CHAPTER 23

RELAPSE PREVENTION, AFTERCARE, AND LONG-TERM FOLLOW-UP

Author | Paul Haber

This chapter provides an overview of relapse prevention and strategies to long-term patient follow-up (aftercare programs), including approaches to working with alcohol-dependent patients who resume heavy alcohol use.

RELAPSE PREVENTION, AFTERCARE, AND LONG-TERM FOLLOW-UP

GOALS OF TREATMENT

Negotiating goals of treatment has already been discussed (Chapter 4) recognizing that abstinence is not the only option. Indeed, many patients are not ready to engage in treatment that sets a goal of abstinence but may accept the need to reduce drinking. Recent research has confirmed that substantial reductions in drinking may be associated with sustained clinical improvements. The World Health Organisation (WHO) has defined four drinking risk levels (very-high-, high-, moderate-, and low-risk) and clinical benefit has been associated with reduction of at least two risk levels reaching low-risk drinking or moderate-risk for those who were initially drinking at very-high-risk levels.

TABLE 23.1: WHO drinking risk levels:

RISK LEVEL	CONSUMPTION (G/DAY)	
	Male	Female
Very - high-risk	101+	61+
High-risk	61 - 100	41 - 60
Moderate-risk	41 - 60	21 - 40
Low-risk*	0 - 40	0 - 20

*Australian consumption guidelines 2020 recommend 10 drinks (100g) per week to maintain low risk drinking for both males and females and no more than 4 drinks (40g) on any one day.

RELAPSE PREVENTION AND MANAGEMENT

Relapse is a common challenge in alcohol treatment; approximately 60 percent of patients return to problematic drinking within the first month of treatment. In this respect, the difficulty of maintaining sustained reduction of alcohol consumption resembles the challenges of maintaining other kinds of behavioural change.

Various internal and external factors (often those associated with drinking in the past) can contribute to relapse risk:

- persisting desire to drink with the belief that consumption can be controlled;
- positive emotional states (e.g. celebration);
- negative emotional states (such as frustration, anxiety, depression or anger);
- interpersonal conflict (such as relationships with partner, work colleagues, friends); and
- direct or indirect social pressure to drink.

Relapse prevention and management strategies are a set of strategies that aim to help the patient maintain treatment gains (see **Chapter 9**). Relapse prevention and management teach patients cognitive and behavioural strategies that help prevent an initial lapse and prevent lapses becoming relapses. These strategies focus on development of coping skills and the self-efficacy to implement these skills, and the attainment of perceived gains for the effort of changing drinking behavior as part of the maintenance of change.

Relapse prevention and management can be assisted through use of medication (including alcohol pharmacotherapies such as naltrexone, acamprosate, disulfiram) for reducing alcohol use or medication for addressing psychological problems, such as anxiety or depression (see **Chapter 10**).

RETRAINING COGNITIVE BIASES TO PREVENT RELAPSE

Biased decision making is a feature of alcohol dependence whereby stimuli, such as tastes, smells, visual cues, and physical and social contexts are increasingly paired to the rewarding effects of alcohol via the brain's reward system. This may result in alcohol-related cues triggering automatic tendencies to resume consumption of alcohol. This process occurs, in part, outside of conscious awareness, which could make it difficult to address. These cognitive biases can be dampened through a computerised cognitive training intervention known as cognitive bias modification (CBM). Over a few sessions (typically 4-6), individuals with alcohol dependence practise repeatedly "avoiding" alcohol cues (e.g., pictures of alcoholic beverages) and "approaching" neutral cues (i.e., non-alcohol-related images). There is some evidence from recent Australian and international studies that CBM delivered as part of inpatient alcohol withdrawal treatment may reduce relapse risk. However, there is not yet sufficient evidence to recommend routine use of CBM in alcohol dependence. More research in a variety of clinical contexts with longer-term follow-up is required.

AFTERCARE

Aftercare generally refers to contact with a clinician or service immediately following intensive treatment, and has the goal of maintaining treatment gains and ensuring timely re-engagement if there is the risk of relapse or in the earliest stages of any relapse. The first 3 months of recovery are critical to success and are characterised by a high risk of relapse. Natural history studies reveal the risk of relapse continues for five years and occasionally even longer. Aftercare acknowledges this risk of recurrence of alcohol use and that to maintain change, ongoing monitoring and assistance is required beyond the initial treatment.

Aftercare is an important part of a comprehensive intervention plan. It is particularly suited to people with severe dependence whose likelihood of relapse is greatest. It provides the individual with a network supportive of sobriety, reinforces skills consistent with maintaining abstinence/controlled drinking and improving psychosocial functioning, and helps the individual negotiate unforeseen challenges.

Aftercare can consist of planned telephone or face-to-face contact following a period of treatment to discuss progress and any problems that may have arisen since the end of active treatment. Often primary care workers (such as general practitioners) can provide this function through ongoing follow-up, often as part of review of other health issues. Clinicians may use referral to self-help programs, such as Alcoholics Anonymous and SMART Recovery®, as forms of continuing care or in addition to a structured aftercare program (see Chapter 11).

Long-term follow up is an important part of a comprehensive treatment plan. Long-term goals include optimising mental and physical health and improving social functioning. It is important to develop an individual management plan to identify particular risks for a patient, identifying a plan to avoid a lapse and a plan to quickly address a lapse so it doesn't become a relapse. This is comparable to escalation planning for other disorders (for example asthma) where early recognition and management can prevent clinical relapse. If the patient continues drinking, a clinical 'harm-reduction' model is appropriate.

	RECOMMENDATION	GRADE OF RECOMMENDATION
23.1	Long-term follow-up of patients following an intensive treatment program is recommended as part of a comprehensive treatment plan, reflecting the chronic relapse possibility of alcohol dependence.	D

SUPPORTING A PERSON DRINKING AT HIGH- OR VERY-HIGH-RISK LEVELS: A HARM REDUCTION APPROACH

Many people will not be receptive or respond to the variety of treatment approaches aimed at reducing their alcohol use and continue to drink at high- or very-high-risk levels, and experience ongoing alcohol-related harms. The principles of clinical harm-reduction interventions recognise that some people will continue to use alcohol and/or other drugs, and aim to work with these

people to nevertheless reduce alcohol-related harms. Priority is placed on immediate and achievable goals, underpinned by values of pragmatism and humanism. Such goals may include achieving a greater number of abstinence days and reducing alcohol consumption on drinking days.

It is critical to undertake a comprehensive risk and medical assessment and design a strategy that reduces identified risks.

Examples of clinical harm-reduction interventions or strategies include:

- Recognising that a person's motivation to change their drinking patterns is not always fixed, and can be influenced by health professionals, families and friends, and changes in circumstances. Building a good therapeutic alliance by attending to their wants and needs can forge the way for subsequent willingness to cut down or stop their drinking. For example, an alcohol-related hospitalisation can act as a 'window of opportunity' to engage the patient in treatment for their alcohol use.
- Maintaining engagement, and an underlying sense of hope for the patient, is important. Strategies to enhance patient engagement may include the clinician attending to barriers posed by the patient's memory or other cognitive disorders, language and/ or cultural issues, or physical disabilities. For example, consider using translation services, appointment reminder systems and strategies to enhance medication adherence.
- Continue to encourage a reduction or cessation of alcohol intake, and regular discussion of available interventions to this end, including psychosocial interventions, self-help groups, and pharmacotherapies (such as naltrexone).
- Provide regular feedback to the patient about the effects of their alcohol use upon their lives, and include feedback from biological testing (such as liver function tests) or psychological testing (including cognitive function testing).
- Minimise the harms associated with polydrug use by advising against and offering treatment for other drug problems.
- Monitor prescribed and complementary use of medications to avoid predictable drug–alcohol interactions (for example, alcohol and paracetamol, benzodiazepines, anti-coagulants, non-steroidal anti-inflammatory drugs). Alcohol and drug interactions are discussed in **Chapter 10**. Identify and respond to problems of poor medication adherence among people who drink heavily.
- Define any specific medical and psychiatric conditions and attend to them systematically with relevant specialist medical teams that communicate regularly. Medical treatment can be of great value in reducing morbidity and mortality associated with continuing alcohol intake. More common medical complications of long-term heavy alcohol use include hypertension, cardiac damage, cerebral atrophy, cerebellar damage, peripheral neuropathy, cirrhosis, coagulopathies, peptic ulcer disease, myopathy and malignancies (breast, liver, oesophagus, colon). These are discussed in **Chapter 4** and **Chapter 22**.
- Offer treatment to minimise the consequences of specific medical complications, such as:
    - thiamine supplements to prevent further central nervous system and peripheral nerve damage
    - antihypertensives for those whose blood pressure fails to normalise on reduction of alcohol consumption

- beta-blocker or variceal banding for portal hypertension
- appropriate nutritional management for advanced liver disease and other organ damage
- falls prevention management for patients with cerebellar damage and/or peripheral neuropathy.

- Engage psychosocial supports (meals-on-wheels, welfare, employment support, community and religious networks, financial or relationship counselling) to reduce family, personal and societal harms.
- Empower family and close friends to reduce availability of alcohol and to encourage further engagement with clinicians able to help with alcohol problems.
- Consider any medico-legal or ethical obligations, including driving assessment, child protection, welfare, guardianship and employment issues for patients in certain trades or professions. These are often complex and specialist advice should be obtained.
- However, limited evidence is available about the outcomes of the harm-reduction oriented interventions described above.
- General practitioners and other health professionals are particularly well placed to maintain long-term contact and promote clinical harm-reduction interventions with people who continue to drink excessively.
- Assertive outreach and involuntary models of care may be considered subject to local availability. A general principle for assertive followup is to utilize the least restrictive approach that is effective and in many cases, regular scheduled followup is an effective approach. These are described in **Chapter 5** and earlier in this Chapter.
- Finally, a managed alcohol program (MAP) is under investigation in Australia and has been shown to reduce alcohol related morbidity in Canadian studies. No such programs are currently operating.

	RECOMMENDATION	GRADE OF RECOMMENDATION
23.2	A range of clinical strategies may be used to reduce alcohol-related harm in people who continue to drink heavily and decline treatment. These include attending to medical, psychiatric, social and medico-legal issues, maintaining social supports, and facilitating reduction in alcohol intake.	D