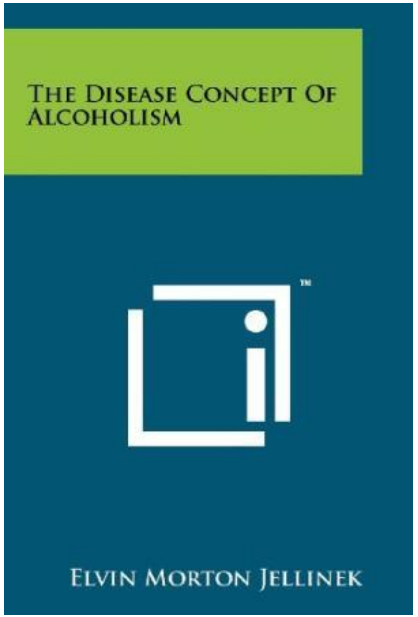
La réduction des risques et des dommages est-elle efficace et quelles sont ses limites en matière d'alcool ?

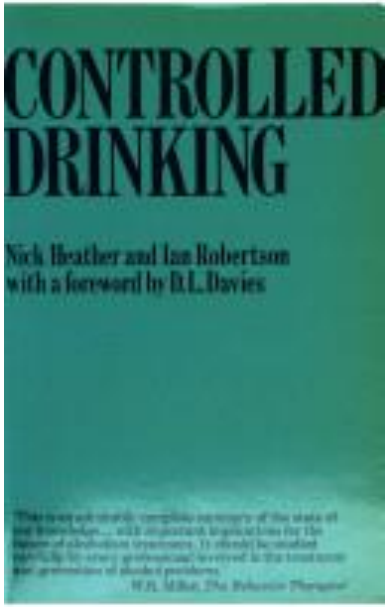
Henri-Jean Aubin
Professeur à l'Université Paris-Sud
Chef du Département de Psychiatrie et d'Addictologie
Hôpitaux Universitaires Paris-Sud

Liens d'intérêt: *H.-J. Aubin déclare avoir participé au cours des trois dernières années à des interventions ponctuelles (essais cliniques, travaux scientifiques, activités de conseil, conférences, colloques) pour les entreprises Bioprojet, D&A Pharma, Ethypharm, Lundbeck, Merck-Serono, Mundipharma, Novartis, et Pfizer. Il a également reçu des financements de recherche de l'Agence Nationale de la Recherche, du Programme Hospitalier de Recherche Clinique, et de l'Institut de Recherche en Santé Publique.*

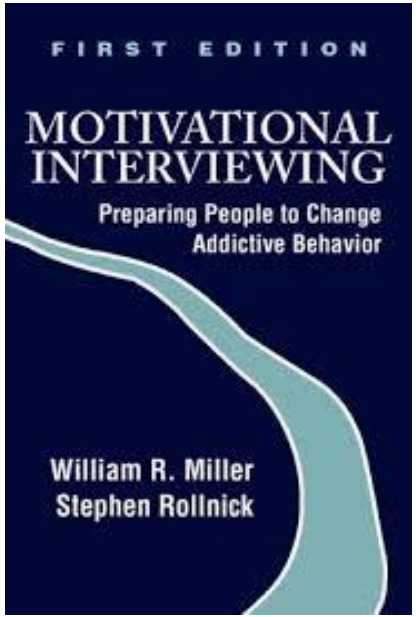
EVOLUTION DES CONCEPTS



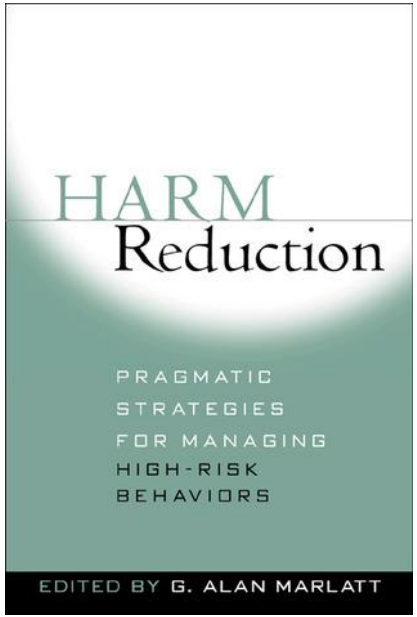
1960



1983



1991



1998

RECOMMANDATIONS

Recommandations de la Société française d'alcoologie

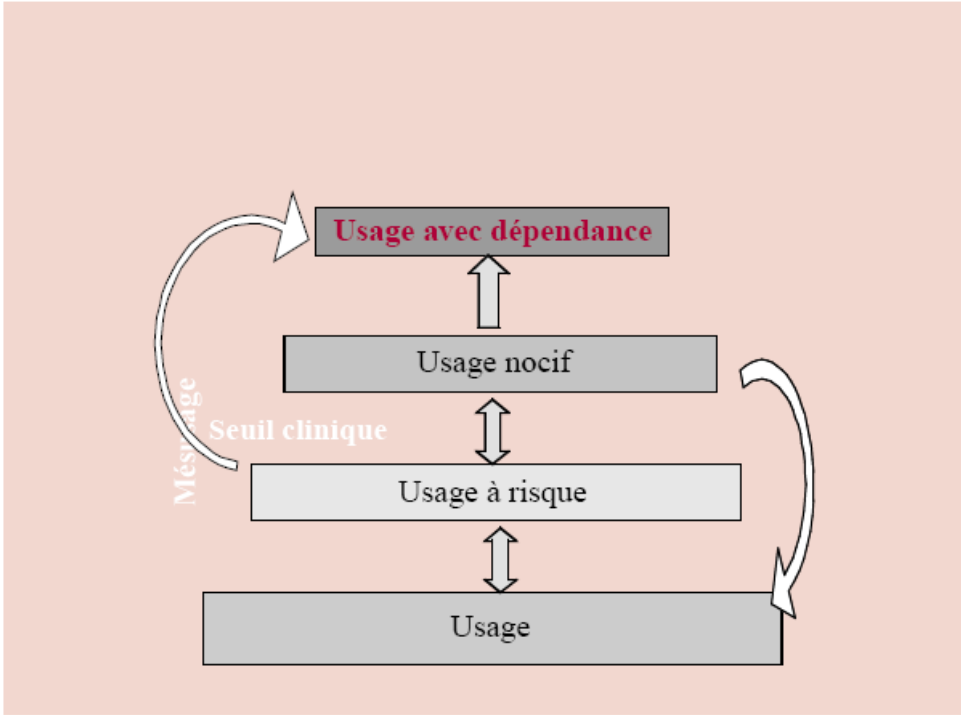
Société Française d'Alcoologie

Reconnue d'utilité publique (décret du 29 octobre 1998)

Les mésusages d'alcool en dehors de la dépendance

Usage à risque – Usage nocif

2003



ALCOOL ET SANTÉ

Drug harms in the UK: a multicriteria decision analysis

David J Nutt, Leslie A King, Lawrence D Phillips, on behalf of the Independent Scientific Committee on Drugs

Lancet 2010; 376: 1558–65
Published Online November 1, 2010
DOI:10.1016/S0140-6736(10)61462-6
See Comment page 1524

Neuropsychopharmacology Unit, Imperial College, London, UK (Prof D J Nutt FMedSci); UK Expert Adviser to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), Lisbon, Portugal (L A King PhD); and Department of Management, London School of Economics and Political Science, London, UK (L D Phillips PhD)
Correspondence to: Prof David J Nutt, Neuropsychopharmacology Unit, Imperial College London, Burlington Danes Building, Hammersmith Hospital, Du Cane Road, London W12 0NN, UK
d.nutt@imperial.ac.uk

Summary

Background Proper assessment of the harms caused by the misuse of drugs can inform policy makers in health, policing, and social care. We aimed to apply multicriteria decision analysis (MCDA) modelling to a range of drug harms in the UK.

Method Members of the Independent Scientific Committee on Drugs, including two invited specialists, met in a 1-day interactive workshop to score 20 drugs on 16 criteria: nine related to the harms that a drug produces in the individual and seven to the harms to others. Drugs were scored out of 100 points, and the criteria were weighted to indicate their relative importance.

Findings MCDA modelling showed that heroin, crack cocaine, and metamfetamine were the most harmful drugs to individuals (part scores 34, 37, and 32, respectively), whereas alcohol, heroin, and crack cocaine were the most harmful to others (46, 21, and 17, respectively). Overall, alcohol was the most harmful drug (overall harm score 72), with heroin (55) and crack cocaine (54) in second and third places.

Interpretation These findings lend support to previous work assessing drug harms, and show how the improved scoring and weighting approach of MCDA increases the differentiation between the most and least harmful drugs. However, the findings correlate poorly with present UK drug classification, which is not based simply on considerations of harm.

Funding Centre for Crime and Justice Studies (UK).

Introduction

Drugs including alcohol and tobacco products are a major cause of harms to individuals and society. For this reason, some drugs are scheduled under the United Nations 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. These controls are represented in UK domestic legislation by the 1971 Misuse of Drugs Act (as amended). Other drugs, notably alcohol and tobacco, are regulated by taxation, sales, and restrictions on the age of purchase. Newly available drugs such as mephedrone (4-methylmethcathinone) have recently been made illegal in the UK on the basis of concerns about their harms, and the law on other drugs, particularly cannabis, has been toughened because of similar concerns.

To provide better guidance to policy makers in health, policing, and social care, the harms that drugs cause need to be properly assessed. This task is not easy because of the wide range of ways in which drugs can cause harm. An attempt to do this assessment engaged experts to score each drug according to nine criteria of harm, ranging from the intrinsic harms of the drugs to social and health-care costs.[1] This analysis provoked major interest and public debate, although it raised concerns about the choice of the nine criteria and the absence of any differential weighting of them.[2]

To rectify these drawbacks we undertook a review of drug harms with the multicriteria decision analysis (MCDA) approach.[3] This technology has been used successfully to lend support to decision makers facing complex issues characterised by many, conflicting objectives—eg, appraisal of policies for disposal of nuclear waste.[4] In June, 2010, we developed the multicriteria model during a decision conference,[5] which is a facilitated workshop attended by key players, experts, and specialists who work together to create the model and provide the data and judgment inputs.

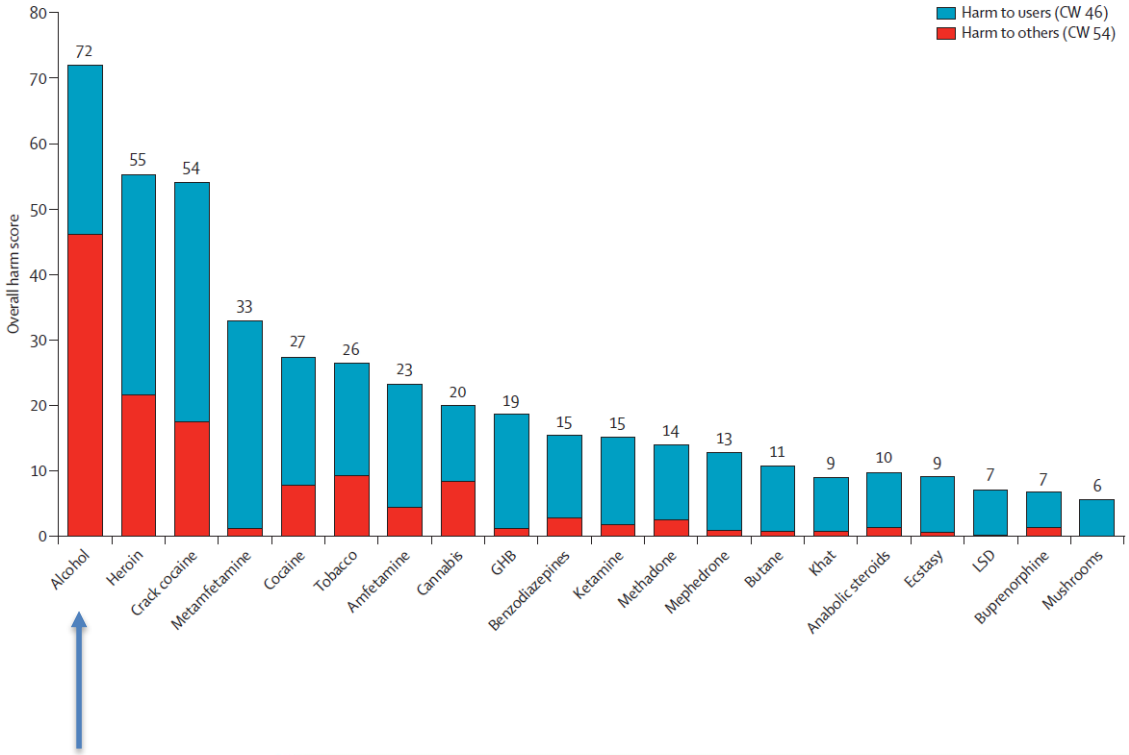
For more on the Independent Scientific Committee on Drugs see: http://www.drugscience.org.uk

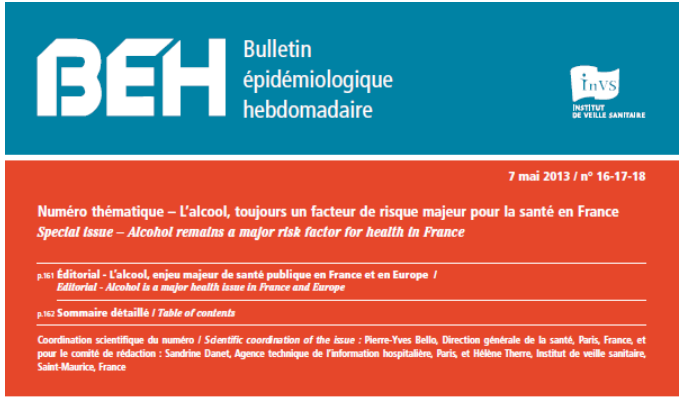
Methods

Study design

The analysis was undertaken in a two-stage process. The choice of harm criteria was made during a special meeting in 2009 of the UK Advisory Council on the Misuse of Drugs (ACMD), which was convened for this purpose. At this meeting, from first principles and with the MCDA approach, members identified 16 harm criteria (figure 1). Nine relate to the harms that a drug produces in the individual and seven to the harms to others both in the UK and overseas. These harms are clustered into five subgroups representing physical, psychological, and social harms. The extent of individual harm is shown by the criteria listed as to users, whereas most criteria listed as to others take account indirectly of the numbers of users. An ACMD report explains the process of developing this model.[4]

In June, 2010, a meeting under the auspices of the Independent Scientific Committee on Drugs (ISCD)—a new organisation of drug experts independent of government interference—was convened to develop the MCDA model and assess scores for 20 representative drugs that are relevant to the UK and which span the range of potential harms and extent of use. The expert group was formed from the ISCD expert committee plus two external experts with specialist knowledge of

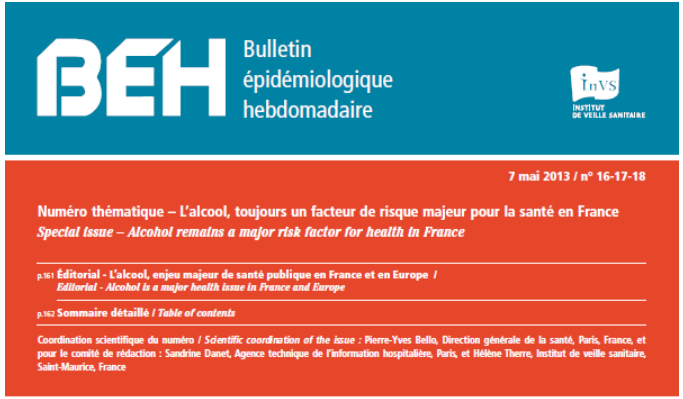




En France, en 2009

49 000 décès attribuables à l'alcool

9,16% des décès

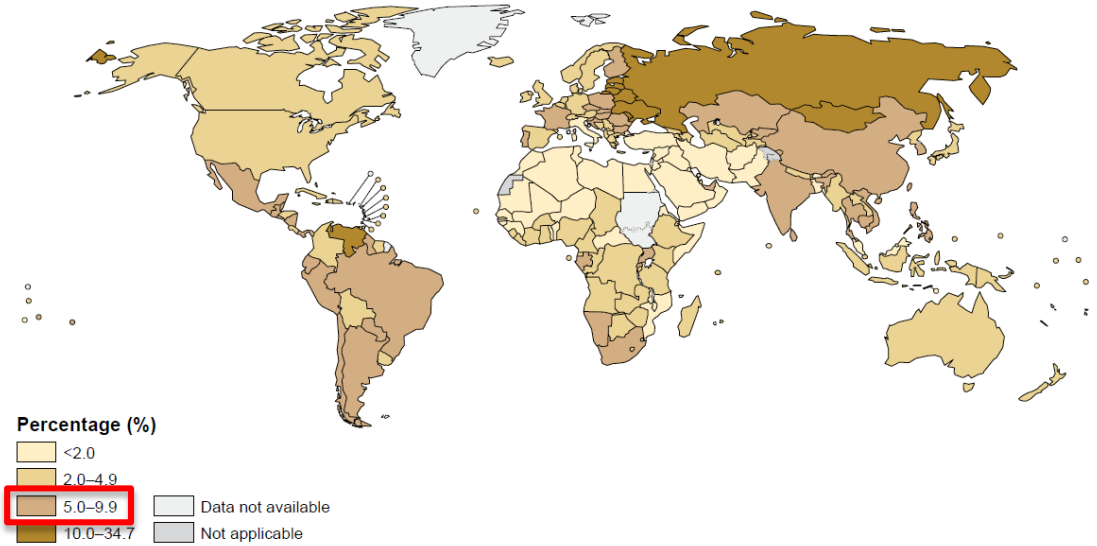


En France, en 2009

49 000 décès attribuables à l'alcool

9,16% des décès

Figure 17. Alcohol-attributable fractions for all-cause deaths (AAFs; %; all ages), 2012



BEH Bulletin épidémiologique hebdomadaire

InVS Institut de veille sanitaire

7 mai 2013 / n° 16-17-18

Numéro thématique – L'alcool, toujours un facteur de risque majeur pour la santé en France

Special issue – Alcohol remains a major risk factor for health in France

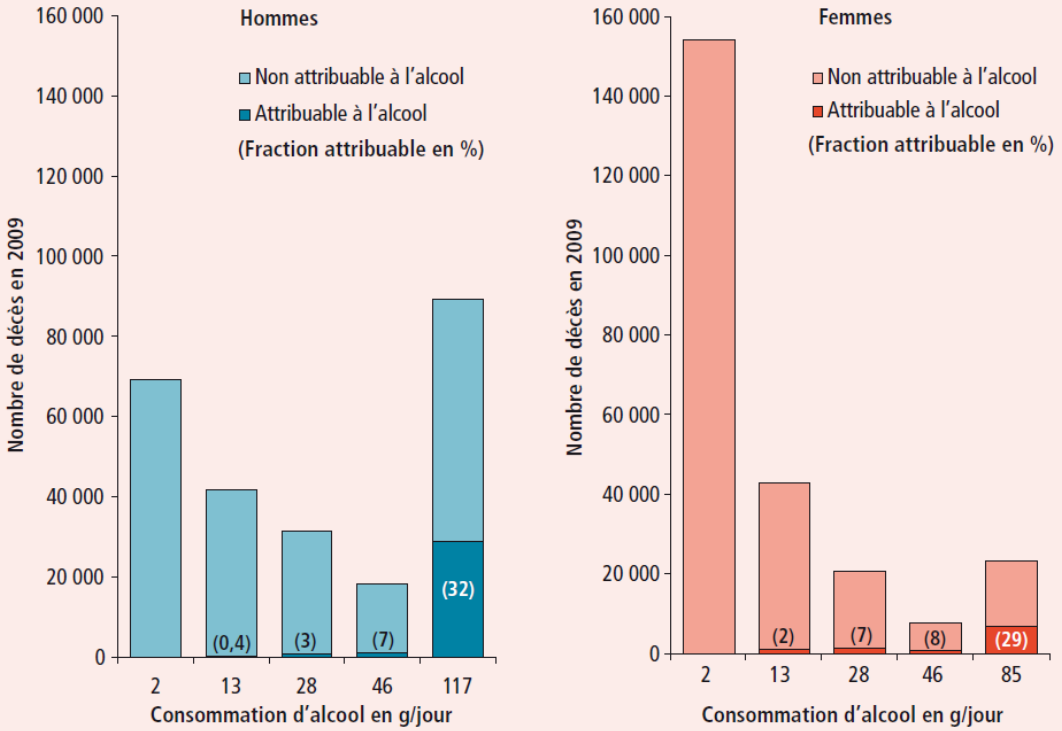
Coordination scientifique du numéro / *Scientific coordination of the issue* : Pierre-Yves Bello, Direction générale de la santé, Paris, France, et pour le comité de rédaction : Sandrine Danet, Agence technique de l'information hospitalière, Paris, et Hélène Therre, Institut de veille sanitaire, Saint-Maurice, France

En France, en 2009

49 000 décès attribuables à l'alcool

9,16% des décès

Figure 1 **Nombre de décès attribuables et non attribuables à l'alcool par classe de dose et par sexe, pour les causes autres que les causes externes, France / *Figure 1 Number of deaths attributable and not attributable to alcohol by dose category and gender, for causes other than external, France***



BEH Bulletin épidémiologique hebdomadaire

InVS Institut de veille sanitaire

7 mai 2013 / n° 16-17-18

Numéro thématique – L'alcool, toujours un facteur de risque majeur pour la santé en France

Special issue – Alcohol remains a major risk factor for health in France

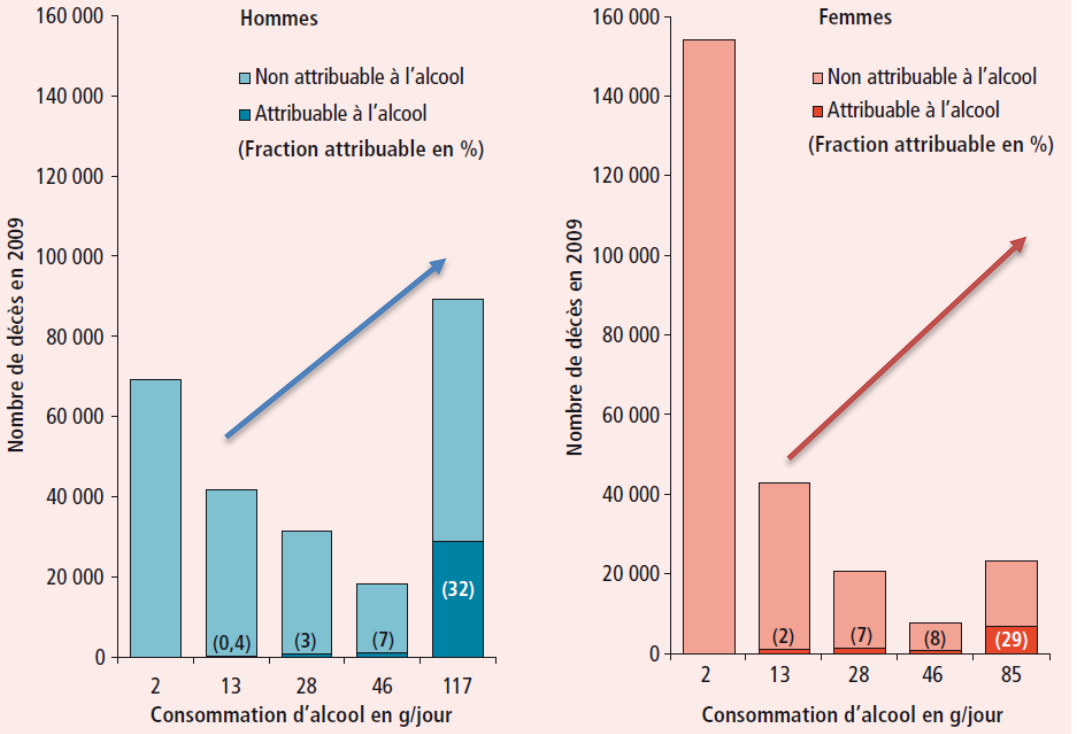
Coordination scientifique du numéro / *Scientific coordination of the issue* : Pierre-Yves Bello, Direction générale de la santé, Paris, France, et pour le comité de rédaction : Sandrine Danet, Agence technique de l'information hospitalière, Paris, et Hélène Therre, Institut de veille sanitaire, Saint-Maurice, France

En France, en 2009

49 000 décès attribuables à l'alcool

9,16% des décès

Figure 1 **Nombre de décès attribuables et non attribuables à l'alcool par classe de dose et par sexe, pour les causes autres que les causes externes, France / *Figure 1 Number of deaths attributable and not attributable to alcohol by dose category and gender, for causes other than external, France***



BÉNÉFICES DE LA RÉDUCTION DE LA CONSOMMATION

Alcohol and Alcoholism Vol. 48, No. 4, pp. 509–513, 2013 doi: 10.1093/alcalc/agt021
Advance Access Publication 26 March 2013

REVIEW

Reduction of Drinking in Problem Drinkers and All-Cause Mortality

J. Rehm[1,2,3,4,5] and M. Roerecke[1,2,*]

[1]Social and Epidemiological Research (SER) Department, Centre for Addiction and Mental Health (CAMH), 33 Russell Street, Toronto, ON, Canada M5S 2S1, [2]Dalla Lana School of Public Health, University of Toronto, Toronto, Canada, [3]Department of Psychiatry, Faculty of Medicine, University of Toronto, Toronto, Canada, [4]PAHO/WHO Collaborating Centre for Mental Health & Addiction, Toronto, Canada and [5]Epidemiological Research Unit, Klinische Psychologie & Psychotherapie, Technische Universität Dresden, Dresden, Germany

*Corresponding author: Tel.: ++1-416-535-8501; E-mail: m.roerecke@web.de

(*Received* 1 *August* 2012; *first review notified* 22 *November* 2012; *in revised form* 20 *February* 2013; *accepted* 24 *February* 2013)

Abstract — Alcohol consumption has been linked with considerable mortality, and reduction of drinking, especially of heavy drinking, has been suggested as one of the main measures to reduce alcohol-attributable mortality. Aggregate-level studies including but not limited to natural experiments support this suggestion; however, causality cannot be established in ecological analysis. The results of individual-level cohort studies are ambiguous. On the other hand, randomized clinical trials with problem drinkers show that brief interventions leading to a reduction of average drinking also led to a reduction of all-cause mortality within 1 year. The results of these studies were pooled and a model for reduction of drinking in heavy drinkers and its consequences for all-cause mortality risk was estimated. *Ceteris paribus*, the higher the level of drinking, the stronger the effects of a given reduction. Implications for interventions and public health are discussed.

BACKGROUND: AGGREGATE-LEVEL STUDIES OF REDUCTION OF DRINKING AND ALL-CAUSE MORTALITY

Alcohol consumption has been linked with considerable mortality as a result of being causally related to >200 International Classification of Diseases codes (Rehm *et al.*, 2009; Lim *et al.*, 2012). Most risk curves for disease and injury outcomes suggest a monotonic dose–response relationship between average volume of alcohol consumption and all-cause mortality where higher levels of volume of alcohol consumed are associated with higher risk for mortality (Rehm *et al.*, 2010a). The most notable exceptions are ischaemic conditions (Patra *et al.*, 2010; Roerecke and Rehm, 2012) and diabetes (Baliunas *et al.*, 2009). Overall, the detrimental effects of alcohol outweigh by far the beneficial effects, and as a result, the risk of mortality increases steadily after 10 g average daily consumption in European populations and is more accelerated with heavy drinking (Rehm *et al.*, 2011; Nichols *et al.*, 2012). As a consequence, reduction of drinking, and especially of heavy consumption, has been suggested as the main measure to reduce alcohol-attributable mortality (Anderson and Baumberg, 2006; Babor *et al.*, 2010), with most of the underlying evidence stemming from aggregate-level studies.

There has been a tradition in alcohol research to study the aggregate-level relationship between *per capita* consumption of alcohol and mortality, both all-cause mortality and various cause-specific mortality such as liver cirrhosis, suicide or categories of unintentional injury [for an overview see (Norström and Ramstedt, 2005)]. In summary, this literature showed that overall changes in aggregate consumption in a country were associated with changes of all-cause mortality of the same direction; i.e. if *per capita* consumption went down, the rate of all-cause mortality went down, and if consumption went up, the rate of all-cause mortality went up (Her and Rehm, 1998; Norström, 2001; Norström and Ramstedt, 2005).

While these data have shown consistent associations, causality cannot be established in ecological studies like this (Morgenstern, 1995, 2008). For instance, it cannot be ruled out that economic conditions led to both a change in the level of drinking and mortality. Natural experiments, defined as empirical studies in which an often abrupt change in conditions occurred, such as a change in alcohol policy or by other factors out of the control of an experimenter and the drinkers concerned, allow better determination of causal direction than simple associations over time. However, alternative explanations such as concurrent secular trends during the time of the natural experiment cannot be ruled out (Cook and Campbell, 1979).

A number of natural experiments, most importantly the so-called Gorbachev reform (Leon *et al.*, 1997), but also the 12-fold rise of taxes on distilled spirits during World War I in Denmark (Thorsen, 1990; Skog, 1993), prohibition in the USA (Dills and Miron, 2004) or the effect of German seizure of wine in France during World War II (Zatonski *et al.*, 2010) all indicate that reduced consumption led to decreases in mortality rates. For illustration, we will just elaborate on the most prominent example, the Gorbachev reform of the 1980s, during which state-owned legal alcohol production was drastically reduced in the Soviet Union. Even though unrecorded alcohol consumption increased, the overall annual consumption of pure alcohol fell from 14.21 *per capita* in 1984 to 10.71 in 1987—a decrease of some 25% (Shkolnikov and Nemtsov, 1997). In that period, all-cause mortality rates in Russia in the 40–44 age range decreased by 39% for men and by 29% for women.

Between 1987 and 1994, after the alcohol ban was rescinded in 1987, alcohol consumption increased again to 14.5 l per capita, slightly more than its former level. In this period, all-cause mortality rates more than doubled for men and almost doubled for women in the age group 40–44 years (Leon *et al.*, 1997). There are few alternative explanations for the decrease in mortality, as most other changes during that time would have led to an expectation of increased mortality. Of course, for the second period between 1987 and 1994, other changes associated with the dissolution of the Soviet Union could easily be hypothesized as responsible for

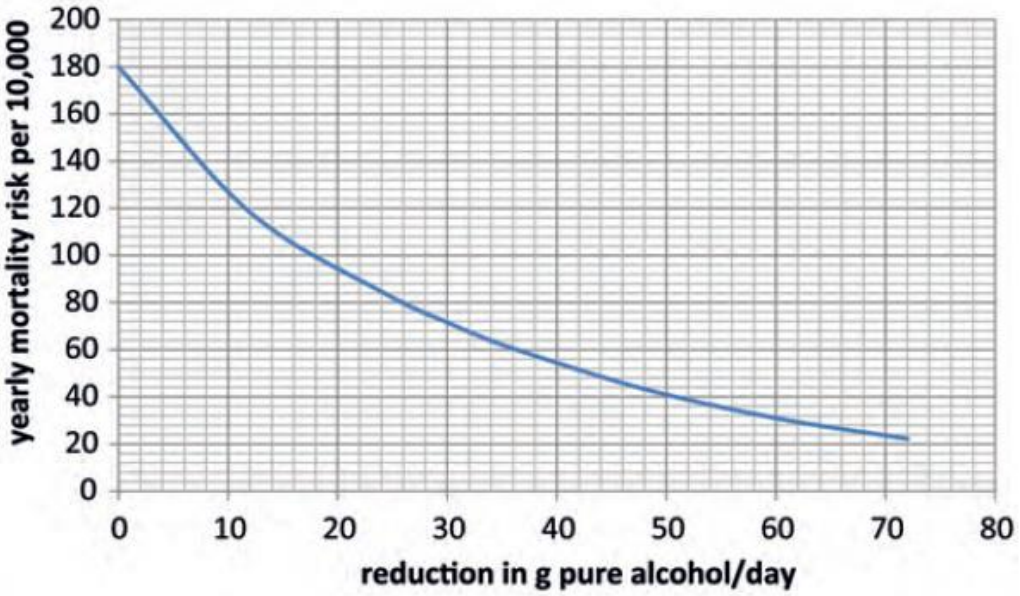


Fig. 2. Reduction of alcohol intake in grams of pure alcohol per day in heavy drinkers and associated mortality risk reduction (based on BI in hospital studies).

Impact de la réduction d'alcool sur la qualité de vie

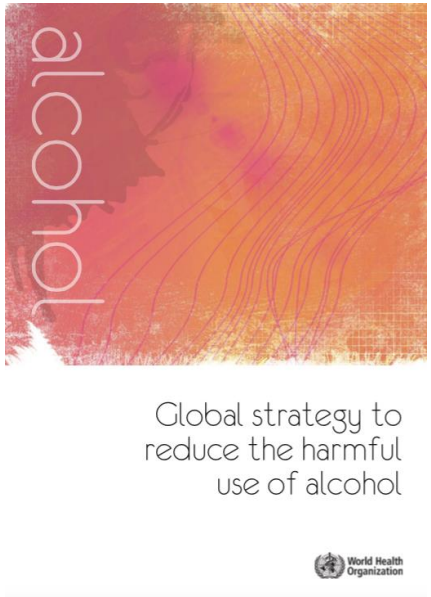
Table 3. Correlation coefficients for the relationship between changes from baseline to Week 24 in the number of monthly heavy drinking days (HDD) and monthly total alcohol consumption (TAC) *versus* changes in patient-reported outcome measures in the total population (nalmefene and placebo pooled data).

	HDD		TAC	
	Pearson Correlation Coefficient[a]	p-value	Pearson Correlation Coefficient[a]	p-value
SF-36 MCS score	-0.1941	<0.0001	-0.2061	<0.0001
SF-36 PCS score	-0.0569	0.2578	-0.0707	0.1596
EQ-5D Utility Index score	-0.0772	0.1217	-0.0761	0.1271
EQ-5D Health State score	-0.2023	<0.0001	-0.1811	0.0003
DrInC Total score	0.2046	<0.0001	0.2446	<0.0001

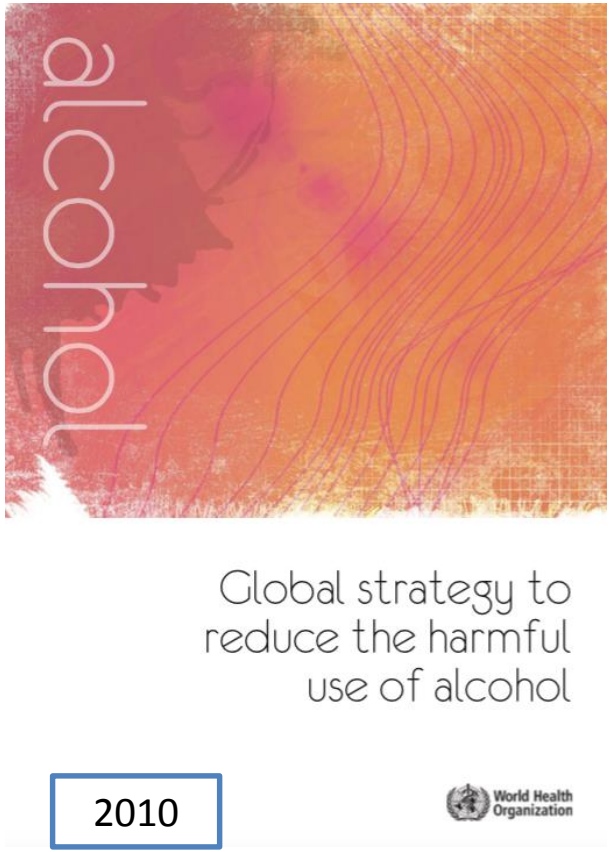
[a] negative values indicate a positive correlation for QoL while positive values indicates a positive correlation for DrInc

DrInC, drinker inventory of consequences; **EQ-5D**, EuroQoL-5 dimensions; **MCS**, mental component summary; **PCS**, physical component summary; **SF-36**, Short-Form health survey-36; **VAS**, visual analogue scale.

Francois C, Rahhali N, Chalem Y, Sorensen P, Luquiens A, Aubin HJ. The Effects of as-Needed Nalmefene on Patient-Reported Outcomes and Quality of Life in Relation to a Reduction in Alcohol Consumption in Alcohol-Dependent Patients. Plos one 2015;10(6):e0129289.



RÉDUCTION DES RISQUES
UNE POLITIQUE DE SANTÉ PUBLIQUE



10 domaines d'action

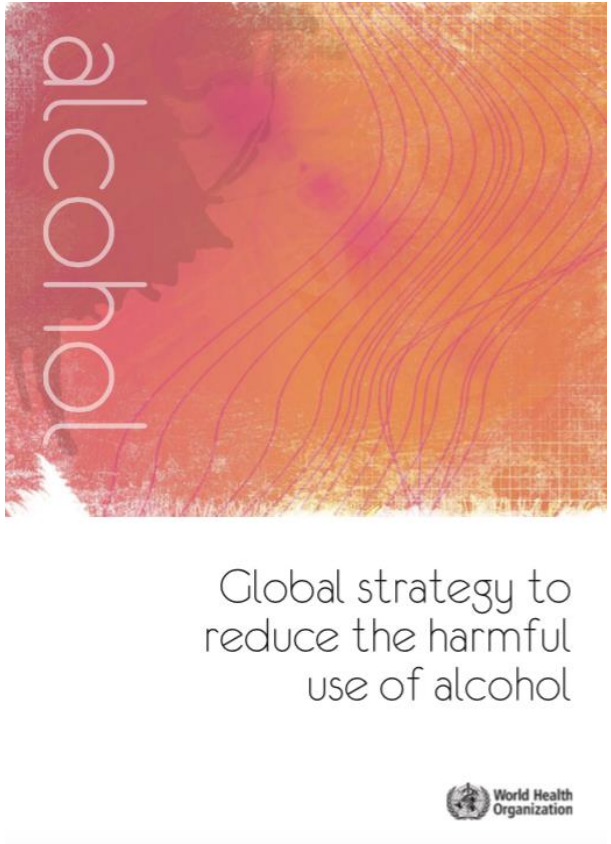
- leadership, prise de conscience et engagement
- action des services de santé
- action communautaire
- politiques et mesures de lutte contre l'alcool au volant
- offre d'alcool
- marketing des boissons alcoolisées
- politiques de prix
- réduction des conséquences néfastes de la consommation d'alcool et de l'intoxication
- réduction de l'impact sur la santé publique de l'alcool illicite ou produit par le secteur informel
- suivi et surveillance

France

Total population: 63 231 000 ➤ Population aged 15 years and older (15+): 82% ➤ Population in urban areas: 85% ➤ Income group (World Bank): High income

POLICIES AND INTERVENTIONS

Written national policy (adopted/revised) / National action plan	Yes (2008/—) / No
Excise tax on beer / wine / spirits	Yes / Yes / Yes
National legal minimum age for off-premise sales of alcoholic beverages (beer / wine / spirits)	18 / 18 / 18
National legal minimum age for on-premise sales of alcoholic beverages (beer / wine / spirits)	18 / 18 / 18
Restrictions for on-/off-premise sales of alcoholic beverages:	
Hours, days / places, density	No, No / Yes, Yes
Specific events / intoxicated persons / petrol stations	Yes / Yes / Yes
National maximum legal blood alcohol concentration (BAC) when driving a vehicle (general / young / professional), in %	0.05 / 0.05 / 0.05 (0.02 public transport)
Legally binding regulations on alcohol advertising / product placement	Yes / Yes
Legally binding regulations on alcohol sponsorship / sales promotion	Yes / Yes
Legally required health warning labels on alcohol advertisements / containers	Yes / Yes
National government support for community action	Yes
National monitoring system(s)	Yes



10 domaines d'action

- leadership, prise de conscience et engagement
- action des services de santé
- action communautaire
- politiques et mesures de lutte contre l'alcool au volant
- offre d'alcool
- marketing des boissons alcoolisées
- politiques de prix
- réduction des conséquences néfastes de la consommation d'alcool et de l'intoxication
- réduction de l'impact sur la santé publique de l'alcool illicite ou produit par le secteur informel
- suivi et surveillance

Action des services de santé

Soutenir les programmes d'**entraide** ou d'**auto-assistance**

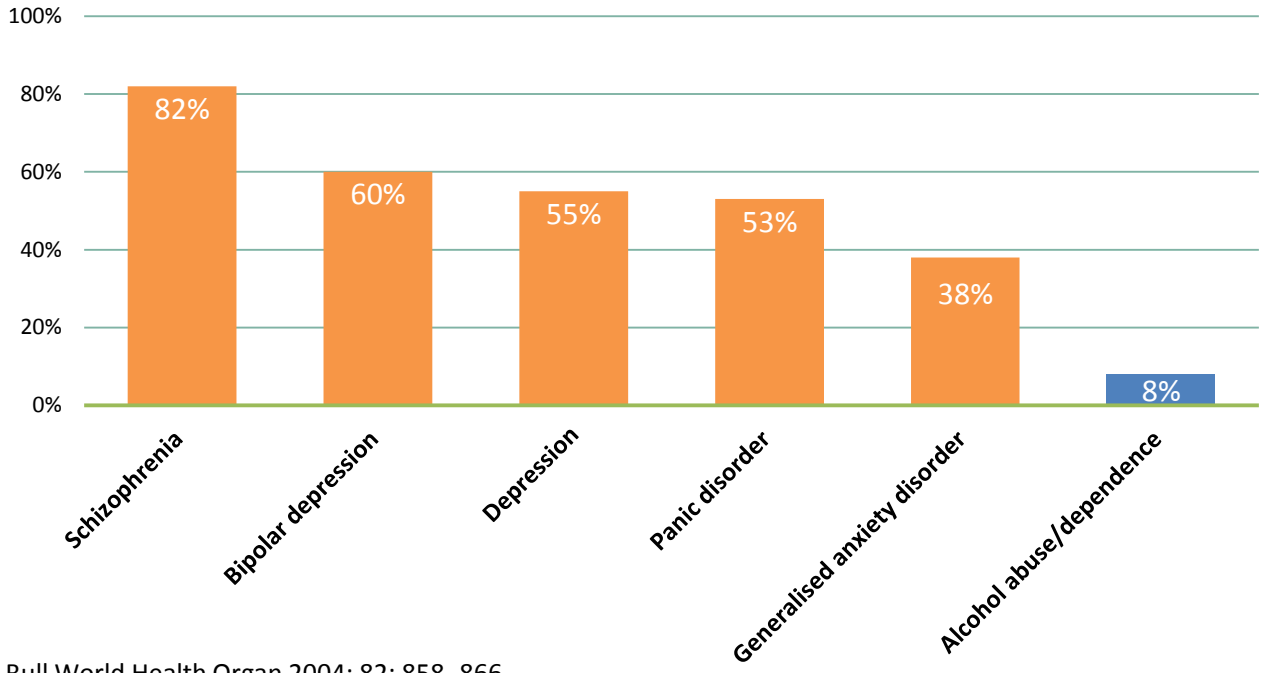
Soutenir les initiatives de dépistage et les interventions brèves dans les **soins primaires** et ailleurs

Soutenir les initiatives de dépistage précoce et prise en charge de la consommation chez les **femmes enceintes** et les femmes en âge de procréer

Développer la prévention et le dépistage du **syndrome d'alcoolisation fœtale**

Augmenter la capacité des systèmes de santé et de protection sociale à assurer la prévention, le traitement et la prise en charge des troubles liés à l'alcool

Sujets en traitement pour troubles mentaux en Europe *dans l'année*



Kohn et al. Bull World Health Organ 2004; 82: 858–866

Addiction
Research & Therapy

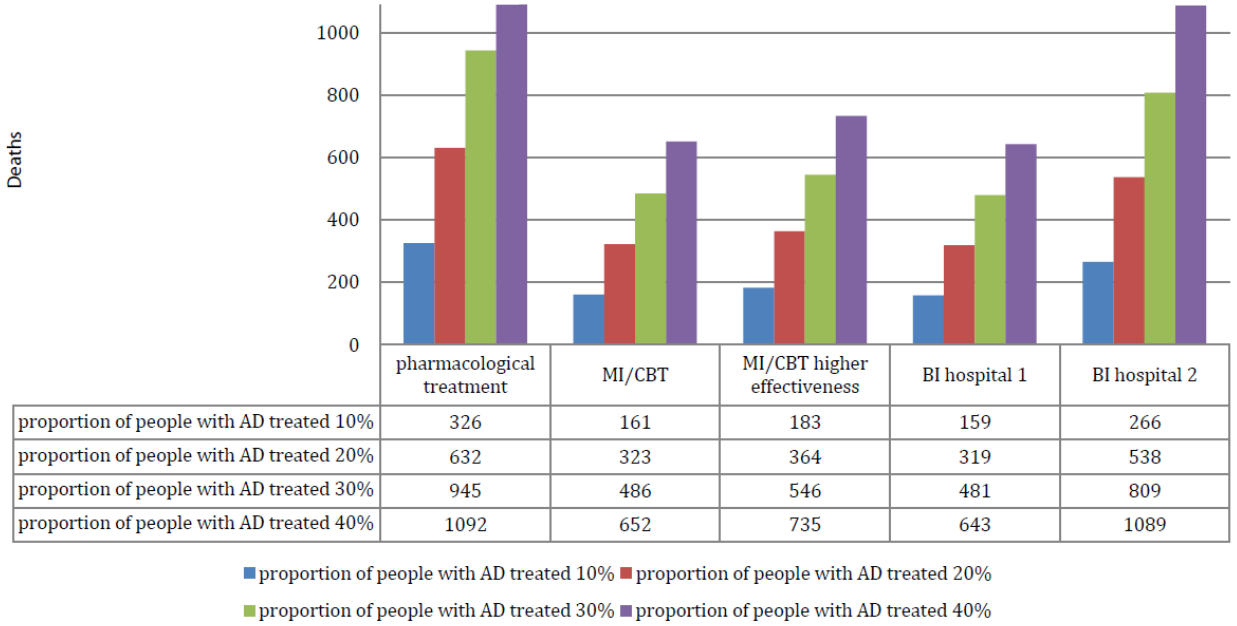
Shield et al., J Addict Res Ther 2013, S7
http://dx.doi.org/10.4172/2155-6105.S7-005

Research Article Open Access

Alcohol Consumption, Alcohol Dependence and Related Harms in France: Increasing Public Health by Increasing the Availability of Treatment for Alcohol Dependence

Kevin D Shield[1,2*], Jürgen Rehm[1-5], Maximilien X Rehm[6], Gerrit Gmel[1,7] and Henri-Jean Aubin[8]

Mortalité évitée en augmentant la proportion de personnes dépendants de l'alcool traitées



	pharmacological treatment	MI/CBT	MI/CBT higher effectiveness	BI hospital 1	BI hospital 2
proportion of people with AD treated 10%	326	161	183	159	266
proportion of people with AD treated 20%	632	323	364	319	538
proportion of people with AD treated 30%	945	486	546	481	809
proportion of people with AD treated 40%	1092	652	735	643	1089

Figure 3b: Deaths avoided under different alcohol dependence treatment scenarios for men in France in 2004.

Addiction
Research & Therapy

Shield et al., J Addict Res Ther 2013, S7
http://dx.doi.org/10.4172/2155-6105.S7-005

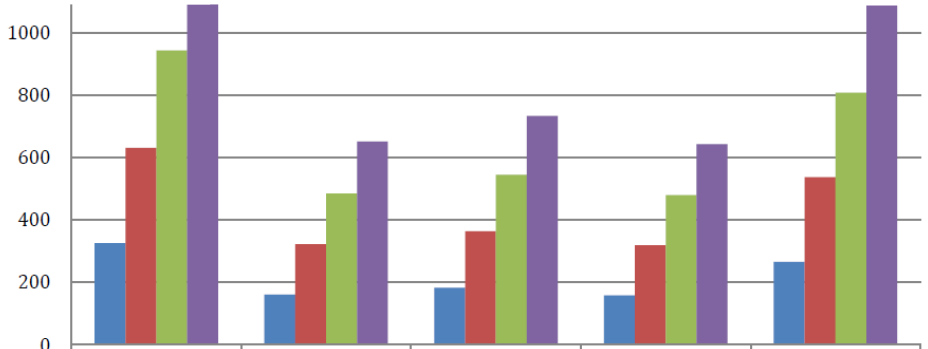
Research Article Open Access

Alcohol Consumption, Alcohol Dependence and Related Harms in France: Increasing Public Health by Increasing the Availability of Treatment for Alcohol Dependence

Kevin D Shield[1,2*], Jürgen Rehm[1-5], Maximilien X Rehm[6], Gerrit Gmel[1,7] and Henri-Jean Aubin[8]

Mortalité évitée en augmentant la proportion de personnes dépendants de l'alcool traitées

Augmentation de la proportion de personnes traitées
Jusqu'à 40%
=
1 311 moins de morts par an



	pharmacological treatment	MI/CBT	MI/CBT higher effectiveness	BI hospital 1	BI hospital 2
proportion of people with AD treated 10%	326	161	183	159	266
proportion of people with AD treated 20%	632	323	364	319	538
proportion of people with AD treated 30%	945	486	546	481	809
proportion of people with AD treated 40%	1092	652	735	643	1089

proportion of people with AD treated 10% proportion of people with AD treated 20%
proportion of people with AD treated 30% proportion of people with AD treated 40%

Figure 3b: Deaths avoided under different alcohol dependence treatment scenarios for men in France in 2004.

RÉDUCTION DES RISQUES
UNE ALTERNATIVE CLINIQUE AUX MODÈLES FONDÉS SUR L'ABSTINENCE

Original Paper

Long-term efficacy, tolerability and safety of nalmefene as-needed in patients with alcohol dependence: A 1-year, randomised controlled study

Wim van den Brink[1], Per Sørensen[2], Lars Torup[2], Karl Mann[3], Antoni Gual[4] for the SENSE Study Group

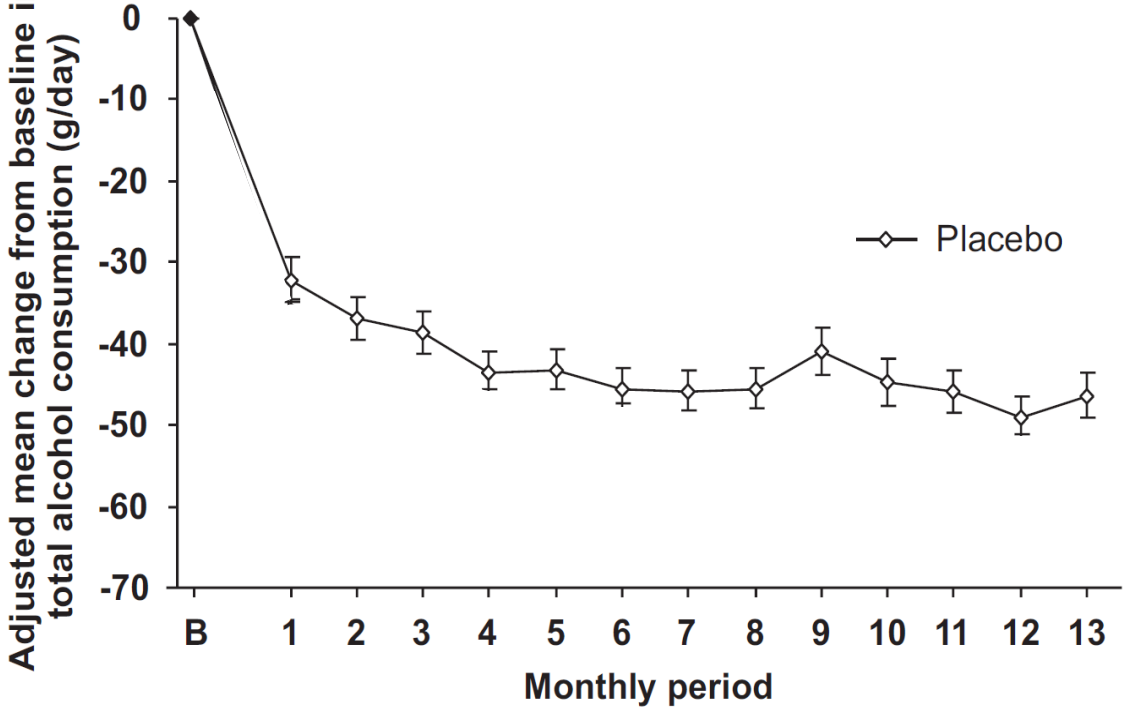
Psychopharm

Journal of Psychopharmacology
1–12

DOI: 10.1177/0269881114527362
jop.sagepub.com
SAGE

Réduction de la consommation d'alcool chez les personnes alcoolodépendantes :
C'est possible !

Répondeurs : 76%

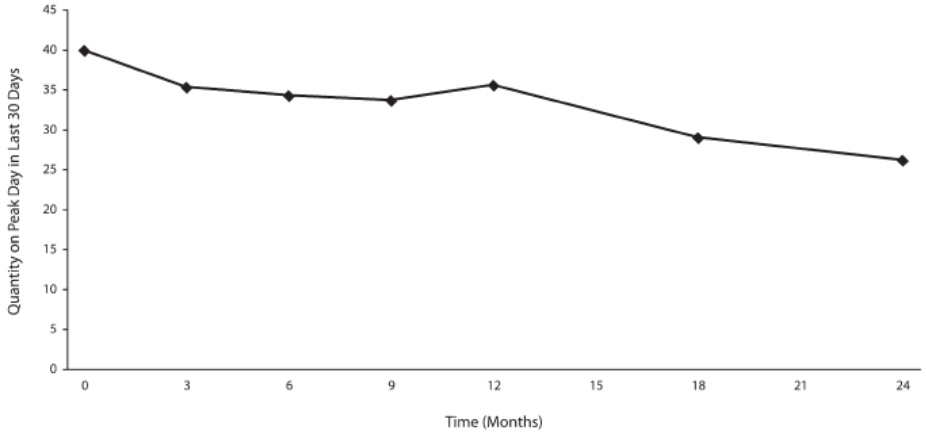


Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories

Susan E. Collins, PhD, Daniel K. Malone, MPH, Seema L. Clifasefi, PhD, Joshua A. Ginzler, PhD, Michelle D. Garner, MSW, PhD, Bonnie Burlingham, MPH, Heather S. Lonczak, PhD, Elizabeth A. Dana, MA, Megan Kirouac, BS, Kenneth Tanzer, BA, William G. Hobson, MA, G. Alan Marlatt, PhD, and Mary E. Larimer, PhD

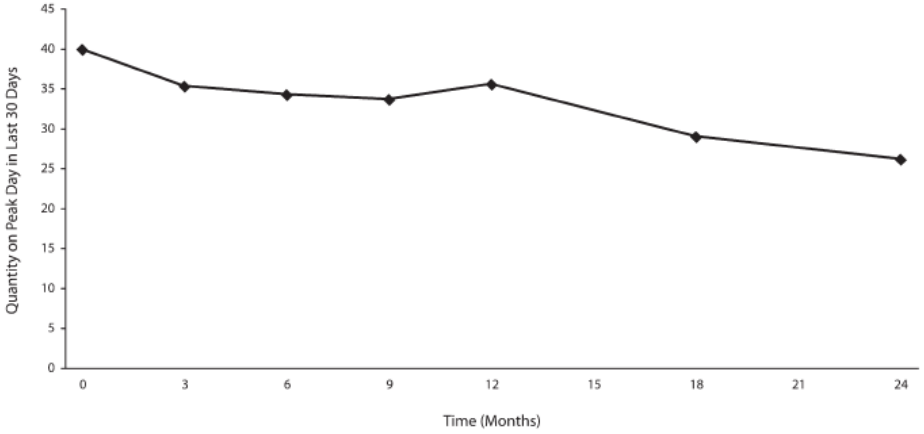
Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories

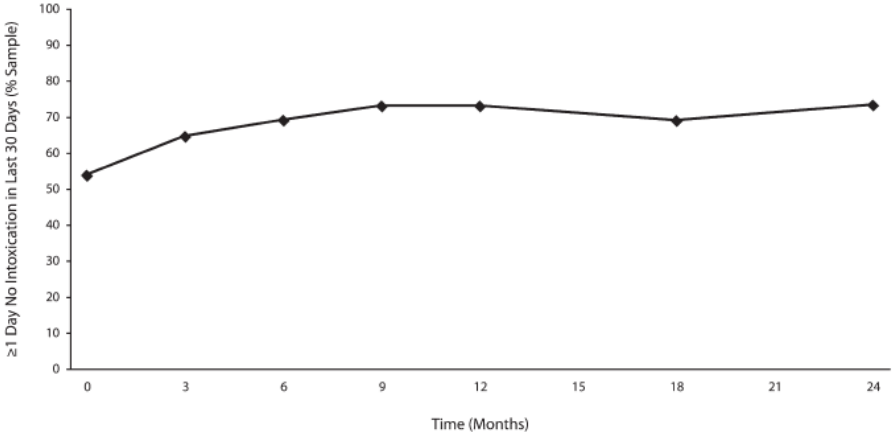
Susan E. Collins, PhD, Daniel K. Malone, MPH, Seema L. Clifasefi, PhD, Joshua A. Ginzler, PhD, Michelle D. Garner, MSW, PhD, Bonnie Burlingham, MPH, Heather S. Lonczak, PhD, Elizabeth A. Dana, MA, Megan Kirouac, BS, Kenneth Tanzer, BA, William G. Hobson, MA, G. Alan Marlatt, PhD, and Mary E. Larimer, PhD



Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories

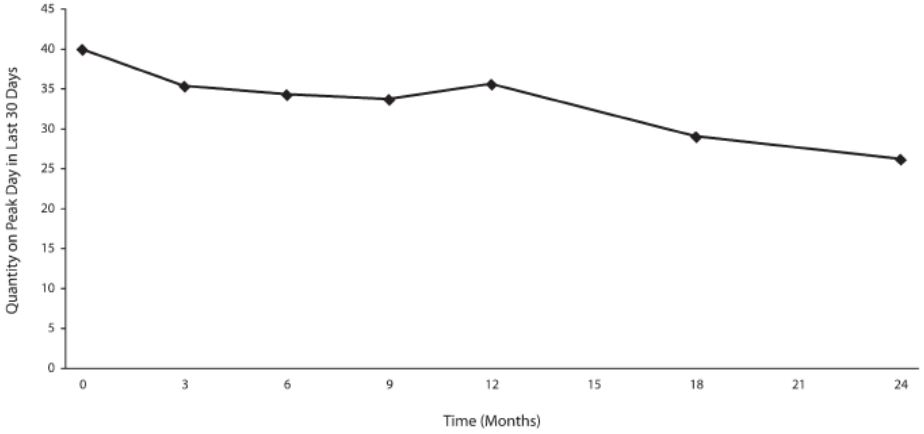
Susan E. Collins, PhD, Daniel K. Malone, MPH, Seema L. Clifasefi, PhD, Joshua A. Ginzler, PhD, Michelle D. Garner, MSW, PhD, Bonnie Burlingham, MPH, Heather S. Lonczak, PhD, Elizabeth A. Dana, MA, Megan Kirouac, BS, Kenneth Tanzer, BA, William G. Hobson, MA, G. Alan Marlatt, PhD, and Mary E. Larimer, PhD

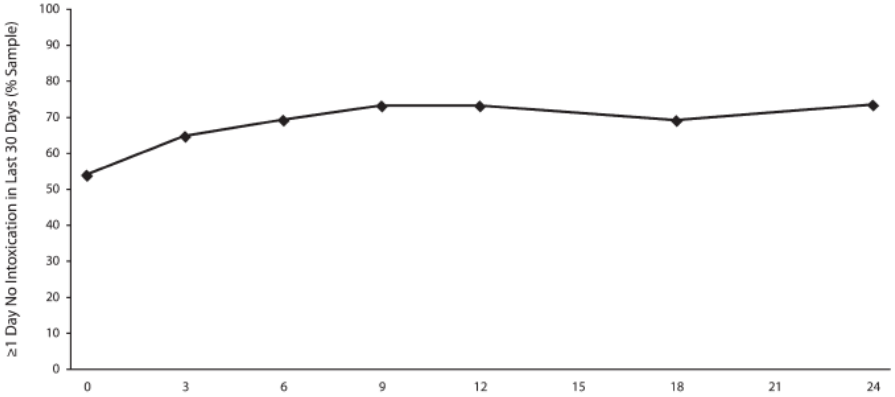


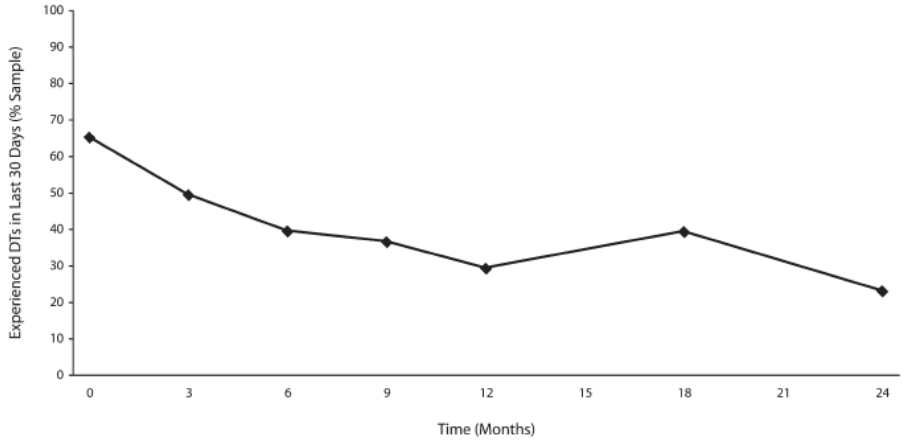


Project-Based Housing First for Chronically Homeless Individuals With Alcohol Problems: Within-Subjects Analyses of 2-Year Alcohol Trajectories

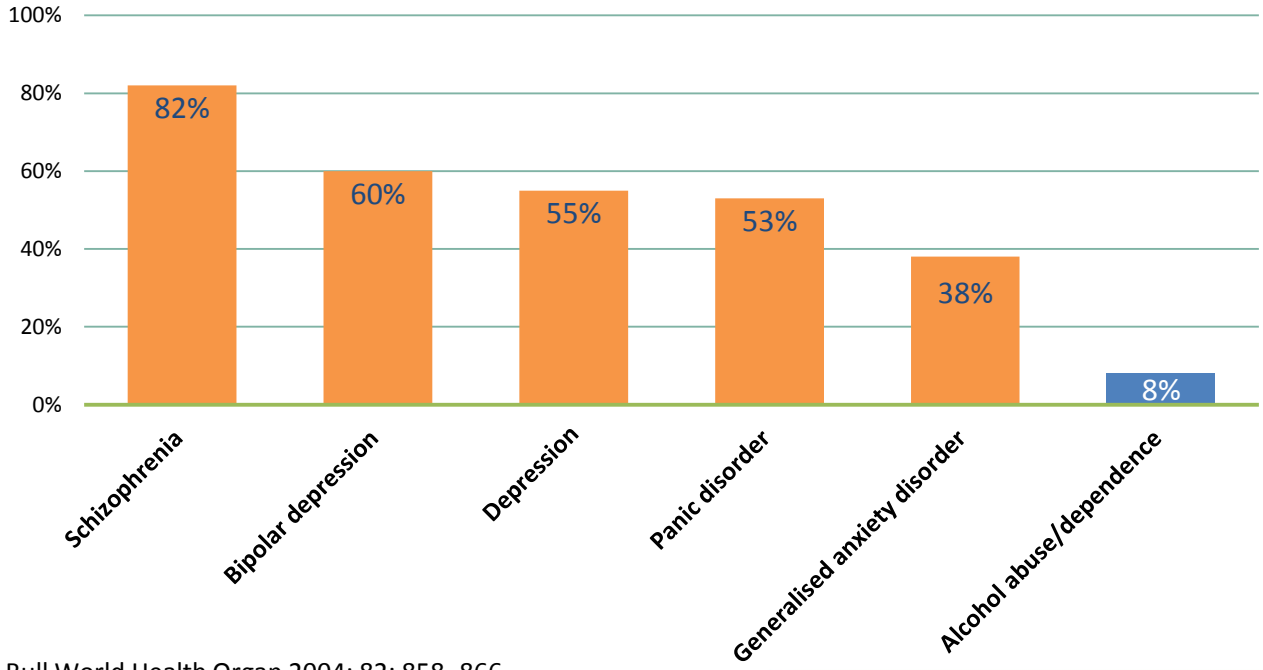
Susan E. Collins, PhD, Daniel K. Malone, MPH, Seema L. Clifasefi, PhD, Joshua A. Ginzler, PhD, Michelle D. Garner, MSW, PhD, Bonnie Burlingham, MPH, Heather S. Lonczak, PhD, Elizabeth A. Dana, MA, Megan Kirouac, BS, Kenneth Tanzer, BA, William G. Hobson, MA, G. Alan Marlatt, PhD, and Mary E. Larimer, PhD







Sujets en traitement pour troubles mentaux en Europe *dans l'année*



Kohn et al. Bull World Health Organ 2004; 82: 858–866

Drug and Alcohol Dependence xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Drug and Alcohol Dependence

journal homepage: www.elsevier.com/locate/drugalcdep

Full length article

A 10-year study of factors associated with alcohol treatment use and non-use in a U.S. population sample

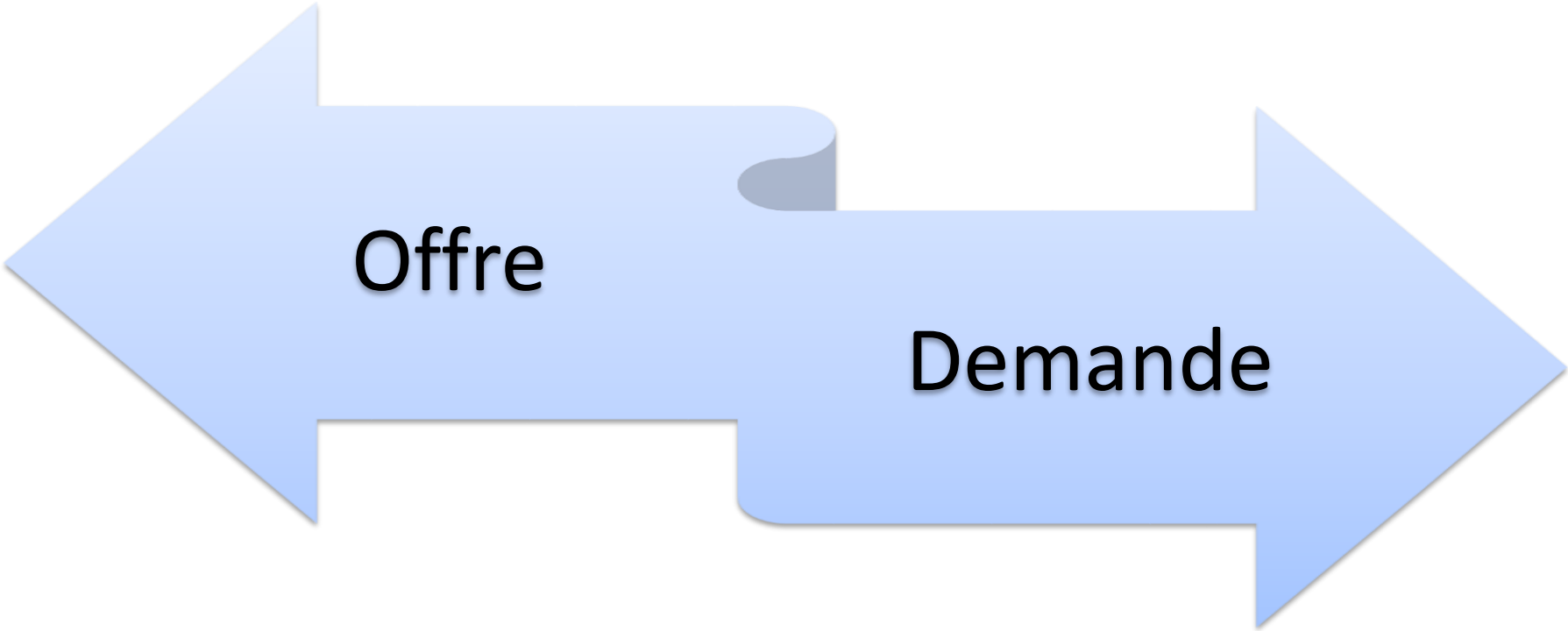
Karen G. Chartier[a,b,*], Kierste Miller[c], T. Robert Harris[d], Raul Caetano[d,e]

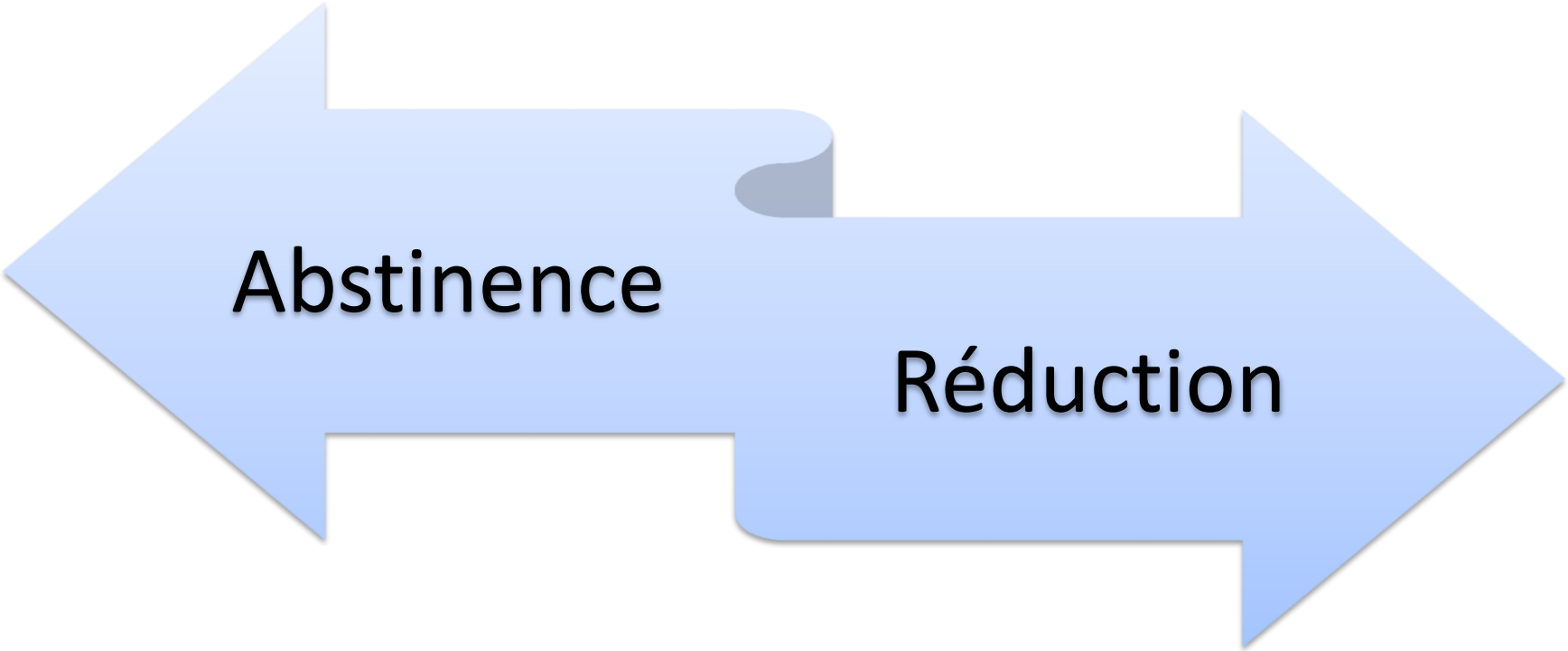
Perceived barriers to treatment for alcohol problems by survey year.

	Rank[a]	1991–1992 N = 1072	2001–2002 N = 1012	p
Predisposing				
Did not think anyone could help	7	9.11 (1.06)	14.15 (1.25)	**.003**
Too embarrassed to discuss it	4	11.06 (1.13)	18.57 (1.75)	**<.001**
Afraid of what others would think	11	7.26 (0.95)	7.82 (1.08)	.699
Hated answering personal questions	9	4.31 (0.70)	10.97 (1.40)	**<.001**
Afraid would be put into the hospital	12	4.14 (0.69)	8.90 (1.25)	**.002**
Afraid of the treatment	13	4.19 (0.64)	8.35 (1.20)	**.003**
Enabling/restricting				
Could not afford to pay	6	11.91 (1.23)	13.20 (1.35)	.493
Did not know any place to go for help	14	5.16 (0.75)	7.51 (0.99)	.061
Did not have a way to get there	16	0.62 (0.20)	3.71 (0.63)	**<.001**
Did not have time	10	7.30 (1.15)	8.29 (1.16)	.543
Had to wait too long	18	0.64 (0.22)	1.21 (0.39)	.211
Inconvenient hours	17	1.23 (0.35)	2.75 (0.55)	.024
Can not speak English well	21	0.00 (0.00)	0.18 (0.09)	.060
Could not arrange child care	20	0.45 (0.18)	0.35 (0.17)	.681
Family member objected	19	0.60 (0.26)	0.94 (0.31)	.417
Afraid would lose job	15	2.05 (0.45)	2.79 (0.72)	.388
Need				
Thought problem was not serious enough	3	24.64 (1.67)	20.66 (1.49)	.081
Thought the problem would get better by itself	2	20.04 (1.66)	32.90 (1.97)	**<.001**
Thought should be strong enough to handle it alone	1	29.84 (1.80)	41.37 (1.95)	**<.001**
Did not think it was necessary (despite family requests)	8	4.57 (0.81)	11.09 (1.29)	**<.001**
Wanted to keep drinking	5	12.78 (1.28)	15.83 (1.37)	.109

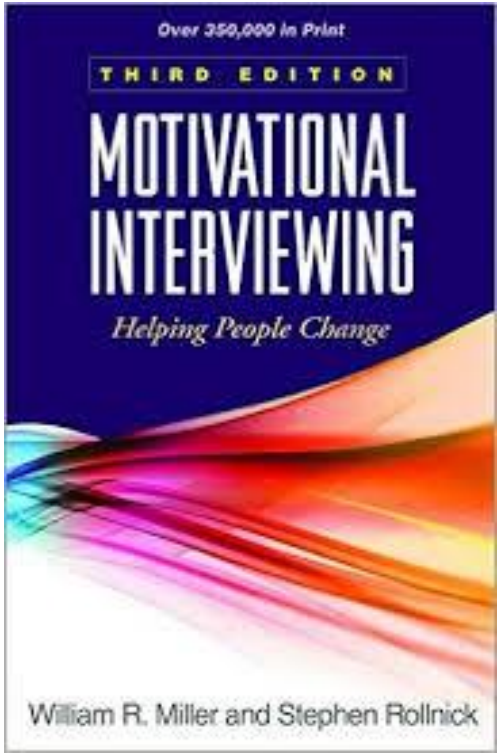
Obstacles à s'engager dans des soins

1. Assez fort pour y arriver tout seul
2. Le problème finira par s'améliorer tout seul
3. Le problème n'est pas suffisamment grave
4. Trop gêné pour en parler
5. Souhaite continuer à boire


Offre
Demande


Abstinence
Réduction

Approche centrée sur le patient



Recommandation de bonne pratique

Mésusage de l'alcool : dépistage, diagnostic et traitement

Société Française d'Alcoologie
Reconnue d'utilité publique
(décret du 29 octobre 1998)

Association Nationale de PRÉVENTION en ALCOOLOGIE et ADDICTOLOGIE
A.N.P.A.A.

EUFAS
EUROPEAN FEDERATION OF ADDICTION SOCIETIES

Quels sont les objectifs de l'intervention thérapeutique ?

Qualité de vie

Quels sont les objectifs de l'intervention thérapeutique ?

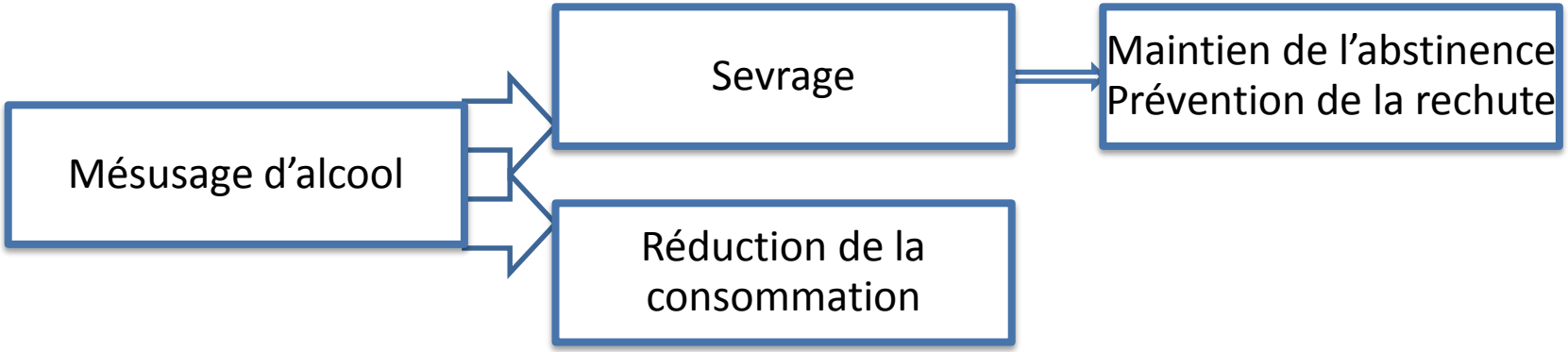
Qualité de vie

- Abstinence
- Réduction de la consommation

Quels sont les objectifs de l'intervention thérapeutique ?

Qualité de vie

- Abstinence
- Réduction de la consommation



Quels sont les objectifs de l'intervention thérapeutique ?

Lors de l'évaluation initiale, il est recommandé d'accepter l'objectif de consommation du sujet

Quels sont les objectifs de l'intervention thérapeutique ?

Lors de l'évaluation initiale, il est recommandé d'accepter l'objectif de consommation du sujet

L'abstinence est l'objectif de consommation le plus sûr pour les personnes souffrant d'un mésusage sévère

Si elles ne souhaitent pas s'engager vers l'abstinence, envisager un accompagnement vers la réduction des dommages.

Quels sont les objectifs de l'intervention thérapeutique ?

Lors de l'évaluation initiale, il est recommandé d'accepter l'objectif de consommation du sujet

L'abstinence est l'objectif de consommation le plus sûr pour les personnes souffrant d'un mésusage sévère

Si elles ne souhaitent pas s'engager vers l'abstinence, envisager un accompagnement vers la réduction des dommages.

Pour les sujets avec une dépendance peu sévère, sans comorbidité significative, et si le soutien social est adéquat, envisager l'objectif de consommation de réduction de la consommation

Quels sont les objectifs de l'intervention thérapeutique ?

L'objectif de réduction de la consommation devrait idéalement viser à ne pas dépasser :

- 21 verres-standard par semaine chez l'homme
- 14 verres-standard par semaine chez la femme

Quels sont les objectifs de l'intervention thérapeutique ?

L'objectif de réduction de la consommation devrait idéalement viser à ne pas dépasser :

- 21 verres-standard par semaine chez l'homme
- 14 verres-standard par semaine chez la femme

Cependant, toute réduction significative de la consommation est susceptible d'apporter un bénéfice substantiel au sujet.

Ainsi, dans une perspective de réduction des dommages, toute cible de la réduction de la consommation est plus acceptable que le *statu quo*, et mérite d'être valorisée.

Recommandations

- Programmes d'entraide et d'auto-assistance
- Médecins généralistes
- Programmes orientés vers les femmes enceintes
- Programmes de réduction des risques en centre d'hébergement social
- Approche thérapeutique centrée sur le patients
- Adapter l'offre de soins aux besoins ressentis par les usagers
- Recommandation de bonne pratique *(Société Française d'Alcoologie)*