DANISH HEALTH AUTHORITY

NATIONAL CLINICAL GUIDELINE ON TREATMENT OF ALCOHOL DEPENDENCE

Quick guide

Offer family-oriented cognitive behavioural therapy for persons with alcohol-related problems who have a family.

Strong recommendation

Updating of the recommendation was not deemed necessary in 2017.

The evidence-based methods in the field of family-oriented treatment for alcohol-related problems mainly comprise various types of cognitive behavioural couples therapy. They are, however, based on a systemic conceptual framework, as the whole family might be affected by and involved in alcohol-related problems, just as the entire family must be included in the changes necessary for attainment of a lasting effect of treatment. Although the studies included primarily involve couples, it is the Danish Health Authority's assessment that it is also a good idea to involve other relatives in the treatment, e.g. siblings or parents.
Individual counselling of the person with alcohol dependence will often be planned before and/or concurrently with involvement of the partner. Trends also suggest that it may be crucial to a positive outcome that the couple be committed to each other and/or can be motivated to commit themselves to the relationship and/or family.
The evidence only applies to families in which it is one of the parents who has alcohol-related problems. The Danish Health Authority has issued a publication on family-oriented treatment for alcohol-related problems. Recent research includes modules with a special emphasis on the parental function as part of the cognitive behavioural couples therapy.

The evidence is different for families in which it is a child/young person who has alcohol-related problems. Involvement of the entire family in family therapy appears to be a fruitful approach in this context.

Offer counselling/guidance to relatives of the person with alcohol dependence.

Strong recommendation

Updating of the recommendation was not deemed necessary in 2017.

Relatives are affected by alcohol-related problems within their immediate family and may consequently require advice and guidance. Counselling is especially relevant for relatives of persons who drink and have not recognised their problematic relationship with alcohol, and for treatment-resistant persons with alcohol dependence. The counselling work usually involves a partner, but parents and siblings may also be included. The aim of the counselling is to create greater wellbeing in the relative as well as changes in the latter's thoughts and behaviour, so that the drinker is motivated to start treatment for alcohol-related problems and/or modify their drinking patterns.

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Counselling for persons with alcohol dependence can be offered in group or individual format, as no difference in the effect of the two formats has been established.

Weak recommendation

Updating of the recommendation was not deemed necessary in 2017.

The Danish Health Authority proposes that one should consider differentiation of groups with abstinence and reduced consumption as the treatment objective, rather than treating persons with different objectives within the same group.

Residential/inpatient treatment and intensive day care can be considered as a treatment format for persons with social problems in addition to alcohol dependence, or in the event of severe alcohol dependence.

Weak recommendation

The recommendation was updated without changes in 2018.

Persons with severe alcohol dependence or simultaneous social problems in addition to alcohol dependence (e.g. unemployment, poor network and homelessness) may need intensive day care or residential/inpatient treatment rather than standard outpatient treatment for alcohol-related problems. Where appropriate the Danish Health Authority proposes that planning of treatment for alcohol-related problems be based on a holistic approach, with intensive day care and residential/inpatient treatment forming constituent elements, which are integrated into a cohesive process involving outpatient treatment for alcohol-related problems and follow-up treatment.

For persons with alcohol dependence and major social problems such as homelessness and/or mental illness, the Danish Health Authority proposes residential/inpatient treatment rather than intensive day care, as the assessment is that this group will probably gain greater benefit from residential/inpatient treatment, e.g. by way of decreased drop-out. One should continue to create coherence with outpatient and follow-up treatment, but there is a lack of good research in this field, thus decisions on intensive day care or residential/inpatient treatment must be based on individual assessments.

For further guidance, please see the Danish Health Authority's advisory material: Quality in treatment for alcohol-related problems. Also please see the national clinical guideline National Clinical Guideline (NCG) Assessment and treatment of concomitant alcohol dependence and psychiatric disorder for the group with both a psychiatric disorder and alcohol-related problems.

Consider the Community Reinforcement Approach (CRA) rather than standard treatment for persons with alcohol dependence who are socially vulnerable.

Weak recommendation

Updating of the recommendation was not deemed necessary in 2017.

CRA is a protocol-based treatment. CRA may be particularly suitable for persons with problems in several areas of life as well as alcohol dependence. The reason is that CRA focuses not only on rectifying alcohol dependence but also on increasing the social involvement of the person with alcohol dependence, e.g. through the person with alcohol dependence getting a working life, a sober network and a better-functioning family life. The focus is on reinforcing the activities in which alcohol does not play a role in the person's life. CRA thus not only reinforces abstinence but also improves the person's chances of remaining sober.

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Consider planning structured treatment for alcohol-related problems that last three months rather than six. After three months assess the need for further structured treatment.

Weak recommendation

The recommendation was updated without changes in 2018.

The Danish Health Authority proposes as a basis that a course of treatment be planned to last three months rather than six. After three months, an active stance must be adopted as to whether the treatment objective has been attained or whether the course of treatment should perhaps be extended. Certain groups of persons with severe alcohol dependency, mental illness or social problems may need more than three months of treatment before treatment is completed and, if necessary, follow-up treatment is offered.

To complement the course of treatment for alcohol-related problems, follow-up treatment is recommended.

Consider offering follow-up treatment after structured treatment for alcohol-related problems in persons with alcohol dependence.

Weak recommendation

Updating of the recommendation was not deemed necessary in 2017.

A process of follow-up treatment may extend over a period of 3-12 months and be implemented by professional providers of treatment for alcohol-related problems and be maintenance-oriented. The focus of follow-up treatment is to prevent relapse and provide rapid help in the event of relapse. Examples of follow-up treatment are telephone calls every other week for a year or group-based/individual counselling using cognitive and/or motivation-seeking techniques.

Only use disulfiram in addition to structured counselling in persons with alcohol dependence who are seeking to achieve abstinence after careful consideration, as the effect is uncertain and there may be adverse reactions.

Weak recommendation **AGAINST**

The recommendation was updated without changes in 2018.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

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It is not good clinical practice to provide supervised disulfiram treatment without simultaneously offering structured counselling to persons with alcohol dependence.

Good practice

Updating of the recommendation was not deemed necessary in 2017.

There may be persons with alcohol dependence who wish to continue disulfiram treatment following completion of counselling. Such a wish should be complied with, provided the continued need for treatment is regularly monitored. If a person with alcohol dependence wants disulfiram without counselling, this wish should not generally be complied with unless the person in question has undergone many courses of counselling.

Offer acamprosate as well as counselling to persons with alcohol dependence who are seeking to achieve abstinence.

Strong recommendation

The recommendation was updated without changes in 2018.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

Consider offering naltrexone as well as counselling to persons with alcohol dependence who are seeking to achieve reduced consumption.

Weak recommendation

The recommendation was updated without changes in 2018.

Naltrexone together with counselling may be relevant in persons with alcohol dependence whose objective is not abstinence.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

Only use nalmefene together with counselling in persons with alcohol dependence after careful consideration, as the effect of nalmefene is uncertain and there may be adverse reactions.

Weak recommendation **AGAINST**

Updating of the recommendation was not deemed necessary in 2017.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

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Consider treatment with either naltrexone or acamprosate as well as structured counselling in persons seeking to achieve long-term abstinence.

Weak recommendation

The recommendation is the same as in the annex (2017).

Naltrexone and acamprosate have differing adverse-reaction profiles, and the choice of treatment will depend on the individual's acceptance of these adverse reactions. The individual doctor in consultation with the person to be treated must thus assess which treatment is the most appropriate.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

Consider treatment with acamprosate rather than disulfiram in addition to structured counselling in persons seeking long-term abstinence.

Weak recommendation

The recommendation is the same as in the annex (2017).

Disulfiram and acamprosate have differing mechanisms of action. The disulfiram/alcohol reaction causes several unpleasant symptoms, the purpose of disulfiram being to stop the person drinking alcohol. Acamprosate, on the other hand, moderates some people's craving for alcohol.

Disulfiram and acamprosate have differing adverse-reaction profiles, and an individual's preference will depend on their desire for an effect and their acceptance of adverse reactions. It will thus be up to the individual doctor in consultation with the person undergoing treatment to assess which treatment best suits that person.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

Consider treatment with naltrexone rather than disulfiram in addition to structured counselling for persons seeking long-term abstinence.

Weak recommendation

The recommendation is the same as in the annex (2017).

Disulfiram and naltrexone have different mechanisms of action. The disulfiram/alcohol reaction causes several unpleasant symptoms, the purpose of disulfiram being to stop the person drinking alcohol. Naltrexone works in that the person simultaneously ingesting alcohol will not attain the expected effect of the alcohol and will thus drink less.

Disulfiram and naltrexone also have differing adverse-reaction profiles, and the choice of drug will thus depend on what the individual wants as regards the effect and acceptance of adverse reactions. It will thus be up to the individual doctor in consultation with the person undergoing treatment to assess which treatment best suits that person.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

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It is good practice only in rare instances to consider nalmefene or acamprosate in addition to structured counselling for persons seeking to achieve reduced consumption.

Good practice

The recommendation is the same as in the annex (2017).

The working group found that there was no clear answer to the question.

Acamprosate has previously been shown to increase the proportion of persons achieving abstinence after a year, but unlike naltrexone it appears not to have any effect on the quantity of alcohol ingested per day of drinking, thus it is not deemed relevant to reducing consumption.

One can in general only expect these pharmacological aids to have a very limited additional effect in terms of reducing consumption.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

It is good practice to administer naltrexone rather than nalmefene as well as structured counselling to persons seeking to reduce consumption.

Good practice

The recommendation is the same as in the annex (2017).

There have not been any studies directly comparing naltrexone treatment with nalmefene treatment, but previous studies have shown that after three months' treatment counselling plus naltrexone leads to a lower alcohol intake per day of drinking than counselling alone.

For further information and points of interest regarding pharmacological treatment, please see p. 7.

Consider treatment with naltrexone rather than acamprosate in addition to structured counselling for persons seeking to reduce consumption.

Weak recommendation

The recommendation is the same as in the annex (2017).

Acamprosate and naltrexone have differing adverse-reaction profiles, and the choice of treatment will depend on the individual's acceptance of these adverse reactions. Assessment of the most appropriate treatment will thus be up to the individual doctor in consultation with the person to be treated. It should particularly be noted that it may be difficult to take acamprosate, as doses must be taken three times daily, and one should discuss whether any supporting measures might help improve compliance.

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Overall information about pharmacological treatment

Disulfiram

The disulfiram/alcohol reaction causes a number of unpleasant symptoms, the purpose of disulfiram being to stop the person in question drinking alcohol. You may consider administering disulfiram to persons with alcohol dependence who wish to take it or who feel that it is effective, provided they are well informed as to the effect and adverse reactions. Some people with alcohol dependence find that taking disulfiram before particularly high-risk alcohol-intake situations is helpful and contributes to prevention of relapse. This use of disulfiram has not been systematically investigated, and the appropriacy of such a strategy will probably be a matter of individual choice.

In treatment with disulfiram one should thus be aware of the potentially fatal disulfiram/alcohol reaction that alcohol intake during disulfiram treatment may cause. Disulfiram treatment thus requires total abstinence. Those who choose disulfiram treatment should be motivated and aware of the disulfiram/alcohol reaction. Persons with memory loss or other cognitive problems (e.g. reduced cognitive function, dementia, psychosis and hepatic coma) should not be given this treatment. When administering treatment with disulfiram you must exercise caution in persons with liver disease.

For the time being it is not possible to say anything about the optimum duration of treatment. If the person in question drinks during treatment with disulfiram, then treatment should be discontinued. If the person with alcohol dependence is compliant and is not drinking after 4-6 weeks, then the treatment with disulfiram and counselling should be continued for 6-12 months.

After treatment with disulfiram (six months after commencement of treatment) there is a tendency towards greater alcohol intake than before treatment, indicating that counselling, especially in connection with disulfiram treatment, should prepare persons in this situation for tackling risk situations when disulfiram treatment has ended.

Acamprosate

Acamprosate should primarily be considered by way of support for persons with alcohol dependence who are seeking abstinence rather than reduced alcohol consumption. It appears that persons whose prominent symptom is a craving or anxiety will particularly benefit from treatment with acamprosate. Caution should be exercised in the event of known kidney disease. The treatment can commence as soon as the person with alcohol dependence understands the scope of the treatment. Treatment should be discontinued if there is no effect after 4-6 weeks of treatment, but it should last for at least 3-6 months if there is an effect. The pharmacological treatment can thus continue after conclusion of counselling. Nothing is known about the effect on abstinence or reduced consumption after a year, and this can be taken into consideration when considering the duration of treatment.

It should particularly be noted that it may be difficult to take acamprosate, as the product must be taken three times daily, and one should discuss whether any supporting measures might help improve compliance.

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Overall information about pharmacological treatment	**Naltrexone** Persons with early onset of alcohol dependence and a family predisposition may particularly benefit from naltrexone treatment. Treatment with naltrexone should be discontinued if there is no effect after 4-6 weeks of treatment, but it should last for 3-6 months if there is an effect. The pharmacological treatment can thus continue after conclusion of counselling. There is no evidence regarding efficacy of treatment beyond a period of 12 months. **Nalmefene** Nalmefene may be relevant for a small group of persons with alcohol dependence who have a high alcohol intake and are not seeking abstinence. Those in question must be persons who meet criteria for alcohol dependence without withdrawal symptoms and persons without any psychiatric comorbidity. Further treatment should take place in a specialised facility for treatment of alcohol-related problems where counselling can also be provided. As regards this situation, there is documentation showing a modest reduction in use of alcohol when taking nalmefene as required in a high-risk situation. Treatment should be stopped if there is no effect after 4-6 weeks of treatment, but it should last for 3-6 months if there is an effect.

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About the quick guide

This quick guide contains the key recommendations from the national clinical guideline on treatment of persons with alcohol dependence. The guideline was prepared under the auspices of the Danish Health Authority.

The focus of the national clinical guideline is treatment of persons with alcohol dependence. The guideline includes recommendations on both pharmacological and non-pharmacological treatment.

The national clinical guideline includes recommendations regarding selected parts of this area, and it cannot stand alone, but must be seen in conjunction with other guidelines, process descriptions etc. in this regard.

Further information is available at sundhedsstyrelsen.dk

On the Danish Health Authority's website (www.sst.dk) the full version of the national clinical guideline is available, including a detailed review of the underlying evidence for the recommendations.

About the national clinical guidelines

This national clinical guideline is one of the national clinical guidelines being prepared by the Danish Health Authority during the period 2017-2020.

Further material regarding the choice of subject, method and process is to be found at www.sst.dk