent to contact the significant other, only the client was included in the study, because of the limited number of eligible participants. When consent to contact the significant other was granted, the significant others eligible for participation (N = 5) were approached by telephone.

Of eligible clients, three declined to participate and three consented but were unexpectedly discharged before conducting the interview. Five clients declined consent to contact their significant other for participation in the study. One of the significant others eligible for participation could not be reached for possible participation.

Data collection

Data was collected between March and May of 2018, by means of semi-structured interviews with clients and significant others. Before data collection started, a pilot interview was conducted, enabling refinement of the initial interview guide and improvement of the interview skills of the first researcher (AW).[27] Clients were interviewed individually, in a private room outside of the ward of admission. Significant others were interviewed in pairs (mother and (step)father) in their home. Interviews were audio-recorded with the participants' permission. In one case, permission for audio recording was not obtained, therefor the interview was recorded using field notes. Observational memos were recorded during the interviews.

Two separate interview guides were constructed (appendix B), one for each participant group, incorporating similar themes based on existing literature regarding the relationship between people with a SUD and their significant others and regarding RP in SUD treatment.[2,28–30] All participants were given a short introduction at the beginning of the interview. Subsequently, basic characteristics (i.e. age, gender, educational level, employment, living situation and nature of relationship) were obtained. Among clients, information about the kind and quantity of substance use was also obtained. Furthermore, clients were asked to fill out the Social Network Questionnaire (SNQ), a combination of the Achenbach System of Empirically Based Assessment (ASEBA)[31] and The Berkman-Syme Social Network Index[32], enabling insight in to the clients' social network to thoroughly describe the sample. Hereafter, an opening question, regarding the relationship with their loved one, was asked. Interviews lasted between 35 and 114 minutes.

Data analysis

The participant characteristics and the outcome of the SNQ were analysed using Microsoft Excel.[33] A thematic analysis of the interview data was conducted for both participant groups separately, according to Braun and Clarke's six-phase framework[34], using NVivo qualitative data analysis software, version 10 (QSR International Pty Ltd, Doncaster, 2014)[35]. First, the researcher transcribed the interviews and subsequently read and re-read these transcripts as well as field notes and observational memos, allowing familiarization with the data. During the second phase, initial codes were derived from the data and relevant data extracts were collated within each code.[34] The first two interviews were coded by two researchers (AW and JH). Differences were discussed until consensus was reached, ensuring unbiased findings.[22] As part of the phases 'searching for themes', 'reviewing themes' and 'defining and naming themes', the researcher analysed the codes and reviewed how each code could fit into an overarching theme. The last phase of the framework entailed the write-up of the report[34]. The results of the analysis per participant group were compared. Member checks on the transcripts of the interviews were performed.[22] However, to date no participants reacted to this request.

Ethical issues

The Medical Ethics Review Committee (METC) of the Radboud University Medical Centre Nijmegen granted ethical approval in January of 2018 (reference no. 2018-4037). Participant data was handled confidentially in accordance with the Dutch Personal Data Protection Act (Wbp)[36] and the General Enactment Data Protection (AVG)[37]. All collected data were provided with a unique participant code and traceable aspects were made anonymous.
The study was conducted with special attention for the risk of conflicting roles and research ethics, because of the occupation of the first researcher as a nurse at one of the participating wards. Participants were only asked to participate when there was no profound relationship with or dependency on the first researcher (AW). Written informed consent was obtained from all participants. Participants were explained that they could withdraw from the study at any time, without stating a reason. Moreover, it was emphasized that the collected data would not be shared with healthcare professionals and would not affect the client's treatment.

RESULTS

Sample

The final sample consisted of eight clients and four significant others. The client group consisted of six men and two women. The (step)parents of two clients formed the significant other group, which consisted of two men and two women. Demographic and clinical sample characteristics are included in table 1.

[INSERT TABLE 1 HERE]

The results of the SNQ showed that the social network of clients primarily consisted of family members and some close friends. One client reported a (sports)club membership. All clients indicated a family member or (ex)spouse as their significant other and reported that trust and the unconditional, self-evident nature of the relationship were important characteristics.

Main results

Three themes were derived from the data with regard to the research questions; Insight, Independence and Availability.

Insight

Clients reported contrasting views regarding the RPP. Most clients described that they had already experienced many relapses and through these experiences had learned under which circumstances they were more at risk of using substances. They had memorized these insights and did not need the RPP anymore. Regularly thinking of the negative consequences of relapsing, for example losing the relationship with their significant other, motivated them to stay sober. Furthermore, some clients described that when confronted with a high-risk situation, they would not think to use their RPP and did not carry it with them.

> *"You don't use it [relapse prevention plan] anymore. No. When you don't want to use [substances] you will do anything in your power to not do it, if you do want to use you are going to do it. [...] I know, when I smoke a pipe [cocaine], then I just know, here we go again, here we go again. Yes. And then you don't think about your relapse prevention plan". (C5)*

Some clients described that they themselves often did not perceive clear warning signs or a build up to a relapse.

> *"Yes, but for me, for me there were no warning signs, all at once it's just there. […] No, it just comes up out of nowhere and we have to take action right away." (C8)*

On the other hand, some clients described that the RPP did help them to identify their personal warning signs, high risk situations and motivation for staying sober and used the RPP as a reminder of these things.

> *"On a daily basis I have to stop myself, and be aware of myself. […] Exactly, uh, yeah [silence]. Yes, that, exactly that is the relapse prevention plan, it is to stop yourself and be aware of your warning signs, what do I feel, how do I act." (C1)*

One significant other described that the RPP could in theory be a useful tool in relapse prevention, but all significant others stated that they had no experience with the RPP in practice.

Independence

All participants stated that the significant other was currently not involved in composing and using the RPP and viewed that the client had the most important role and responsibility in the choice between using substances and staying sober. Significant others were thought to be more or less powerless.

> *"Yes, but you do have to do it yourself. You are the one who created it and everything that comes along with it." (C4)*

> *"Yes, what are things you can help him with, there.. I can tell him a hundred thousand times, […] it's not good for you, you shouldn't do it. It's something they have to do themselves. […] We do tell him, yes, we can help you, we want to help you, but with the other thing [addiction], he has to do it himself." (SO1)*

Talking about the relationship with their loved one was often emotional for clients as well as for significant others. Most clients did not want to burden their significant other with their addiction and its consequences and felt guilty to ask them for help. Two clients shared their thoughts regarding this feeling of burden and guilt:

> *"I.. you think.. I am burdening other people with my stupid story.. with the hassle, with the hassle.. Yeah, it's uh.. all very negative, yeah, but that's.. that's how I experience it. I burden others with my stupid story, with my hassle…" (C1)*

> *"No, I just hate it. […] I hate it, I've asked them for too much already. You know, they've been busy with it [addiction] for far too long and I just want to give them some peace in that area." (C4).*

> *"…She [mother] keeps me busy and distracts me, that she does, but I also said like, 'you guys have your own life and I already asked you for só múch'. Infact, it's my choice, I'm the one who holds back on asking them for help." (C4)*

On the other hand, two clients reported that their significant other could supplement the clients' views regarding warning signs. One client, who experienced the involvement of his significant other in the RPP stated:

> *"Actually, I would have preferred that it had happened much earlier. [...] Also, also including the warning signs, actually the relapse prevention plan, that also uh, because maybe they see more than me. That's often the case um.. you yourself, you see things and healthcare professionals see things, but they [significant other] could maybe notice even more". (C1)*

Availability

All participants described that an important role for the significant other to be there for the client when they needed them. The fact that their significant other remained in contact through everything they experienced together, the support given and doing fun things together as part of this relationship were important to most clients.

> *"No, I just want finally want to show them [significant others] that I can do it right just for once, you know? Yes." (C6)*

> *"Now uh, while being in [institution] our son has asked; if I experience such a craving moment again, can I call you guys, because when I call you, it always subdues". (SO3)*

All significant others described that the most important thing they could do for the client is to be there for them and show them the joy of a life without substance use.

> *"The only thing that we feel we can do […] is like, yes, when we go out, we take him with us and try to show him the other side of life, that it can also be fun, that it can also be beautiful, that there are also wonderful things about life". (SO1)*

> *I: "What I very much hear in your story, just taking him with you, letting him experience fun things". SO3: "Yes. Yes. […] That it's also possible withóút drugs!". (SO3).*

Furthermore, both clients and significant others described that the significant other was able to recognize whether the client was having a hard time. Both parties stated that significant others could only try and talk about these observations with the client, to increase their awareness, but this often could not stop the client from using substances. A client reflected on this role and how this feedback had however helped him:

> *"No, she [significant other] tells me 'I notice this and that'. Than I go and investigate if it's true. You know, I can't see it myself. […] I come here, I see myself in the mirror, but I don't see myself, that's how your brain works. […] She, look, it's just like my mother and father, the thing with my voice with my mother, she notices something is not right, last year, she heard it in my voice, something is not right with me. Do you see? But I did not say anything to anyone. […] Just talking to me, my voice…" (C8)*

Significant others stated that they would like to be more involved in the RPP and treatment in general. Their personal knowledge of their loved one could supplement healthcare professionals and cooperation between the two could benefit the client. Two significant others reflected on their preferences regarding this cooperation:

> *SO3: "That you [healthcare professionals] call us, like, we've tried to, but we can't convince him…" SO4: "we can't succeed". SO3: "…can you guys maybe help think of something. […] And that's when you can assist and cooperate". SO4: "Yes, exactly that, assisting, assisting each other, like, we can't seem to do it, and this doesn't work and that doesn't work, can you help think of something or think about it." (SO3 and SO4)*

All significant others described negative experiences with and lack of trust in healthcare professionals, which formed an obstacle in their cooperation with them. They experienced that the client rarely asked them for help, and that healthcare professionals only involved them when something went wrong, for example when the client had relapsed.

> ***SO2: "…but, in an institution, where basically the goal is to re-integrate back in to the community.."*** *I: "Do I understand correctly that you're saying that the community and the social network should indeed be involved in this?"* ***SO2: "[…] Yes, and then, you can't just act like, I [healthcare professional] just do everything that I want and you [significant other] just have to do as I say and I am going to behave antisocially."*** *(SO2).*

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

This study provides insight into the views and preferences of clients regarding the RPP and the role of the significant other within this plan. Clients' views and preferences regarding the RPP are contrasting, but overall they describe that the RPP does not add to internalized insights, gained through experiencing a relapse. RP therapy as a whole has shown to be effective in especially alcohol and polysubstance use disorders.[38] Comparing these contrasting opinions to participant characteristics shows that clients who describe the RPP as helpful report an addiction to alcohol, whereas most clients that describe the RPP as unhelpful report polysubstance use. Regarding the social network outline and quality of contact, there were no clear differences visible. Different from the current results, van Meijel et al. (2002) found that the symptom recognition plan, comparable to the RPP, increased the clients' self-management and ability to prevent or delay relapse[15], but sufficient insight in to their illness was a necessity[21]. Despite the important difference in the participants' diagnosed disorder, the differences in experiences with and efficacy of early recognition and intervention could be explained by the content and structure of the intervention protocol as opposed to that of the RPP clients were familiar with in the current study.

Furthermore, clients' use of the RPP in practice is limited, because they do not think of using their RPP when confronted with a high-risk situation and because of the current physical shape the RPP. Gustafson et al. (2014) conducted a RCT on the effects of a smartphone application, containing information on personal high-risk situations, warning signs and possible interventions (like relaxation exercises), among clients with an alcohol addiction, leaving residential treatment.[39] This study shows that clients in the intervention group showed significantly fewer risky drinking days than patients in the control group.[39] The limited use of the RPP could however possibly be explained by the clients' insufficient insight in to their illness and incapability to clearly distinguish and describe their personal warning signs.

Participants stated that the client has the most important role and responsibility in preventing relapse, but the relationship with and availability of the significant other is an important protective factor. These results show a resemblance with the study conducted by van Meijel, et al. (2002), in which clients also reported the importance of availability, in this case of their parents. Parents on the other hand reported that although they felt that being available for their loved one was more or less self-evident, they often experienced it as a burden[15]. Studies show that family members can indeed be negatively affected by the substance use of their loved one.[2,40,41] The thought of burdening their significant other is also an important obstacle for clients with a SUD to involve their significant other in the RPP.

Lastly, significant others describe that they can only help retain the clients' motivation for sobriety by enabling the client to experience the beauty of a life without substance use. This belief is in line with the basic principles of CRA. A systematic review on the efficacy of CRA shows that this indeed could benefit the client, while positive experiences with substance abuse are replaced by sober positive experiences which reinforce a sober lifestyle.[42] However, both clients and significant others report that the significant other is also able to observe warning signs often not perceived by the client, and share these observations. These results imply that the role of the significant other in the RPP can be more active.

Various strengths and limitations can be distinguished. By including both clients and significant others, two parties which have an important role in the RPP, both perspectives are represented in the study. However, due to difficulties in gaining access to significant others, resulting in an underrepresentation of their perspective, the conclusions based on these perspectives should be drawn with care. Moreover, the significant others included in the study were solely (step)parents to one of the clients, which harms the transferability[25] of results. Additional research, including a larger sample in which both perspectives are equally represented, is needed to gain a more unbiased insight into the views of significant others. Another limitation of the study is that data analysis was primarily conducted by the first researcher (AW), with a risk of biased results.

Lastly, the first researchers' occupation of healthcare professional on of the wards where the study was conducted, can be seen as a limitation, due to risk of conflicting roles which could harm the study's overall trustworthiness.[25] However, through detailed attention to a minimal level of dependency in the relationship between the client and the researcher and profound awareness and constant reflection on the effect of the researchers' role on the research process, this conflict and its possible consequences are minimized and reflexivity[25] is enhanced.

In conclusion, these findings are the first step in uncovering the views and preferences of clients with a SUD and their significant others regarding the RPP and the role of the significant other. The RPP, in its current shape, does not seem to be the useful tool it is designed to be, in helping client with a SUD prevent relapse. However, the outcomes of studies on the use and efficacy of the RPP in other, but comparable, shapes and within other populations show promising results. Due to the lack of available research regarding the efficacy of the RPP within addiction mental healthcare and the limited quality of the present study, additional research is needed to uncover if the structure and shape of the intervention might need to be evaluated and altered. Although significant others currently have a more implicit role in relapse prevention and the RPP, the current findings show that there is reason to believe that significant others can play a more explicit role in relapse prevention. These

findings could be an onset to evaluate the involvement of significant others, but further research into the form and willingness of both parties to increase involvement, taking into account the perceived and experienced burden, is needed. Healthcare professionals should focus on increasing the clients' insight and ability to distinguish warning signs and supporting the significant other in their current role in relapse prevention. Furthermore, focus should be on creating an open dialogue between clients and their significant others regarding their desired involvement and experienced burden.

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APPENDIX A: THE RELAPSE PREVENTION PLAN

Relapse prevention plan	BSN : Client nr. : Surname : Name : Date of birth : Address :
Last altered on : Name creator : Established on : Next planned evaluation : Who know the content of the plan? : Crisis card distributed : Contact #1 Name contact : Nature of relationship : Phone number : Healthcare provider #1 Name healthcare provider : Nature of relationship : Phone number :	
Green: Stable - Relaxed	
What do I notice	
What do other people see and hear	
What do I do	
What do others do	
Yellow: Tense	
What do I notice	
What do other people see and hear	
What do I do	
What do others do	
Orange: Disordered – Very tense	
What do I notice	
What do other people see and hear	
What do I do	
What do others do	
Red: Crisis – I am in danger	
What do I notice	
What do other people see and hear	
What do I do	
What do others do	

Tips on how people should interact with you #1 Do's : Dont's : BOR/TOR Additional agreements : When BOR/TOR : In which phase BOR/TOR :

APPENDIX B: TABLES AND FIGURES

Table 1: Participant characteristics (N=12)

	CLIENTS (N=8)		SIGNIFICANT OTHERS (N=4)	
	N	**MEAN (RANGE)**	**N**	**MEAN (RANGE)**
AGE (YEARS)		44.3 (28 – 53)		57 (51 – 62)
GENDER				
MALE	6		2	
FEMALE	2		2	
EMPLOYMENT				
UNEMPLOYED	8		2	
FULL-TIME EMPLOYMENT	-		2	
MARITAL STATUS				
MARRIED	-		4	
UNMARRIED	7		-	
DIVORCED	1		-	
LEVEL OF EDUCATION				
PRIMARY	1		-	
LOWER VOCATIONAL	-		1	
SECONDARY	6		2	
HIGHER VOCATIONAL	-		1	
ACADEMIC	1		-	
SUBSTANCE USE				
POLI SUBSTANCE USE	5			
ALCOHOL	4			
HEROIN	3			
COCAINE	4			
KETAMIN	1			
BENZODIAZEPINES	1			
GHB	1			
AMPHETAMINE	1			
LIVINGSITUATION				
LIVING IN INSTITUTION	3			
LIVING ALONE	4			
LIVING WITH CHILDREN	1			
NATURE OF RELATIONSHIP				
FRIEND			-	
FAMILY			4	
AQUENTENCE			-	

APPENDIX B: INTERVIEW GUIDES

INTERVIEW GUIDE CLIENTS

Key concept	Question
Relationship with client with SUD	You named […] as a person who is significant to you. What can you tell me about the relationship you have with your loved one? - What are important things in this relationship? - How is the contact with your significant other at this moment? - How did your addiction influence this relationship?
The role of the significant other in the RPP and relapse prevention	How is your significant other currently involved in the treatment of your loved one? - What are your views on this? - How would you like your significant other to be involved in your treatment?
	Did you ever experience a relapse into substance use? - If so, to your knowledge, when was the last time? - Can you tell me more about this situation (process leading up to the relapse and period of substance use)? - What was the reaction of your significant other to your relapse? - What are your thoughts on what your significant other could do to prevent you from relapsing?
	After you are discharged, how do you see the role of your significant other in supporting you to stay sober?
Relapse prevention plan	Are you familiar with the relapse prevention plan? - If so, what is your opinion of the relapse prevention plan?
	How is your significant other currently involved in the relapse prevention plan and in relapse prevention? - What is the role of your significant other in the relapse prevention plan?
	We just discussed your most current relapse. Can you recall if you had a relapse prevention plan at the time? - How did the relapse prevention plan influence this situation? - What could the influence have been of a relapse prevention plan, do you think?

INTERVIEW GUIDE SIGNIFICANT OTHERS

Key concept	Question
Relationship with client with SUD	Your loved one has named you as a significant person to them. Can you tell me more about the relationship you have with your loved one? - What are important things in this relationship? - How is the contact with your loved one at this moment? - How did the addiction of your loved one influence this relationship?
The role of the significant other in the RPP and relapse prevention	How are you currently involved in the treatment of your loved one? - What are your views on this? - How would you like to be involved in the treatment of your loved one?
	Has your loved one to your knowledge, ever experienced a relapse into substance use? - If so, to your knowledge, when was the last time? - Can you tell me more about this situation? - What was your reaction to the relapse of your loved one? - What are your thoughts on what you could do to prevent your loved one from relapsing?
	After your loved one is discharged, how do you see your role in supporting your loved one to stay sober?
Relapse prevention plan	Are you familiar with the Relapse Prevention Plan? - If so, what is your opinion of the relapse prevention plan? - If not, what do you think the relapse prevention plan should entail?
	How are you currently involved in the relapse prevention plan and in the process of preventing your loved one to relapse into substance use? - What is your role in the relapse prevention plan? - How do you see your role in the relapse prevention plan?
	We just discussed the most current relapse of your loved one. Can you recall if your loved one had a relapse prevention plan at the time? - How did the relapse prevention plan influence this situation? - What could the influence have been of a relapse prevention plan, do you think?