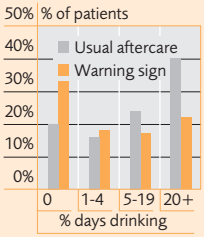
# 14.7 Warning sign aftercare for English drinkers improves attendance and avoids relapse

**Findings** Aftercare sessions training drinkers to recognise and cope with the warning signs of impending relapse helped sustained the gains from an intensive day programme.

The study took place at a national health service unit which offered a six-week, abstinence-oriented programme for dependent drinkers. Of 210 patients who'd completed this programme, 124 had a history of at least two relapses (needed to inform the aftercare programme) and agreed to enter the trial. All but a few were unemployed and before treatment they were drinking an average 30 UK units (240g) of alcohol on each of the seven days in ten on which they drank.

Half were randomly allocated to normal aftercare – up to three weekly support groups plus access to the unit's recreational and social facilities. The other half were also offered 15 individual counselling sessions modelled on an influential US approach called Early Warning Signs Relapse Prevention Training. During this, patients are helped to recognise personal warning signs of relapse by analysing their most recent attempts at recovery, and then to develop ways to manage these episodes without a return to drinking. Typically, over 13 of the 15 sessions were attended. As a result, over the follow-up year patients typically attended 16 aftercare sessions compared to six under normal procedures.

Over the same year, the benefits were reflected in significantly fewer drinking days (22% of warning sign patients drank on a fifth or more of days compared to 40% in usual aftercare ◤ *chart*), fewer heavy drinking days (corresponding figures 18% and 28%), avoidance of any return to heavy drinking (45% v 26%), and improved mental well-being. In monetary terms, warning sign patients absorbed slightly less health service and rehabilitation resources, though slightly more if the warning sign regime was itself costed in. However, neither difference approached statistical significance.




**In context** The aftercare programme was tested on a particularly problematic sample – patients severe enough to qualify for an intensive programme and among these, those with a history of repeated relapse – yet raised post-treatment outcomes to a relatively high level. How far this was due to the new techniques or instead to the offer of extra aftercare sessions, individual attention (not offered in normal aftercare), or the therapists' enthusiasm, is impossible to say. But with this 'hard-to-help' group, the therapists believe extra aftercare would have been of little value if it had consisted only of unfocused, supportive counselling. Completion of the prior treatment suggests that the patients were highly motivated. Less motivated patients may not have taken advantage of the new aftercare regime.

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Other studies have also found that greater access to and use of aftercare services are related to better outcomes. They also suggest that with less severely affected clients, aftercare need not be as intensive as may have been needed in the featured study. Alternative procedures include following initial support groups with regular phone calls, found at least as effective as entirely face-to-face contact for all but the most relapse-prone cocaine and/or alcohol dependent patients in Philadelphia. In Chicago, a quarterly check up on how former patients were doing, plus referral if needed to a liaison worker, doubled the number of relapsers who re-entered treatment, though many still failed to do so. Other studies have shown that proactively re-contacting former patients can transform aftercare attendance.

**Practice implications** The study demonstrates that in more or less routine practice at an NHS alcohol treatment unit, providing attractive, fairly intensive and well structured one-to-one aftercare helps sustain treatment gains without imposing a significantly greater financial burden on health and social services. Given sufficient flexibility in resource allocation, this means that such aftercare can be funded without having to pay for it by restricting access to the initial treatment. To further conserve resources, continuing one-to-one contact could be reserved for patients at greatest risk of relapse, likely to be those who had the greatest difficulty in the initial treatment and who lack internal psychological or external social resources. If this option is chosen, it should be combined with proactive monitoring of all patients to pick up one those whose circumstances change or who were not as relapse-resistant as they seemed.

**Featured studies** Bennett G.A. *et al*. "A randomised trial of early warning signs relapse prevention training in the treatment of alcohol dependence." *Addictive Behaviors*: 2005, 30, p. 1111–1124 AC

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