A Need for Support After Drug and Alcohol Treatment

Deborah Ann Koopman

Bradley University, Peoria, Illinois

Abstract

A client's success or relapse has traditionally been a standard way of measuring the quality of drug and alcohol addiction rehabilitation programs. Huge amounts of time, money, and energy are poured into these programs with continued high levels of relapse after treatment. Clients who relapse typically suffer job loss, poor and irreversible health related issues, scarred relationships with family and friends, and higher medical costs. The current standard of care stops at the completion of treatment even though the first 30 days following treatment has been identified as a crucial period when relapse often occurs. The aim of this quality improvement project was to develop, implement, and assess the effectiveness of a direct client support program for those who have completed drug and alcohol treatment and were making a transition home. The design for this project was the Six Stigma methodology for process improvement. The overall goal was to improve the outcomes of clients during the transition home through the use of direct client engagement and support via phone calls, visits, and the *7 Essential Elements of Recovery Checklist*. All clients who had just completed a rehabilitation program at the participating facility were invited to participate in this 30-day project if they had access to a phone and were able to set up at least one additional weekly visit via face-to-face or skyping. Of the 20 participants that were enrolled in the 30-day program, 12 successfully completed the program (60%), one relapsed and withdrew from the program (5%), and seven did not even start the program (35%). This project successfully showed that those who participated in the direct client engagement support program did well with the extra support offered. Participants reported that the *7 Essential Elements of Recovery Checklist* was a visual guide that helped them to stay on track with their daily goals and kept them focused and motivated each day.

ACKNOWLEDGMENTS

This project could not have been possible without the support of my interdisciplinary team. I would first like to thank my advisor, Dr. Brubaker for her constant support, guidance, encouraging words, and driving force which guided my perseverance through this whole project. I appreciate your quick response to emails, calls, and texts as I moved through each step of this project.

I would like to thank Jennifer Haubert, CNP for her guidance, and encouragement through the practicums I followed her in. I appreciate the hands-on practice, and the deeper knowledge of understanding drug and alcohol addiction that I gained through the experiences of assessing the patients, taking an accurate history, and learning from each of the patient's we had trusted to our care. You taught me to look beyond the patient, and use active listening, and to meet the patient right where they were. These are lessons I will carry forward always. This project would not have been possible without your teachings, guided support, and encouragement. Thank you for sharing your knowledge bank with me always and for mentoring me.

I also owe many thanks to Brad Patterson, Addiction Counselor, who allowed me to attend meetings he held during the patient's rehabilitation program. If it were not for you, this project would not have been possible. I am grateful for our time together and for your teachings of recovery, and for allowing me to use the tool "*The 7 Essential Elements of Recovery Checklist"* that you created. Your tool proved to be a cornerstone in this study. Thank you for believing in me and mentoring me.

I would also like to thank the Drug and Alcohol Facility that allowed me to work with Jennifer and Brad. Your doors were always wide open, and your staff always greeted me with a smile. I wish I could shout your name from the mountain top and I only pray that more people find out about your wonderful rehabilitation center and that you continue to grow and continue to touch many lives. I will forever be grateful for the lessons I have learned from the time I spent at the facility, in group or in assessing new patients, and for the staff and addicts that were so open sharing their stories with me.

I would also like to extend a thank my Academic Advisor Rachel Borton, and to the staff at Bradley University that played a part in setting up preceptors, practicums, and hands on experience with the Rehabilitation Center and for their guidance in helping me decide on a topic for this study that I could have passion for and really enjoy the time I spent working on this project.

I would like to thank my current preceptor Tami Hogie-Lorenzen for being with me today and for taking the time to invest her time in my Capstone presentation and for providing a place to present today also.

I would also like to thank my husband, and family for allowing me to spend the time I needed to on this project, and for being self-sufficient to make this project flow smoothly. I couldn't have done this without your love and support.

TABLE OF CONTETS

A Need for Support After Drug and Alcohol Treatment

Background/Significance

A client's success or relapse was a standard way of measuring quality rehabilitation. According to Dictionary.com LLC (2017), the word "relapse" means "to fall or slip back into a former start of practice".

For this project, 175 hours were spent observing drug and alcohol rehabilitation to identify if a gap existed between the time rehabilitation treatment was finished and when the client made the transition home. The role of therapy was observed to see if follow up supports allowed for more success and to see if the client was part of a supportive follow-up aftercare program made a difference in the transition home.

Time was spent with a mentor in a nationally known drug and alcohol rehabilitation center. The center was known for helping clients with their addictions in a way that is natural, meaning the doctor discontinued all drugs that have an addictive property to them. Many people come to the facility from all over the United States because of this. The facility takes a Biblical approach, as the clients were at their lowest point and need something positive in their lives. It was essential to know how addiction works with the mind, body, and spirit to be able to take a holistic approach to clients also (Project Know Understanding Addiction, 2017). It has been interesting to have learned from each situation and to have listened to why the client have chosen to come to rehabilitation, what their goals were, and what have made them relapse to reenter the rehabilitation program. I also listened for the reasons that caused the drug or alcohol dependency, the problems the dependency created with family, friends, and work, what brought the client to the point of wanting help (whether legal or personal), and what were their concerns or fears when returning home. The gap I identified during this observation time was that clients

were not successful or were relapsing because there was no follow-up supports put in place before the client transitions back home

According to the office manager at the Rehabilitation Center, the average cost of drug and alcohol rehabilitation varies, but usually costs between $10,500 - $31,000 for the stay. Some insurances have a cap on what the facility could charge per day, and that was honored. Some clients have a difficult time paying, so sometimes the state could provide assistance. The client always pays part of the fee, so they work toward the goal of staying clean K. M. Reynolds (personal communication, October 10, 2017).

To help reduce the incidence of relapse, I would like to implement a post-discharge follow-up program by offering them a paper checklist to use daily on their own, 2-3 phone sessions weekly, and 1-2 visiting sessions weekly. This was currently not being done. To implement this program, I would stay in touch with the clients for the first 30 days following treatment to ensure that they were feeling connected to someone, have someone to reach out to, and were making it to their appointments. It was also important for the clients to be given a list of resources before they leave treatment so that when stressful situations come up they could pull up a list of resources and reach out to someone that may be able to help. Clients turn to alcohol and drugs for many reasons, but mostly to escape the pain of real life. Also, there were a lack of coping skills, lack of education, and lack of emotional support in the clients that enter rehab (Dual Diagnosis.org, 2017). Many of the clients that I have observed have not finished high school. They have a low self-esteem because of this. Mental health and substance abuse go hand and hand, and they both need to be integrated into the aftercare program to be successful and to fix the root of the problem (Dual Diagnosis.org, 2017).

The observations made during the time at the facility were just the tip of the iceberg, as it

was also important for the client to be followed by their primary doctor after treatment. There needs to be a referral for mental health also. Anxiety and depression have been real mental health issues leading clients to make poor choices to use drugs and alcohol (Dual Diagnosis.org, 2017). There were meetings for Alcohol Anonymous and Narcotics Anonymous to attend, but no one was following up with the client on a personal basis to help support them or to encourage them to go to follow-up meetings, counseling sessions, or doctor appointments. The first 30 days following treatment was a crucial period when relapse often occurs (Dual Diagnosis.org). I hope to create an intervention by offering a program that keeps in contact with the client through continuous follow-up supports after discharge from the treatment facility.

The Problem Statement

There were many questions surrounding the issue of drug and alcohol rehabilitation. What was being done today, what works best, what was failing, and what could change for the better in drug and alcohol rehabilitation? (Clay, 2015; Dual Diagnosis.ORG, 2017; National Institute on Drug Abuse, 2017; Project Know Understanding Addiction, 2017). Was drug and alcohol abuse related to mental illness, death, and criminal activity or behaviors? (Clay, 2015; Dual Diagnosis.ORG., 2017; National Institute on Drug Abuse, 2017; Project Know Understanding Addiction, 2017). These were concerns because a huge amount of time, money, and energy, healthcare, and relationship repair were poured into rehabilitation, but the current standard of care stops at the completion of treatment. This termination of care should be evaluated to prevent early relapse with a program implemented to offer support to those clients who transfer back home. Americans have experienced high levels of relapse after treatment that negatively impact their relationships and families, job status, medical costs, and health (Dual Diagnosis.ORG, 2017). These clinical practice issues and problems were real and have been

shown to hinder the client from succeeding when they transition back into their home environment (Project Know Understanding Addiction, 2017). If nursing practice continued with follow up care, more clients would have a better chance of success. If relapse continued, Americans suffer job loss, poor and reversible health related issues, scarred relationships with family and friends, and higher medical costs (Project Know Understanding Addiction, 2017).

Project Aim

The project aim was to develop, implement, and assess the effectiveness of a direct client support program for those who have completed drug and alcohol treatment and were making a transition home.

Clinical Research Question

For clients being discharged from a drug and alcohol rehabilitation facility (P), how does having a direct client engagement and support program (I) compared to not having a direct client engagement and support program (C), affect the success or relapse rate O) within the first 30 days following treatment (T)?

Congruence with Organizational Strategic Plan

The organizational strategic plan was to use active listening and observation to discover reasons for drug and alcohol use, identify triggers for using, discover what brought them to rehab, discover if there were dual diagnoses, and to discover what could be done to support them once leaving the treatment center.

Synthesis of Literature

Search strategy. Several databases were used in this research which included: Research Gate, BMC Public Health, APA, American International Journal of Social Science, International Journal of Collaborative Research in Internal Medication and Public Health. These were

qualitative studies. Key words used in this search were transitional care, cure, therapy, rehabilitation, client, remedy, AA, DA, dry-out, medical help, aftercare, harm reduction, inpatient, outpatient, recovery, service-user, social support, substance abuse, treatment. This search yielded 37 articles which were reviewed in this search.

The Evidence. Several researchers have studied the impact of comorbidities on drug and alcohol abuse. According to Dual Diagnosis.org (2017), having a dual diagnosis was a common finding with drug and alcohol clients and integrated treatment of the substance abuse and the mental illness offer more support to the client. Aftercare is crucial to take part in after the rehabilitation was completed. This was when the real work started in the weeks, months, and years to come while the individual was at high risk for relapse. The components of effective programs include learning about triggers, coping with stressors and cravings, thinking through the outcome of a relapse, and keeping a lapse from turning into a relapse (Dual Diagnosis.ORG., 2017). There were many contributing factors and antecedents which trigger relapse. According to Lian and Chu (2013), drug abuse relapse has contributing factors. These factors could be so debilitating that relapse could become possible and providers need to consider all contributory factors that could lead to and become antecedents of future relapse for the client. In this study, 20 clients were studied and interviewed to give a perspective on the factors that became debilitating for them and why they turned to drug addiction. The author concluded that dual diagnoses usually leads to anxiety and depression, family issues of physical or emotional abuse, or homelessness (Lian & Chu, 2013).

Many researchers have explored various treatments for drug and alcohol abuse. According to Blevins, Abrantes, and Stephens (2016) there was a direct relationship between antecedents, drinking alcohol or participating in drug use, and the consequences that follow. The

researchers explored motivational pathways and demonstrated that once the clients could get treatment and acknowledge triggers within themselves, they could learn to use motivation to overcome the darkest days and the worse cravings. The clients were taught how to avoid these triggers, and how to react to the triggers when the situation is not avoidable. The authors concluded that it was important to have supports in place before transferring home (Blevins, et al., 2015).

Empirical support is needed to provide the clients holistic care. Benishek, Kirby, Leggatt, and Padovano (2010) interviewed 136 providers to assess their beliefs of empirical support in the form of the following interventions: Contingency management, motivational interviews, relapse prevention, 12-step approaches, and verbal confrontation. The providers reported that verbal confrontation, 12-step programs, and contingency management were less effective. The researchers called for new strategies to be put in place to start new successful means of changing beliefs. These included one-on-one counseling, encouragement, understanding, active listening, and involvement centered around the client's current situation (Benishek et al., 2010).

Holistic care provides care that was client centered. Emeries (2017) studied the importance of offering holistic care that was tailored to the client along with attending to the needs of children when the client was receiving rehab. The researcher concluded that it was important to provide a safe and environmental friendly nonjudgmental atmosphere to rest, recover, and refocus on their addiction. The client should have a nonjudgmental atmosphere to be able to feel open and safe to share their feelings, mental health issues, thoughts of self-harm, discuss their failures and disappointments, and their deepest fears. This was an emotional time for the client, and it could be very scary also because they have formed a habit to take away their

painful thoughts, their physical pain, or to escape their past. (Emeries, 2017).

Researchers reported that having aftercare program supports in place before a transition home begins to offer the client a better chance of success if the client shows readiness and is goal orientated. In fact, the Center for Substance Abuse Treatment have reported that long-term aftercare reduces relapse and helps the transition back into the community be successful. Aftercare improved post-prison outcomes and was associated with less relapse (Center for Substance Abuse Treatment, 2005). The findings indicated a better chance of relapse if the client had no support systems in place after treatment. The researchers further suggested that with proper follow up in place, clients may have a better chance of success (Center for Substance Abuse Treatment, 2005).

Several researchers studied the progression of drug and alcohol addiction. Fredericks and Samuel (2014) interviewed clients to ascertain their addiction process, path to rehabilitation, recovery, relapse, and the ongoing struggle to stay clean and fight some tough cravings. The researchers found that some of the behaviors noted were illegal behaviors or dishonest behaviors, and this was due to the way the cravings controlled the behavior. Cravings occur because of chemical and physical changes the drugs had on the brain which activated the addiction center of the brain and deactivated the thinking and problem-solving part of the brain. This caused the client to relapse and prevented success of staying clean (Fredericks & Samuel, 2014).

One research study by Bergman, Hoeppner, Nelson, Slaymaker, and Kelly (2015) completed a study showed positive results when clients were involved in ongoing continuing care for those who were residing in a sober environment and were working a 12-step program which includes having a sponsor, completing step work, have contact with outside members, and continuous dichotomized yes or no system. This study associated recovering clients with

abstinence better than those without ongoing continuing care by 1.3 times greater if they were involved in an activity related to recovery, and 3.2 times greater if they were involved in five activities related to recovery. This shows that active involvement and community-based resources could positively affect outcomes for a recovery client after residential treatment (Bergman et al., 2015).

In fact, the Treatment Center of the Palm Beaches LLC (2018) states that 40-60% of users relapse and overdose within in the first 30 days of completing treatment. Relapse was noted to occur when returning to old social groups or environments. Other reasons were mental breakdowns, or simply craving the drug or alcohol they were using before treatment.

In contrast to relapsing within the first 30 days following treatment, Castaneda (2017) stated that 40 to 60% of people who completed treatment relapse within a year. This was because drug and alcohol use take over the decision- making capabilities in the prefrontal cortex of the brain and battles for control of this part of the brain creating an internal battle clients could not recognize or fight alone. Clients need to stay away from the people and situations (triggers) that tempt them to use again and need to learn new skills to cope effectively. Castaneda stated that to prevent relapse the client could join a 12-step program, surround themselves with positively sober people, practice HALT (which stands for the prevention of being hungry, angry, lonely, tired), learn new ways to cope and be vigilant, and if relapse occurs, reach out for help (Castaneda, 2017).

Strengths and limitations. The strength of this evidence-based information was attained from well-known, and reliable sources. The limitation of the evidence-based information was that there were limited amounts of literature regarding research from 2012-2018, and few quantitative studies.

The Conceptual and Theoretical Framework. The Disease Model of addiction in Treatment drove this project**.** First introduced by Huss in 1849, this model could be used to explain how addiction was responsible for changes in the body and mind. The Disease Model details physical and behavioral changes **i**n the brain and body during the detox process, and the complications that were ongoing due to addiction. Proponents of this model realize that there were parts of the brain that were remodeled causing some centers of the brain to activate and others not to work properly. This could lead to risky behavior, and not making safe choices due to impulsiveness. Addiction could cause the body to undergo changes that were sometimes permanent and irreversible. The longer the addiction was present, the greater the damage. Damages seen in addiction include liver failure, cirrhosis, hepatitis A, B, and C, kidney injury, pancreatitis, high blood pressure and diabetes. The Disease model fits well with the project as it describes how during the early stage of sobriety, the desire to use lingers due to the brain remembering the rush that accompanied the surge of dopamine. Assisting the recovery client in overcoming this desire requires ongoing behavioral interventions, including focus**i**ng on behavioral interventions, roleplay, peer support, and relapse prevention (Recovery & Addiction, 2017).

Methodology

Clients who are discharged from treatment to home or from a half-way house to home face many challenges without continued support, especially in the first 30 days following discharge. Without continued support, these first 30 days could trigger relapse very quickly (Treatment Center of the Palm Beaches LLC, 2018). All clients that participated in this study signed a consent and a HIPAA form. This project served as a continued support to offer direct client engagement through phone calls and visits and assisted with daily reflection of decision

making through completion of the *7 Essentials Elements for Recovery Checklist* (Patterson, B.) (see Appendix A).

Project Design The design for this quality improvement project was the Six Sigma methodology for process improvement. This was a discipline and improvement approach which was applied to define, measure, analyze, and improve the outcomes of clients during the transition home through the use of direct client engagement and support by phone calls, visits, and the *7 Essential Elements of Recovery Checklist*. The program was designed around an understanding of the triggers, behaviors, and dual diagnoses of the participants, need for changes, and their perspective on treatment and fear of relapse which was gained through personal observation.

Setting

The program was offered to those clients finishing up treatment within a drug and alcohol rehabilitation facility serving the Southwest region of South Dakota.

Project plan/Population sample

The population within the chosen drug and alcohol rehabilitation facility consists primarily of Caucasian, Native American, African American, and Hispanic men and women between the ages of 21-60 years old. This facility could admit and treat a maximum of 60 inpatients at any given time. All clients who had just finished rehabilitation at the facility were invited to participate in this project if they had access to a phone and were able to set up at least one additional weekly visit with me. This visit was done in person or through skyping, as long as we could see each other face to face to keep the relationship strong and growing.

Tools/ Instruments

The tool that was used in this project to evaluate progress was the *7 Essential Elements of*

Recovery Checklist which was offered direct client reflection on the pillars of recovery. Data collected from t*he 7 Essential Elements of Recovery Checklist* included meeting attendance, working steps with their sponsor, individual counseling, working on relationships, eating healthy, exercising and sleep hygiene, working at a job, and growing spiritually each day. Permission was obtained from the author to use this tool for the project (see Appendix B). A weekly evaluation form was created for use at the end of each week to rate the program overall and to identify need for additional support (see Appendix C). Each of these tools allow 30 days of recording responses and allowed personal reflection and prompted quick intervention by me if additional support was needed.

Project plan

The project plan included a program to support the client who was transitioning home to continue direct client engagement through focusing on the *7 Essential Elements of Recovery Checklist*, a daily evaluation form, 2-3 phone calls weekly, and 1-2 skype or face-to-face visits weekly. Clients were instructed to complete the *7 Essential Elements of Recovery Checklist* and the evaluation form daily. Their answers were recorded and reviewed during weekly phone calls and visits, and I intervened if needed. The program allowed the client time to self-reflect on the progress they had made and focused on good behavior and good decision making to allow continued growth. All clients had a phone number to call if they needed assistance between phone calls and visits. At the end of the 30 days, the client decided whether to continue or discontinue the support program. Each week for two months, two to three clients who were discharged were invited to participate in this project. A total of 20 participants were invited to participate in this project. Each participant was assigned a number and the number was matched to a phone number and their first name. All names were kept confidential and were not used in

any data collection. The only purpose of the name was to provide a friendly environment for calling or visiting. This way the participant felt connected, remained anonymous, and their identity remained secured. The race, age and sex of the participant was recorded for purposes of this research. Each participant received a paper copy of the *7 Essential Elements of Recovery Checklist* and the evaluation form. They were asked to sign a HIPAA release form and a consent form to participate in the project. Participants had access to a phone number for emergency needs, such as relapse or other coping issues that may have occurred during the 30 days. The caller gave their identifying number, and all calls remained confidential. The only data that was recorded for these phone calls was the issue presented and the need for continued support. This emergency contact phone number was monitored by a Drug and Alcohol Counselor, or Family Nurse Practitioner (FNP) Preceptor, if I was unavailable.

Outcomes. The desired participant outcomes of this program were as follows: Abstain from using drugs and alcohol for 30 days, to use direct client engagement, and comply with phone calls and visits. The overall program outcome that was measured was the relapse rate of participants. The effectiveness of the program was measured at the end of the project.

Procedures for data collection. Data were collected from both tools during phone calls and visits, and at the end of the 30 days to watch for relapse occurrence and for opportunities to provide support. The phone calls and visits were conducted by a Drug and Alcohol Counselor, or FNP Preceptor, if I was unavailable. The data collected during the phone calls and visits were recorded on a *7 Essential Elements of Recovery Checklist* and evaluation from for each client. All data were kept in a secured and locked place for the duration of the project. The response rate was recorded also, along with the average fall-off rate at the end of the 30 days.

If someone other than the participant answered the phone, or the call went to an

answering machine, a message was left stating, “Hello, this is Deb Koopman, calling for (participant’s name). Please return a call to 605 929 5198”. Consent was collected in order to leave a message (see Appendix D).

Evaluation and sustainability plan. The data reflects how the participants felt about direct client engagement, if the client felt supported enough, and if the client needed more help to prevent relapse. Aggregate data and the 30-day relapse rate were analyzed to see if the overall program was successful. At the end of the 30 days, the facility was given all rights to the project.

Timeline. The timeline for this program followed the participants from day one post treatment through day 30 post treatment. The participants had the opportunity to continue to work the program after the 30 days.

Data Analysis

Data were analyzed to determine what worked well, what didn’t work well, what didn’t work at all, and what could be improved. This process allowed for the identification of what the next steps were to improve the outcome-based performance measures needed to assess change, and to address the need for the change. Responses to the evaluation form were analyzed for mean scores. An aggregate 30-day relapse rate was computed to find if the program was a success. The *7 Essential Elements of Recovery Checklist* was used only to provide visual goal orientated support to the response rate.

Ethical Issues

The ethical aspects of project implementation were protected by removing all personal identifiers of the participants. Each participant was given a paper copy of the *7 Essential Elements of Recovery Checklist* and the evaluation form and I recorded their answers under their

assigned number during phone calls or visits and at the end of the 30 days. A private phone number was used for all calls made or received by me for this project. The rights and welfare (including data integrity/security), privacy, and confidentiality, were protected by informed consent. Each participant was made aware of their legal rights, integrity, security, privacy, confidentiality in writing before the consent was collected (see Appendix E). As a vulnerable population, all information and participation were protected by confidentiality, and used only for the purpose of this program. Information collected was not shared, all identifiers were removed, first names were coded with a number to correspond to a phone number (kept separated from one another), and all data was kept in a locked secure place. Approval for this project was be obtained from the Bradley University Committee on the Use of Human Subjects in Research (CUHSR) (See Appendix F). The rehabilitation facility accepted Bradley University's CUHSR IRB decision and had asked for a HIPAA release form to be signed by me (see Appendix G). The clients signed a HIPPA release form also (see Appendix H).

Organizational Assessment

The chosen drug and rehabilitation facility supported the implementation of this direct client engagement and support program, phone calls, and visits, as it had the potential to prevent the client from relapsing and fueled their chances of recovery. There were no anticipated barriers on the part of the organization. The client was held accountable if they were willing to participate. If the client needed help or felt themselves slipping they could call the support number at any time.

The risks of this project were very small, no more than what you encounter in normal life. The possible risk for the participants in this project was a breach of confidentiality through inadvertent disclosure of their participation. Their name was kept confidential throughout the

entire process, to help protect against a breach in confidentiality.

The role of inter-professional collaboration was to make phone calls and visits, monitor and intervene with participants when needed, collect data from the *7 Essential Elements Checklist* and evaluations, record the input, assess progress, and make changes as needed. I served as the main contact for the project. A drug and alcohol counselor and my preceptor served as my mentors and back up staff as needed in my absence.

Cost factors

Budgetary needs for this program included the cost of making copies $20.00, and gas for visits $200. The phone for the project was a soft phone application. To avoid most of the costs associated with the implementation of this program, visits were set up consecutively for those in close proximity. This kept the cost of gas down and helped with time management while driving between appointments. The copies of the tool were made at my home.

Organizational support for the project was obtained from a designated drug and alcohol counselor and an FNP. All labor involved was volunteered as an act to pay-it forward, and I was responsible for start-up and maintenance costs involved in implementing and continuing the program for the duration of the project. The facility now has all rights to the project.

Results

Of the 20 participants that were enrolled in the program, 12 successfully completed the program (60%), one relapsed and withdrew from the program (5%), and seven did not even start the program (35%).

Data were analyzed to determine what worked well, what didn't work well, what didn't work at all, and what could be improved. This process allowed for the identification of what the next steps need to be taken to improve the outcome-based performance measures, the need to

assess change, and the need to address the changes.

The program worked very well. It ran smoothly and those that participated were excited about communicating their progress, their needs, and their concerns. What didn't work well was that if the participant did not provide the correct contact information, they could not be contacted. What didn't work at all was that the participants did not want to meet face-to-face, so that will not be attempted again. What could be improved would be to set up the best times to contact each participant, and to offer options as to how to be contacted by phone, text, email, or facetime.

Table 1.

Communication Attempts Made to Participants and Number of Responses from Participants

Participant's Assigned number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Attempts in Communication Made by Team	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Number of Times Participants Responded.	2	0	5	5	5	1	5	5	3	3	3	1	5	5	3	0	5	0	0	0
Overall Response Rate	56%																			

Note. Communication attempts included calls, texts, emails, and visits/facetime made over the 30-day time period.

Communication attempts were made through calls, texts, emails, and visits/facetime to each participant five times throughout the 30 days. The type of attempt used was determined by how the participant stated he or she wanted to communicate. Of the 20 participants that enrolled in the program, eight (40%) responded every time, seven (35%) responded some of the time (1-3 times), and five (25%) did not respond to any of the five communication attempts. The overall response rate was 56% (see Table 1).

Table 2.

7 Essential Elements for Rehabilitation Checklist Details

Participant Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Percent successful
Relapse	N	X	N	N	N	Y	N	N	N	N	N	X	N	N	N	X	X	X	X	X	92%
Use checklist	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Have a sponsor	Y	X	N	Y	Y	X	Y	Y	Y	N	N	X	Y	Y	Y	X	X	X	X	X	75%
Speak to a counselor by phone	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
See counselor face to face	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Attend a meeting	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Reach out for support	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Work with a sponsor	Y	X	N	Y	Y	X	Y	Y	Y	N	N	X	Y	Y	Y	X	X	X	X	X	75%
Be of Service	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Fellowship outside meeting	Y	X	Y	Y	Y	X	Y	Y	Y	N	Y	X	Y	Y	Y	X	X	X	X	X	92%
Cont. Care Meeting	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Work on relationships	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Work with a higher power	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Relationship with self	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Good diet	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Exercise	Y	X	Y	Y	Y	X	Y	Y	Y	N	Y	X	X	Y	Y	X	X	X	X	X	80%
Good sleep	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Be to work 15 minutes early	Y	X	X	Y	Y	X	X	Y	Y	X	Y	X	X	Y	Y	X	X	X	X	X	67%
Work a full day	Y	X	X	Y	Y	X	X	Y	Y	X	Y	X	X	Y	Y	X	X	X	X	X	67%
Did the best at work	Y	X	X	Y	Y	X	X	Y	Y	X	Y	X	X	Y	Y	X	X	X	X	X	67%
Did not overwork	Y	X	X	Y	Y	X	X	Y	Y	X	Y	X	X	Y	Y	X	X	X	X	X	67%
Guarded my recovery in romance	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%

Was not selfish or harmful in romance	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Sought a higher power	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%
Prayed and meditated	Y	X	Y	Y	Y	X	Y	Y	Y	Y	Y	X	Y	Y	Y	X	X	X	X	X	100%

Note. Collected during communication with participants. Y=yes completed the task weekly, N=no did not complete the task weekly, X= did not respond to communication or responded only once and were not included in the data analysis.

The *7 Essential Elements of Recovery Checklist* was used only to provide visual goal orientated support to the participants. They were encouraged to use this checklist to become grounded in their recovery and to provide instruction for daily living which was broken down into simple steps that were answered in a yes or no fashion. If the participant completed the task the box was marked with a "Y" and if not, it was marked with a "N" or simply left blank. During each communication, participants were asked if they were accessing the checklist and their responses to each checklist statement were recorded. During the 30 days, there was one relapse recorded (participant #6) and the participant dropped the program even after attempts to intervene (see Table 2).

Table 3.

Program Evaluation

Participant Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	Item Mean Score
I feel my needs are met while engaged in this program.	5	X	5	5	5	X	5	5	5	5	5	X	5	5	5	X	X	X	X	X	5
I feel I am making progress in this program.	4	X	5	5	5	X	4	5	4	4	5	X	5	5	4	X	X	X	X	X	4.58
The program has helped me stay focused on preventing	5	X	5	5	5	X	5	5	5	5	5	X	5	5	5	X	X	X	X	X	5

relapse.																					
I am making good choices and considering my actions before acting.	4	X	5	5	5	X	5	5	5	4	5	X	5	5	5	X	X	X	X	X	4.83
When I am stressed out I turn to other options besides drugs and alcohol.	5	X	4	5	5	X	5	4	5	5	5	X	5	4	5	X	X	X	X	X	4.75
Overall Program Evaluation Mean	4.83																				

Note. Item mean scores represent participant means for each statement. 1=strongly disagree, 2=disagree, 3=undecided, 4=agree, 5=strongly agree, X=did not participate.

Responses to the program evaluation form were recorded during each communication with the participants. At the end of the 30 days, an item mean score was computed for each participant along with an overall program mean. All responses ranged from agree to strongly agree with an overall program mean of 4.83 (see Table 3).

An overall 30-day aggregate relapse rate was computed for the 15 participants that responded to at least one communication attempt. During week one, one participant relapsed, interventions were attempted but were unsuccessful and the participant withdrew from the program. Two participants started but did not complete the program. Twelve participants were successful and continued with the program for the entire 30 days. Relapse data was not available for those that did not complete the entire 30-day program. The overall 30-day aggregate relapse rate for the 13 participants for whom data was available was 8%.

Discussion of Results linked to Project Objectives

The PICOT question for this project was, “For clients being discharged from a drug and alcohol rehabilitation facility (P), how does having a direct client engagement and support program (I) compared to not having a direct client engagement and support program (C), affect the success or relapse rate O) within the first 30 days following treatment (T)?” The data showed that this project was successful in offering a direct client engagement and support program to those who wanted to participate, and it may have offered added support to those who needed it. This may have added to the success rate. Of the 20 participants that enrolled in the program, 12 successfully completed the program (60%), one relapsed and withdrew from the program (5%), two started but did not complete the program (10%), and five did not even start the program (25%).

The desired participant outcomes of this program were to abstain from using drugs and alcohol for 30 days, to use direct client engagement, and to comply with communication. The overall program outcome that was measured was the 30-day relapse rate of the participants that started the program and responded to at least one communication attempt (n=15). Only one participant is known to have relapsed and this occurred during the first week of the program. There may have been contributing factors for this participant at home that could be identified, but not necessarily avoided. This participant had many responsibilities at home that may have overstressed the participant and made it too hard to transition back to those responsibilities at hand including caregiving 24 hours a day for a challenged sibling, working full time, being the sole provider, poor coping skills, and high risk for returning to familiar behaviors to cope with the stress.

The data speaks for itself. It was found that 60% (n=12) of those that started the study were successful, and 5% (n=1) of the participants relapsed and stopped participating despite

intervention attempts. Overall, all of the participants signed the consent, indicating that they agreed to participate, but 35% (n=7) did not take part in the project after signing up. Data showed that those who had supports in place with communication were more successful during the first 30 days.

Table 2 shows that those involved in a direct client engagement program were more successful than those who did not respond. During the 30 days, there was one relapse recorded and the participant dropped the program even after attempts to intervene. Many of the participants transitioning back to the community had to start over looking for employment and extra support was given in this area. These participants did an excellent job overcoming these challenges and set up interviews to secure new jobs. One of the supports I assisted with was practicing interview questions with some of the participants. This assisted them in securing new positions. Some of the participants could not exercise due to health complications. These complications affected their daily living skills, and each overcame these challenges to keep working towards success. Many participants stated that they used the checklist as a visual guide and it helped them to stay on track with their daily goals and kept them focused and motivated each day.

Using this checklist allowed for intervention early when extra guidance was needed. When I would ask the checklist questions, the questions prompted me to dig deeper into the issue. When I did this I was able to assist the participant with the need at hand. Some of the things I assisted with were: Finding a sponsor, listening when the participant needed to vent, talking through a difficult situation, role playing to prepare the participant for a difficult situation, offering praise and reassurance, and celebrating their small successes through the 30-day process.

Not many treatment centers offer a transitional program like this program did. Therefore, it was likely to have a positive impact on this sensitive population because a holistic approach was taken for their spiritual guidance and for their addiction. Each participant with dual diagnoses was met where they were mentally, physically, and spiritually.

Discussion of Limitations

There were many important findings in this project, but there were also some limitations that should be discussed. First, because counselors participating in this project were volunteers at the treatment center, results may not be generalizable to programs led by substance abuse counselors working at facilities that hold paid positions. Different outcomes may occur because the volunteer staff have faced addiction and were able to relate with the personal experiences of those recovering from drug and alcohol abuse. Additionally, different staff approaches, different teaching and interactive methods, and the presence of dual diagnoses could affect outcomes of post-treatment support programs.

At least one participant was not able to be contacted by the number given on the forms. No attempt was made to locate the correct number. If this was a simple mistake on the participant's part, this could have affected the participant's outcome as participation may have prevented relapse or assisted the participant with their needs and needed interventions and support. The decision not to try locating the participant's phone number was a difficult one, as we wanted to offer support to all that signed up for added support during the transition home. This created a barrier for the team, but each participant was clearly told they will not be contacted if they do not write down correct contact information.

The sample used in this project could have been limited by the geographical restraints which limits the generalizability of the findings. The rehabilitation center draws clients from all

across the United States. The location of each participant offered a set of challenges for those who would have liked to meet face-to-face but had to settle for facetime because of their distance. Lack of face-to-face contact may have been one of the factors that influenced those participants who signed up for the program but didn't start the program.

Further, there may have been considerable cultural and spiritual differences, since this project followed the foundation of the treatment center emphasizing that a higher spiritual power was an important part of recovery. This could have impacted and affected the outcomes for those who do not share in those specific beliefs. Careful consideration and respect were given to not mention God, however, it could have been offensive to those participants who misinterpreted this concept. Future research is needed to study the effects of rehabilitation with the foundation of believing in a higher spiritual power and the outcomes.

Finally, the methods used in this project were based on the current belief of one treatment center and other treatment centers may operate differently which could potentially affect the outcomes of the participants.

Discussion of Implications and impact to practice

This project successfully showed that those who participated in the direct client engagement and support program did well with the extra support in place. The support offered a place to turn to, a person to confide in, and someone to hold their hand along the beginning of a long journey.

The results of this project could be used in the future to convince those in charge of treatment centers that direct client engagement and support after discharge is worthwhile and cost-effective. Also, a future addict in recovery may appreciate the knowledge that those who were involved with an aftercare support program did well, while outcomes of those that did not

participate remain a huge unknown. The results of this project showed evidence that supports positive outcomes when direct client support is provided post treatment.

Conclusion

The value of the project to health care and practice will add evidence to support positive outcomes for those transitioning home after acute drug or alcohol treatment with direct client engagement and supports in place. The *7 Essential Elements of Recovery Checklist* provided the participants a visual goal orientated daily list to guide their success. When used along with weekly contact, counselors can collect data, provide feedback, encourage participants to stay clean and avoid relapse, and flag the need for additional support or intervention.

To implement this project, I used the DNP Essentials V: Health Care Policy for Advocacy, Essential VI: Interprofessional Collaboration for Improving Patient and Population Health Outcomes, and Essential VII: Clinical Prevention and Population Health for Improving the Nation's Health (AACN, 2006).

To meet DNP Essential V, I was an advocate for the social justice for this specific vulnerable population by implementing the program to provide support to the patient to bridge the gap of transitioning back to society. I treated each participant with dignity and respect, offered active listening, was present when the participant needed me to be I kept an open mind, considered their point of view, advocated for their needs, was fair, honest, and I offered resources when needed. Most of all, this project gave me a first-hand appreciation for each individual's situation.

The DNP Essential VI taught me to work successfully with a collaborative team during the planning and implementation process of the program. I was able to visualize my progress

and strengthen my skills. I worked on communication, asked questions, practiced active listening, made team decisions, voiced my concerns, and was given feedback from the team.

The DNP Essential VII helped me stay focused on preventing relapse of two or more patients who entered the program. I offered care specific to each patient and focused on the best outcomes possible while supporting each participant.

This project will leave a paper tool for future patients to visualize goals and progress if used. It offered an easy way to collect data, stay active in the transition process, and to flag the need for support or intervention. It provided feedback from the participants and encouraged them to stay clean and not relapse.

The plan for dissemination of this project is to publish the results in a peer-reviewed journal and present at local, regional, and/or national conferences to educate other providers and addicts on the benefits of direct client engagement in their own rehabilitation. Programs of this type can offer support to start a new life, build new relationships, and bridge broken relationships. Having a support person to call for assistance with finding resources or to talk through a difficult situation has been a valuable asset to this project. I hope to publish this project and help as many people as I can.

Attainment of personal and professional goals

In this project, those who took part in direct client engagement and completed the program were successful and made it through the first 30 days of transitioning home. It is not known if all of those who did not complete the program made it through the first 30 days of transitioning home. It is my personal and professional goal to work towards finding a way to further help clients that have relapsed, and also reach those that did not participate in the program. I would like to work towards a 100% success rate of drug and alcohol rehabilitation

across the board. I have a passion for this particular population, and I want to make the world a better place by being a cornerstone for those who will benefit from direct client engagement and having a support system.

References

Association of Colleges of Nursing (AACN), 2006. The essentials of doctorial education for advanced nursing. Retrieved from www.aacn.nche.edu

Benishek, L., Kirby, K., Leggett, K., & Padovano, A. (2010). Beliefs about the empirical support of drug abuse treatment interventions: A survey of outpatient treatment providers. *Drug and Alcohol Dependence 107*(2010*), 202-208*. Retrieved from http://www.sciencedirect.com/science/article/pii/S0376871609004037

Bergman, B., Hoeppner, B., Nelson, L., Slaymaker, V., & Kelly, J. (2015). The effects of continuing care on emerging adult outcomes following residential addiction treatment. *Drug and Alcohol Dependence, 153,* 207-214. Retrieved from https://scholar.harvard.edu/johnfkelly/publications/effects-continuing-care-emerging-adult-outcomes-following-residential

Blevins C., Abrantes A., & Stephens R. (2016). Motivational pathways from antecedents of alcohol use to consequences: a structural model of using alcohol to cope with the adverse effect on drug and alcohol abuse. *American Journal of Drug and Alcohol Abuse*, 1-9. Retrieved from https://www.docphin.com/research/article-detail/18476289/PubMedID-27111187/Motivational-pathways-from-antecedents-of-alcohol-use-to-consequences-a-structural-model-of-using-alcohol-to-cope-with-negative-affect

Center for Substance Abuse Treatment (2005). 10 Treatment for Offenders Under Community Supervision. In Substance Abuse Treatment for Adults in the Criminal Justice System: A Treatment Improved Protocol (TIP) Series, No. 44. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK64141/

Clay, R. (2015). Treating drug abuse. As deaths from heroin increase, psychologists are exploring what kind of treatment works best. *American Psychological Association, 46*(2)*, 46.* Retrieved from http://www.apa.org/monitor/2015/02/drug-abuse.aspx

Castaneda, R. (2017). Why do alcoholics and clients relapse so often? *US News and World Report.* Retrieved from https://health.usnews.com/wellness/articles/2017-04-24/why-do-alcoholics-and-clients-relapse-so-often

Dictionary.com, LLC. (2017). Retrieved from http://www.dictionary.com

Dual Diagnosis.org. (n.d.). Aftercare for drug and alcohol rehab. Retrieved from http://www.dualdiagnosis.org/aftercare-for-drug-and-alcohol-rehab/

Fredericks, J. & Samuel, E. (March 2014**).** Drugs and Recovery: A Qualitative Study in Atlantic Canada. *American International Journal of Social Science, 3*(2), 28-34. Retrieved from: http://www.aijssnet.com/journals/Vol_3_No_2_March_2014/4.pdf

Lian, T., & Chu, F. (2013). A qualitative study on drug abuse relapse in Malaysia: Contributory factors and treatment effectiveness. *International Journal of Collaborative Research on Internal Medicine & Public Health 5*. 217-232. Retrieved from: http://internalmedicine.imedpub.com/a-qualitative-study-on-drug-abuse-relapse-inmalaysia-contributory-factors-and-treatmenteffectiveness.php?aid=6266

National Institute on Alcohol Abuse and Alcoholism (n. d.). Alcohol's effect on the body. Retrieved from https://niaaa.nih.gov/alcohol-health/alcohols-effects-body

National Institute on Drug Abuse (2016). How is cocaine addiction treated? Retrieved from https://www.drugabuse.gov/publications/research-reports/cocaine/what-treatments-are-effective-cocaine-abusers

National Institute on Drug Abuse (2018). Principles of Drug Addiction Treatment: A Research-

Based Guide (Third Edition): How effective is drug addiction treatment? Retrieved from https://www.drugabuse.gov/publications/principles-drug-cliention-treatment-research-based-guide-third-edition/frequently-asked-questions/how-effective-drug-cliention-treatment

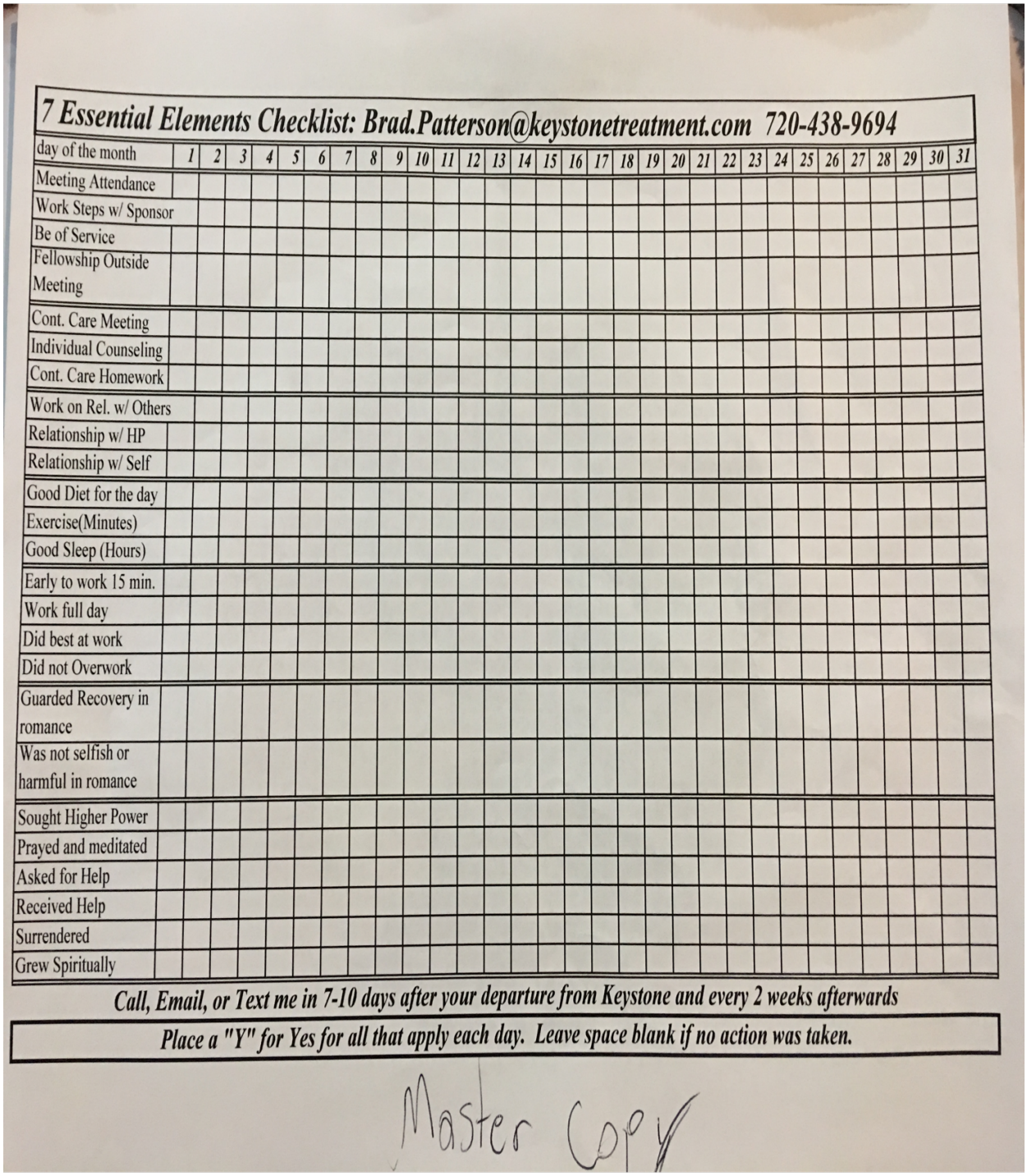
Patterson, B. (2018). *7 Essential Elements of Recovery Checklist*.

Project Know Understanding Addiction. (2013). Drug addiction & alcoholism stats in the United States. Retrieved from http://www.projectknow.com/research/alcohol-and-drugs/

Pedroso, R., Kessler, F., & Pechansky, F. (2013). Treatment of female and male inpatient crack users: A qualitative study. *Trends in Psychiatry and Psychotherapy 35*(1), 36-45. Retrieved from https://www.researchgate.net/publication/260770867_Treatment_of_female_and_male_inclient_crack_users_A_qualitative_study

The Treatment Center of the Palm Beaches LLC (2018). *Overdoses Occur Often in First 30 Days After Treatment*. Retrieved from https://www.thetreatmentcenter.com/blog/overdoses-first-30-days-after-treatment/

Appendix A ***7 Essential Elements Checklist***



7 Essential Elements Checklist: Brad.Patterson@keystonetreatment.com 720-438-9694

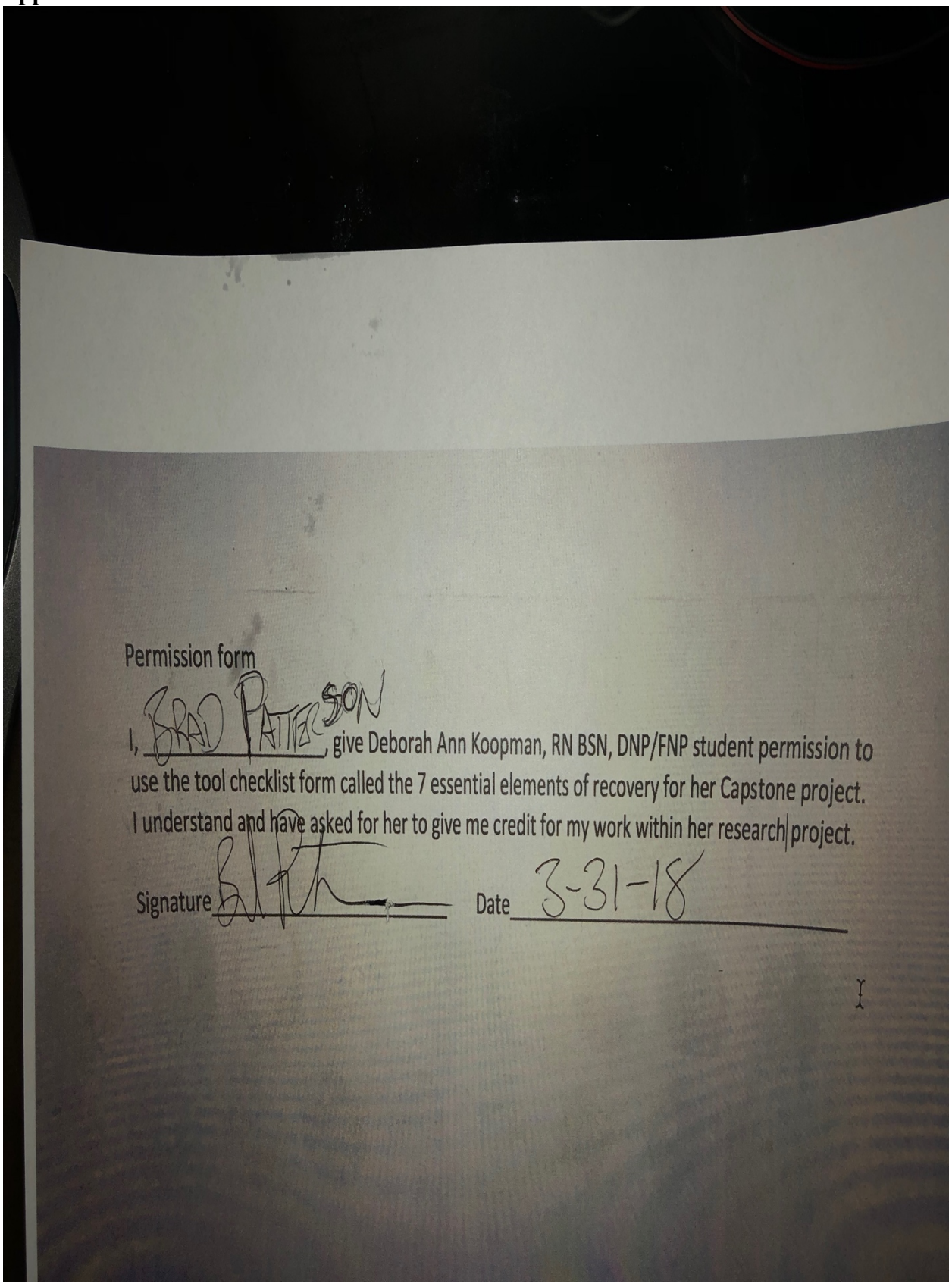
day of the month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Meeting Attendance																															
Work Steps w/ Sponsor																															
Be of Service																															
Fellowship Outside Meeting																															
Cont. Care Meeting																															
Individual Counseling																															
Cont. Care Homework																															
Work on Rel. w/ Others																															
Relationship w/ HP																															
Relationship w/ Self																															
Good Diet for the day																															
Exercise(Minutes)																															
Good Sleep (Hours)																															
Early to work 15 min.																															
Work full day																															
Did best at work																															
Did not Overwork																															
Guarded Recovery in romance																															
Was not selfish or harmful in romance																															
Sought Higher Power																															
Prayed and meditated																															
Asked for Help																															
Received Help																															
Surrendered																															
Grew Spiritually																															

Call, Email, or Text me in 7-10 days after your departure from Keystone and every 2 weeks afterwards

Place a "Y" for Yes for all that apply each day. Leave space blank if no action was taken.

Master Copy

Appendix B. Permission Form for the Use of the Tool



Permission form

I, BRAD PATTERSON, give Deborah Ann Koopman, RN BSN, DNP/FNP student permission to use the tool checklist form called the 7 essential elements of recovery for her Capstone project. I understand and have asked for her to give me credit for my work within her research project.

Signature _____ Date 3-31-18

Appendix C Weekly Online Survey

Participants assigned number_____ Date _____

Please place the corresponding number in the blank to rate your evaluation of this program.
Strongly disagree (1). Disagree (2). Undecided (3). Agree (4). Strongly agree (5).

I feel my needs are met while engaged in this program.

_____

I feel I am making progress in this program.

_____

The program has helped me stay focused on preventing relapse.

_____

I am making good choices and considering the responsibility of my actions before acting.

_____

When I am stressed out, I turn to other options besides drugs and alcohol

_____

****

I would like to be contacted by my support person. (Please check this daily and a support person will contact you.

_____YES or _____NO

Please list the best number to reach you _____

****

Appendix D Consent to Leave a Message

By signing this consent, I _____agree to allow Deborah Koopman, a Nurse Practitioner student, to leave the following message if someone other than you answer the phone, or the call goes to an answering machine: “Hello, this is Deb Koopman, calling for (participant’s name). Please return a call to 605 929 5198”.

Appendix E Informed Consent

BRADLEY UNIVERSITY

Information and Consent Form

Study Title: A Need for Support After Drug and Alcohol Treatment

I. Invitation to be part of a research study:

You are invited to participate in a research study. Taking part in this research project is voluntary. All clients 18 years of age and older who have completed drug or alcohol rehabilitation at the participating facility, who are willing to sign a consent form, use the checklist, evaluation form, have access to a phone, and are willing to visit 1-2 times a week face to face (in person or by skyping) will be invited to participate in the program.

II. Key information regarding this study:

The purposes of the study will research if direct client engagement and support benefits the outcome the recovering drug or alcohol addict. For 30 days, the you will use the checklist, evaluation form, have access to a phone, and are willing to visit 1-2 times a week face to face (in person or by skyping) will be invited to participate in the program. At any time, the client can also make direct calls for additional support if intervention is needed. After completion of the program, the client can decide to continue with the program, but no further findings will be recorded beyond the initial 30 days for the purpose of this study.

III. What is the purpose of this study?

The purpose of the study is to develop, implement, and assess the effectiveness of the direct client support program, for those who have completed drug and alcohol treatment and are making a transition home.

IV. What will happen if you take part in this study?

If you take part in the study you will be asked to use the checklist, evaluation form, have access to a phone, and are willing to visit 1-2 times a week face to face (in person or by skyping), and report any relapses during the 30 days. "We will use some of your personal information collected in the treatment program you are being release from. You will give permission to use this information on another form. If someone other than the participant answers the phone, or the call goes to an answering machine, a message will state, "Hello, this is Deb Koopman, calling for (participant's name). Please return a call to 605 929 5198". Consent will be collected in order to leave a message.

V. What are the risks of participating in the study?

The risks of this study are very small, no more than what you would encounter in normal life. The possible risk for you in this study is breach of confidentiality through inadvertent disclosure of your participation. Your name will be kept confidential throughout the entire process, to help protect against a breach in confidentiality.

VI. What are the benefits of participating in the study?

The benefits of participating in the study are having a constant access to support. Also, the *7 Essential Elements of Recovery Checklist* and evaluation form will provide daily reflection of the choices made, along with guidance for a healthy and balanced lifestyle which is broken down into simple questions created to stay focused on holistic self-care. By participating in this study, the client may feel more confident, focused, and supported during this difficult transitional time. The client may feel satisfaction by knowing that participation in the study may lead to changes that eventually offer support to other clients in the future.

VII. What other options are there if you choose to not participate in this study?
If you choose not to participate in this study, you have the option to use the *7 Essential Elements of Recovery Checklist* which will be given to you upon discharge. No follow up will be done.

VIII. What are the costs?
There are no costs for participation in this study. Other people may need to see this information. Other people; including: Bradley University (members of the Committee of the Use of Human Subjects in Research) and practitioners at the Keystone Treatment Center. A description of this study will be posted on http://ClinicalTrials.gov, and summary results of this study may be posted on this website at the conclusion of the research. No information that can identify you will be posted.

XI. After the study, what will happen to the data collected?
We will keep your research data to use for future research. Your name and other information that can directly identify you will be kept secure from the information collected as part of the project. We may share your research data with other investigators without asking for your consent again, but it will not contain information that could directly identify you.

XII. Your participation in this study is voluntary
Taking part in this study is completely voluntary. You may choose not to take part or may leave the study at any time. You do not need to answer any question you do not want to answer. You may withdraw before the study is completed but any data that is collected before the time of withdrawal will be recorded for the purpose of the study and is subject to future research without asking for consent again. Participation may be terminated by the principal investigator if the participant manipulates the study or the contact support number in any way is at the principal investigator's discretion.

Your refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled.

How will your information be protected?
We plan to publish the results of this study. To protect your privacy, we will not include any information that can directly identify you.

We are collecting the data confidentially. You will be assigned a number and identified only by that number for the purposes of the study. There is no link between your name and the research record. Your name and other information that can be used to identify you will be stored separately from the data collected for this study.

There are no limitations to confidentiality. You may reach out for support when you need to. All phone calls and skype will be to support you and will not be used for the purposes of this study. In the case of a relapse we will simply record when in the 30 days the relapse occurred. Everything else will be kept confidential. We will do our very best to support you through this study.

Who should I call with questions or problems about this study?
If you have any questions about this study, please contact the researcher in charge of this study:

Deborah Koopman, RN, BSN
DNP/FNP Student at Bradley University
(605)929-5198,
deborah.koopman@mail.bradley.edu

(or)

Cindy Brubaker, faculty advisor at Bradley University
(309) 677-2547
cindyb@fsmail.bradley.edu

XII. Who should I contact with questions about my rights as a research participant?
If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Committee of the Use of Human Subjects in Research (CUHSR)
Bradley University
1501 W Bradley Avenue
Peoria, IL 61625
(309) 677-3877

XIII. Where can I get more information?
Additional information may be obtained from:

Keystone Treatment Center
1010 E 2nd Street
Canton, SD 57013
(605) 519-2077

Brad Patterson, Drug and Alcohol Counselor at Keystone Treatment Center/Mentor)
(702) 438-9694
brad.patterson@keystonetreatment.com

(Jennifer Haubert, Family Nurse Practitioner at Keystone Treatment Center/Preceptor)
(605) 838-7447

jroemen@yahoo.com

XIV. Your informed consent

You are voluntarily making a decision to participate in this study. Your signature means that you have read and understood the information presented and have decided to participate. Your signature also means that the information on this consent form has been fully explained to you and all of your questions have been answered to your satisfaction. If you think of additional questions during the study, you should contact the researcher(s).

I agree to participate in this study.

_____ _____

Signature of Participant **Date**

_____

Printed Name

I verify that I received a copy of this informed consent for my keeping and signed both copies of free will.

_____ _____

Signature of Participant **Date**

Appendix F CUHSR Approval

Dear Investigators:

Your study (CUHSR 27-18) "*A NEED FOR SUPPORT AFTER DRUG AND ALCOHOL TREATMENT"* has been reviewed and was found to be expeditable under Category 5: Research on individual or group characteristics of behavior.

All vita and ethics certificate are on file.

Be aware that future changes to the protocol must first be approved by the Committee on the Use of Human Subjects in Research (CUHSR) prior to implementation and that substantial changes may result in the need for further review.

While no untoward effects are anticipated, should they arise, please report any untoward effects to CUHSR promptly (within 3 days).

As this study was reviewed and approved for one year, the maximum allowed under regulations. Please complete a final status report when the study is completed. If the study is not completed within one year, please submit a Continuing Review form before the one-year date with adequate time for CUHSR to review to prevent a lapse in approval. These forms can be found on our website, http://cushr.bradley.edu/#Forms.

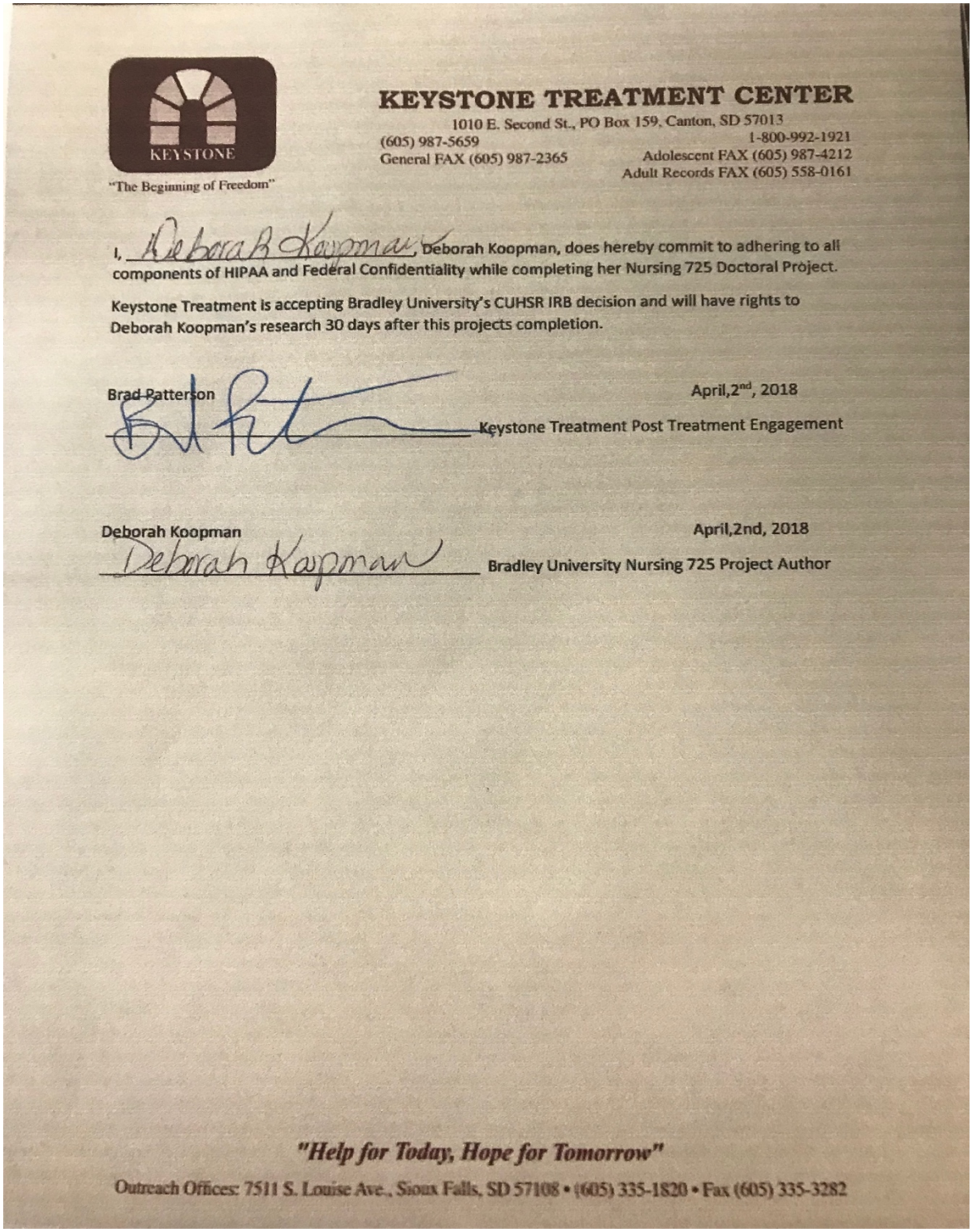
This email will serve as your written notice that the study is approved unless a more formal letter is needed. Just let me know.

Andrew J Strubhar, PT, PhD
Associate Chairperson, CUHSR
Bradley University

--
Andrew J Strubhar, PhD, PT
Associate Professor
Associate Department Chair
DPT Graduate Program Coordinator
Associate Chair CUHSR
Bradley University
Department of Physical Therapy and Health Science

1501 W. Bradley Ave
Peoria, IL 61625
(309)-677-3489
ajs@bradley.edu

Appendix G HIPAA Form



KEYSTONE

"The Beginning of Freedom"

KEYSTONE TREATMENT CENTER

1010 E. Second St., PO Box 159, Canton, SD 57013
(605) 987-5659
General FAX (605) 987-2365
1-800-992-1921
Adolescent FAX (605) 987-4212
Adult Records FAX (605) 558-0161

I, Deborah Koopman, Deborah Koopman, does hereby commit to adhering to all components of HIPAA and Federal Confidentiality while completing her Nursing 725 Doctoral Project.

Keystone Treatment is accepting Bradley University's CUHSR IRB decision and will have rights to Deborah Koopman's research 30 days after this projects completion.

Brad Patterson — April,2nd, 2018
Keystone Treatment Post Treatment Engagement

Deborah Koopman — April,2nd, 2018
Deborah Koopman
Bradley University Nursing 725 Project Author

"Help for Today, Hope for Tomorrow"

Outreach Offices: 7511 S. Louise Ave., Sioux Falls, SD 57108 • (605) 335-1820 • Fax (605) 335-3282

Appendix H HIPAA Client Form

HIPAA Release Form

The Health Insurance Portability and Accountability Act, also known as HIPAA, was created in 1996 by the US Congress to protect the privacy of your health information. The act prohibits your health care providers from releasing your health care information unless you have provided your health care provider with a HIPAA release form.

Unless you have provided a signed release form, your health care providers are prohibited from discussing any aspect of your medical information with anyone who is not directly involved in your care.

If you sign this document, you give permission to Deborah Koopman, a Nurse Practitioner student, Cindy Brubaker, faculty advisor at Bradley University, Brad Patterson, Drug and Alcohol Counselor at Keystone Treatment Center, Jennifer Haubert, Family Nurse Practitioner at Keystone Treatment Center/Preceptor, the Keystone Treatment Center,
and the Committee of the Use of Human Subjects in Research (CUHSR) Bradley University to participate in this study as her Capstone project, to use or disclose (release) your health information that identifies you for the research study described here:

> The purpose of the study is to develop, implement, and assess the effectiveness of the direct client support program, for those who have completed drug and alcohol treatment and are making a transition home. This study will be called *A Need for Support After Drug and Alcohol Treatment.*

The health information that we may use or disclose (release) for this research includes:

Data will be collected during phone calls and visits, and at the end of the 30 days to watch for relapse occurrence and for opportunities to provide support. The phone calls and visits will be conducted by the Nurse Practitioner student, a Drug and Alcohol Counselor, or FNP Preceptor. The data collected will be recorded on a *7 Essential Elements of Recovery Checklist* and evaluation form for each client. This data may include name, age, gender, race, diagnosis, previous interventions, reason listed for entering rehab, your substances of choice, history of previous treatments, reason for using drugs or alcohol, presence of dual diagnosis, current diagnosis, family history of substance abuse, how old you were when you started using drugs or alcohol, and what the influence was (friends, family, or other). All data will be kept in a secured and locked place for the duration of the project. The response rate will be recorded also, along with the average fall-off rate at the end of the 30 days.

If someone other than the participant answers the phone, or the call goes to an answering machine, a message will be left stating, “Hello, this is Deb Koopman, calling for (participant’s name). Please return a call to 605 929 5198”. Consent will be collected in order to leave a message.

The personal information listed above may be used by and/or disclosed (released) to:

> By signing this document, you authorize Deborah Koopman, a Nurse Practitioner Student, Cindy Brubaker, faculty advisor at Bradley University, Brad Patterson, Drug and Alcohol Counselor at Keystone Treatment Center/Mentor, Jennifer Haubert, Family Nurse Practitioner at Keystone Treatment Center/Preceptor, the Keystone Treatment Center, and the Committee of the Use of Human Subjects in Research (CUHSR) Bradley University to use and /or disclose (release) your health information for this research. Those persons who receive your health information may not be required by Federal privacy laws (such as the Privacy Rule) to protect it and may share your information with others without your permission, if permitted by laws governing them.

Please note that you do not have to sign this Authorization, but if you do not, you may not receive research-related treatment.

Please note that you may change your mind and revoke this Authorization at any time, except to the extent that Deborah Koopman, a Nurse Practitioner Student, Cindy Brubaker, faculty advisor at Bradley University, Brad Patterson, Drug and Alcohol Counselor at Keystone Treatment Center/Mentor, Jennifer Haubert, Family Nurse Practitioner at Keystone Treatment Center/Preceptor, the Keystone Treatment Center, and the Committee of the Use of Human Subjects in Research (CUHSR) Bradley University has already acted based on this Authorization. To revoke this Authorization, you must write to:

Deborah Koopman, RN, BSN
DNP/FNP Student at Bradley University
(605)929-5198,
deborah.koopman@mail.bradley.edu

(or)

Cindy Brubaker, faculty advisor at Bradley University
(309) 677-2547
cindyb@fsmail.bradley.edu
Keystone Treatment Center
1010 E 2nd Street
Canton, SD 57013
(605) 519-2077

(or)

Brad Patterson, Drug and Alcohol Counselor at Keystone Treatment Center
(702) 438-9694
brad.patterson@keystonetreatment.com

(or)

(Jennifer Haubert, Family Nurse Practitioner at Keystone Treatment Center/Preceptor)
(605) 838-7447

jroemen@yahoo.com

(or)

Committee of the Use of Human Subjects in Research (CUHSR)
Bradley University
1501 W Bradley Avenue
Peoria, IL 61625
(309) 677-3877

This authorization does not have an expiration date at this time but will expire when the research study is published.

I agree to participate in this study.

_____ _____
Signature of Participant **Date**

_____
Printed Name

I verify that I received a copy of this informed consent for my keeping and signed both copies of free will.

_____ _____
Signature of Participant **Date**

By signing I am stating that I have received a copy of this form.

_____ _____
Signature Date

_____ _____
Witness Date

Deborah Ann Koopman DNP/FNP Student _____