

Chapter 11. Aftercare and long-term follow-up

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

Aftercare

Aftercare generally refers to contact with a clinician or service immediately following intensive treatment, and has the goal of maintaining treatment gains. The first 3 months of recovery are critical to success and are characterised by a high risk of relapse. Aftercare acknowledges that severe alcohol problems are prone to recurrence and that maintenance of change may require ongoing monitoring and assistance beyond the active phase of 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 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 Alcoholic Anonymous and SMART Recovery®, as forms of continuing care or in addition to a structured aftercare program (see Chapter 8).

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. If the patient continues drinking, a clinical 'harm-reduction' model is appropriate.

Recommendation	Strength of recommendation	Level of evidence
11.1 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	IV

Working with the persistent problem drinker

Many people will continue to drink at excessive levels, experience alcohol-related harms, and will not be receptive or respond to the variety of treatment approaches aimed at reducing their alcohol use. 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.

Examples of clinical harm-reduction interventions or strategies include:

- 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 (such as the mini-mental state examination).
- 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 Appendix 4. Identify and respond to problems of poor medication adherence in heavy drinkers.
- Use strategies to enhance patient engagement. This 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.
- 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 3.
- 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 damaged patients
 - 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.
- Recognise that patient's motivation to change their drinking patterns is not fixed, and can be influenced by health professionals, families and friends, and changes in circumstances. 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.

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.

Recommendation	Strength of recommendation	Level of evidence
11.2 A range of clinical strategies should be used to reduce alcohol-related harm in people who continue to drink heavily and resist treatment. These include attending to medical, psychiatric, social and medico-legal issues, maintaining social supports, and facilitating reduction in alcohol intake.	D	IV

