GOOD PRACTICE RECOMMENDATION

Alcohol misuse: screening, diagnosis and treatment

According to the "Clinical practice recommendations" method

February 09, 2015
Good practice recommendations (GPR) are defined in the field of health as methodically developed proposals to help practitioners and patients find the most suitable treatment in given clinical circumstances.

These are part of an objective for improving the quality and safety of treatment. The ‘Clinical practice recommendations’ (CPR) method, applied to drafting a GPR, is a rigorous method for summarising the state of the art and scientific data at a given moment, described in the scientific rationale based on:
- the participation of professionals along with representatives of patients and users concerned by the theme of the GPR;
- transparency with regard to the critical analysis of the literature, the key parts of the discussions and decisions made by members of the working group, formal opinions of the members of the review group, and all participants in the different groups;
- independent drafting of recommendations, due to the autonomy of the groups involved (working group, review groups);
- management of the interests declared by the working group experts.
GPR do not excuse healthcare professionals from showing discernment in terms of patient management, which should be based on their own observations and deemed the most suitable.

This good practice recommendation was drawn up as per the method summarised in Appendix 1 of the document.

For information, the CPR method is described in the methodological guide issued by the *Haute Autorité de Santé* (HAS) available on its website: drafting of good practice recommendations - ‘Clinical practice recommendations’ method - www.has-sante.fr

The recommendations are available for download on the following sites:
  sfalcoologie.asso.fr
  anpaa.asso.fr
  eufas.net

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<table>
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<tr>
<th>Sponsor</th>
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Alcohol misuse: screening, diagnosis and treatment

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<table>
<thead>
<tr>
<th>National review group</th>
<th>37 participants</th>
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<tr>
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<td>The composition of the group is described in the ‘Participants’ section on page 134.</td>
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I. INTRODUCTION

➢ **Context for drafting the good practice recommendation**

The Société Française d’Alcoologie (SFA) included the drafting of good practice recommendations on ‘Alcohol misuse: screening, diagnosis and treatment’ in its 2013-2014 working programme.

The SFA proposed several recommendations on this subject between 1999 and 2003. However, the field of alcohol studies, and addiction studies more generally, has undergone rapid developments since then. The concepts, knowledge and practices have changed, new medicinal products are currently being evaluated, and some are available on the market. Baclofen has become more widely prescribed.

Not so long ago, less than 10% of people suffering from an alcohol use disorder were taken care of in Europe. Reluctance to engage in abstinence was the first reason put forward by subjects with an alcohol use for not applying for treatment. Such a deplorable observation should encourage us to make additional efforts to meet our patients’ needs as they perceive them. It seems obvious that general practitioners’ involvement is crucial for reducing the treatment gap in alcohol misuse.

The recommendations on this subject thus needed to be updated. The SFA has agreed to operate based on the rigorous ‘Clinical practice recommendations’ method with a funding provided by public and private sources.

The SFA wished to fully involve the Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA, state-approved since 1880 and popular education approved since 1974) in this project, and to extend the discussions to foreign colleagues, within the European Federation of Addiction Societies (EUFAS). Particular attention was given to the general practitioners’ role when directing the present work.

➢ **Definitions**

There are 5 categories of alcohol use:
- total abstinence,
- simple use (low-risk use),
- misuse, which includes 3 categories:
  - at-risk use,
  - harmful use,
  - use with dependence.

Non-use, simple use and at-risk use represent the asymptomatic forms of use, for which no patent consequences of use currently exist.

Alcohol-related disorders, represented by harmful use and use with dependence, correspond to the symptomatic forms of use, i.e. with visible social, psychological or medical consequences.

The main objectives of the management of alcohol misuse are to avoid progression towards complications and to reduce harm resulting from this behaviour, thereby reducing mortality due to these disorders, their high morbidity, whether somatic, psychological or social, and to improve patient quality of life.
Objective of the recommendation
The objective of this project is to improve the quality of management of persons who misuse alcohol.

Population concerned
These recommendations concern all patients who misuse alcohol.

Professionals concerned
Although many professionals are potentially concerned by addictive behaviour (health, social, judicial, educational fields, etc.), these recommendations are mainly intended for general practitioners, addiction specialists and, as a general rule, all healthcare professionals, physicians (notably internists, hepatogastroenterologists, occupational physicians, neurologists, psychiatrists, etc.), along with nurses, psychologists, midwives, pharmacists, support groups, etc., involved in managing patients who misuse alcohol.

Questions examined in this recommendation

I/ DEFINITIONS AND IDENTIFICATION
1. How is alcohol misuse defined?
2. Which professional categories should screen for alcohol misuse?
3. When should alcohol misuse be detected?
4. How should alcohol misuse be detected
   - in adults?
   - in pregnant women?
   - in the elderly?
   - in adolescents?
5. How should addiction, together with the somatic, psychiatric and social symptoms related to alcohol misuse, be assessed?

II/ THERAPEUTIC INTERVENTIONS
6. What are the objectives of therapeutic intervention?
7. What types of therapeutic intervention should be proposed?
8. How should patient resistance be managed?
9. How should intervention be planned?
10. How should treatment be conducted with a view to reducing drinking?
11. How should treatment be conducted with a view to detoxification?
12. How can relapse be prevented?
13. What are the indications for referral to specialist intervention?
14. What are the indications for residential treatment?
15. What is the role of non-pharmacological and non-psychotherapeutic interventions (socio-educational intervention, occupational therapy, psychomotor education, specialised education, physical activities, etc.)?
16. How should alcohol misuse be managed in specific populations: pregnant women, adolescents, the elderly, or individuals suffering from somatic or psychiatric comorbidities, multiple substance use, social difficulties, persons on probation, etc.?
17. How to respond to critical situations relating to alcohol use?
18. Place and role of family and environment (including working environment)
19. What is the role of support groups for patients or people affected by alcohol use disorders?

**Key messages**
Two essential messages of these recommendations are pointed up in this short section. They are followed by a practical synopsis intended for carers in the field, notably general practitioners.

➢ *Classification of the levels of evidence used for this recommendation*
(Also see Appendix 5. Working method; ‘Methodology’ chapter)

<table>
<thead>
<tr>
<th>Classification of levels of evidence</th>
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<tbody>
<tr>
<td><strong>A</strong> Established scientific evidence</td>
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</table>
Based on studies with a high level of evidence - *level of evidence 1* -:
- randomised comparative trials with high power and no major biases,
- meta-analysis of randomised comparative trials,
- decision analysis based on properly conducted studies. |
| **B** Scientific assumption |  
Based on a scientific assumption provided by studies with an intermediate level of evidence - *level of evidence 2* -:
- randomised comparative trials with low power,
- properly conducted non-randomised comparative studies,
- cohort studies. |
| **C** Weak level of evidence |  
Based on studies with a lower level of evidence:
- *level of evidence 3* -:
  case-control studies
- *level of evidence 4* -:
  retrospective studies,
- case series,
- comparative studies with major biases. |
| **EC** Expert consensus |  
If no studies are available, the recommendations are based on a consensus between working group experts, after consulting the review group.  
The absence of classification does not mean that the recommendations are not relevant and useful. However, this should prompt additional studies. |

➢ **Warning**
It is important to note that funding for this project was provided by public and private sources. Hence, the recommendations thus drawn up are not approved by the *Haute Autorité de Santé*, which does not accept any projects funded in partnership with industry.
II. RECOMMENDATIONS

The terms highlighted in yellow appear in the glossary. These are highlighted when they first appear in the text of the Recommendations.

How is alcohol misuse defined?

Among alcohol users, there is a continuum between low risk alcohol use and the more severe forms of alcohol-related disorders, with major repercussions resulting from use\(^1\)-\(^7\). The following types of use may be distinguished, according to increasing risk: total abstinence\(^6\), asymptomatic drinking (low risk use and at-risk use) for which evident consequences of use do not, or do not yet, exist and, lastly, alcohol-related disorders which correspond to symptomatic drinking, i.e. evidenced by visible consequences from a social, psychological or medical perspective.

**TOTAL ABSTINENCE**
Total abstinence is defined by the absence of use\(^6\). This may be characterised as\(^6\):

- primary, when describing initial abstinence (children, pre-teens) or a lasting or, indeed, permanent choice (personal and/or cultural preferences in adults);
- secondary, when it follows a period of misuse.

**SIMPLE USE**
Low-risk use is defined by use which is both: 1) asymptomatic, and 2) below French recommended limits (text box 3).

**MISUSE**
Misuse covers the types of use which give rise to negative consequences, and those likely to do so.
By definition, alcohol misuse includes at-risk use and alcohol-related disorders (text box 1).

At the same time, several risk levels have been defined by the World Health Organization (WHO), with different limits for males and females\(^8,\,9\) (text box 2).
**Text box 1**

*Use, misuse, use-related problems: a continuum*

- Dependence
- Harmful use
- At-risk use
- Low-risk use

**Text box 2**

*Risk levels of drinking according to the WHO*

According to the WHO, alcohol use may be categorised in different health risk levels\(^8,9\).

### WHO criteria for risk of consumption on a single drinking day in relation to acute problems

<table>
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<tr>
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<th>Total use (g/day)</th>
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<tr>
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<td>Males</td>
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<tr>
<td>Low risk</td>
<td>1 to 40</td>
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<tr>
<td>Medium risk</td>
<td>&gt;40 to 60</td>
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<tr>
<td>High risk</td>
<td>&gt;60 to 100</td>
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<tr>
<td>Very high risk</td>
<td>&gt;100</td>
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### WHO criteria for risk of usual consumption in relation to chronic problems

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<tr>
<td></td>
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<td>&gt;40 to 60</td>
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<tr>
<td>High risk</td>
<td>&gt;60</td>
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</table>
In France, this risk limit is defined as 21 units per week for males and 14 units per week for females\textsuperscript{6} (text box 3).

**Text box 3**

*Definition of French risk limits*

The measuring unit for defining the French risk limits is a standard unit. A standard unit is defined as a 10-g quantity of pure alcohol, approximately equivalent to 10 cl of wine, 25 cl of 5% vol. beer, or 3 cl of 40% vol. alcohol.

The following limits were chosen:

- not more than 4 units on each occasion for occasional use
- not more than 21 units per week for regular use in males (3 units/day on average)
- not more than 14 units per week for regular use in females (2 units/day on average).

As these limits are now fairly widely adopted by French healthcare professionals, it would seem unwise to change them.

**AT-RISK USE**

At-risk use is the least severe form of misuse. At-risk use is asymptomatic, but is liable to lead to harm in the shorter or longer term\textsuperscript{6, 7}. The concept of at-risk use is not found in the psychiatric classification systems in the *Diagnostic and Statistical Manual* (DSM) or in the international classification of diseases (ICD), but has been proposed by the WHO\textsuperscript{7}.

In France, at-risk use is defined by use liable to lead to harm in the shorter or longer term. This risk should be represented in two ways\textsuperscript{6}:

- Firstly, a delayed and cumulative risk: in France, it was considered that morbidity and mortality increase after 21 units per week in males and 14 units per week in females (see text box 3). A standard unit is defined as a 10-g quantity of pure alcohol.
- And also an immediate risk, since use may become harmful in certain circumstances:
  - In the event of at-risk behaviour
    - Driving
    - Control post
  - In the event of individual risk
    - Rapid consumption or use combined with other psychoactive substances
    - Concomitant organic or psychiatric disorders
    - Changes in tolerance
    - Specific physiological situations (pregnancy, sleep debt, etc.).

**ALCOHOL-RELATED DISORDERS**

Alcohol-related disorders are defined by the existence of symptoms, and not by a specific level of use. The essential characteristic of alcohol-related disorders is a collection of cognitive, behavioural and physiological symptoms, showing that the subject is continuing to drink alcohol despite significant problems related to use. According to the type of classification (ICD-10, DSM-IV or DSM-5), physical, psychological or social complications related to use, a desire (often powerful, and sometimes compulsive) to drink, loss of control of use, or continued use in hazardous situations may be observed.
The main diagnostic classification systems recognise at least two levels of severity for alcohol-related disorders. DSM-IV-TR proposes two hierarchical diagnoses: abuse (text box 5) and dependence (text box 6).  

Text box 4

**Alcohol-related disorders or alcohol use disorders? Which terminology?**

Alcohol-related disorders correspond to the disease classification categories described in ICD-10, DSM-IV and DSM-5:

- ICD-10: acute intoxication, harmful use, dependence syndrome, withdrawal state, withdrawal state with delirium, psychotic disorder, amnesic syndrome, residual and late-onset psychotic disorder, other mental and behavioural disorders, unspecified mental and behavioural disorder.

- DSM-IV: alcohol dependence, alcohol abuse.

- DSM-5: alcohol use disorder, alcohol intoxication, alcohol withdrawal, other alcohol-induced disorders, unspecified alcohol-related disorder.

**For these clinical practice recommendations, the decision was made to focus on the ICD-10 classification, proposed by the WHO.**

In this classification, alcohol-related disorders notably include diagnosis of harmful use and dependence syndrome. **The term ‘alcohol use disorder’ refers to the diagnosis proposed by the DSM-5.**

Text box 5

**Criteria for Substance Abuse (DSM-IV-TR)**

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home, such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school, neglect of children or household

2. Recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use)

3. Recurrent substance-related legal problems (e.g. arrests for disorderly conduct related to substance use)

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance (e.g. arguments with spouse about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for Substance Dependence for this class of substance
Text box 6

**Criteria for Substance Dependence (DSM-IV-TR)**

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) Tolerance, as defined by either of the following:
   (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   (b) markedly diminished effect with continued use of the same amount of the substance

(2) Withdrawal, as manifested by either of the following:
   (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substance)
   (b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) The substance is often taken in larger amounts or over a longer period than was intended

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) A great deal of time is spent in activities necessary to obtain the substance (e.g. appointments with numerous doctors or travelling long distances), use the substance (e.g. smoking continuously), or recover from its effects

(6) Important social, occupational, or recreational activities are given up or reduced because of substance use

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g. continued cocaine use despite admitting to cocaine-related depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

ICD-10 also proposes two hierarchical diagnoses: harmful substance use (text box 7) and substance dependence (text box 8)\(^\text{11}\).
Alcohol misuse: screening, diagnosis and treatment

Text box 7

**Harmful Use (ICD-10)**

A pattern of psychoactive substance use that is causing damage to health. The damage may be physical (as in cases of hepatitis from the self-administration of injected drugs) or mental (e.g. episodes of depressive disorder secondary to heavy consumption of alcohol).

The patient does not meet the criteria for dependence.

Text box 8

**Dependence syndrome (ICD-10)**

A definite diagnosis of dependence should usually be made only if three or more of the following have been present together at some time during the previous year:

a) a strong desire or sense of compulsion to take the substance;

b) difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use;

c) a physiological withdrawal state when substance use has ceased or been reduced, as evidenced by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms;

d) evidence of tolerance, such that increased doses of the psychoactive substances are required in order to achieve effects originally produced by lower doses (clear examples of this are found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users);

e) progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects;

f) persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use, or drug-related impairment of cognitive functioning; efforts should be made to determine that the user was actually, or could be expected to be, aware of the nature and extent of the harm.

In both systems, if dependence is diagnosed, a diagnosis of abuse (DSM-IV TR) or harmful use (ICD-10) is impossible. In this respect, dependence is perceived as a more severe form of alcohol-related disorders. DSM-5 proposes a diagnosis based on 11 criteria: Alcohol use disorder: with three severity levels: low (at least 2 out of 11 criteria present, moderate (at least 4) and severe (at least 6) (text box 9).
Text box 9

**Substance use disorders (DSM-5)**

1: Recurrent alcohol use resulting in a failure to fulfil major role obligations at work, school, or home (e.g. repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household).

2: Recurrent alcohol use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by alcohol use).

3: Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.

4: Tolerance, as defined by either of the following:
   - A need for markedly increased amounts of alcohol to achieve intoxication or desired effect;
   - A markedly diminished effect with continued use of the same amount of alcohol.

5: Withdrawal, as manifested by either of the following:
   - The characteristic withdrawal syndrome for alcohol when stopping or markedly reducing use;
   - Alcohol is taken to relieve or avoid withdrawal symptoms.

6: Alcohol is often taken in larger amounts or over a longer period than was intended.

7: There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

8: A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.

9: Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

10: Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

11: **Craving**, or a strong desire or urge to use alcohol.

There is now a consensus on the concept of a severity gradient for alcohol-related disorders\(^1\)-\(^7\),\(^9\). The reference classification system for coding diseases in France is the WHO International Classification of Diseases. This makes a distinction between harmful use and dependence.

**RECOMMENDATIONS**

1.1. Misuse includes 3 categories:
   - at-risk use,
   - harmful use,
   - use with dependence.

In at-risk use, evident consequences of use do not, or do not yet, exist.

Alcohol-related disorders, which are harmful use and use with dependence, correspond to symptomatic drinking.
1.2. A standard unit is defined as a 10-g quantity of pure alcohol, approximately equivalent to 10 cl of wine, 25 cl of 5% vol. beer, or 3 cl of 40% vol. alcohol.

1.3. At-risk use corresponds to intake of more than 21 units per week for males, or more than 14 units per week for females; more than 4 units on each drinking occasion; any use in certain circumstances (childhood, pregnancy, driving an automobile or operating a machine, certain disorders, etc.).

1.4. Alcohol-related disorders are a collection of cognitive, behavioural and somatic symptoms, showing that the subject is continuing to drink alcohol despite significant problems related to use. Physical, psychological or social complications related to use, a desire (often powerful, and sometimes compulsive) to drink, loss of control of use, or continued use in hazardous situations may be observed.

1.5. A severity gradient for alcohol-related disorders exists.

1.6. According to the International Classification of Diseases, alcohol-related disorders include two hierarchical diagnoses: harmful use and dependence.
2

Which professional categories should screen for alcohol misuse?

Screening for alcohol misuse is effective and relevant in general medicine\textsuperscript{13, 14} (level of evidence 1) and in primary care\textsuperscript{15} nursing practice (level of evidence 1). General practitioners, as well as other healthcare professionals, should therefore be the key players in detecting alcohol problems, throughout an individual's life and healthcare path\textsuperscript{13} (grade A).

The detection of alcohol misuse involves incorporating the relationship skills necessary in order to broach the issue of alcohol use with the patient. Primary care professionals who feel incompetent or reluctant to discuss alcohol problems with patients can improve their practice by undergoing a specific training\textsuperscript{16} (level of evidence 1). The professionals concerned should therefore receive training in detecting misuse in patients' interests (grade A).

The use of standard questionnaires by non-nursing professionals has not been properly assessed\textsuperscript{17}. Furthermore, the use of questionnaires by non-health professionals may be a source of ethical problems relating to the confidentiality of medical information. It is therefore recommended that non-health professionals having suspected an alcohol problem automatically guide the subject to a suitable healthcare professional for the circumstances, i.e.: general practitioner, medical/social professionals for socio-educational aspects, physicians responsible for implementing compulsory treatment orders or therapeutic injunctions for the judicial sector, healthcare personnel working in prisons for the prison sector, or in occupational medicine for the professional sector, and in school health for the educational sector, and perinatal professionals for pregnant women (EC).

RECOMMENDATIONS

2.1. As a matter of priority, screening for alcohol misuse is the task of general practitioners as well as other healthcare professionals (grade A).

2.2. It is recommended that all healthcare professionals receive initial and/or continuing training in order to acquire these skills (grade A).

2.3. All professionals not working in the health field, suspecting a person of alcohol misuse, should encourage them to receive support and guide them to a competent healthcare professional.
When should alcohol misuse be detected?

The first form of misuse, at-risk use, may extend over a long period, which is asymptomatic by definition. This is why it is important not to wait for warning signs before considering detecting alcohol misuse (EC).

According to the National Institute on Alcohol Abuse and Alcoholism, alcohol misuse should be investigated in the following situations:
- during a routine examination;
- when prescribing a medicinal product known to interact with alcohol (antibiotics, antidepressants, antihistamines, benzodiazepines, muscle relaxants, opioid analgesics, anti-inflammatory agents, warfarin, etc.);
- during admission to an emergency department;
- in pregnant women or women hoping to conceive;
- in persons at high risk of excessive drinking: smokers, adolescents and young adults;
- in persons with health problems often related to excessive alcohol use: hypertension, cardiac arrhythmia, dyspepsia, liver disease, depression or anxiety, insomnia, trauma;
- in persons suffering from a chronic disorder refractory to treatment: pain, diabetes, gastrointestinal disorders, depression, heart disease, hypertension.

Screening should be recorded and regularly updated in the medical file, as data on use change over time. The presence of alcohol misuse can become apparent at any age, from childhood to the elderly (level of evidence 2). Therefore, screening for alcohol misuse should be adapted to age (grade B). In children, it is recommended that investigations begin by exploring any experimentation with alcohol (‘Has the person already consumed alcohol at least once?’) (EC).

In view of their specific vulnerability to occurrence of misuse or the consequences thereof, certain populations require special surveillance with regard to the level of alcohol use: pregnant women (level of evidence 2), adolescents (level of evidence 1), subjects suffering from psychiatric disorders (level of evidence 2) or other substance use disorders (level of evidence 2), elderly subjects (level of evidence 2), and subjects in a vulnerable socio-economic situation (level of evidence 2; grade B). Professionals should pay particular attention to children in vulnerable families, and to the impact of alcohol within the family system.

RECOMMENDATIONS

3.1. Screening for alcohol misuse should concern all patients, regardless of age (grade B). In children, it is recommended that steps first be taken to detect whether any experimentation with alcohol has occurred (EC).
3.2. Alcohol misuse should be investigated:
  • during a routine examination;
  • when prescribing a medicinal product known to interact with alcohol (antibiotics, antidepressants, antihistamines, benzodiazepines, muscle relaxants, opioid analgesics, anti-inflammatories, warfarin, etc.);
  • during admission to an emergency department;
  • in pregnant women or women hoping to conceive;
  • in persons at high risk of excessive drinking: smokers, adolescents and young adults;
  • in persons with health problems often related to excessive alcohol use: hypertension, cardiac arrhythmia, dyspepsia, liver disease, depression or anxiety, insomnia, trauma;
  • in persons suffering from a chronic disorder refractory to treatment: pain, diabetes, gastrointestinal disorders, depression, heart disease, hypertension.

3.3. Certain particularly exposed or vulnerable populations should undergo intensified surveillance of alcohol use: pregnant women, adolescents, subjects suffering from psychiatric disorders or other substance use disorders, elderly subjects, subjects in a vulnerable socio-economic situation (grade B).
How should alcohol misuse be detected:
- in adults?
- in pregnant women?
- in the elderly?
- in adolescents?

A/ How should alcohol misuse be detected in adults?

• On what signs should alcohol misuse be suspected?
Social indicators are generally the earliest signs:\problems with work, financial situation, marital situation, recurrent relationship problems, domestic violence, etc.
The most common clinical indicators are non-specific: sleep disorders, depression, anxiety, hypertension, recurrent accidents, dilated facial capillaries, red eyes, gastrointestinal disorders, cognitive disorders, etc.
Positive laboratory indicators are often observed later on and cannot be relied on as a routine method of detection (EC) (cf. Appendix 2).

• What steps should be followed in order to detect misuse?
Alcohol use should preferably be broached openly with a patient, from the outset avoiding closed questions which limit the information spontaneously provided by the subject (EC). In the course of this discussion, the items to be investigated as a matter of priority are those covered by the 3 AUDIT-C questions (cf. Appendix 1; Glossary) (grade B). AUDIT-C is a questionnaire which establishes a score based on three questions. A score greater than or equal to 3 in females, or greater than or equal to 4 in males suggests alcohol misuse. A score greater than or equal to 10 in females or in males suggests alcohol dependence.
The complete form of the AUDIT questionnaire, consisting of 10 questions, is also helpful in clarifying the repercussions of alcohol use (cf. Appendix 1; Glossary) (grade B). Misuse should be suspected in patients with a score of 7 or more for males, and 6 or more for females. Lastly, the FACE questionnaire can also be used (cf. Appendix 1; Glossary). This is a French 5-item clinical instrument based on a simplified version of the AUDIT questionnaire, and which can be helpful to detect harmful use in the general population. Misuse is suspected for a score greater than or equal to 5 in males, and 4 in females.

• What to do if misuse is detected?
- Detection of misuse should be stated in the patient’s medical file.
- It is necessary to investigate for addictive, somatic, cognitive, psychiatric, and social comorbidities relating to misuse.
- Intervention should then be planned according to the level of severity and repercussions observed: all degrees of management may be envisaged, from brief intervention to complex intervention in a hospital environment, via outpatient intervention in an addiction treatment, support and prevention centre (CSAPA).
B/ How should alcohol misuse be detected in pregnant women?

Any alcohol use in pregnant women should be perceived as misuse. The risks are two-fold: for the woman herself, based on her intake, and also for the unborn child. The consequences, often overlooked by professionals and the general public, can be serious due to the foeto-toxicity of alcohol. These consequences vary considerably from one individual to another, and are grouped under the term ‘Foetal alcohol spectrum disorder’ (FASD - approximately 1% of infants born in France -), including ‘Foetal alcohol syndrome’ (FAS). Exposure to alcohol during pregnancy is the leading cause of avoidable mental deficiency in France.

Due to the lack of a current consensus on a possible alcohol toxicity threshold for the foetus\(^{37}\) (level of evidence 2), abstinence from alcohol is recommended throughout pregnancy as a precaution (EC).

The detection of alcohol misuse requires all medical and medical/social professionals involved in monitoring pregnant women (gynaecologists/obstetricians, paediatricians, midwives\(^{38}\), general practitioners, other professionals working in perinatal medicine) to acquire certain fundamental skills (EC). It is therefore recommended that all professionals involved in monitoring pregnant women receive training in the detection of use, together with the potential risks to the foetus and infant (grade B), and in the guidance to be proposed. Empathy from the professionals and their ability to develop a trusting relationship are fundamental to detection. Detection takes place by means of open questions similar to those used in the general population.

The question concerning use should be raised routinely during the first antenatal consultation during the medical interview, during the early antenatal interview and, ideally, during each appointment or home visit. The professional should take the patient's personal, family and environmental context into account (whether suggestive or not).

The medical file must be updated in order to envisage, if use is detected, the procedure to be followed at the time of birth, in the postnatal sector, in order to help the young mother to focus on her newborn baby as much as possible and encourage continued coordinated support after discharge.

The professional should be mindful as to the development of intrauterine growth restriction (IUGR), without any other known cause, and to whether the mother has already had one or more children in whom IUGR was diagnosed without a specific aetiology, or who present disorders possibly caused by foetal exposure to alcohol.

The AUDIT and particularly the AUDIT-C questionnaires may also be used. These are the most extensively validated\(^{39}\) (level of evidence 1) and have been translated into French. These are therefore additional recommended screening instruments (grade A) able to be incorporated into self-administered questionnaires.

If the pregnant woman occasionally drinks alcohol, repeated brief interventions, by any professional, are effective in promoting abstinence\(^{40}\) (level of evidence 1). However, detection of use, which is ongoing or has recently stopped, requires rapid referral of the future mother for addiction management (EC). Knowledge of local resources is vital in
order to set up medical, psychological and social support involving multiple partnerships, based on the needs identified.

The **pre-conception consultation** should be highlighted among women and couples of child-bearing potential. This provides certain information early on, including the risks related to alcohol use during pregnancy and while breastfeeding. Stopping contraception in the hope of conceiving is also an opportune moment to discuss this subject (EC).

It is recommended that information on the potential risks due to foetal alcohol exposure be widely circulated, particularly among young people via their prevention programme (EC).

### C/ How should alcohol misuse be detected in the elderly?

In elderly subjects (aged over 65 years) who drink alcohol to excess, approximately two-thirds of cases are the result of continued, long-standing **misuse**.

In the other cases, misuse begins late, after the age of 60. Tolerance to the effects of alcohol decreases with age: frequent disorders, multiple medication use, and physiological decline in tolerance to the effects of alcohol. In the United States, the recommendations for lower-risk alcohol use have been adapted to the elderly: after the age of 65 years, consumption of no more than one unit on average per day, and three units occasionally is recommended\(^1\)\(^8\), \(^4\)\(^1\).

**Specific characteristics of detection in the elderly**

Rather than routine detection, it is generally recommended that targeted detection be set in place alongside populations perceived as being ‘at high risk’ after having identified predictive factors for misuse (male gender, tobacco use, social difficulties) or when faced with non-specific symptoms frequently encountered at home or during consultations: sleep disorders, falls, malnutrition, anxious or depressive symptoms, cognitive disorders, and chronic pain\(^4\)\(^1\).

As in younger subjects, clinical and laboratory findings (mean corpuscular volume - MCV -, gamma-glutamyl transferase - GGT -, and carbohydrate deficient transferrin - CDT -) display too limited sensitivity for early detection in primary care. Laboratory tests may, however, provide an additional perspective after exploring declared alcohol use during careful discussion.

Traditional diagnostic instruments, although effective in elderly subjects, still have their place if no other alternatives are available in routine practice\(^4\)\(^2\) (level of evidence 3). However, lower AUDIT cut-offs should be considered for elderly than for adults.
D/ How should alcohol misuse be detected in adolescents?

In France, as in many other Western countries, experimentation with alcohol use and drunkenness mainly occurs during adolescence\(^{43}\) (level of evidence 2). Alcohol misuse during this period could lead to specific damage to brain maturation processes and neuropsychological development in adolescents\(^{44}\) (level of evidence 2). Furthermore, the onset of misuse with repercussions from adolescence is a demonstrated risk factor for developing a long-term alcohol-related disorder with a poor prognosis, and also for developing psychiatric disorders and other addiction problems\(^{45}\) (level of evidence 2).

For all of these reasons, adolescence is a particularly vulnerable period with regard to alcohol, which requires regular vigilance and surveillance of alcohol use and rapid intervention in the event of misuse (grade B).

Adolescence is also a highly vulnerable period for experimentation and continued use of tobacco, cannabis or indeed other psychoactive substances. More generally, it is a period in which at-risk behaviour can develop. Problematic use of psychoactive substances often falls within the scope of a general psychological/environmental context which should be evaluated.

Beyond an approach involving individual products, this evaluation should be more comprehensive, focusing on health risks and taking care of oneself. In this respect, the various questionnaires supporting the detection process can be used to identify any worrying signals. Their meaning and function should be investigated through an evaluation of the psychological/environmental context.

AUDIT, a questionnaire validated in the French language\(^{35}\) (level of evidence 2) and in adolescents\(^{46}\), is the reference for screening for alcohol misuse (grade B). The collective expertise of the INSERM (Institut national de la santé et de la recherche médicale) on addictive behaviours in adolescents (2014) recommends the use of the ‘DEP-ADO’ structured interview. Due to the duration of this interview (10 minutes), other questionnaires may be preferable: the CRAFFT\(^{47}\) and TSTS\(^{48}\) tests, also validated, are indicated for skimming over other associated risks (accidents, suicide, other toxic substances). These constitute a support for structuring an interview aiming to identify factors for weakness, malaise and other behaviours, including binge drinking.

The investigation for alcohol misuse in young people requires specific precautions in order to guarantee confidentiality for the adolescent, but also to negotiate the direct and/or indirect involvement of family and carer resources at a later stage.

This vigilance should be exercised by all healthcare professionals involved in managing adolescents (attending physician, midwife, medical personnel or school nurse in the field of health prevention, university prevention, family planning and education centres, etc.).

Furthermore, in adolescence, alcohol misuse may occur in the context of domestic alcohol problems, in which case the prognosis for addiction is more unfavourable\(^{49}\) (level of evidence 2). For this reason, it is strongly recommended that the detection of alcohol misuse in an adolescent be accompanied by a general family meeting and evaluation (grade B).
RECOMMENDATIONS

4.1. The detection of misuse is based on 3 fundamental questions which are covered in the AUDIT-C questionnaire (grade B). A score greater than or equal to 3 in females, or greater than or equal to 4 in males suggests alcohol misuse. A score greater than or equal to 10 in females or in males suggests alcohol dependence.

4.2. Alcohol misuse should be suspected when faced with the presence of social, clinical, or laboratory indicators, for excessive alcohol use (EC). Social indicators are generally observed earlier on: problems with work, financial situation, marital situation, recurrent relationship problems, domestic violence, etc. The most common clinical indicators are non-specific: sleep disorders, depression, anxiety, hypertension, recurrent accidents, dilated facial capillaries, red eyes, gastrointestinal disorders, cognitive disorders, etc.

4.3. The detection of alcohol misuse should take place during a discussion with the patient, avoiding closed questions insofar as possible (EC).

4.4. Detection of misuse should lead to:
1) reporting of this information in the patient's file;
2) investigation for complications of misuse;
3) planning of intervention according to the level of severity.

4.5. Due to the lack of a current consensus on an alcohol toxicity threshold for the foetus, abstinence from alcohol is recommended throughout the duration of pregnancy (EC).

4.6. It is recommended that all professionals involved in monitoring pregnant women receive training in the detection of use, together with the guidance to be proposed (grade B).

4.7. It is recommended that the question on use be raised as from the first antenatal consultation, and during each appointment, and that the medical file be updated to facilitate management of the mother and child. The AUDIT questionnaire and the simplified version (AUDIT-C) are the reference instruments for detection (EC).

4.8. Detection of use having recently stopped or which cannot be stopped in a pregnant woman requires referral for management of addiction (EC) and medical, psychological and social monitoring as part of multiple partnerships.

4.9. Intrauterine growth restriction, without any other known cause, should be a warning sign (EC).

4.10. It is recommended that pre-conception consultations be developed in order to inform young women on the reasons for advocating abstinence from alcohol during pregnancy and while breastfeeding.

4.11. It is recommended that information on the potential risks of alcohol use in pregnancy be widely circulated, particularly among young people in the context of existing prevention programmes (EC).
4.12. In elderly subjects, the presence of recurrent falls, or the onset - or exacerbation - of cognitive or psychiatric disorders should prompt investigation for alcohol misuse (grade B).

4.13. The greater vulnerability to alcohol observed among elderly subjects is an incentive for recommending lower risk levels, although these cannot be accurately determined (EC). Likewise, lower AUDIT cut-offs should be considered for elderly than for adults.

4.14. Adolescence is a particularly vulnerable period from a neuropsychological and social perspective with regard to alcohol, which requires all healthcare professionals likely to encounter an adolescent to assess alcohol use, with rapid intervention in the event of misuse (grade B).

4.15. AUDIT, a questionnaire validated in the French language and in adolescents is recommended as the reference screening instrument for alcohol misuse in adolescents (grade B).

4.16. Detection of alcohol misuse in an adolescent should be accompanied by a broader evaluation of associated use of tobacco, cannabis, and other psychoactive substances. It should also be associated with a rapid evaluation of mental health and environment, particularly the family context (grade B).
5

How should addiction, together with the somatic, psychiatric and social symptoms related to alcohol misuse, be assessed?

• EVALUATION OF ADDICTION

It is worth measuring the average alcohol intake and the frequency of heavy drinking days (greater than or equal to 6 standard units), two parameters which have demonstrated a proportional relationship with the main medical risks related to alcohol\(^{50, 51}\) (level of evidence 1).

Dependence severity scales exist. Their French versions are mainly used in research, with no real interest in clinical practice (such as the Alcohol Dependence Scale\(^{52}\)). The severity of alcohol misuse can also be simply measured by counting the number of diagnostic criteria for use disorder as per DSM-5\(^{5}\).

AUDIT-C can be used for a rapid assessment of severity in the context of primary care. A score greater than or equal to 3 in females, or greater than or equal to 4 in males suggests alcohol misuse\(^{33}\). A score greater than or equal to 10 in females or in males suggests alcohol dependence\(^{34}\).

The history of misuse should be specified: duration of disorder, periods of improvement, or indeed abstinence. The history and efficacy of the different therapeutic interventions should also be collected.

The presence of other substance use disorders, or behavioural addiction should be investigated routinely, particularly tobacco use, cannabis use and problem gambling.

• SOMATIC EVALUATION

With 49,000 deaths attributable to alcohol (9%) in France in 2009, out of a total of 535,000 deaths, the harm to health is considerable. Alcohol is responsible for a high proportion of early deaths. As an example, the proportion of deaths attributable to alcohol was found to be 33%, compared to 10% for cancer and 8% for cardiovascular diseases\(^{51}\).

Screening for complications is part of patient management (grade A).

- Neuropsychological impairments induced by alcohol may affect memory, executive functions such as inhibition, shifting, planning or memory capacity\(^{53}\) (level of evidence 2). To an extreme degree, severe acute forms may be a cause for concern, such as Wernicke’s encephalopathy or chronic forms, such as Korsakoff syndrome. Screening for neuropsychological impairments can be performed by clinicians not specialising in neuropsychology, using the Montreal Cognitive Assessment (MoCA)\(^{54, 55}\); this assessment should be performed without alcohol use and after stopping benzodiazepines (EC). If neuropsychological impairment is suspected, it is recommended that the neuropsychological evaluation be performed by specialist professionals (grade C).

Other central complications (for instance, cerebellar impairment) or peripheral complications (polyneuritis) should be investigated by means of a clinical examination. With the exception of Wernicke’s encephalopathy\(^{56}\) (level of evidence 1), structural (or anatomical) brain imaging
has limited sensitivity for detecting alcohol-related cognitive impairment; it is above all useful in ruling out a differential diagnosis (EC).

- **Nutritional deficiencies** are often associated with alcohol misuse. Neurological or neuropsychological impairments should lead to investigation for nutritional deficiencies\(^57\), notably thiamine (vitamin B1)\(^58\) (grade A). Protein/calorie malnutrition criteria are evaluated as per the criteria issued by the *Haute Autorité de Santé* (HAS 2003 for adult subjects and HAS 2007 for elderly subjects): body mass index, albumin, prealbumin, evaluation of weight loss. In the event of clinical signs of Wernicke’s encephalopathy (even for an incomplete presentation), the subject should be urgently hospitalised and receive treatment with thiamine by intravenous injection\(^59\) (grade A).

- **Alcoholic liver disease (ALD)** is a common complication of excessive alcohol use. It is clinically asymptomatic for years, and has several lesion stages, with various combinations. The steatosis (90% of drinkers consuming more than 6 units per day) is asymptomatic and reversible; the steatohepatitis (10 to 35% of patients hospitalised for alcoholism) is most often asymptomatic in the absence of cirrhosis. The cirrhosis (often irreversible) has an estimate prevalence of 10 to 20% among drinkers consuming more than 6 units per day\(^60\). Cirrhosis may be asymptomatic (compensated) or associated with complications (decompensated), the most frequently reported being ascites, digestive haemorrhage, encephalopathy and infection. **Hepatocellular carcinoma** (HCC) usually develops in the context of compensated cirrhosis, with a long asymptomatic phase.

The diagnostic aspects of these disorders are the subject of an international consensus\(^60\). The diagnosis of ALD is based on a combination of:
1) past or present alcohol misuse;
2) evocative laboratory findings (moderate cytolysis, from two to five times the upper limit of the normal range, predominantly for aspartate aminotransferase (ASAT) **transaminases**, and a marked increase in gamma-glutamyl transferase (GGT);
3) elimination of other causes of liver disease.

In current drinkers, normal liver function tests are able to rule out significant ALD (but not its occurrence in the future).

The diagnosis of compensated cirrhosis is coded, based on the presence and/or combination of clinical signs (hard liver with typical sharp lower edge, numerous spider angiomas), laboratory signs (prothrombin time (PT) < 70%, thrombocytopenia resistant to withdrawal, presence of beta-gamma bridging on protein electrophoresis), ultrasound signs of cirrhosis or presence of oesophageal or gastric varices. These signs have a high positive predictive value, but a low negative predictive value, hence the absence thereof does not rule out diagnosis. According to the results, a specialist opinion is helpful in order to discuss liver biopsy, as the non-invasive tests used for evaluation of hepatitis C have not been validated for ALD. In case of a known cirrhosis, the onset of a jaundice or any other complication calls for urgent management\(^60\)–\(^62\). Furthermore, it is essential to ensure screening and prevention of complications (investigation for oesophageal varices or HCC, vaccination against hepatitis A and B, and removal of certain medications) (grade B).
• **LABORATORY EVALUATION**

- Laboratory tests to investigate for somatic complications of alcohol use (complete blood count (CBC), PT, ASAT, alanine aminotransferase (ALAT), GGT) should be performed at the start of each new primary care sequence or in a specialist setting, and at least every year during outpatient follow-up (grade B). In the event of abnormal findings, the work-up should include the test for compensated cirrhosis (grade B).
- Screening for hepatitis B and C virus is recommended when alcohol misuse is associated with risk factors (history of drug addiction, particularly intravenous drug users, unprotected sexual intercourse, etc.) (grade B). This is also recommended when there is an increase in transaminases, particularly if it predominantly concerns ALAT.
- Screening of HIV serological status should be proposed based on the existence of risk factors and requires the subject's agreement.

• **PSYCHIATRIC EVALUATION**

More than a third of subjects who misuse alcohol develop a psychiatric comorbidity at some point in their life, notably depression, anxiety disorder, or increased suicide risk. Conversely, psychiatric comorbidities are associated with a risk of more severe alcohol misuse and alcohol misuse exacerbates psychiatric symptoms. Concomitant occurrence reduces compliance with treatment. **Personality disorders** (notably antisocial personality disorders) and type 1 **bipolar disorders** are conventionally associated with a high risk of alcohol use disorder (level of evidence 2).

In order to rule out the responsibility of excessive alcohol use in the manifestation of psychiatric symptoms, a period of abstinence (in the event of a severe use disorder), or low-risk use (in the event of moderate misuse) of at least two weeks is recommended before ruling out a psychiatric disorder related to substance use or initiating specific pharmacological treatment (grade C).
An in-depth assessment conducted by a psychiatrist may be necessary, possibly envisaging therapeutic intervention coordinated with the healthcare professional responsible for managing misuse.

Given the high prevalence of suicide risk among patients who misuse alcohol, this risk should be routinely assessed, regardless of the level or specialist nature of initial management.

• **SOCIAL EVALUATION**

The social evaluation of alcohol misuse is not different from that conducted within the scope of other chronic disorders. Nevertheless, the investigation for elements shedding light on factors for vulnerability, together with the analysis of education, professional and family status are part of the initial examination. In the event of a severe use disorder, the improvement in living conditions is an important aspect for effective management. The subject's status should be described with regard to the stability of their social connections which will be assessed in terms of (EC):
- solitary lifestyle or with partner, stable family relations - or not - and housing conditions: home, vulnerable conditions, etc.
- the values conveyed by their social circle with regard to alcohol use: social circle indulging in high levels of use, or, on the other hand, encouraging moderation or indeed abstinence,
- qualifications, aptitude and professional activities: stable or precarious employment, disability, adult disability allowance, etc.
- social welfare (compulsory and optional), possible listing as a chronic condition, ‘**ALD 30**’ (*Affection de longue durée*), if justified by frequent recourse to treatment,
- recognition of a physical, cognitive or psychiatric disability (via French departmental centre for disabled people - **MDPH**) or protected adult status (placed under guardianship or supervision) may be justified.
Lastly, the subject's judicial situation should be assessed.

**RECOMMENDATIONS**

**5.1.** The severity of alcohol misuse may be determined by counting the number of diagnostic criteria for use disorder (DSM-5), the average daily alcohol use, and the average number of days of excessive use per month (grade A). AUDIT-C can be used for a rapid assessment of severity in the context of primary care. A score greater than or equal to 3 in females, or greater than or equal to 4 in males suggests alcohol misuse. A score greater than or equal to 10 in females or in males suggests alcohol dependence.

**5.2.** Due to the high risk of comorbidities, investigation for other substance use disorders and behavioural addictions should be routinely performed when meeting and following up a subject who misuses alcohol (grade B).

**5.3.** Clinical and laboratory screening and management of somatic or psychiatric complications of alcohol misuse are a part of management and should be organised by the physician or team responsible for alcohol misuse (grade A). Depending on diagnostic difficulties, specialist referral should be proposed secondarily.

**5.4.** The Montreal neuropsychological assessment (MoCA) may be used in order to screen for cognitive disorders induced by alcohol, either if there are doubts as to the presence of a cognitive disorder, or more routinely in more severe forms of misuse (EC). Screening for cognitive disorders should be performed allowing a suitable length of time after withdrawal. However, neuropsychological impairments can only be diagnosed after a full assessment has been performed by a specialist professional. This specialist assessment is recommended in the event of positive screening, in a context of recurrent relapses, alcoholic liver disorder or nutritional deficiencies (EC).
This assessment is associated with an investigation for neurological clinical signs of vitamin B1 deficiency and a nutritional work-up including protein, albumin, and evaluation of weight loss (grade A).
If signs of Wernicke's encephalopathy develop, the subject must be hospitalised and receive urgent administration of parenteral thiamine (vitamin B1) (grade A).

**5.5.** Investigation for alcoholic liver disease should be performed by means of clinical and laboratory tests (CBC, PT, ASAT, ALAT, GGT) in all subjects displaying alcohol misuse, initially, then at least every year during outpatient follow-up (grade B). In the event of abnormal findings, the work-up (clinical examination, protein electrophoresis, liver ultrasound) should
include the test for compensated cirrhosis (grade B). In case of a known cirrhosis, the development of a jaundice or any other signs of decompensation (ascites, digestive haemorrhage, encephalopathy, infection) require urgent referral to a liver specialist (grade B).

**5.6.** Psychiatric comorbidities should be routinely investigated. This exacerbates the severity of alcohol misuse and reduces sensitivity to treatment. Particular attention should be given to suicide risk (grade B).

**5.7.** The social evaluation will take into account the characteristics of the family, housing conditions, professional situation, financial situation and judicial situation.
What are the objectives of therapeutic intervention?

In a way, the objective of treatment for alcohol misuse is initially to improve the subject’s quality of life. Hence, according to the subject’s specific situation, therapeutic intervention should target physical and mental health, interpersonal, social and professional adaptation, the judicial situation, and other addictive or at-risk behaviours. However, a genuine improvement in the subject’s situation requires a major change in alcohol use, whether aiming for abstinence or reducing alcohol use. This is why treatment generally initially targets a change in use and stabilisation.

Treatment goals have been the subject of controversy, notably for alcohol-dependent individuals.

While it is readily acknowledged, for non-dependent individuals, that simply reducing drinking below a risk level is usually satisfactory, abstinence has long been considered as the only treatment goal among dependent individuals. However, it has been shown that certain dependent individuals could have a stable remission without abstinence, and that accepting the subject’s preferences for the treatment goal (in contrast to it being imposed by healthcare professionals, from their own point of view) yields better results. For instance, the UKATT in Great Britain showed that, among patients receiving specialist care for their alcohol problems, 54% chose an abstinence goal, and 46% a moderation goal. The one-year success rate was higher among patients initially aiming for abstinence (30%) compared to the others (23%). However, this difference was not significant, showing that the moderation goal could have a decent success rate. Moreover, if healthcare professionals accept the moderation goal, this is less of a deterrent for individuals suffering from alcohol misuse and not inclined towards abstinence, when embarking upon a treatment programme.

Lastly, the most recent recommendations recognise the possibility of including moderation in addition to abstinence in the treatment goal for alcohol-dependent individuals.

This is why it is logical to follow National Institute for Health and Care Excellence (NICE) guidance on treatment goals:

1. In the initial assessment in specialist alcohol services of all people who misuse alcohol, agree the goal of treatment with the service user. Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity (for example, depression or alcohol-related liver disease). When a service user prefers a goal of moderation but there are considerable risks, advise strongly that abstinence is most appropriate, but do not refuse treatment to service users who do not agree to a goal of abstinence.

2. For harmful drinking or mild dependence, without significant comorbidity, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence.

3. For people with severe alcohol dependence, or those who misuse alcohol and have significant psychiatric or physical comorbidity, but who are unwilling to consider a goal of abstinence or engage in structured treatment, consider a harm reduction programme of care. However, ultimately the service user should be encouraged to aim for a goal of abstinence.
The recommendations issued by the British National Health Service may also be accepted concerning persons consulting in a primary care setting, detected as having an alcohol problem, despite not initially seeking treatment for their alcohol use. Among at-risk and harmful drinkers detected in generalist settings, the moderation goal should normally be accepted. Although a person’s preference for abstinence should always be respected, it is likely that the great majority of individuals recruited opportunistically would reject advice to abstain and would only respond to an intervention which allowed them to continue to drink, albeit at reduced levels. However, it should be noted that certain patients displaying harmful use, hence without dependence, may have a disorder which requires a recommendation for abstinence (for example, liver failure).

What should the goal of moderation aim for? These recommendations vary considerably from one country to another. In France, it is recommended that intake be limited to below at-risk use: 21 standard units per week for males, and 14 standard units per week for females (cf. text box 3, page 11). However, it should be noted that any significant reduction in average alcohol use, as in the proportion of days with excessive use, is liable to provide substantial benefit to the individual in terms of quality of life, morbidity and mortality. Hence, from the perspective of reducing harm, any target for reducing alcohol use is more acceptable than the status quo, and is worth highlighting. As some patients can only make progress in stages, healthcare professionals are then led to adapt the goals for moderation according to the available resources.

**RECOMMENDATIONS**

6.1. Therapeutic intervention aims for a change in alcohol use: abstinence or moderation (EC).

6.2. In the initial assessment in specialist alcohol services of all people who misuse alcohol, set the goal of treatment with the service user (grade B).

6.3. Abstinence is the appropriate goal for most people with alcohol dependence, and people who misuse alcohol and have significant psychiatric or physical comorbidity (for example, depression or alcohol-related liver disease) (EC). If they are unwilling to consider a goal of abstinence, consider a supported harm reduction programme of care.

6.4. For harmful drinking or mild dependence, without significant comorbidities, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence (EC).

6.5. The goal for moderation should ideally aim not to exceed 21 standard units per week for males and 14 standard units per week for females (EC). However, any significant reduction in average alcohol use, as in the proportion of days with excessive use, is liable to provide substantial benefit to the individual (grade A). Hence, from the perspective of reducing harm, any target for reducing alcohol use is more acceptable than the status quo, and is worth highlighting. As some patients can only make progress in stages, healthcare professionals are then led to adapt the goal for moderation according to the available resources.
7
What types of therapeutic intervention should be proposed?

Numerous therapeutic interventions have been proposed for patients with alcohol misuse. These involve a wide range of different techniques such as simple assessment combined with counselling (brief interventions), prescription of one or more medications (drug therapy), socio-educational interventions, various forms of psychotherapy, approaches to physical mediation, other family-based or occupational approaches, taking place in an outpatient or residential setting.

Although healthcare specialists and support facilities are still essential, the diverse nature of situations and the extreme differences between the concerned individuals allow a great variety of interventions, bearing in mind that their association, combination or simultaneous implementation (usually for a few months, or more long term as required) significantly increase their effectiveness. The numerous approaches available can therefore cater to a wide range of demands and situations.

I/ GENERAL PRINCIPLES

As a general rule, the intensity of treatment can be adapted to the severity of misuse. Although this concept has not been formally established in the field of alcohol studies, it is nonetheless noted that brief interventions are intended for subjects with a mild form of misuse: at-risk use or a mild alcohol-related disorder. Conversely, pharmacological treatment is reserved for dependent patients, not because this treatment is not effective in less severe forms of misuse, but because the medicines agencies have restricted the marketing authorisation (MA) to dependence. Lastly, hospitalisation is clearly preferably reserved for the most severe forms of misuse.

It should also be noted that all therapeutic interventions do not have the same level of evidence in terms of effectiveness, and probably not the same level of effectiveness.

Miller WR et al. systematically compiled and analysed efficacy studies in the field of alcohol misuse, up to 2002. This project, known as the Mesa Grande project, made it possible to classify the different types of therapeutic interventions with cumulative scores for evidence of effectiveness. Despite being dated, and not therefore taking into account the most recent therapeutic interventions and studies, the classification of therapeutic interventions according to Mesa Grande reveals the highly diverse nature of the explored interventions, together with their credibility in terms of evidence of effectiveness (cf. Appendix 4: Mesa Grande summary tables).

Certain principles apply to all types of therapeutic interventions, regardless of the severity of misuse or the disorder, at any point of the patient’s therapeutic programme.

1/ Promote therapeutic partnerships

This involves building a trusting relationship with the patient, based on empathic listening, showing the desire to help to solve problems expressed by the individual, in a non-judgemental manner. This type of approach should allow the therapist and patient to agree on the definition of the problem to be solved, and on the treatment goals to be pursued. Evidently, the definition of the problem, like the treatment goals, may change over time.
The stigma of alcohol misuse should be taken into account, which may cause the subject to minimise their use and the consequences thereof.

2 /Promote support from the family
The patient's family can contribute to his/her progress. It is often helpful to involve the family in care, by providing information on alcohol misuse, and, with the patient's agreement, including them in the discussion on treatment goals and strategies. By extension, the same recommendation can be broadened to involve people in the community.

II/ PSYCHOSOCIAL INTERVENTIONS

Psychosocial interventions are historically pre-eminent in the range of available therapeutic resources. Over the years, these have become enriched by numerous approaches: psychoanalytical, social, systemic, physical, meditative, support, cognitive, behavioural and motivational. Assessment thereof often clashes with the scarcity of studies and methodological limitations, preventing adequate comparison of the different techniques. Hence, at present, it does not seem possible to claim that one type of psychosocial intervention is superior to another. However, insofar as some interventions have benefited from a higher level of research, some techniques demonstrate a de facto greater level of evidence in terms of efficacy.

Regardless of the type of psychosocial intervention used, the therapist's personal qualities play a decisive role in the effectiveness of the intervention. The qualities which help make the intervention more effective are as follows: an empathic and supportive approach to the patient, building a relationship clearly focused on the treatment goal, encouraging autonomy and use of external resources. The least effective therapists are more distant, critical, make the patient feel a sense of guilt, and are more focused on themselves than on the patient, while attempting to control their decisions and avoid difficult questions. Brief interventions benefit from a high level of evidence, affirming that they have a modest effect on reducing alcohol use in primary care. Their effectiveness is well established in the primary care setting in particular. The other interventions benefiting from a satisfactory level of evidence are motivational interviews and cognitive behavioural therapies.

1/ Brief interventions
The term 'brief interventions' refers to several types of interventions, which is sometimes a source of confusion. We refer herein to opportunistic brief interventions intended for individuals not seeking help for alcohol misuse, having been identified by a healthcare professional, as opposed to interventions intended for patients presenting a specific request for help to solve an alcohol problem; the term 'brief intervention' thus refers to the relatively brief nature of the intervention, compared to more long-term interventions. Brief interventions are intended for individuals who misuse alcohol and who only display few or no signs of dependence. They are designed as part of a public health approach, so as to be able to reach as many people as possible when their alcohol problem has not yet become too significant, using limited and easily multiplicable means. Brief interventions last 5 to 20 minutes in general. After detection of the problem, the practitioner proposes a targeted intervention on the ‘alcohol problem’ (concept of early detection and brief intervention). There is no definitively standardised method for conducting a brief intervention. It may take place during a single session, or may be repeated. For example, emergency department interventions are usually unique, without any follow-up.
The WHO (World Health Organization) and the NIAAA (National Institute on Alcohol Abuse and Alcoholism, in the United States) have both proposed frameworks for brief intervention. According to the WHO, a brief intervention can include the following elements:
- return the results of detection tests stating that their drinking corresponds to the ‘at-risk drinking’ category,
- provide information on the specific risks incurred by continuing to drink alcohol in this way,
- decide on a goal for changing behaviour,
- advise as to the limits not to be exceeded (not more than 21 units per week for males, or 14 units per week for females),
- encourage them by explaining that, among individuals with at-risk alcohol use, the goal is to return to social alcohol use.

According to the WHO, brief interventions should be proposed for males with a score comprised between 7 and 12 in the AUDIT questionnaire or who drink 25 units of alcohol or more per week, together with females with a score comprised between 6 and 12 in the AUDIT questionnaire or who drink 21 units of alcohol or more per week\textsuperscript{20}.

**Table (7)1**

\textit{Relationship between levels of intervention and risk levels}\textsuperscript{20}

<table>
<thead>
<tr>
<th>Risk level</th>
<th>Criteria</th>
<th>Intervention</th>
<th>Role of general practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk</td>
<td>Alcohol use (grams/week)</td>
<td>&lt; 210 g/wk males &lt; 140 g/wk females*</td>
<td>Primary prevention</td>
</tr>
<tr>
<td></td>
<td>Audit questionnaire</td>
<td>&lt; 7 males &lt; 6 females</td>
<td>Health education, reinforcement</td>
</tr>
<tr>
<td></td>
<td>Audit C questionnaire</td>
<td>&lt; 4 males &lt; 3 females</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Face** questionnaire</td>
<td>&lt; 5 males &lt; 4 females</td>
<td></td>
</tr>
<tr>
<td>At-risk</td>
<td>Alcohol use (grams/week)</td>
<td>≥ 210 g/wk males ≥ 140 g/wk females*</td>
<td>Advice</td>
</tr>
<tr>
<td></td>
<td>Audit questionnaire</td>
<td>7-12 males 6-12 females</td>
<td>Detection, evaluation, brief intervention</td>
</tr>
<tr>
<td></td>
<td>Audit C questionnaire</td>
<td>4-10 males 3-10 females</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Face** questionnaire</td>
<td>5-8 males 4-8 females</td>
<td></td>
</tr>
<tr>
<td>Problematic</td>
<td>Presence of one or more types of harm</td>
<td>Advice, brief intervention and regular surveillance</td>
<td>Detection, evaluation, brief intervention, monitoring</td>
</tr>
<tr>
<td>Alcohol-dependence</td>
<td>ICD-10 or DSM-IV criteria</td>
<td>Specialist treatment</td>
<td>Detection, evaluation, referral, monitoring</td>
</tr>
<tr>
<td></td>
<td>Audit questionnaire</td>
<td>≥ 13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Audit C questionnaire</td>
<td>≥ 10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Face** questionnaire</td>
<td>≥ 9</td>
<td></td>
</tr>
</tbody>
</table>

\*Any consumption for pregnant women, adolescents under the age of 16 or people with an illness or following a treatment is not advised.


In the United States, the NIAAA developed a 4-step brief intervention programme (all steps starting with the letter ‘A’: Ask; Assess; Advise; At follow-up continue support)\textsuperscript{18}:
1. Quantify the amount of alcohol consumed;
2. Assess the harm related to use;
3. Inform and advise on at-risk use and harm related to alcohol use;
4. Follow up management in the same areas as for step 3.
The effect of a brief intervention tends to dissipate over time and it is often worth repeating this intervention, particularly in the primary care setting.

There are a number of more in-depth interventions, such as the ‘Alcochoix +’ programme, originated from Quebec and adopted in Switzerland and France. This programme offers a 6-step manual. It may be carried out individually after an explanatory meeting, with a professional who will guide the individual (2 to 6 meetings, each lasting 30 to 45 minutes) or even in a group setting.

A systematic review listed 34 different programmes\textsuperscript{83}. The aspects usually examined during programmes for reducing alcohol consumption are strengthening motivation, developing self-control, encouraging taking on alternative activities (other than activities related to alcohol consumption) and improving social skills. The aspect which appears to be the most effective is to encourage the self-assessment of consumption, i.e. asking the patient to monitor the number of units consumed each day, using a diary, notebook, computer file or smartphone application. The second most effective aspect consists in regularly inciting the patient to commit to reducing alcohol use.

The systematic reviews on the effectiveness of brief interventions led to the following conclusions\textsuperscript{7}:

- brief interventions may take on different forms and be applied in varied contexts. These are effective in patients displaying at-risk or harmful use, in reducing their consumption to a lower risk level (grade A);
- the effect continues to be observed for periods of up to two years after the intervention\textsuperscript{84} (grade B);
- repeated interventions may be necessary in order to sustain the effect over longer periods (grade B);
- brief interventions enable a reduction in alcohol-related mortality (grade A);
- opportunistic brief interventions have not been shown to be effective in patients with moderate to severe dependence;
- opportunistic brief interventions are said to have a considerable impact on public health when effectively applied routinely in primary care (grade B)\textsuperscript{84-87};
- the effectiveness of brief interventions applied in emergency admission departments is still controversial\textsuperscript{88, 89};
- the effectiveness of brief interventions applied in a general hospital context has been demonstrated in males (few females were included in the studies)\textsuperscript{90} (grade A);
- brief interventions applied to patients with moderate psychiatric disorders enable a short-term reduction in alcohol consumption (grade B);
- brief interventions applied to syringe exchange programmes enable a reduction in alcohol consumption (grade B);
- the effectiveness of brief interventions applied to pregnant women has not yet been established;
- brief motivational interventions enable a reduction in consumption and in the frequency of binge drinking among university students (grade B);
Alcohol misuse: screening, diagnosis and treatment

- brief interventions, involving simple structured advice on reducing consumption, have been shown to be effective in improving state of health among individuals displaying at-risk or harmful use (grade B);
- more comprehensive brief interventions, involving one or more sessions lasting 20-30 minutes, and comprising cognitive behavioural and motivational aspects, have not been shown to be superior to brief interventions (grade A);
- the majority of primary care professionals do not yet appear to have adopted detection and brief interventions as part of their practice (EC);
- the main obstacles to adopting detection and brief interventions in primary care are insufficient time and the lack of appropriate remuneration\(^ {91,92}\) (grade C);
- telemarketing seems to have the best cost/effectiveness ratio for spreading the concept of detection and brief intervention in primary care (grade B);
- training can improve the implementation of detection and brief interventions in primary care. However, training should be adapted to the obligations and needs of the concerned healthcare professionals (grade C).

2/ Low-intensity psychosocial interventions

A number of low-intensity programmes have been developed, mainly for patients suffering from moderate dependence with grade A and grade B effectiveness\(^ 7\).

- Certain cognitive behavioural programmes comprising three sessions have been shown to be effective in females suffering from moderate dependence.
- A single marital therapy session is effective for patients suffering from moderate dependence, in a stable social situation and a relatively secure marital situation.
- The non-confrontational style and principles of the motivational interview should be adopted by professionals specialising in the treatment of alcohol misuse.
- Motivational interviews improve the effectiveness of more intensive psychosocial interventions.
- Although no evidence is currently available for the long-term efficacy of motivational interviews, this type of intervention enables patients to be better prepared for more intensive treatments.
- When used alone, motivational interviews are not more effective than other psychosocial interventions, but require fewer sessions and therefore have a better cost/effectiveness ratio.

<table>
<thead>
<tr>
<th>Table (7)2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparison between a confrontational approach and a motivational approach(^ 7)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Confrontational approach</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Heavy emphasis on acceptance of self as ‘alcoholic’; acceptable of diagnosis seen as 2. essential for change.</td>
</tr>
<tr>
<td>Emphasis on disease of alcoholism which reduces personal choice and control.</td>
</tr>
<tr>
<td>Therapist presents perceived evidence of alcoholism in an attempt to convince the service user of diagnosis.</td>
</tr>
<tr>
<td>Resistance seen as ‘denial’, a trait</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Motivational approach</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>De-emphasis on labels; acceptance of ‘alcoholism’ label seen as unnecessary for change to occur.</td>
</tr>
<tr>
<td>Emphasis on personal choice regarding future use of alcohol and other drugs.</td>
</tr>
<tr>
<td>Therapist conducts objective evaluation but focuses on eliciting the service user’s own concerns.</td>
</tr>
<tr>
<td>Resistance seen as an interpersonal</td>
</tr>
</tbody>
</table>
characteristic of problem drinkers requiring confrontation.

behaviour pattern influenced by the therapist’s behaviour; resistance is met with reflection.

| Comparison between a cognitive behaviour approach and a motivational approach |
|-----------------------------------------------|-----------------------------------------------|
| Cognitive behaviour approach | Motivational approach |
| Assumes that the client is motivated; no direct strategies for building motivation for change. | Employs specific principles and strategies for building client motivation. |
| Seeks to identify and modify maladaptive cognitions. | Explores and reflects client perceptions without labelling or correcting them. |
| Prescribes specific coping strategies. | Elicits possible change strategies from the client. |
| Teaches coping behaviours through instruction, modelling, directed practice and feedback. | Responsibility for change methods is left with the client no training, modelling or practice. |
| Specific problem-solving strategies are taught. | Natural problem-solving processes elicited from the client. |

3/ Specialist psychosocial interventions

- Community reinforcement
  Although not widely developed in France, community reinforcement combines supervised prescription of disulfiram (Antabuse®), motivational counselling and cognitive behavioural therapy, and attempts to help the patient to commit to returning to work and other social activities.
  This type of intervention has been shown to be effective, particularly in patients suffering from severe dependence (grade A).
  Prescription of disulfiram is an essential part of community reinforcement. This intervention is particularly effective among patients who are social outcasts, suffering from severe dependence, and for whom other treatments have failed (grade A).

- Behavioural self-control training
  This is a type of cognitive behavioural intervention adapted to the moderation goal, rather than abstinence.
  It is based on setting limits for drinking, daily monitoring of alcohol use, control of the rate of drinking, drink-refusal skills training, setting up self-reward systems for successful behaviours, analysis of high-risk situations and training alternative behaviours.
  Behavioural self-control training is currently the most effective psychosocial intervention with the goal of moderation (grade A). A systematic review of the efficacy of cognitive behavioural
techniques aiming for reduced alcohol use showed that the most important aspect is the daily monitoring of consumption\textsuperscript{43}.

- **Coping** and social skills training
  This psychosocial intervention is fairly developed in France. For example, it forms the basis of the PHARES\textsuperscript{93} video programme. This is a cognitive behavioural programme applied to individuals or groups, aiming to improve the patient's social relationship skills, management of negative emotions, daily living, and cope with high-risk situations for alcohol use. This cognitive behavioural therapy is effective in patients suffering from moderate dependence (grade A). The treatment goals may be adjusted according to patient preferences and requirements (EC).

- **Interventions based on mindfulness**
  This is a third-generation cognitive behavioural intervention. Mindfulness comprises two components: on the one hand, focusing on the present moment, and on the other hand, acceptance, equanimity and curiosity regarding their experience, whether positive or negative. Focusing on the present shields the subject from regrets concerning the past and worries about the future. Observing our experience with curiosity causes us to realise that a difficult internal state can be tolerate, in spite of everything, and that our experiences change. Hence, difficult experiences are always transient; our thoughts and emotions are not necessarily an accurate reflection of reality\textsuperscript{94}. Interventions based on mindfulness are currently experiencing a growing popularity in the field of addiction, mood disorders, anxiety disorders and personal development disorders\textsuperscript{94}. A few studies have shown that this new approach may have a positive impact on alcohol use\textsuperscript{95} (grade C).

**III/ PHARMACOLOGICAL INTERVENTIONS**

*For specific populations (pregnant women, adolescents, the elderly, etc.), refer to Question 16.*

The main goals of pharmacological interventions are to prevent or treat alcohol withdrawal syndrome (AWS), assist moderation, sustain abstinence, or to treat somatic or psychiatric comorbidities.

Owing to the prevalence of alcohol misuse, its numerous consequences and the small number of patients treated (5-10%), reducing consumption to below the risk levels currently represents a new treatment goal in certain patients\textsuperscript{8, 75}. **Craving** and inadequate behavioural self-control favour relapse. The main relapse-prevention medicinal products interfere with the reinforcement mechanisms associated with alcohol intake.

Pharmacological interventions should be envisaged in combination with psychosocial interventions (EC)\textsuperscript{53}.

- **Benzodiazepines (BZD) and prevention of withdrawal syndrome**
  Numerous ‘tranquillisers’ and GABAergic products have been used in this indication, and benzodiazepines have been widely assessed.

  A summary of 64 studies (more than 4,000 patients) comparing the efficacy of benzodiazepines versus placebo and other medicinal products in the prevention of withdrawal syndrome (notably generalised seizures) shows that this therapeutic class is effective in this indication\textsuperscript{96}.
The use of agents with a long half-life is therefore preferable[^7][^97][^98]. These enable a better stability of serum concentrations, and seem more effective on the risk of recurrence of symptoms, seizures and anxiety related to withdrawal. Diazepam is one of the agents recommended for first-line treatment due to its rapid action, long half-life and experience in terms of efficacy[^7][^75].

It is undoubtedly worth pointing out that BZD are not indicated for helping to sustain abstinence (EC). However, no definitive conclusions in terms of safety can be drawn as there are too many differences between studies.

**Dosage and prescribing regimen**

The objective of sedation is to obtain a calm but vigilant state. Two regimens are possible.

- **Prescription of fixed doses spread over 24 hours**
  
The initial dose depends on the clinical evaluation (presence of symptoms, intensity of symptoms during previous withdrawal, usual length of time between waking up and having the first drink, extent and frequency of use). The dosage is gradually reduced (even daily) based on the symptoms, with the aim of limiting treatment to 5 to 10 days[^7].

As an example, the reference system for good clinical practice proposed in 2006 by the Société Française d’Alcoologie suggested two prescribing regimens for outpatient detoxification[^99]:

- Two to four tablets containing 10 mg of diazepam daily for two or three days, then reduction over 4 to 7 days, and discontinuation.
- Six tablets containing 10 mg of diazepam on the first day, and reduced by one tablet per day up to discontinuation.

- **Personalised prescription adapted to symptoms**[^100]

In this scenario, each benzodiazepine dispensing procedure is subject to a withdrawal score (Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale or Cushman score). This has the benefit of using the lowest total doses and reducing the treatment duration. It involves regular evaluation, several times a day, and thus applies more to residential care[^75].

For patients with a difficulty to communicate, a history of seizures, an unstable psychiatric comorbidity or an associated addiction, this appears less suitable compared to prescription at a fixed dose[^98].

A loading dose may be administered if there is a history of complications or if withdrawal syndrome becomes exacerbated (as an example, the Australian recommendations proposed diazepam 20 mg twice per hour up to 60 to 80 mg or light sedation)[^98].

**Treatment duration and dosage**

The quantities are gradually reduced, and prescriptions after the first week should be avoided, apart in case of complications (seizures, hallucinations, delirium tremens, anxiety syndrome) or associated addiction due to the risk of rebound and dependence[^98]. In a residential setting, BZD treatment may be prolonged beyond 3 weeks if necessary[^75], as in severe initial withdrawal syndrome, associated BZD dependence, or serious history of withdrawal.

Dose adjustment is guided by more or less regular clinical surveillance. This is based on withdrawal symptom evaluation scales (CIWA-Ar scale or Cushman score)[^101][^102] used in a residential and outpatient setting. Measurements take place at regular intervals, adapted to the severity of disorders, up to stabilisation[^98].

BZD doses are reduced in adolescents and the elderly.
**Precautions for use**

Outside the context, BZD are to be avoided in patients suffering from alcohol misuse. The doses are limited during home treatment in order to prevent overdose and diversion. A family member may supervise dosing.

BZD with a short half-life (oxazepam) are to be used with caution in the event of recent head injury, respiratory disorders, and morbid obesity\(^98\). Severe liver failure is a contraindication for all systematic benzodiazepines due to the risk of encephalopathy. These should only be prescribed in the event of patent signs of withdrawal, adapting doses to symptoms, with rigorous clinical surveillance several times a day, possibly based on the CIWA-Ar scale or Cushman score.

In the event of liver failure, benzodiazepines with a shorter half-life and eliminated by conjugation, such as oxazepam, were conventionally recommended in order to limit any possible accumulation and associated undesirable effects. However, the use of these BZD does not completely eliminate the risks of accumulation, and their anticonvulsant protection is lower due to greater fluctuations in plasma levels\(^103\). Double alcohol-benzodiazepine dependence is treated by increasing the BZD dosage initially prescribed, or by changing the agent by a BZD with a long half-life. The initial daily dose is calculated based on the evaluation relating to the severity of the withdrawal syndrome, by adding the equivalent of the daily BZD dose taken\(^68\).

In the event of overdose, the antidote, intravenous flumazenil, is administered gradually owing to the risk of seizures, in appropriate facilities or in an intensive care unit. Prescription of benzodiazepines calls for particularly careful surveillance in patients receiving opioid replacement therapy: good cardiorespiratory safety should be verified at the start of treatment, particularly at night.

- **Thiamine (vitamin B1)**

  Thiamine (vitamin B1) deficiency is common in alcohol-dependent individuals, 30 to 80% of whom present clinical or laboratory signs of deficiency. Excessive alcohol use associated with malnutrition exacerbates the limited absorption of thiamine\(^104-106\). The prescription of thiamine, recommended for the prevention and treatment of symptoms of Wernicke's syndrome, was the subject of an evaluation including numerous case studies and two studies collated as part of a Cochrane evaluation\(^105, 107-109\). Based on two literature reviews, the latter validates the use of thiamine in the short-term treatment of Wernicke's syndrome. However, insufficient evidence is available (notably in terms of randomised clinical trials) to guide clinicians in terms of dose, frequency, route of administration or treatment duration for prophylaxis and curative treatment.

  The current recommendations are based on empirical clinical practice and expert opinion\(^7, 98, 104\). The minimum dosage to be used in order to be effective is said to be 200 mg daily\(^110\). Adaptation of Anglo-Saxon recommendations in France should take into account the differences in the packaging used for the treatment.

  The financial cover for this type of treatment should also be taken into account in certain situations involving social vulnerability.

  A distinction is made between prophylaxis and treatment with regard to administration of thiamine. Therapeutic regimens are proposed as an indication, based on existing recommendations.
Prophylaxis
1) Absence of malnutrition: international references propose a dose of 300 mg daily for 5 days, via the oral route, able to be continued for approximately two weeks. Treatment could be adapted as follows in France (owing to different treatment packaging): a dose of 500 mg daily for 5 days via the oral route, followed by a dose of 250 mg daily for approximately two weeks.

2) Signs of deficiency and malnutrition, high-level use and impact on health (notably cognitive disorder and alcoholic liver disease): the parenteral route is preferable due to absorption problems. The benefits of slow intravenous administration largely outweigh the relatively low risk of anaphylaxis. The proposed dose is 300 mg daily via the parenteral route for 5 days, then 300 mg daily via the oral route. In France, a dose of 500 mg daily via the parenteral route, divided into two intakes over 24 hours, for five days, followed by oral treatment until a balanced diet is resumed, may be proposed.

3) If intravenous glucose infusion is necessary, prior parenteral administration of 500 mg of thiamine in 100 ml of 0.9% sodium chloride, over 30 minutes, is recommended.

Treatment
Suspected Wernicke's encephalopathy requires curative treatment with high-dose thiamine, via the parenteral route, over a short period of time. The international recommendations propose daily doses ranging from 500 mg to 1.5 g for 3 to 5 days, followed by oral treatment. In France, a daily dose of 1 g for 5 days, followed by oral treatment, could be proposed. Treatment is to be initiated as soon as an apparent diagnosis of Wernicke's encephalopathy is made, bearing in mind that the classic triad (consciousness disorders, ataxia and oculomotor paralysis) is only said to be present in 10% of cases and certain clinical presentations (delirium tremens, hepatic encephalopathy, head injury, etc.) can lead to difficult diagnosis.

- Other vitamins
In malnourished patients, supplementation with multivitamins and trace elements (vitamin B6, PP, C, folic acid, zinc and magnesium) may be envisaged for a few days. Due to neurotoxic effects, the prescription of vitamin B6, at a limited dosage, should not ideally be continued beyond a period of one month. The US health authorities, as an example, have defined a maximum dosing level of 100 mg daily.

- Disulfiram (Esperal®)
Disulfiram blocks the degradation of acetaldehyde through inhibition of aldehyde dehydrogenase which causes the antabuse effect (ethanol-disulfiram reaction due to accumulation of acetaldehyde) when consuming alcohol (warmth, redness, vomiting, tachycardia, or even more severe reactions, including cardiovascular or neurological). This treatment, a deterrent to resuming consumption due to the threat of an aversive reaction, is indicated in motivated patients who wish to achieve abstinence by means of this medicinal product.
Owing to its contraindications (hepatic, renal, cardiovascular, neurological, pregnancy), drug interactions, and potential dangers of the antabuse effect, this medicinal product is proposed as a second-line treatment after acamprosate or naltrexone.
An interval should be allowed between the last alcohol intake and the administration of the medication (at least 24 hours, at a dose of 250 to 500 mg/day as a single dose). Supervision of
treatment improves compliance and therapeutic efficacy (fewer relapses; alcohol resumed later than for acamprosate or naltrexone at 12 weeks; fewer days of high-level consumption). Follow-up is twice monthly for 2 months, then monthly for 4 months, and twice yearly thereafter\textsuperscript{75} (EC).

The patient and his/her family should be informed of the risks of an antabuse effect with any source of alcohol (beverage, food, perfume, etc.), the risk of peripheral neuropathy, and the hepatotoxic risk related to this medicinal product (fatigue, jaundice) which requires treatment discontinuation and urgent consultation.

A recent meta-analysis confirmed the efficacy of this treatment, still widely prescribed in numerous countries\textsuperscript{113} (grade A).

- **Acamprosate (Aotal\textsuperscript{®})**
  Its action mechanism has not been fully elucidated. Developed as a GABA-A agonist (similarities with taurine), then perceived as a glutamergic antagonist (NMDA and mGluR/5 receptors) which was able to correct glutamergic reinforcement induced by chronic alcohol use, it is finally the associated calcium (calcium acetyl-homotaurinate) which could be the underlying factor for its different therapeutic effects\textsuperscript{114}.

Acamprosate is superior to placebo in terms of sustained abstinence, number of alcohol-free days, and risk of relapse at 3 and 12 months after withdrawal\textsuperscript{115} (grade A). Acamprosate is superior to naltrexone in terms of sustained abstinence (grade C).

The medicinal product is introduced as soon as possible after withdrawal (<60 kg: 1,332 mg/day; > 60 kg: 1,998 mg/day as 3 doses). It is prescribed for a period of one year (see French marketing authorisation - MA -); however, treatment may be continued while a benefit exists and the patient wishes to do so\textsuperscript{59, 75}.

- **Naltrexone (Revia\textsuperscript{®})**
  This mu (but also kappa and, to a lesser degree, delta) opioid receptor antagonist diminishes the activation of the reward circuit induced by alcohol (lesser release of dopamine in the nucleus accumbens) thereby diminishing the reinforcing value of alcohol and the desire to drink.

Naltrexone reduces alcohol intake and relapses (grade A), and gives rise to a greater reduction in craving and high-level consumption days than acamprosate (grade A), but appears less effective in terms of sustained abstinence\textsuperscript{116} (grade C). This medicinal product seems beneficial among high-level users, although the results are contradictory for severely dependent subjects. The naltrexone-acamprosate combination is inconsistently superior to placebo and to acamprosate in terms of resumed consumption and high-level consumption\textsuperscript{115} (grade B).

Naltrexone is prescribed after withdrawal (25 then 50 mg/day as a single dose). The duration of prescription is 3 months (MA), as the beneficial effect subsides after a few months. However, treatment may be continued for up to 6 months, or while a benefit exists and the patient wishes to do so\textsuperscript{59, 75}.

As regards both acamprosate and naltrexone, these medicinal products should be discontinued after 4-6 weeks if alcohol use persists\textsuperscript{59, 75} (EC).
Nalmefene (Selincro®)
This medicinal product is indicated for reducing alcohol consumption in alcohol-dependent patients (level of evidence 1, grade A). Nalmefene is a mu and delta opioid receptor antagonist, and a kappa-receptor partial agonist, with a longer action duration and less hepatotoxicity than naltrexone. The therapeutic effect could be supported by a diminished craving for reward (mu-transmission) and dysphoric phenomena (kappa transmission). Treatment (not more than one tablet daily) is not taken systematically, but on demand, every day the patient anticipates a risk of drinking.  

Medicinal products currently in evaluation

Baclofen (Liorésal®)
By activating GABA-B inhibitory receptors, baclofen diminishes the reinforcing properties of alcohol (including lesser release of dopamine) and induces notably anxiolytic sedative effects (level of evidence 4, grade C).
This is thus said to reduce craving for reward and relief, hence relapses. Despite conflicting results in controlled low-dose studies, observational studies show that it may be necessary to use high doses, with treatment personally tailored in terms of the dose to be gradually reached, and a distribution of dosing during the day according to craving. It is proposed on an off-licence (MA) basis if treatment is not possible or has failed to 1/ maintain abstinence and prevent relapse with acamprosate, naltrexone or disulfiram, 2/ reduce consumption with nalmefene.

Prescribing has been governed by a temporary recommendation for use (TRU) since March 2014, with online declaration and patient follow-up. The prescribing duration is not known, and certain patients require long-term treatment. This medicinal product is currently the subject of several randomised, placebo-controlled studies evaluating its efficacy in sustaining abstinence after withdrawal and in reducing consumption (level of evidence 4, grade C).

Gamma-hydroxybutyrate (GHB)
There are more targets than for baclofen: GHB and GABA-B receptor agonist, and also GABA-A via the transformation of GHB into GABA.
Prescribed in France as an anaesthetic agent (gamma-OH®) and for sleepiness caused by narcolepsy (sodium oxybate, Xyrem®), it has been marketed for several years in Italy and Austria in the treatment of alcohol dependence (Alcover®). At 3 months, GHB (50 mg/kg as 3 doses) is more effective than disulfiram and naltrexone in sustaining abstinence and reducing craving after withdrawal, without inducing more undesirable effects (level of evidence 1, grade B). However, there is a risk of misuse, particularly among multiple agent users. This medicinal product is the subject of a multicentre study in France and in Europe on sustained abstinence. When discontinuation of baclofen and GHB is envisaged, it should take place gradually as rapid withdrawal can induce seizures and delirium tremens as with alcohol.
RECOMMENDATIONS

7.1. It is recommended to promote a therapeutic partnership with the patient: an empathic and supportive approach to the patient, building a relationship clearly focused on the treatment goal, encouraging autonomy and use of external resources (EC).

7.2. The patient’s family can contribute to his/her progress. It is often helpful to involve the family in care, by providing information on alcohol misuse, and including them in the discussion on treatment goals and strategies (EC). By extension, the same recommendation can be broadened to involve people in the community.

7.3. Among the different types of psychosocial interventions, brief interventions, motivational interviews and cognitive behavioural therapies have a satisfactory level of evidence (grade A).

7.4. Brief interventions may take on different forms and be applied in varied contexts. Their effectiveness has been demonstrated in a primary care setting in hospital departments.

7.5. Brief interventions are effective in individuals displaying at-risk use or harmful use, in reducing their consumption to a lower risk level (grade A). The aspect which appears to be the most effective is to encourage self-assessment of consumption, i.e. asking patients to monitor the number of units consumed each day, using a diary, notebook, computer file or smartphone application. The second most effective aspect is to regularly incite the patient to commit to reducing alcohol use (grade B).

7.6. Brief motivational interventions enable a reduction in consumption and in the frequency of binge drinking among university students.

7.7. Opportunistic brief interventions are said to have a sizeable impact on public health when effectively applied routinely in primary care (grade B).

7.8. Training can improve the implementation of detection and brief interventions in primary care (grade B). However, training should be adapted to the obligations and needs of the concerned healthcare professionals.

7.9. The style and principles of the motivational interview should be adopted by professionals specialised in the treatment of alcohol misuse (grade B).

7.10. Motivational interviews improve the effectiveness of more intensive associated psychosocial interventions (grade A).

7.11. Behavioural self-control training is currently the most effective psychosocial intervention with the goal of moderation (grade A). It is based on limit setting for drinking, daily monitoring of alcohol use, controlling drinking rate, drink-refusal skills training, setting up self-reward systems for successful behaviours, analysis of high-risk situations and alternative behaviours training. Daily monitoring of consumption seems to be the most effective aspect of this intervention (grade B).
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7.12. Benzodiazepines are still the first-line medical treatment for alcohol withdrawal syndrome (grade A), giving preference to agents with a long half-life (EC).

7.13. The indication for and tailoring of benzodiazepine treatment is guided by regular and rigorous clinical surveillance, which may be supported by the withdrawal symptom evaluation scales (CIWA-Ar scale and Cushman score) (grade B).

7.14. Benzodiazepine doses should be adapted according to the severity of withdrawal symptoms and treatment tolerability (grade B).

7.15. In the event of contraindication to benzodiazepines (chronic respiratory failure, decompensated cirrhosis of the liver with ascites, jaundice or Prothrombin time <50%, obesity, elderly patients, etc.), and a risk of withdrawal syndrome, hospitalisation is strongly recommended. Benzodiazepines should be administered according to an symptom-triggered protocol, only in the event of patent signs of withdrawal and after re-assessment of each dose. Benzodiazepines with a short half-life (such as oxazepam) have not demonstrated better safety in this situation, and their half-life may be prolonged in the event of liver failure.

7.16. Personalised prescription adapted to symptoms applies more to residential care. This is not appropriate for patients with difficulty in communicating, history of seizures, unstable psychiatric comorbidity or associated addiction (grade B).

7.17. Treatment with benzodiazepines is only justified beyond a period of a week in the event of persistent withdrawal symptoms, withdrawal events or associated benzodiazepine dependence (grade B).

7.18. In the event of severe withdrawal symptoms or withdrawal events, treatment with benzodiazepines should not be continued for more than four weeks, including the dose reduction phase (grade C).

7.19. Routine prescription of thiamine (vitamin B1) should be adapted to nutritional status (EC).

7.20. Intravenous glucose infusion requires prior injection of thiamine via the parenteral route (grade C).

7.21. Acamprosate, naltrexone and disulfiram are the medicinal products used to help achieve sustained abstinence, and to prevent relapse after withdrawal (level of evidence 1, grade A). It is recommended that treatment compliance be encouraged, ideally associated with personalised psychosocial support (EC).

7.22. Acamprosate (GABA-glutamate-calcium modulator) and naltrexone (opioid antagonist) aim to reduce craving and are proposed on a first-line basis for a duration of 12 and 3 months, respectively, (level of evidence 1) or while a benefit exists (EC).
7.23. Disulfiram is an aversive treatment proposed for patients motivated to use this medicinal product, on a second-line basis owing to its undesirable effects (antabuse effect) (grade A).

7.24. Nalmefene, an opioid antagonist, is the first medicinal product to be authorised for reducing alcohol consumption (level of evidence 1, grade A). It should be associated with adapted psychosocial support.

7.25. Baclofen (level of evidence 4, grade C) and gamma-hydroxybutyrate (GHB) (level of evidence 1, grade B) are GABAergic agents currently undergoing evaluation in sustained abstinence. Baclofen is also being studied in terms of reducing alcohol use (level of evidence 4, grade C). It is the subject of a temporary recommendation for use, with online declaration and patient follow-up.
8

How should patient resistance be managed?

The resistance of the patient to change is a central symptom due to its high prevalence in the early phases of the therapeutic management of alcohol misuse. This highly clinically significant phenomenon has not, however, been widely studied. The field is therefore relatively unstable in terms of the level of scientific evidence, as the elements presented stem more from expert opinion rather than scientific evidence established on the basis of methodologically satisfactory studies.\textsuperscript{123}

Motivational interviewing\textsuperscript{124} is an interview style derived from humanistic psychotherapy, specifically adapted to the management of alcohol misuse. Motivational interviewing uses an empathic style, based on non-judgemental listening, characterised by unconditional acceptance of the situation from both the patient's and interviewer's perspective. Due to this accepting and benevolent approach, management of resistance, often referred to as denial by alcohol-dependent patients, is one of the foundations of motivational interviews. The patient's resistance to changing their behaviour is thus perceived not as a characteristic specific to the patient's personality, but rather as the result of their interaction with their environment: family, colleagues or carers.

Before the motivational interview takes place as part of the treatment for alcohol dependence, the healthcare professional often would have adopted a different point of view from the patient's. The repercussions of alcohol use on health are at the forefront of the carer's concerns. Then they adopt the attitude described as the righting reflex\textsuperscript{125}: all steps must be taken to ensure that the patient behaves in a favourable manner with regard to his/her health. The meeting of patient ambivalence and the carer's righting reflex has been described as the source - or reinforcement - of the patient's resistance to changing his/her behaviour.\textsuperscript{126, 127} It should also be noted that, when a carer meets an alcohol-dependent patient and wishes to help modify his/her consumption, they are faced with an individual who has often experienced considerable pressure from his/her family or work colleagues to change his/her behaviour. The subject has therefore developed a certain degree of resistance to change over many years by the time they meet a carer wishing to help them adopt behaviour patterns more favourable to his/her health.

Because ambivalence and resistance constitute the cardinal symptoms of the clinical presentation observed in an alcohol-dependent patient, the carers should recognise this resistance and adapt their intervention according to its intensity. For this purpose, questions to measure resistance to change may be used; for example: ‘On a scale of 0 to 10, how important is it to modify your alcohol intake?’, or ‘To what extent do you feel capable of modifying your intake?’ or ‘How ready do you feel to modify your alcohol intake?’. In order to envisage a change in behaviour, the patient should feel confident and free faced with this change, and not feel under pressure. Motivational interviewing offers a patient-focused approach: empathic, highlighting their autonomy and mindful of the rate at which they are dealing with change\textsuperscript{125}. Broaching the subject by asking the patients for permission to discuss their alcohol use is a means of highlighting their autonomy and freedom to decide. The healthcare professional adjusts to the patient's degree of motivation; they accept the idea that change is a process, is not continuous, and may fluctuate relatively quickly. When carers
are dealing with a highly resistant patient, they touch on all of the advantages of alcohol use and maintain this behaviour so as to build a trusting relationship. When all of these aspects have been mentioned, the healthcare professionals can explore any less positive effects of alcohol use with the patient.

During the therapeutic process, when resistance lowers and the patient starts to prepare for change, they gradually mention more aspects in favour of the change (more views in favour of the change, and fewer arguments in favour of the statu quo). The carer acknowledges that a change has become possible when patients first mention the importance of changing, then their ability to change, before being able to plan this change.

When the ability to change increases, the patient starts to approach a change in behaviour. Exploration of a hypothetical change enables the change to be explored with patients who are not yet ready to change\textsuperscript{128}.

**RECOMMENDATION**

8.1. In a relationship with more of a supporting role rather than an expert/patient relationship, managing patient ‘resistance’ requires an empathic interview style based on the following principles (grade B).

1/ Ask the patient for permission to discuss his/her alcohol use.
2/ Explore the ambivalence by discussing both the positive and negative aspects of consumption.
3/ Measure the degree of resistance to change, using questions such as: ‘On a scale of 0 to 10, how important is it to modify your alcohol intake?’, or ‘To what extent do you feel capable of modifying your intake?’ or ‘How ready do you feel to modify your alcohol intake?’.
4/ Mention a hypothetical change, what this could be, its expected benefits, the strategies which could be used, etc.
9
How should intervention be planned?

It is normal for patients who misuse alcohol to follow a non-linear process in terms of consumption, consequences of consumption, and treatment goals. Although in the absence of therapeutic intervention there is a general trend towards exacerbation, we can observe improvements, sometimes spontaneous, or relapses, in a real-life context\(^\text{129}\). Consumption goals may fluctuate from one period to another, between a goal for a reduction in alcohol use or abstinence, and can vary either way. Motivation for change can be volatile\(^\text{124}\). Healthcare professionals should adapt their interventions to these changes in situation, motivation and treatment goals.

Therapeutic intervention should be planned differently, according to the consumption goal:
- abstinence goal
- moderation goal.

For an abstinence goal, intervention typically takes place in two phases\(^\text{6, 68}\):
1. assisted alcohol withdrawal;
2. maintenance of abstinence (or relapse prevention).

These two phases are distinguished as they require different therapeutic strategies, particularly in the pharmacotherapeutic field. Preparation for the assisted alcohol withdrawal phase ideally involves dealing with motivational aspects, intervention of the family, evaluation of somatic and psychiatric status and social situation.

However, for a moderation goal, an assisted alcohol withdrawal period is not necessarily envisaged\(^\text{8}\). There is no clear distinction between the moderation period and the relapse prevention period, as the two goals are generally combined. Once again, work on moderation may be preceded by a preparatory period, which can include motivational aspects, intervention of the family, evaluation of somatic and psychiatric status and social situation.

**Treatment of comorbidities**
Regardless of the alcohol consumption goal determined with the patient, particular attention should also be given to concomitant disorders.

- **Other addictions**

Other addictions can be associated with alcohol: tobacco (60-70%), other drugs (about 13%), notably cannabis (10%) and opioid substitutes (2-3%)\(^\text{130}\).

Reducing or stopping alcohol use can help to stop using other substances, including tobacco. But it can also sometimes be accompanied by a carry on other consumptions (especially cannabis) (EC)\(^\text{131}\). Hence, the whole addiction problem should be treated\(^\text{7}\). Repeated motivational intervention aiming at encouraging patients to stop smoking is recommended for patients who also smoke, at any point of their programme to modify their alcohol misuse\(^\text{132-134}\).

Comorbidities with other addictive behaviours should also lead to other adapted interventions being implemented.
• **Psychiatric comorbidities**
  The existence of a psychiatric disorder is a vulnerability which can hinder a lasting change in alcohol use and encourage relapse.
  Depression is common (80%, including 67% at the start of withdrawal), but only 10-15% persist after withdrawal. The persistence of depressive symptoms 2 to 4 weeks after withdrawal should be verified before introducing antidepressant treatment.
  Other psychiatric disorders are also more common in these patients and require evaluation and specialist therapeutic intervention: bipolar, psychotic (15-35%), anxiety (27%), dependent (16%), antisocial (11%), and borderline (10%) disorders.

• **Somatic comorbidities**
  These are common. Cognitive disorders in particular affect the patients’ investment in their treatment programme and treatment compliance, and therefore hinder their commitment to treatment and lasting change and encourage relapse.
  Sleep disorders should be routinely investigated and treated (sleep hygiene rules, if necessary, hypnosis), as persistence thereof after withdrawal is a predictive factor for relapse.

**RECOMMENDATIONS**

9.1. It is normal for patients who misuse alcohol to follow a non-linear process in terms of consumption. Both improvements and exacerbations can occur spontaneously. This process is also non-linear in terms of consumption goals. Healthcare professionals should adapt their interventions to these changes in situation, motivation and treatment goals (EC).

9.2. Intervention focusing on reducing consumption does not usually involve an alcohol withdrawal period (grade B).

9.3. Intervention focusing on abstinence typically involves an alcohol withdrawal period, which may require specific treatment (grade A).

9.4. Other addictions with or without other substances should be routinely detected throughout the patient's treatment process and taken into account in the overall management of addiction (EC). Repeated motivational interventions aiming at encouraging patients to stop smoking is recommended for patients who also smoke, at any point of their programme to modify their alcohol misuse (grade C).

9.5. Depressive and anxiety symptoms are common and sometimes severe in patients who misuse alcohol. As these usually regress further to withdrawal, it is recommended that persistence of symptoms be verified 2 to 4 weeks after withdrawal before maintenance therapy is envisaged.
10
How should treatment be conducted with a view to reducing drinking?

Although abstinence is recognised as being a preferable consumption goal in patients suffering from severe dependence, or misuse associated with major somatic or psychiatric comorbidities, certain patients do not choose this option, either because they cannot accept the idea of completely stopping drinking, or because they feel incapable of doing so, notably by being unable to identify the practical solutions to be implemented. Reducing consumption is an alternative goal, which can be directly proposed to patients with misuse of limited severity, or to patients with a more severe disorder but not wishing to attempt abstinence.

1. **CONSUMPTION GOALS**

In France, it is recommended that intake be limited to below at-risk use: intake of more than 21 units per week for males, or more than 14 units per week for females; more than 4 units for each drinking occasion; any use in certain circumstances (childhood, pregnancy, driving an automobile or operating a machine, certain disorders, etc.). However, any reduction in alcohol use can have a significant impact on health. Due to the exponential relationship between alcohol use and the risk of death, a given degree of reduction in consumption has an even larger impact the higher the level of initial consumption. For example, a reduction corresponding to 36 grams of alcohol per day was calculated as inducing a reduction in the risk of death three times greater in a drinker consuming 96 g/day compared to a drinker consuming 60 g/day. Hence, it is recommended that consumption below the at-risk levels be targeted insofar as possible, although any lasting reduction in consumption should be accepted as a positive result, and may be an initial step towards a greater reduction.

2. **STRATEGIES FACILITATING A REDUCTION IN ALCOHOL USE**

**Psychosocial interventions**

*Also see, if necessary, Question 7, section II/ Psychosocial interventions.*

Psychosocial interventions were the only therapeutic strategies available up to the beginning of 2010. Since then, medicinal strategies have also become available. The psychosocial interventions recommended for reducing alcohol use are evidently first and foremost brief interventions (grade A), particularly for subjects displaying misuse of limited severity. More intense psychosocial interventions are well adapted to reducing alcohol use: motivational interventions and cognitive behavioural programmes, notably including behavioural self-control training. The most important therapeutic element appears to be daily self-assessment of consumption" (grade A).
Medicinal products
Medicinal products for reducing alcohol consumption are only indicated in dependent individuals.
Nalmefene is the first medicinal product to have received a French marketing authorisation (MA) in the indication for reducing alcohol consumption.
Although naltrexone is normally indicated for the prevention of relapse after withdrawal, certain data indicate possible efficacy in reducing alcohol use\(^{135}\).
The prescription of baclofen for reducing alcohol use among alcohol-dependent patients has been governed by a temporary recommendation for use (TRU) since March 2014, with online declaration and patient follow-up.
The different strategies for reducing alcohol use combine psychological/educational-type intervention, medical management and drug prescription.

RECOMMENDATIONS

10.1. Although abstinence is recognised as being a preferable consumption goal in patients suffering from severe dependence, or misuse associated with major somatic or psychiatric comorbidities, certain patients do not choose this option, either because they cannot accept the idea of completely stopping drinking, or because they feel incapable of doing so, or because it is not compulsory. Reducing consumption is an alternative goal, which can be directly proposed to patients displaying misuse of limited severity, or to patients with a more severe disorder, but not wishing to - or not yet able to - attempt abstinence.

10.2. It is recommended that consumption below the at-risk levels be targeted insofar as possible, although any lasting reduction in consumption should be accepted as a positive result, and may be an initial step towards a greater reduction. It is recommended that self-assessment of consumption be encouraged, i.e. asking patients to monitor the number of units consumed each day, using a diary, notebook, computer file or smartphone application.

10.3. It is recommended that the patient be regularly encouraged to commit to reducing their alcohol use.

10.4. Medicinal products for reducing alcohol consumption are only indicated in dependent individuals.

10.5. Nalmefene is indicated for reducing alcohol consumption in dependent individuals.

10.6. The prescription of baclofen for reducing alcohol use among alcohol-dependent patients has been governed by a temporary recommendation for use (TRU) since March 2014, with online declaration and patient follow-up.
11

How should treatment be conducted with a view to detoxification?

Detoxification is the process of rapidly achieving an alcohol free state. Alcohol withdrawal is defined as the cessation of alcohol consumption, whether accidental, imposed by certain circumstances or with a therapeutic view in a patient who misuses alcohol. It may lead to withdrawal syndrome.

Withdrawal syndrome covers graded symptoms (minor, moderate, severe) occurring immediately or up to ten days after stopping consumption. These symptoms correspond to a mental, behavioural and physical craving.

Withdrawal syndrome combines several types of symptoms to varying degrees.
- Subjective disorders: anxiety, agitation, irritability, insomnia, nightmares;
- Autonomic disorders: perspiration, tremor, tachycardia, hypertension;
- Gastrointestinal disorders: anorexia, nausea, vomiting, diarrhoea.

After a few hours, this presentation may subside, become exacerbated, or become complicated with withdrawal events (hallucinations, seizures, delirium).

Risk factors predisposing patients to onset of complications are severe misuse, history of withdrawal syndrome and withdrawal events, multiple substance addiction and associated comorbidities.

Withdrawal syndrome is limited in intensity and free from complications in 95% of alcohol-dependent individuals. Only a small number of patients (10 to 20%) require management in the context of therapeutic withdrawal ideally falling within the scope of a treatment project.

Conversely, not all treatment projects involve detoxification or, even more so, medically-managed detoxification.

The objectives of therapeutic withdrawal are:
- to screen and manage withdrawal symptoms,
- to prevent the occurrence of severe complications.

GENERAL MANAGEMENT PRINCIPLES

- Management falls within the scope of medical/psychosocial intervention with multiple graded approaches proposed after clinical evaluation according to the patient's needs. This falls within the scope of general support and a treatment programme.

Referral for more adapted treatment (outpatient or residential) takes place with motivated agreement from the informed patient (treatment adherence yields better results). Explanation of the detoxification process enables more effective management. Combined tobacco cessation is proposed and encouraged. Post-detoxification organisation is routinely explained.

Preparation for detoxification helps improve its quality and thus reduces the risk of relapse.
A medically-managed detoxification project may be deferred so that there is sufficient time to meet all of the psychosocial conditions necessary for its proper implementation, and for subsequent sustained abstinence. In all cases, patient support can always lead to a future detoxification project.

- **Hospital-based residential detoxification** only concerns 10 to 30% of detoxification cases. The indications are:
  - delirium (mental confusion possibly accompanied by hallucinations) or epileptic seizures during evaluation;
  - a history of delirium or epileptic seizures;
  - high-dose multiple substance use, notably former, daily and high-dose use of benzodiazepines (BZD) (in order to adjust drug treatment without inducing concomitant benzodiazepine withdrawal; this should be touched on at a later stage).

Residential treatment should also be envisaged on a case-by-case basis under certain circumstances:
- alcohol-related: extent of withdrawal syndrome, failure of repeated outpatient detoxification,
- somatic or psychiatric: severe or unstable comorbidity, age-related frailty;
- socio-environmental: pressing demand from family, limited social support, precarious social situation;
- general: pregnancy.

Sometimes detoxification is required during hospitalisation for another reason in a non-addiction department, warranting recourse to the addiction liaison and care team (ELSA).

- **Outpatient detoxification**

Outpatient detoxification should be preferred apart from the indications for residential detoxification described above. This enables effective treatment in the patient’s usual living environment, while limiting costs. It takes into account any existing comorbidities related - or not related - to alcohol and ongoing treatments.

Regular clinical follow-up in an outpatient context, at home, involves both the attending physician and associated carers.

**PHARMACOLOGICAL TREATMENT FOR WITHDRAWAL**

For specific populations (pregnant women, adolescents, the elderly, etc.), refer to Question 16.

- **Indications**

Detoxification does not often require pharmacological treatment. Withdrawal syndrome is far from being a routine occurrence, even in alcohol-dependent individuals. The objective of pharmacological treatment is to prevent or reduce severe withdrawal symptoms and the complications arising from eliminating alcohol. It should be adapted to each patient.

Oral administration is preferred, but parenteral administration may prove necessary in the event of severe problems or complications (vomiting, confusion). In this case, the intravenous
(IV) route is more suitable in the event of coagulation disorders, and enables better bioavailability\textsuperscript{68}.

- **Benzodiazepines**
  
  *Also see Question 7, section III/ Pharmacological interventions, paragraph: BZD and prevention of withdrawal syndrome.*
  
  These are currently the first-line drug treatment for alcohol withdrawal syndrome, when this proves necessary\textsuperscript{137}.
  
  It should be noted that these are not routinely prescribed, their dosage should be adapted to the severity and progression of withdrawal syndrome and treatment tolerability, and the treatment duration should not normally be more than a week.

- **Vitamins**
  
  *Also see Question 7, section III/ Pharmacological interventions, paragraphs: Thiamine (vitamin B1) and other vitamins.*
  
  All patients initiating withdrawal should routinely receive thiamine. To date, there are no objective findings making it possible to strictly define the dosage and frequency of thiamine administration \textsuperscript{107}. At an interval from detoxification, discontinuation of supplementation with thiamine is dependent on the clinical outcome, in all cases\textsuperscript{68}. Continued alcohol use should lead to continued prescription of thiamine\textsuperscript{98} although there is no clinical evidence for recommending long-term prophylaxis\textsuperscript{98}.

- **Other therapeutic classes**
  
  The following agents: baclofen, acamprosate, gamma-hydrobutyric acid (GHB), and beta-blocking agents are not recommended for assisting withdrawal, based on current knowledge\textsuperscript{122}.
  
  Certain antiepileptic drugs (carbamazepine, valproate, gabapentin) appear to be an interesting alternative due to their properties and limited side effects; however, these have not demonstrated superior efficacy to BZD\textsuperscript{138-140}.
  
  Initiation of antidepressant treatment is not indicated during withdrawal. Disorders apparently of a psychotic nature, not responding to conventional sedative treatment, may justify the use of neuroleptics\textsuperscript{68}.

- **Concomitant medication**
  
  This should be adapted to the patient's clinical and laboratory status. In the event of established withdrawal syndrome, adequate fluid intake should be ensured (on average 2 litres daily) to compensate for losses (vomiting, perspiration, diarrhoea), without hyperhydration and allowing for correction of any electrolyte disturbances: gradually for hyponatraemia, and by joint supplementation with potassium and magnesium for hypokalaemia\textsuperscript{68}.

**TREATMENT OF COMPLICATIONS**

**Seizures during withdrawal**

Other aetiologies outside the context of withdrawal events should be ruled out. After an episode of seizures related to withdrawal, benzodiazepines are administered as soon as possible at a sufficient dose to avoid recurrence and progression towards delirium tremens\textsuperscript{98}.
Delirium tremens
The first-line treatment is still benzodiazepines, to be used at high doses, at least until light sedation is achieved. Hospitalisation is mandatory and care should be taken to ensure that the environment is as calm as possible. If BZD is not sufficient to control agitation, antipsychotic agents may be prescribed in addition. If delirium tremens is refractory to these measures, transfer to intensive care should be envisaged.

RECOMMENDATIONS

11.1. Treatment of withdrawal is based on a medical/psychosocial approach, adapted to the needs and choices of the informed patient (EC). Residential detoxification is indicated in the following cases: delirium (mental confusion possibly accompanied by hallucinations) or epileptic seizures at the time of evaluation; history of delirium or epileptic seizures; high-dose multiple drug use, notably a concomitant benzodiazepine detoxification project. Residential treatment should also be envisaged on a case-by-case basis under certain circumstances: extent of withdrawal syndrome, failure of repeated outpatient detoxification, severe or unstable comorbidity, age-related frailty, pressing demand from family, limited social support, precarious social situation, pregnancy (EC).

11.2. Outpatient detoxification should be preferred apart from the indications for residential detoxification (EC).

11.3. In the majority of cases, detoxification does not require pharmacological treatment (grade B) provided thorough clinical evaluations take place beforehand and regularly thereafter. When the conditions are not met, preventive treatment should be routinely implemented. Benzodiazepines are the first-line drug treatment (grade A).

11.4. Initiation of an antidepressant treatment is not indicated during detoxification, unless the patient displays disproportionate depressive symptoms relative to his/her alcohol use (EC).
12 How can relapse be prevented?

I. WHAT ARE THE TREATMENT GOALS?

Until recently, abstinence was perceived as the only treatment goal in alcohol-dependent patients\(^\text{63, 68}\). When the treatment goal is abstinence, the therapeutic regimen usually includes initial provision for alcohol detoxification. Relapse prevention corresponds to the therapeutic phase following alcohol withdrawal.

Relapse after detoxification was formerly defined as having the first drink. More recently, relapse has been defined by the resumption of high-level use (greater than or equal to 5 units/day on a single occasion for males aged under 65 years; greater than or equal to 4 units/day for males aged over 65 years and females)\(^\text{18}\). It should be noted that these levels were defined by the US Food and Drug Administration, with a unit corresponding to 14 grams of alcohol, whereas a standard unit in France corresponds to 10 grams\(^\text{77}\).

II. HOW CAN THESE BE ACHIEVED?

1. Treatment project

This should be defined with the patient, in keeping with his/her life goals, motives, cognitive capacities, and his/her somatic, psychological, family and professional context\(^\text{63}\). Motivation has a major role and function as patients have to be an active part of their own treatment project.

In order to achieve this, adapted management, by networking with different partners, will be proposed: 1) on an outpatient basis to assist sustained abstinence by medical/social means, notably the attending physician, addiction treatment, support and prevention centres (CSAPA) and hospital appointments; 2) on a part-time hospitalisation basis for patients who require specific continuous care, or alternatively, on a full-time hospitalisation basis while maintaining a certain degree of autonomy; 3) on a full-time hospitalisation basis so as to manage acute episodes, comorbidities likely to encourage relapse; 4) on an aftercare and rehabilitation basis (Soins de suite et de réadaptation addictologique) to encourage sustained abstinence and reduce the risk of relapse.

2. Medicinal approaches

If necessary, refer to Question 7, section III/ Pharmaceutical interventions.

The first-line treatments for relapse prevention are acamprosate and naltrexone (EC). Acamprosate seems more effective in maintaining strict abstinence, whereas naltrexone has the distinctive feature of being better able to prevent patients from slipping back into high-level use\(^\text{141, 142}\) (grade A).

Disulfiram may be proposed on a second-line basis (EC) in patients motivated to maintain abstinence, and informed of the risk of the antabuse effect. This treatment is effective, particularly when tablet intake is supervised\(^\text{113}\) (grade A).
Baclofen is proposed on an off-label (marketing authorisation - MA) basis if treatment with acamprosate, naltrexone or disulfiram is not possible or has failed. Prescriptions have been governed by a temporary recommendation for use (TRU) since March 2014, with online declaration and patient follow-up.

3. **Psychosocial approaches**  
*If necessary, refer to Question 7, section II/ Psychosocial interventions.*

These approaches are manifold and heterogeneous, and some require special resources and trained teams (physicians, psychologists, trainers, etc.). They aim to keep the patient committed and motivated regarding the therapeutic project, to identify situations which lead to craving and resumed use, and to manage them by setting up new behavioural strategies and challenging **silent assumptions** (for example: ‘*I am incapable of abstaining*’, ‘*I am incapable of being loved*’, ‘*I am useless*’). For sustained abstinence, deactivation of the ‘abstinence violation effect’, nurtured by a strong commitment to abstinence and belief in the inevitability of relapse when taking the first drink, is also worth mentioning. The abstinence violation effect is apparent when taking the first drink. This is reinforced by feelings of guilt and shame, and then increases the risk of control loss regarding consumption and the risk of relapse.

Management of the patient’s environmental context is key. Family involvement (spouse, family, friends, etc.) through information, education, individual or group management is effective in sustaining abstinence at 2 years.

According to severity, the intervention may range from simple counselling to structured management. Misuse which is moderate in intensity is treated by means of psychosocial intervention without immediate pharmacological treatment, whereas moderate to severe forms will involve a combination of several types of therapeutic, psychosocial and pharmacological interventions, based on patient and environmental characteristics (for example, varying degrees of cognitive behavioural therapies, motivational interviews, coping strategies, exposure to stimuli combined with the behavioural approach, community reinforcement, reinforcement contingencies, varying degrees of behavioural marital and family therapy, environmental therapy, social networks)\(^1\)\(^2\),\(^1\)\(^4\). Ultimately, these different approaches allow the patient to reinvest him/herself in different lifestyle activities (social, sports and cultural activities, professional reintegration) and, in the end, to improve his/her quality of life\(^7\)\(^5\).

**RECOMMENDATIONS**

12.1. Relapse prevention is a term used to define a treatment goal which is applicable after detoxification.

12.2. Treatment goal (EC):  
- falls within the scope of a personalised treatment project defined with the patient,  
- generally focuses on abstinence, but may include a goal to reduce consumption,  
- utilises different resources to sustain abstinence (or a reduced consumption) and prevent relapse.
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12.3. Psychosocial approaches are graded according to the severity of misuse and adapted to patients and their families (grade B):
- moderate misuse may be treated by means of psychosocial intervention without pharmacological treatment,
- more severe misuse, with dependence, may immediately involve a combination of psychosocial interventions and pharmacological treatment. Family involvement should be encouraged (grade B).

Cognitive behavioural therapies are effective in supporting the patient (grade A) although other approaches are said to be indirectly beneficial, notably in strengthening motivation (grade C).

12.4. Medicinal treatments should be automatically associated with adapted psychosocial support (grade A).

12.5. Increased compliance with medicinal treatment improves therapeutic efficacy.

12.6. The first-line medicinal treatments for relapse prevention are acamprosate and naltrexone (EC). Acamprosate seems more effective in maintaining strict abstinence, whereas naltrexone has the distinctive feature of being better at preventing patients from slipping back into high-level use (grade A).

12.7. Disulfiram may be proposed as second-line treatment (EC) in patients motivated to sustain abstinence, and informed of the risk of the antabuse effect. This treatment is effective, particularly when tablet intake is supervised (grade A).

12.8. Baclofen is proposed off-label (marketing authorisation - MA) if treatment with acamprosate, naltrexone or disulfiram is not possible or has failed. Prescriptions have been governed by a temporary recommendation for use (TRU) since March 2014, with online declaration and patient follow-up.
What are the indications for referral to specialist intervention?

As for other disorders, the general practitioner remains pivotal in terms of management. Allowing long-term support, the general practitioner is the first port of call for both patients and their families. General practitioner support requires appropriate training in general medicine. Evidently, the role of the general practitioner will depend considerably on his/her level of training in the management of addictive behaviours, particularly alcohol misuse.

In the context of this supportive relationship, general practitioners need to rely on a range of partnerships, which are all too frequently poorly identified. It is essential to help them to identify the protagonists and organisations able to provide follow-on or complementary intervention in their healthcare region. Therefore, this involves helping general practitioners to become less isolated by placing them in contact with personnel and organisations close to their area of practice, through local networking.

In addition to partners involved in the treatment of addictions, the general practitioner can evidently work with specific professionals, based on the characteristics of the subject (pregnant women, presence of somatic, psychiatric comorbidities, etc.).

I. WHAT TYPE OF INTERVENTION FOR WHICH PATIENT?

The stepped care model involves grading the intensity of therapeutic interventions. The intensity of a therapeutic intervention plays a part in the type of psychosocial intervention (number and duration of sessions, level of training required for healthcare personnel carrying out the intervention), the implementation of pharmacotherapeutic intervention, the multidisciplinary nature of the healthcare team, and, lastly, whether the intervention is of a residential nature or not.

In this model, low-intensity treatment is initially proposed to patients, combined with follow-up and evaluation of the effectiveness of the intervention. In the event of failure, the next level of intervention is envisaged, and so on. In order for this model to function correctly, it should be acknowledged that the subject can start his/her treatment path at any level of intensity, and not only at the lowest level of intensity. While a brief intervention, usually performed by general practitioners, is to be implemented on a first-line basis in most individuals in whom misuse has been detected, it appears that patients suffering from a very severe level of misuse, notably with withdrawal syndrome, somatic and psychiatric comorbidities, or an extremely precarious social situation, could benefit from specialist or even residential intervention from the outset. It is also recommended that patients be allowed to choose, in collaboration with their therapist, the level of intensity to which they wish to commit.

Another approach was developed by the American Society of Addiction Medicine based on the assumption that the treatment of addicts should be adapted to the clinical needs of each patient at a given moment in their path.

Needs should be defined based on a comprehensive multidimensional evaluation, including somatic, neurocognitive, emotional, behavioural, psychological and social aspects, severity of
behaviour, existence of multiple substance use, motivation for change, and patient’s choice. This evaluation is associated with therapeutic programmes graded in terms of intensity: brief intervention, outpatient follow-up, intensive outpatient follow-up, including outpatient hospitalisation, residential treatment and intensive residential treatment. The idea is to achieve the best possible match between the patient's needs at a given moment and the intensity of management, avoiding under-treatment, a source of inefficacy and human/economic consequences (repeated hospitalisation) and over-treatment, a source of additional costs.

This approach converges with good practice principles aiming for evidence-based alcohol studies. It also tends towards a harmonisation of management indications, supported by validated criteria.

These two approaches are not exclusive. They enable the diversity of the healthcare system to be clearly identified, both seek the best response for each patient and involve re-assessment at regular intervals.

II. INDICATIONS FOR REFERRAL TO SPECIALIST INTERVENTION

The indications for resorting to specialist intervention depend on the level of training of the healthcare professional in the management of alcohol misuse. All general practitioners should have received training in detecting alcohol misuse and in conducting a brief intervention. If the patient does not fall within the scope of a brief intervention, or if the latter does not yield satisfactory results, more intensive intervention should be proposed.

Numerous therapeutic interventions may be envisaged at the general practitioner's surgery (non-exhaustive list) (EC):
- moderately intensive psychosocial intervention, based on strengthening motivation for change, strengthening family support, facilitating the possibility of seeking help from mutual support groups, or compliance with pharmacological treatment;
- drug treatment (nalmefene or baclofen) for patients not wishing to attempt abstinence, but wishing to reduce their alcohol use;
- prevention of withdrawal syndrome;
- drug treatment with a view to sustain abstinence or prevent relapse (acamprosate, naltrexone, disulfiram, baclofen).

Recourse to specialist intervention will be envisaged by healthcare professionals:
- if they have not received training in - or feel unable to offer - these interventions beyond brief intervention, or if the latter has failed (EC);
- if the overall evaluation of the subject reveals signs indicating severe alcoholic behaviour or severe comorbidities (somatic, psychiatric, social, or multiple substance use) requiring specialist management.

Certain therapeutic interventions are difficult to envisage in a general practice setting. They concern patients suffering from very severe misuse, notably with major physical dependence, somatic and psychiatric comorbidities, or in an extremely precarious social situation. These
interventions may require more experienced multidisciplinary teams or teams equipped with residential resources.

The treatment path of patients suffering from misuse depends on the specific characteristics of their healthcare region: existence of an adapted network, proximity of an addiction treatment, support and prevention centre (CSAPA), a hospital team or psychiatric team offering treatment for alcohol misuse. It is advisable to include in this list professionals who do not necessarily specialise in addiction, such as certain specialist physicians, psychologists, social workers, and dieticians, etc. Regional characteristics will dictate the type of approach sought by healthcare professionals, based on their patient’s specific situation (EC).

**RECOMMENDATIONS**

**13.1.** All general practitioners should have received training allowing them to detect alcohol misuse and carry out brief intervention (EC).

**13.2.** If the subject does not fall within the scope of brief intervention, or if the latter does not yield satisfactory results, more complex therapeutic interventions may be envisaged at the general practitioner’s surgery (non-exhaustive list) (EC):
- moderately intensive psychosocial intervention, based on strengthening motivation for change, strengthening family support, facilitating the possibility of seeking help from mutual support groups, or compliance with pharmacological treatment;
- drug treatment (nalmefene or baclofen) for individuals not wishing to attempt abstinence, but wishing to reduce their alcohol use;
- prevention of withdrawal syndrome;
  - drug treatment with a view to sustain abstinence or prevent relapse.

**13.3.** Certain therapeutic interventions are difficult to envisage in a general practice surgery. They concern patients suffering from very severe misuse, notably with severe physical dependence, somatic and psychiatric comorbidities, or in an extremely precarious social situation. These interventions may require more experienced multidisciplinary teams, or teams equipped with residential resources (EC).

**13.4.** Recourse to specialist intervention will also be envisaged by healthcare professionals if they have not received training in - or feel unable to offer - these interventions beyond brief intervention, or if the latter has failed (EC).

**13.5.** Specific regional characteristics in terms of the healthcare system determine the patient’s treatment path (EC).
What are the indications for residential treatment?

Residential treatments involve a round the clock patient management in a structure that provides housing, meals and treatment (simple or complex detoxification treatment; non-specialised stay in a general psychiatric unit or follow-up and rehabilitation centre ‘Soins de suite et de réadaptation’; therapeutic community).

Medical literature on indications for residential treatment is scarce, meaning that very little evidence-based information is available. The bulk of the research was on indications for residential detoxification; other types of residential treatment, such as follow-up and rehabilitation centres, whose structures and therapeutic programmes vary with culture and country, were not thoroughly explored.

The characteristics making one treatment modality preferable over another were not studied in-depth. Yet, such attributes are crucial to guiding the choice of treatment method. In general, it appears that the subjects in the most dire situations, and the most dire social situations in particular, as a result of their addiction experience better results in a residential facility than in an outpatient facility. Very recent studies on homeless people provided support for the use of residential facilities prior to treatment. Older subjects may also require hospitalisation more frequently.

It is also important to consider what subjects want. If a subject accepts the treatment methods being offered, the outcome tends to improve.

Until now, residential treatment has almost always involved abstinence rather than a reduction in use as the goal.

INDICATIONS FOR RESIDENTIAL DETOXIFICATION

An exhaustive literature review comparing outpatient and hospital-based detoxification programmes did not demonstrate any difference in efficacy between outpatient detoxification and residential withdrawal, as evidenced by the better cost/effectiveness ratio of outpatient detoxification. The majority of studies compared residential treatment with outpatient treatment and did not demonstrate residential treatment superiority. In a very small number of studies, the duration of residential treatment did not seem to play a role beyond two months. However, the most serious patients were excluded from comparative studies, and some conditions drastically limited patients’ ability to undergo outpatient detoxification.

Although there is limited evidence generated through clinical research, there is a consensus on the indications for residential detoxification:
- delirium (mental confusion that may be accompanied by hallucinations) or seizures during evaluation,
- history of delirium or seizures,
- high-dose polydrug use, especially daily, historical and high doses of benzodiazepines (EC).

Certain circumstances also require residential withdrawal treatment to be determined on a case-by-case basis:
- alcohol-related: severity of withdrawal syndrome, failure of repeated outpatient detoxification attempts,
- somatic or psychiatric: severe or unstable comorbidity, age-related frailty,
- socio-environmental: urgent requests from family and friends, weak social support system, unstable social situation,
- general: pregnancy.

The feasibility of outpatient withdrawal must be evaluated in consideration of the situation as a whole rather than with respect to an isolated aspect of the situation, all the while incorporating the preferences of the patient.

Generally speaking, in addition to the aforementioned residential detoxification indications, hospitalisation for treatment is especially indicated in the following cases:
- severe acute intoxication with potential complications,
- complex treatment, failure of previous treatments administered in less intensive residential or outpatient frameworks.
Cognitive disorders may also require hospitalisation for an evaluation and initial treatment.

**INDICATIONS FOR HOSPITALISATION IN A FOLLOW-UP AND REHABILITATION CENTRE**

Hospitalisations in ‘post-cure’ units or follow-up and rehabilitation centres are mainly for subjects with a very severe form of misuse, and particularly serious, long-standing dependence syndrome. Such hospitalisations are mainly for people with significant somatic or psychiatric comorbidities or in a difficult social situation due to their housing conditions or an environment that does not really support treatment attempts. Subjects with significant cognitive disturbances would especially benefit from prolonged hospitalisation away from alcohol to enable them to gradually regain the cognitive abilities required to increase their motivation to change and adopt strategies that will prevent relapse.

**INDICATIONS FOR INVOLUNTARY HOSPITALISATION**

There is little literature on the efficacy of involuntary hospitalisations for alcohol abusers. The Haute Autorité de Santé (HAS, the French National Authority for Health) has published general recommendations on involuntary treatment.

**RECOMMENDATIONS**

**14.1.** It is preferable to provide treatment for alcohol abuse on an outpatient basis (grade A).

**14.2.** Residential withdrawal is indicated in the following cases:
- delirium (mental confusion that may be accompanied by hallucinations) or seizures during evaluation,
- history of delirium or seizures,
Alcohol misuse: screening, diagnosis and treatment

- high-dose polydrug use, especially daily, historical and high doses of benzodiazepines (EC).

Certain circumstances also require residential withdrawal treatment to be determined on a case-by-case basis (EC):
- alcohol-related: severity of withdrawal syndrome, failure of repeated outpatient detoxification attempts\textsuperscript{149},
- somatic or psychiatric: severe or unstable comorbidity, age-related frailty,
- socio-environmental: urgent requests from family and friends, weak social support system, unstable social situation,
- general: pregnancy.

The feasibility of outpatient detoxification must be evaluated in consideration of the situation as a whole rather than an isolated aspect of the situation, all the while incorporating the preferences of the patient.

14.3. Longer term residential treatment, such as in a follow-up and rehabilitation centre, should be foreseen in the following circumstances (EC):
- failed prior attempts at correctly implementing treatment,
- dependence requiring an initial alcohol abstinence period to ensure optimal treatment, whereby it appears to be impossible for the patient to undergo withdrawal in an outpatient setting, such as:
  - concurrent psychiatric disorders for which the primary or secondary cause can be difficult to establish
  - cognitive disturbances or other severe somatic consequences,
- unstable social situation (with particular attention paid to ensuring that there is stable housing in an environment that does not expose the patient to excessive alcohol upon discharge from the residential treatment facility),
- urgent request by the patient or the patient's family and friends making difficult keeping the patient at home within the context of outpatient treatment, even intensive outpatient treatment.

14.4. The choice of structure must cater to the patient's priority needs (cognitive and psychiatric state, psychiatric disorders, motivations) as much as possible within the context of the locally available facilities (EC).

When patients are hospitalised in non-specialised addiction structures, the alcohol addiction must be treated by an addiction treatment and liaison team (ELSA) (EC).

14.5. Complex residential treatment must be integrated into a comprehensive treatment programme and end with an outpatient follow-up that is organised beforehand (EC).

14.6. Acute or chronic alcohol intake can, in rare cases, require involuntary hospitalisation provided that this intake is associated with psychiatric disorders and/or a history of suicide attempts and/or an immediately foreseeable risk to the patient and/or others.

In the event that acute intoxication requires hospitalisation, it is recommended to institute first-line treatment in a \textit{service d'accueil des urgences} (SAU, or emergency department) because of the overwhelming somatic risk (EC).
What is the role of non-pharmacological and non-psychotherapeutic interventions (socio-educational intervention, occupational therapy, psychomotor education, specialised education, physical activities, etc.)?

Persons who misuse alcohol gradually relinquish different sources of pleasure and habits other than alcohol over time, sometimes to the detriment of bodily care or attention to their appearance. Moreover, subjects occasionally use alcohol to procure a feeling of wellbeing, as an anaesthetic against unpleasant sensations or to facilitate human contact.

For all of these reasons, in certain subjects, it is worth proposing non-pharmacological interventions which could make it easier for subjects to resume social interaction, and regain access to various pleasures and habits, or allow them to start paying attention to their body and appearance again.

Although most treatment goals can be found in all the types of interventions, different types of workshops can be identified.
- **Activities involving physical mediation**: physical exercise, different relaxation methods (sophrology, balneotherapy, acupuncture, yoga, etc.), occupational therapy, etc.
- **Expressive and creative mediation activities** proposed by occupational therapists and art therapists in particular.
- **Socio-therapeutic activities** aiming to strengthen interpersonal capacities, often highly damaged after a long period of severe alcohol misuse, and vital in order to create a new social network compatible with abstinence or low-level alcohol use.
- **Cognitive activities** with spatio-temporal restoration: cognitive remediation workshop, press review workshop, educational workshop on alcohol-related disorders, stress management, etc.

I / EFFICACY OF NON-PHARMACOLOGICAL INTERVENTIONS ON ALCOHOL USE

Very few studies have examined the effectiveness of these various activities in terms of preventing relapse and achieving a reduction in drinking in people who misuse alcohol.

The period when patients want to change their drinking behaviour constitutes a ‘learning period’, during which individuals can make more general changes designed to improve their lifestyle as a whole.

Regular physical activity is often considered to be effective, making subjects more engaged in the change and boosting their self-esteem, but insufficient data are available to confirm this conviction\(^{151,152}\).

Acupuncture has shown equivocal results and the poor methodological quality and the limited number of trials do not allow any conclusion about the efficacy of acupuncture for treatment
of alcohol dependence. National Institute for Health and Care Excellence (NICE) recommends conducting larger-scale randomised studies.

II/ EFFICACY ON COMORBIDITIES OF ALCOHOL MISUSE

✓ **Anxiety and depression**

Anxiety disorders are often associated with alcohol misuse and a number of studies have demonstrated the benefits of some of these activities in the treatment of anxiety. The interventions having demonstrated the best levels of efficacy to reduce anxiety associated with alcohol misuse are physical activity, relaxation methods and self-help manuals (bibliotherapy). Muscle relaxation has been shown to significantly reduce anxiety in patients, with results practically comparable to those achieved with cognitive behavioural therapy after four months of treatment (grade C).

The evidence is more limited with respect to the contribution of acupuncture, music, autogenic training (a method of self-relaxation from physical concentration) and meditation in the treatment of generalised anxiety disorder (grade C).

There may also be depressive components associated with alcohol misuse. A study on the use of a yoga technique (Sudarshana Kriya Yoga), based on rhythmic breathing, has demonstrated a significant reduction in depressive components when patients are undergoing alcohol withdrawal (grade C).

Therapeutic activities can also help motivate patients to take part in other therapies. For example, music therapy improves engagement in other group therapies. The workshop brings enjoyment and motivation and increases their feeling of belonging to the group (grade C). Likewise, occupational therapy and various cognitive workshops (press workshop, memory workshop, etc.) target other, longer-term goals: restoration of self-esteem, increased autonomy, verbalising of emotions, spatio-temporal restoration, capacity to fit into a group (notion of re-socialisation) (EC).

✓ **Cognitive disorders**

Since the 1980s, numerous studies have demonstrated the existence of cognitive disorders in patients who misuse alcohol. These disorders can be an obstruction to psychological management using motivational or cognitive behavioural methods and reveal the value of optimised and tailored treatment. Rehabilitation protocols developed for people who misuse alcohol focus on the cognitive areas that are disturbed by the disorder: executive processes, episodic memory, working memory and attentional functions (in order of importance).

Cognitive remediation in people who misuse alcohol with neuropsychological repercussions is currently little used. A recent review of the literature reinforces, in a moderate yet significant way, the efficacy of alcohol misuse treatments, encouraging their incorporation into treatment programmes (grade C). The medical (risk of relapse linked to cognitive disorders) or socioprofessional (reintegration) stakes are therefore high.

In practice, the management of cognitive disorders in addiction medicine requires a global, holistic approach, combining cognitive (taken by staff trained in these techniques) and psychosocial rehabilitation.
III/ NON-SPECIFIC EFFICACY

The majority of these activities appear to have a non-specific psychotherapeutic effect, which, in addition to an effect on alcohol use or psychopathology, may result in a better social adjustment, an improved self-esteem and, more generally, a better quality of life.

It is important to develop applications of these techniques in structures offering long-term follow-up to these patients (addiction treatment, support and prevention centres, day hospitals, addiction aftercare and rehabilitation units), and to promote applied research in this field (EC)\textsuperscript{158-162}.

RECOMMENDATIONS

15.1. Although there is still a lack of conclusive data at present, therapeutic workshops involving physical mediation, expression and creation, and socio-therapeutic activities are often considered to be effective in patients with severe alcohol use disorders, particularly in terms of providing a better social adjustment, an improved self-esteem and a greater commitment to lifestyle changes (EC).

15.2. Therapeutic workshops must be led by professionals and tailored to each patient (EC).

15.3. Cognitive remediation reinforces, in a moderate yet significant way, the efficacy of alcohol misuse treatments. Incorporation of this type of intervention into treatment programmes is recommended (grade C).
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How should alcohol misuse be managed
in specific populations:
pregnant women, adolescents, the elderly,
or individuals suffering from somatic or psychiatric comorbidities,
multiple substance use, social difficulties,
persons on probation, etc.?

PREGNANT WOMEN

Any woman of childbearing age demonstrating alcohol misuse should be provided with specific information concerning the issues related to her misuse if she becomes pregnant (EC). This information should be provided by a general practitioner or an addiction service. The objective of this intervention is to make sure the patient is better informed about the specific risks and the measures to be taken immediately in the event of a planned - or unplanned - pregnancy (EC). This intervention, which differs from a formal pre-conception consultation (see Question 4), should preferably be conducted by a health professional having received prior training in this area (EC).

In the absence of any current international consensus with respect to the existence of alcohol toxicity thresholds in the embryo or foetus, abstinence throughout pregnancy is recommended, regardless of the severity of alcohol misuse (EC). Consequently, any alcohol drinking during pregnancy is considered to be misuse.

Pregnancy in a woman misusing alcohol is an addiction medicine priority, requiring the cessation of all alcohol use as soon as possible, irrespective of the term at which the intervention takes place (EC). The patient must be managed by a multidisciplinary community/hospital team with her agreement.

If medically-assisted withdrawal is necessary during pregnancy, benzodiazepines (BZD) are recommended (grade B), since their use does not appear to cause malformations (level of evidence 1) (EC). If there is a major risk that the woman will start drinking again after withdrawal, the possibility of long-term hospital admission to protect the foetus may be considered, if possible in a psychiatric/addiction therapy mother-and-baby unit (EC).

No medicinal treatments designed to help maintain abstinence or achieve a reduction in alcohol use have been properly evaluated in pregnant or breastfeeding women. Outside pregnancy, these treatments are usually recommended only for severe forms of misuse. It is therefore recommended that no treatments other than alcohol withdrawal be initiated in pregnant or breastfeeding women (EC).

In the event of a pregnancy occurring in a patient obviously stabilised by pharmacological treatment, the continuation of this treatment should be considered on a case-by-case basis, weighing up the benefit/risk ratio (EC). Treatment with disulfiram represents an exception to this recommendation and it is preferable to discontinue it due, in particular, to the unknown...
risks on the foetus (EC). In other cases, the decision must be a pragmatic one, reached after multidisciplinary consultation involving at least the patient's own doctor, the addiction specialist, the obstetrician and the regional pharmacovigilance centre (EC).

Close clinical and ultrasound monitoring of the pregnancy must be organised in women who misuse alcohol, particularly if they have not stopped drinking (EC).

**CHILDREN AND ADOLESCENTS**

This population should ideally be referred for specific counselling (such as ‘young drinkers’ counselling) or specific hospitalisation, separate from adults (EC).

In children and adolescents, aspects relating to their upbringing and the family's relationship with alcohol are major factors influencing the severity of the problem and its prognosis (level of evidence 1)\(^{165}\).

Routine investigation, to identify the presence of any addiction problems in the parents, is therefore recommended (grade C).

However, systematic family therapy has been shown to be less effective than individual management in the least severe forms of misuse (level of evidence 3). Consequently, the initiation of family therapy should be decided on a case-by-case basis (EC).

Any adolescent under the age of 16, detected as an alcohol misuser, should undergo a paediatric psychiatric assessment (grade C), because early-onset alcohol misuse is often associated with psychiatric comorbidities and family difficulties\(^{166}\) (level of evidence 2).

Although the prognosis is more unfavourable in the event of alcohol misuse before the age of 16\(^{167,168}\) and the goal of abstinence is often preferable, given that it is often difficult to get these young patients to agree to abstain, it may be necessary to set a goal of reduction of drinking, as part of a risk reduction strategy (EC).

Given the absence of specific data on the subject, first-line treatments to help maintain abstinence do not have a marketing authorisation for subjects under the age of 18. In this case, their use must be considered on a case-by-case basis and only for severe misuse, particularly when there are signs of withdrawal (EC). The use of these treatments for less severe misuse should only be considered following repeated failure of psychosocial measures alone (EC).

**PATIENTS OVER THE AGE OF 65 YEARS**

The effectiveness of a brief intervention, tailored to elderly subjects, has been demonstrated in terms of reducing weekly alcohol intake, number of acute episodes, proportion of patients drinking excessively\(^{41}\) (grade A).

For cases of severe misuse, it would appear to be reasonable to offer assisted withdrawal in a hospital setting in patients over the age of 75-80 years in order to control or more easily prevent serious complications: delirium tremens, convulsions, falls, intracerebral haematomas. In addition, it is essential to ensure good hydration and fluid-electrolyte balance in these subjects, who frequently have cardiovascular problems and in whom this balance is precarious.
The onset of withdrawal syndrome may be delayed in the elderly compared to younger patients. Given the pharmacokinetic and pharmacodynamic modifications observed in this population, particular caution is required when prescribing benzodiazepines (greater sensitivity). The latter remain the treatment of choice but, in contrast with younger adult populations, it is recommended that benzodiazepines with a short half-life be favoured (oxazepam, lorazepam, etc.) since they reduce the risk of accumulation (level of evidence 1)\textsuperscript{169, 170}, and the resulting effects: sedation, falls (level of evidence 2)\textsuperscript{171} (grade B). Initial doses must be reduced by 30 to 50% (EC).

Medicinal treatment designed to achieve a reduction in alcohol use or prevent relapses is no different than in younger patients.

Social and environmental management aimed at combating isolation is particularly important insofar as it is a major cause of alcohol misuse in the elderly (level of evidence 2)\textsuperscript{172}. For patients living in their own homes, meal delivery and home-help services as well as community nurse visits can help them maintain abstinence (EC). They are also a way of alerting medical and social services in the event of difficulties. For patients living in an institution, improving their living environment, involving support groups and breaking their solitude are also invaluable.

**SOMATIC COMPLICATIONS**

Patients who misuse alcohol and have organic complications must be offered coordinated care, involving an addiction specialist, the concerned specialist(s) and their own general practitioner (EC).

Given the absence of clear data relative to the existence of a toxicity threshold in patients with liver cirrhosis, pancreatitis, cognitive disorders, ataxia or peripheral neuropathy, alcoholic cardiomyopathy, an alcohol-related cancer or other chronic somatic complications related to alcohol, a goal of abstinence is recommended in these situations (EC).

If the patient is unwilling to stop drinking, intermediate objectives to reduce his/her alcohol use may be envisaged, with a view to limit the damage, but the final goal remains total abstinence (EC).

Following a liver transplant, some people do appear to be able to resume stable low-risk alcohol use\textsuperscript{173} (level of evidence 3), but in view of the current absence of sufficient ongoing data and given the significant impact of resumed misuse on the transplanted organ, a strategy of continued abstinence should be maintained if possible (EC).

In case of severe liver failure (ascites, prothrombin time <50%, jaundice), the use of naltrexone is contraindicated, but the use of acamprosate is possible.

In less severe alcoholic liver diseases, including compensated cirrhosis, naltrexone treatment is possible as long as monthly laboratory tests are performed (prothrombin time, transaminases).

Baclofen at a dose of 30 mg/d has demonstrated encouraging results in cirrhosis patients (level of evidence 2)\textsuperscript{118}. To date, higher dosages have not been assessed in this population. Severe liver failure is a contraindication to the prescription of baclofen in the context of the temporary recommendation for use (TRU) published by the *Agence nationale de sécurité du*
The cognitive disorders induced by alcohol are often reversible following detoxification, but their persistence is a factor that has a negative impact on treatment compliance and living conditions\textsuperscript{175}. Consequently, if an alcohol-induced cognitive disorder is suspected or diagnosed - particularly combined with alcoholic liver disease or nutritional deficiencies - management in a hospital setting is preferable to outpatient management in order to obtain definite abstinence (EC).

Treatment must be tailored to the individual and be for a duration appropriate to the severity of the cognitive deficit (EC).

**PSYCHIATRIC COMORBIDITIES**

The presence of depression symptoms - sometimes severe - is often observed in patients presenting non-stabilised alcohol misuse. In the majority of cases, these symptoms quickly disappear after detoxification or a significant reduction in alcohol use\textsuperscript{176} (level of evidence 2). Consequently, the introduction of an antidepressant therapy should only be considered after psychiatric reassessment of a patient in remission - i.e. one who has abstained or been drinking at a low-risk level for 2 to 4 weeks (grade B). At the present time, no particular antidepressant treatment appears to have been shown to be better than any other in this specific population\textsuperscript{177} (level of evidence 1).

Severe symptoms of depression may be an indication for medically-managed detoxification in a residential setting (EC).

Alcohol misuse frequently causes symptoms of anxiety, which are sometimes severe. In this case too, symptoms disappear - or often improve - following detoxification or a marked reduction in alcohol use (level of evidence 2)\textsuperscript{178}. As with depression symptoms, medicinal treatment of the anxiety disorder using antidepressant therapy should only be considered after psychiatric reassessment of a patient in remission - i.e. one who has abstained or been drinking at a low-risk level for 2 to 4 weeks (grade B).

**CONCOMITANT ADDICTIONS**

The presence of concomitant addictions systematically requires a global management programme incorporating all substances, including smoking.

In the event of medically-managed detoxification, quitting smoking at the same time reduces the subsequent alcohol relapse rate\textsuperscript{179} (level of evidence 2). It is therefore recommended that a smoking cessation approach be encouraged and that pharmacological assistance be systematically offered to smokers when they are giving up alcohol, in either a hospital or an outpatient setting (grade B).

**SOCIAL AND JUDICIAL PROBLEMS**

Medically-assisted alcohol withdrawal in homeless people should preferably be carried out in hospital, with the aim of monitoring and identifying any somatic or psychiatric comorbidities. This requires prior social care and finding an accommodation for the patient being discharge from hospital (EC).
Alcohol misuse: screening, diagnosis and treatment

In the event of major social vulnerability, priority should be given to a goal of abstinence. However, this goal is often too far beyond these individuals' capacities given the context in which they have been living for a long period. Support to help them reduce their drinking must promote access to care in all areas of health and, possibly, prepare for subsequent abstinence (EC). The setting up of aftercare should be considered.

Although the use of alcohol in prison is theoretically prohibited, misuse among prisoners is very common\(^\text{180}\) (level of evidence 3), and their access to addiction treatments in addiction treatment, support and prevention centres run by prisons (CSAPA and CSAPA-Prison) or regional medical and psychological services (SMPR) should be promoted (grade C).

In the event of medically-assisted withdrawal in a patient with contraindications to outpatient withdrawal, as a precaution, it is recommended that the withdrawal be carried out during hospitalisation in an inter-regional secure hospital unit (UHSI) (EC).

With respect to people receiving addiction treatments in the context of a compulsory treatment order, the ethical obligation to respect medical confidentiality requires that treatments remain focused on the patient and his/her personal goals (EC).

**RECOMMENDATIONS**

16.1. Any woman of childbearing age misusing alcohol should be provided with specific information concerning the issues related to her misuse and her treatment if she becomes pregnant (EC).

16.2. Abstinence throughout pregnancy is recommended (EC).

16.3. A pregnancy in a woman who misuses alcohol is an addiction emergency requiring her to stop misusing as soon as possible (grade A).

In the event of remission, with misuse replaced by low-risk alcohol use before the pregnancy, the treatment goals should be modified to encourage abstinence (EC).

16.4. In the event of medically-assisted withdrawal during pregnancy, the use of benzodiazepines is recommended (grade B). If there is a major risk that the woman will start drinking again after withdrawal, the possibility of long-term hospital admission to protect the foetus should be considered, if possible in a mother-and-baby unit (EC).

16.5. As a precaution, it is recommended that no relapse prevention treatments be initiated in pregnant or breastfeeding women (EC).

In the event of a pregnancy occurring in a patient obviously stabilised by pharmacological treatment, the continuation of this treatment should be considered on a case-by-case basis, weighing up the benefit/risk ratio, following multidisciplinary consultation (EC). Treatment with disulfiram should be stopped, however, due to the unknown risks on the foetus (EC).

16.6. Children and adolescents who misuse alcohol should preferably be referred to a specialist service (such as ‘young drinkers’ counselling) or specific hospitalisation, separate from adults (EC).
16.7. In children and adolescents misusing alcohol, a psychiatric assessment is recommended (grade C); routine investigation to identify the presence of any psychiatric and addiction problems in the parents is also recommended (grade C).

16.8. Treatment of alcohol misuse differs little between the elderly and younger adult patients. The specific features of treatment in the elderly are a more systematic use of residential detoxification programmes in patients over the age of 75, the use of shorter acting benzodiazepines (oxazepam, lorazepam) in the event of medical treatment for withdrawal syndrome, and at initial doses 30 to 50% lower than in younger adults. One of the specific aims of social management is to combat isolation.

16.9. Patients who misuse alcohol and have organic complications must be offered coordinated care, involving an addiction specialist, the concerned specialist and their own general practitioner (EC).

16.10. In the event of alcohol misuse complicated by liver cirrhosis, pancreatitis, cognitive disorders, ataxia, peripheral neuropathy, alcoholic cardiomyopathy, an alcohol-related cancer or other chronic somatic complications related to alcohol, a goal of abstinence should be preferred (EC).

16.11. A diagnosis of a major depressive episode and the introduction of an antidepressant should only be considered following remission of the misuse, i.e. abstinence or low-risk use for 2 to 4 weeks (grade B).

16.12. It is recommended that a smoking cessation approach be encouraged and that pharmacological assistance be systematically offered to smokers when they are giving up alcohol, in either a hospital or an outpatient setting (grade B). It is recommended that the concomitant management of any other addiction or substance misuse observed in a patient be offered (EC).

16.13. Medically-assisted alcohol withdrawal in a homeless person must be carried out in hospital (grade C). It is essential that social care be organised prior to withdrawal.

16.14. In the event of major social vulnerability, priority should be given to a goal of abstinence. If a drinking reduction programme is temporarily implemented, it must be designed to promote access to care and prepare for subsequent abstinence (EC).

16.15. Alcohol misuse treatment for prisoners should be delivered in addiction treatment, support and prevention centres in the prison environment (CSAPA) or by regional medical and psychological services (SMPR) (EC). In the event of medically-managed detoxification in a prisoner with contraindications to outpatient detoxification, this should ideally be carried out in an inter-regional secure hospital unit (UHSI) (EC).

16.16. With respect to people receiving an addiction treatment in the context of a compulsory treatment order, the ethical obligation to respect medical confidentiality requires that the treatment remains focused on the patient and his/her personal goals (EC).
Critical situations that can be encountered in the field of alcohol misuse and dependence include a variety of situations in which the consequences of drinking become difficult to tolerate or are suddenly perceived as such. They require a rapid response on the part of the primary care provider, often the subjects' own general practitioner or an outpatient specialist worker or social worker.

Several types of situations are possible.

- An acute somatic complication requires non-specific management, which may involve emergency hospital admission. It is important to screen for a risk of withdrawal syndrome in any patient admitted to an emergency department, in order to initiate appropriate preventive treatment. An epileptic seizure or delirium tremens may also trigger emergency hospitalisation. Any patient who misuses alcohol and is hospitalised for any reason - related or otherwise to his/her drinking - must benefit from at least a brief intervention delivered by the addiction liaison and care team (ELSA).  

- Acute alcohol intoxication may also require hospitalisation in an emergency department when it is pathological (inebriation with motor excitation, seizures or delusions, alcoholic coma) or causes an accident. This requires a short hospitalisation, generally in a very short-stay admissions unit, until normalisation of symptoms followed by an addiction liaison and care team intervention.

- An ‘urgent need for treatment’ is defined by a situation in which a subject - or his family - requests rapid or immediate treatment for his/her alcohol problem. This usually occurs following a critical situation: ultimatum or strong family or work pressure, drink-driving control, loss of home, children taken into care, or following a realisation of the extent of difficulties or somatic impact. It is very rarely a genuine emergency, but it is useful to address the demand quickly in order to take advantage of the subject’s motivation to start specific treatments. The first step is to assess the patient with tact and empathy. If he/she is very inebriated, diplomatically curtail the interview and suggest seeing the patient again soon, when they have not been drinking as much. In all cases, it is important to look for any immediate major risk - particularly of suicide - that may require emergency hospitalisation, even without consent. All types of options are possible following this assessment: see the patient again soon after an attempt to cut down drinking or initiation of an outpatient detoxification programme, referral to schedule specialist outpatient or hospital care, suggestion of contact with mutual support group, etc.). It is important to be able to offer reasonable time frames, meaning that a general practitioner must build up a network of specialist correspondents and see the patient again soon.
• Hetero-aggressive behaviour with acute agitation, endangering oneself or others in a context of severe inebriation sometimes places the general practitioner in the front line. In this event, it is necessary to call emergency services, who will send the police or fire service, often culminating in the patient's hospitalisation. While waiting for emergency services to arrive, it is important to try to maintain contact with the patient, managing his/her aggression and striving to remain as calm as possible, without taking any unnecessary risks.

• Some patients present severe and continuous levels of inebriation that place them in short-term danger, in both somatic and cognitive terms. This is usually combined with social isolation, sometimes placing social workers in the front line, anxious and depressive symptoms, anorexia and weight loss, with a low level or even non-existent demand for assistance on the part of the patient or, above all, a demand on the part of the family. In this case, a motivational approach is required to attempt to engage the patient in his/her treatment. Sometimes, exacerbation of the situation can lead to emergency calls (made by the family, a social worker) for a home visit, culminating in admission to an emergency department for 'deterioration of general condition', with marked weight loss and walking difficulties or general negligence. The issue of hospitalisation without the patient's consent is raised in rare cases. In the absence of this eventuality, patients are hospitalised in a medical department for treatment of somatic conditions and it is important to initiate an addiction treatment during the hospital stay with the help of the addiction liaison and care team.

• There are social critical situations: violence towards family, in particular conjugal violence or violence towards children, threats made to neighbours, risk of loss of home as a result of antisocial behaviour or non-payment of rent. The patient's demand may be either weak, or focused on the social aspects, or made under pressure from family or social services. Assessing the situation and the degree of urgency is difficult. It is important for the physician to identify social contacts (regional or municipal social welfare centre, etc.). The issue of reporting a danger to minors may also be raised. For social workers, it is important to identify a medical contact.

**RECOMMENDATIONS**

17.1. A critical situation requires rapid assessment by a primary service provider, enabling a prompt response and referral to the relevant care service. It is important to take advantage of times when a patient demands treatment to try to initiate a strategy, while being careful not to seek instant, superficial solutions (EC).

17.2. Recourse to emergency services should be rare and limited to severe somatic complications, suicidal crises or states of agitation with aggressive behaviour towards others or towards the patient his/herself (grade C).

17.3. Hospitalisation without the patient's consent must remain exceptional (grade C).

17.4. The possibility of alcohol misuse must be investigated in all hospitalised patients. The addiction liaison and care team should be consulted for any patient who misuses alcohol admitted to hospital or treated in the emergency department. Such patients must benefit, at least, from a brief intervention (grade A).
18
Place and role of family and environment (including working environment)

The social, family^{182} (level of evidence 1) or working environment^{183} (level of evidence 2) may constitute a significant vulnerability or protection factor for a subject with respect to alcohol. The environment can promote misuse as a result of the values conveyed, the usual level and frequency of alcohol use and the pressure it can exert on an individual's drinking behaviour. Conversely, the environment can play a protective role for the opposite reasons and via the support it may offer for any measures designed to improve lifestyle and in response to stressful life events. On the other hand, alcohol misuse can cause social, family or work complications and hence damage the environment's capacity to provide support^{184} (level of evidence 2).

For these reasons, any management of alcohol misuse requires an assessment of the subject's social, family and work situations (grade B) and should systematically aim to directly encourage family and friends to increase their support for reducing alcohol use or achieving abstinence. That is why it is recommended that the regular participation of a family member in consultations dedicated to alcohol misuse treatment be encouraged (EC).

If any problems are identified in one or more of these environmental components, management must incorporate a variety of solutions. These are related, in particular, to the proactive mobilisation of family, social and support group resources, available locally and in the usual living environment. They are part of a coordinated care path, promoting the continuity and synergy of players and their respective interventions.

In the event of major isolation, social vulnerability or homelessness, associating care with certain addiction aftercare and rehabilitation units (SSRA) and/or residential social rehabilitation centres (CHRS) improves the addiction and psychosocial prognosis^{185} (grade C). For these populations or these problems, the help of social and care workers must be sought when implementing these institutional solutions (grade C).

In the event of marital or family problems, the use of marital^{186} (level of evidence 3) or family (level of evidence 4) therapy sessions in adults appears to be effective in terms of improving the misuse prognosis. Consequently, these types of therapy are recommended when marital or family problems are identified (grade C).

In adolescents with the least severe forms of misuse, individual interventions have demonstrated better results than family interventions (level of evidence 1). Since systematic interventions have only been assessed in the most severe forms, it is recommended that the relevance of family therapy be assessed on a case-by-case basis, depending on the severity of the misuse and the presence of identified family problems (EC).

In the event of work-related problems associated with or promoting alcohol misuse, it may be important to protect the patient by signing him/her off work temporarily or implementing extended sick leave (EC). This decision is made by the general practitioner, if necessary after consulting the addiction specialist, who intervenes as joint care provider to the patient.
In the event of persistent problems at work, it is recommended that the occupational physician be associated in the patient's care - with the patient's consent - in order to assess the relevance of a return to work and any conditions to be met (EC).

RECOMMENDATIONS

18.1. Any alcohol misuse management process requires an assessment of the subject's social and family situations and work difficulties (grade B).

18.2. For subjects remaining socially integrated or retaining their family links, exchanges with care providers, requested by patients, their families or the professionals themselves, contribute to a therapeutic alliance. The patient remains the main actor and beneficiary of this alliance.

18.3. In the event of major isolation, social vulnerability or homelessness, it is recommended that institutional solutions be implemented - with the assistance of social workers if necessary -, such as addiction aftercare and rehabilitation units (SSRA) and/or residential social rehabilitation centres (CHRS) (grade C).

18.4. In the event of marital or family problems, the provision of psychotherapeutic support via marital or family therapy sessions is recommended in adults, since this can improve the addiction prognosis (grade C). In adolescents, family therapy should be implemented on a case-by-case basis, in the absence of any demonstrated effectiveness of systematic family therapy (EC).
What is the role of support groups for patients or people affected by alcohol use disorders?

Mutual support groups are involved at every stage in the management of people dependent on alcohol. In France, most of these groups focus on helping people to remain abstinent, with the exception of groups that campaign for the use of baclofen. However, this does not prevent them from welcoming anyone, irrespective of their situation with respect to alcohol. Alcoholics Anonymous (AA) is the only group in France to offer a highly structured recovery programme for anyone contacting the group. However, it does not offer social activities (apart from meetings), unlike other mutual support groups, for which one of the operating principles remains the organisation of a very diverse range of social activities (singing, music, sport, sightseeing visits, etc.), designed to recreate social links and build self-esteem.

Numerous studies suggest that being part of a mutual support group helps maintain long-term abstinence in willing patients\textsuperscript{187, 188} (grade C). A few studies have compared encouragement to take part in Alcoholics Anonymous' 12-step programme with other types of management and have not demonstrated any significant difference in alcohol use results\textsuperscript{189} (grade B). The most constant result of these studies is that people who regularly attend meetings have a better prognosis than those who do not - or only infrequently - attend these meetings (grade B). But these studies are marked by methodological biases related to participant selection.

The health professional must provide information on the existence of mutual support groups and facilitate participation in these if the patient requests this (EC). The Société Française d'Alcoologie proposes a leaflet presenting the main support groups (www.sfalcoologie.asso.fr). A direct meeting with a support group member during addiction treatment increases participation in mutual support groups\textsuperscript{190, 191} (grade C). Within addiction treatment structures, it is recommended that the on-site intervention of mutual support groups be facilitated, on condition that these support groups are well identified and incorporated into the local or national health and social system fabric (EC).

**RECOMMENDATIONS**

19.1. Regular participation in mutual support groups can improve the addiction treatment prognosis for certain patients (grade C). Patients must be informed about the existence of these support groups and access to them must be facilitated (grade C).

19.2. Within addiction treatment structures, it is recommended that the on-site intervention of mutual support groups be facilitated, on condition that these support groups are well identified and incorporated into the local or national health and social system fabric (EC).
III. KEY MESSAGES

The choice of treatment goal should take patient's preferences into consideration

The objective of treatment for alcohol misuse is primarily to improve the subject's quality of life. Hence, according to the subject's specific situation, therapeutic intervention should target physical and mental health, interpersonal, social and professional adaptation, the judicial situation, and other addictive or at-risk behaviours. This is why treatment generally initially targets a change in alcohol use and stabilisation. Treatment goals have been the subject of controversy, notably for alcohol-dependent individuals. While it is readily acknowledged, for non-dependent individuals, that simply reducing drinking below a risk level is usually satisfactory, abstinence has long been considered as the only treatment goal among dependent individuals. It has, however, been shown that certain dependent individuals could have a stable remission without abstinence, and that accepting the subject's preferences for the treatment goal (in contrast to it being imposed by healthcare professionals, from their own point of view) yields better results. Moreover, if healthcare professionals accept the moderation goal, this is less of a deterrent for individuals suffering from alcohol misuse and not inclined towards abstinence, when embarking upon a treatment programme. This is why the current guidelines differ clearly from the previous recommendations.

1. In the initial assessment, agree the goal of treatment with the service user.

2. Abstinence is the appropriate goal for most people with alcohol dependence and people who misuse alcohol and have significant psychiatric or physical comorbidity. If they are unwilling to consider a goal of abstinence, consider a supported harm reduction programme of care.

3. For harmful drinking or mild dependence, without significant comorbidities, and if there is adequate social support, consider a moderate level of drinking as the goal of treatment unless the service user prefers abstinence or there are other reasons for advising abstinence.

4. The goal for moderation should ideally aim not to exceed 21 standard units per week for males and 14 standard units per week for females. However, from the perspective of reducing harm, any target for reducing alcohol use is more acceptable than the status quo, and is worth highlighting. As certain patients can only make progress in stages, healthcare professionals are then led to adapt the goal for moderation according to the available resources.

The general practitioner is the pivot of the healthcare circuit

The general practitioner remains pivotal in terms of management. Allowing long-term support, the general practitioner is the first port of call for both patients and their families.

1. All general practitioners should have received training allowing them to detect alcohol misuse, and carry out brief intervention.
2. If the subject does not fall within the scope of brief intervention, or if the latter does not yield satisfactory results, more complex therapeutic interventions may be envisaged at the general practitioner's surgery (non-exhaustive list):
- moderately intensive psychosocial intervention, based on strengthening motivation for change, strengthening family support, facilitating the possibility of seeking help from mutual support groups, or compliance with pharmacological treatment;
- drug treatment for individuals not wishing to attempt abstinence, but wishing to reduce their alcohol use;
- prevention of withdrawal syndrome;
- drug treatment with a view to maintain abstinence or prevent relapse.

3. Certain therapeutic interventions are difficult to envisage in a general practice surgery. They concern patients suffering from very severe misuse, notably with severe physical dependence, somatic and psychiatric comorbidities, or in an extremely precarious social situation. These interventions may require more experienced multidisciplinary teams, or teams equipped with residential resources.

4. Recourse to specialist intervention will also be envisaged by general practitioners if they have not received training in - or feel unable to offer - these interventions beyond brief intervention, or if the latter has failed.

5. Specific regional characteristics in terms of the healthcare system determine the patient’s healthcare circuit.
Alcohol misuse: screening, diagnosis and treatment

Synopsis for the general practitioner

<table>
<thead>
<tr>
<th>I know low-risk drinking limits</th>
<th>I know how to explain a standard unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Never more than 4 units at a time for occasional use.</td>
<td>A standard drink or unit is defined as 10 grams of pure alcohol, equivalent to approximately 10 cl of wine, 25 cl of 5% ABV beer, or 5 cl of 40% ABV spirits.</td>
</tr>
<tr>
<td>▪ No more than 21 units/week for regular use in males.</td>
<td></td>
</tr>
<tr>
<td>▪ No more than 14 units/week in females.</td>
<td></td>
</tr>
</tbody>
</table>

Packaging equivalences (standard unit)

<table>
<thead>
<tr>
<th>25 cl beer</th>
<th>33 cl beer</th>
<th>50 cl beer</th>
<th>Wine 7 units</th>
<th>Champagne 7 units</th>
<th>Port 12 units</th>
<th>Whisky 22 units</th>
<th>Brandy/Liqueur 22 units</th>
<th>Vodka 25 units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 unit</td>
<td>1.5 units</td>
<td>2 units</td>
<td>7 units</td>
<td>7 units</td>
<td>12 units</td>
<td>22 units</td>
<td>22 units</td>
<td>25 units</td>
</tr>
</tbody>
</table>

I recognise alcohol misuse

▪ At-risk use:
  ✓ Occasionally or regularly exceeds thresholds, without any physical, psychological or social damage for the time being;
  ✓ Alcohol use below thresholds but in specific at-risk situations (minors, pregnant women, elderly people, driving, incompatible medications or medical conditions, work or sports activities, etc.).
▪ Harmful use: physical, psychological or social damage, but without factors indicative of dependence.
▪ Dependence: powerful urge to drink alcohol, loss of control of drinking or continued drinking in dangerous situations.

I dare to talk about it

▪ I adopt an empathetic style when talking.
▪ I request the patient’s permission to discuss his/her alcohol use.
▪ I explore the patient’s ambivalence, questioning him/her about the positive and negative aspects of alcohol use.
▪ I assess the patient’s stated alcohol use, using the AUDIT-C questionnaire, for example.

I identify when?

▪ Routine and regular check-ups.
▪ Damage potentially related to alcohol.
▪ In the event of pregnancy (or desire to become pregnant).
▪ In the event of exposure/vulnerability (adolescence, very elderly, social vulnerability, psychiatric problems or other addictions).
▪ Medical conditions resistant to treatments.
▪ Medications incompatible with alcohol.
▪ Any negative physical, psychological or social change.

I periodically assess alcohol consumption (AUDIT-C)

Over the past year (number of points allocated in brackets):

▪ How often do you have a drink containing alcohol?
  □ Never (= 0) □ Once a month (= 1) □ 2 to 4 times a month (= 2) □ 2 to 3 times a week (= 3) □ 4 or more times a week (= 4)

▪ How many standard drinks containing alcohol do you have on a typical day when you are drinking alcohol?
  □ 1 or 2 (= 0) □ 3 or 4 (= 1) □ 5 or 6 (= 2) □ 7 to 9 (= 3) □ 10 or more (= 4)

▪ How often do you have 6 or more drinks on one occasion?
  □ Never (= 0) □ Less than once a month (= 1) □ Once a month (= 2) □ Once a week (= 3) □ Daily or almost daily (= 4)

→ Probable misuse: score ≥ 4 in men and ≥ 3 in women.
→ Probable dependence: score ≥ 10 in either gender.
Alcohol misuse: screening, diagnosis and treatment

Irrespective of the AUDIT-C score, I assess average daily alcohol consumption (DAC); I look for comorbidities

- Other substance use disorders and behavioural addictions.
- Alcohol-related physical conditions (liver disease, cancers, hypertension, etc.).
- Psychiatric illnesses.
- Social problems.

AUDIT-C ≥ 4 (men) or ≥ 3 (women) and < 10

No comorbidity  
Comorbidity

Action: motivational-type psychosocial intervention

Ideal objective: reduction  
Ideal objective: abstinence

Ultimate goal: ⬇️ risks  
Objective accepted by patient: reduction or abstinence  
Ultimate goal: ⬇️ damage

Action: psychosocial intervention for reduction or abstinence

Result: objective met?

No  
Yes  
Action: psychosocial follow-up

Psychosocial interventions are within my scope of expertise

Motivational aspects
- Alcohol consumption: emphasise personal choice.
- Focus on the patient’s concerns.
- Praise progress and small successes.
- You may express concern about the patient’s health and link this to alcohol use.
- Avoid labelling the patient (with a stigmatising diagnosis).
- Avoid forcing the patient’s resistance.

Reduction in alcohol use
- Stress the importance of keeping a drinking diary.
- Set an alcohol consumption objective together.
- Positively point out each success.
- Encourage seeking of concrete strategies to solve residual difficulties.

Maintenance of abstinence
- Positively point out each success.
- Seek and point out the benefits related to abstinence (health, social).
- Encourage seeking of concrete strategies to manage urges to drink alcohol.
- Highlight the importance of support from family or friends, direct the patient towards a mutual support group.
Alcohol misuse: screening, diagnosis and treatment

AUDIT-C ≥ 10

**Action:** motivational-type psychosocial intervention

**Ideal objective:** abstinence

**Objective accepted by patient:** reduction

**Action:** psychosocial intervention

**Result:** objective met?

Yes → **Action:** psychosocial follow-up

No → **Action:** medicinal products indicated in reduction: nalmefene or, as a second-line treatment, baclofen (temporary recommendation for use) + psychosocial follow-up

**Action:** referral for specialised treatment in the event of a complex situation or failure

Long-term objective when the patient is ready: abstinence

---

I know how to identify, prevent and treat alcohol withdrawal syndrome

<table>
<thead>
<tr>
<th>Warning signs</th>
<th>I provide support during withdrawal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Usually:</td>
</tr>
<tr>
<td>Tremor</td>
<td>• previous withdrawals have not caused any signs of alcohol withdrawal;</td>
</tr>
<tr>
<td>Sweating</td>
<td>• the patient is seen at the start of withdrawal and does not present any alcohol withdrawal syndrome</td>
</tr>
<tr>
<td>Agitation</td>
<td>➔ Straightforward monitoring without medication.</td>
</tr>
<tr>
<td>Fast pulse</td>
<td>If risk of withdrawal symptoms:</td>
</tr>
<tr>
<td>Raised blood pressure</td>
<td>Benzodiazepines as first-line therapy.</td>
</tr>
</tbody>
</table>
Alcohol misuse: screening, diagnosis and treatment

I know the indications for assisted withdrawal in a residential setting

- Delirium or seizures at the time of assessment or past history of them.
- Concomitant use of psychoactive substances at high doses, in particular daily doses, for long periods and with strong doses of benzodiazepines.
- Severity of withdrawal syndrome, failure of repeated outpatient withdrawal programmes.
- Severe or unstable comorbidities, age-related frailty.
- Urgent demand of family, low level of social support, vulnerable social situation.
- Pregnancy.

I know which first-line therapies to prescribe

- Vitamin B1, 500 mg per day for 1 to 3 weeks, depending on the severity of the misuse.

For outpatient withdrawal

- Aim for the lowest effective dose of benzodiazepines, over the shortest period. For example
  - Valium 10 (diazepam):
    - 1-1-1-1 on the 1st + 2nd days of alcohol withdrawal
    - 1-0-1 on the 3rd day
    - 0-0-1 on the 4th day
    - 0-0-1 on the 5th day
- Stay at home for the first 2 days.
- Do not drive during treatment.
- Consider a sick leave and see patient again soon to adjust dosage on basis of withdrawal symptoms or level of sedation.

For a reduction objective

- Secinco (naloxone):
  - 1 tab every day that the patient thinks there is a risk that he/she may drink.
  - Should ideally be taken 2 hours before the time when there is a risk of drinking, or in the morning.
  - 1 pack
- See patient again after 1 week, then after 2 weeks, then at least once monthly for at least 6 months.
- Prescription following an unsuccessful attempt to reduce drinking for 2 weeks, without medication.

For maintenance of abstinence

- Revia (naltrexone): 1 tab in the morning.
  - 1 pack of 28 tabs, renewable.
- In all cases, see the patient again at least once monthly. Treatment for 3 months.

- Actal (acamprosate): 2 tabs morning/noon/evening.
  - 1 pack of 180 tabs, renewable.
- In all cases, see the patient again at least once monthly. Treatment for 1 year.

Comply with the MA recommendations, in particular the contraindications, such as opioids (analgesics or substitution therapy) for example, with naltrexone and naloxone, and monitor the onset of any withdrawal symptoms or side effects in order to control them.

I know which second-line therapies to prescribe

- Esperal (disulfiram) in maintenance of abstinence: ½ to 1 tab in the morning. Never combine with alcohol. Treatment for 1 month, renewable. See the patient again every month.

Badifen in the maintenance of abstinence or reduction of alcohol consumption:

- It is mandatory to visit the website related to the temporary recommendation for use (TRU) https://www.trubadifen.org and register the patient.
- Carefully follow the website recommendations and produce a prescription for a maximum of 1 month of treatment, indicating “Off-label prescription”.
- Give the patient the monthly treatment certificate, which can be printed from the portal.
- Start with a ½ tablet of badifen 10 mg three times daily for 2 to 3 days, then ½ + ¼ + 1 (2-3 days), then ¼ + ¼ + 1 (2-3 days), then 1 + 1 + 1 (2-3 days), then increase by one tablet every 3 days until the onset of an effect of badifen.
- Above the dose of 120 mg/day, the prescriber must seek the opinion of a physician experienced in the treatment of alcohol dependence.
- If treatment is stopped, it must be withdrawn gradually (over 1 to 4 weeks, in stages of 10 to 15 mg every 2 days, for example).
APPENDIX 1. ABBREVIATIONS, ACRONYMS AND GLOSSARY

- **Abbreviations and acronyms**

  AA: Alcoholics Anonymous
  ALAT: Alanine aminotransferase
  ALD: *Affection de longue durée* (chronic condition) (see glossary)
  ALD: Alcoholic liver disease (see glossary)
  ANAES: *Agence nationale d'accréditation et d'évaluation en santé* (French national agency for health accreditation and evaluation) (no longer exists as a separate entity, having been incorporated into the *Haute Autorité de santé* -French Health Authority- in 2004)
  ANSM: *Agence nationale de sécurité du médicament et des produits de santé* (French national agency for the safety of medicines and healthcare products)
  ARPS: Alcohol-Related Problem Survey
  ASAT: Aspartate aminotransferase
  AUDIT: Alcohol Use Disorder Identification Test (see glossary)
  AWS: Alcohol withdrawal syndrome (see glossary)
  BZD: Benzodiazepines (see glossary)
  CBC: Complete blood count
  CDT: Carbohydrate deficient transferrin
  CHRS: *Centre d'hébergement et de réinsertion sociale* (French residential social rehabilitation centre) (see glossary)
  CIWA-Ar: Clinical Institute Withdrawal Assessment for alcohol (see glossary under ‘CIWA-Ar scale’)
  CMP: *Centre médico-psychologique* (French medical and psychological treatment centre)
  CPR: Clinical practice recommendations
  CSAPA: *Centre de soins, d'accompagnement et de prévention en addictologie* (French addiction treatment, support and prevention centre) (see glossary)
  DSM: Psychiatric classifications of the Diagnostic and Statistical Manual (see glossary)
  EC: Expert consensus (classification of level of evidence; see appendix 1. Working method)
  ELSA: *Equipe de liaison et de soins en addictologie* (French addiction liaison and care team) (see glossary)
  EMA: European Medicines Agency
  EUFAS: European Federation of Addiction Societies
  FAS: Foetal alcohol syndrome
  FASD: Foetal alcohol spectrum disorder
  GGT or Gamma GT: Gamma glutamyl transferase
  GHB: Gamma hydroxybutyrate
  GPR: Good practice recommendations
  HAS: *Haute Autorité de Santé* (French Health Authority)
  HCC: Hepatocellular carcinoma (see glossary)
  ICD: International classification of diseases (see glossary)
  INSERM: *Institut national de la santé et de la recherche médicale* (French national institute for health and medical research)
IUGR: Intrauterine growth restriction
IV: Intravenous
MA: Marketing authorisation (see glossary)
MCV: Mean corpuscular volume (of red blood cells)
MDPH: Maison départementale des personnes handicapées (French departmental centre for disabled people) (see glossary)
MoCA: Montreal Cognitive Assessment (see glossary)
NIAAA: National Institute on Alcohol Abuse and Alcoholism
NICE: National Institute for Health and Care Excellence (see glossary)
PT: Prothrombin time
SAU: Service d’accueil des urgences (French hospital emergency department)
SFA: Société Française d’Alcoologie (French Alcohol Studies Society)
SMPR: Service médico-psychologique régional (French regional medical and psychological treatment service)
SSRA: Soins de suite et de réadaptation addictologique (French addiction aftercare and rehabilitation unit)
TRU: Temporary recommendation for use (see glossary)
UHSI: Unité hospitalière sécurisée inter-régionale (French inter-regional secure hospital unit)
WHO: World Health Organisation.

Glossary

**Abstinence** (from a substance)
Temporary or permanent total absence of use of the substance. Abstinence may be primary (no previous experimentation of the substance) or secondary (past experimentation). Abstinence may be one of the treatment goals fixed at a given time by a person presenting substance misuse.

**Alcohol withdrawal** (symptoms, syndrome)
Set of symptoms belonging to a syndrome that occurs after stopping or suddenly reducing alcohol use in a dependent subject having previously developed cerebral neuroadaptive processes in response to alcohol. Alcohol withdrawal may be characterised by neurovegetative signs (sweating, tremor, tachycardia, hypertension) or neurocognitive signs (agitation, confusion, convulsions, delirium).

**Alcoholic liver disease (ALD)**
Alcohol-induced liver damage, characterised by specific histological, clinical and paraclinical features. The main types of damage are hepatic steatosis (fatty liver disease), liver cirrhosis, alcoholic hepatitis and hepatocellular carcinoma.

**ALD 30**
List of 30 chronic conditions (‘affections de longue durée’ or ALD in French) for which patients in France are exempted from any contribution to treatment costs.
Alcohol misuse: screening, diagnosis and treatment

**Antenatal consultations**
Antenatal consultations - of which there are 7 - are compulsory appointments for monitoring a woman's pregnancy. The first antenatal consultation must take place before the 14th week of pregnancy, with the following visits being carried out a rate of one per month. These consultations are carried out by a physician (gynaecologist/obstetrician, medical gynaecologist, general practitioner) or a midwife, who checks that the pregnancy is progressing properly and verifies foetal development.

**Assisted alcohol withdrawal** (treatment)
Medical prevention or treatment of alcohol withdrawal syndrome requiring a treatment protocol and specific monitoring.

**AUDIT and AUDIT C questionnaires**
The ‘Alcohol Use Disorder Identification Test’ (AUDIT) questionnaire, developed by the World Health Organisation, includes 10 items designed to detect at-risk or harmful alcohol use in the general population.
### Alcohol misuse: screening, diagnosis and treatment

Read questions as written. Record answers carefully. Begin the AUDIT by saying ‘Now i am going to ask you some questions about your use of alcoholic beverages during this past year.’ Explain what is meant by ‘alcoholic beverages’ by using local examples of beer, wine, vodka, etc. Code answers in terms of ‘standard drinks’. Place the correct answer number in the box at the right.

<table>
<thead>
<tr>
<th>Question</th>
<th>1. How often do you have a drink containing alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never [Skip to Qs 9-10]</td>
</tr>
<tr>
<td></td>
<td>(1) Monthly or less</td>
</tr>
<tr>
<td></td>
<td>(2) 2 to 4 times a month</td>
</tr>
<tr>
<td></td>
<td>(3) 2 to 3 times a week</td>
</tr>
<tr>
<td></td>
<td>(4) 4 or more times a week</td>
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<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) 1 or 2</td>
</tr>
<tr>
<td></td>
<td>(1) 3 or 4</td>
</tr>
<tr>
<td></td>
<td>(2) 5 or 6</td>
</tr>
<tr>
<td></td>
<td>(3) 7, 8, or 9</td>
</tr>
<tr>
<td></td>
<td>(4) 10 or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>3. How often do you have six or more drinks on one occasion?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) Less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) Less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>4. How often during the last year have you found that you were not able to stop drinking once you had started?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) Less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>9. Have you or someone else been injured as a result of your drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) No</td>
</tr>
<tr>
<td></td>
<td>(2) Yes, but not in the last year</td>
</tr>
<tr>
<td></td>
<td>(4) Yes, during the last year</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) Never</td>
</tr>
<tr>
<td></td>
<td>(1) Less than monthly</td>
</tr>
<tr>
<td></td>
<td>(2) Monthly</td>
</tr>
<tr>
<td></td>
<td>(3) Weekly</td>
</tr>
<tr>
<td></td>
<td>(4) Daily or almost daily</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(0) No</td>
</tr>
<tr>
<td></td>
<td>(2) Yes, but not in the last year</td>
</tr>
<tr>
<td></td>
<td>(4) Yes, during the last year</td>
</tr>
</tbody>
</table>

---

Record total of specific items here

*If total is greater than recommended cut-off, consult User’s Manual.*
The Audit-C contains the first three questions of the Alcohol Use Disorders Identification test (AUDIT). The Audit-C questionnaire scores are easy to calculate. The figure of the column corresponding to each response selected by the patient should be recorded by the physician in the last column on the right. All results should then be added and recorded in the ‘Total’ box.

### 1. How often do you have a drink containing alcohol?

<table>
<thead>
<tr>
<th></th>
<th>Never (0 point)</th>
<th>Monthly or less than monthly (1 point)</th>
<th>2 - 4 times/month (2 points)</th>
<th>2 - 3 times/week (3 points)</th>
<th>4 or more times a week (4 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2. How many standard drinks containing alcohol do you have on a typical day drinking?

<table>
<thead>
<tr>
<th></th>
<th>1 or 2 (0 point)</th>
<th>3 or 4 (1 point)</th>
<th>5 or 6 (2 points)</th>
<th>7 or 9 (3 points)</th>
<th>10 or more (4 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 3. How often do you have six or more drinks on one occasion?

<table>
<thead>
<tr>
<th></th>
<th>Never (0 point)</th>
<th>Less than monthly (1 point)</th>
<th>Monthly (2 points)</th>
<th>Weekly (3 points)</th>
<th>Daily or almost daily (4 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The first three questions of the AUDIT or AUDIT-C are used to detect at-risk use of alcohol. The following 7 questions of the AUDIT are used to detect harmful use.

**Behavioural addiction**

A behavioural addiction, or non-substance-related addiction, is characterised by the fact that a set of behaviours, not related to usage of a substance and initially a source of controlled satisfaction in the subject's life, become more and more intrusive to the point that they gradually cause negative social and medical consequences.

**Benzodiazepines**

Class of psychotropic substances used as medicinal products which act by simulating GABA-A brain receptors. Benzodiazepines are among the products used in the management of **assisted withdrawal** from alcohol.

**Binge Drinking**

Type of alcohol misuse characterised by drinking large quantities of alcohol over a limited period of time.

**Bipolar disorders** (affective disorders)

Bipolar disorders are psychiatric disorders characterised by pathological mood fluctuations. Several types of bipolar disorders have been described, the most characteristic being type I (alternating episodes of major depression and clearcut episodes of mania) and type 2 (alternating episodes of major depression and episodes of hypomania).

**Brief intervention**

Type of intervention usually appropriate to **primary care** settings and designed to achieve the following during the course of a single interview: 1) assess a subject's substance use with a view to detect misuse; 2) inform the subject of the risks related to misuse and define the appropriate drinking level depending on the situations; 3) stimulate the subject's motivation to change his/her drinking behaviour from then on.
**Centre de soins, d’accompagnement et de prévention en addictologie (CSAPA) (French addiction treatment, support and prevention centre)**
Addiction treatment, support and prevention centres, which are medical or sociomedical institutions specialising in the management of addiction problems, have existed since 2007.

**Centre d’hébergement et de réinsertion sociale (French residential social rehabilitation centre)**
Residential social rehabilitation centres are social care institutions responsible for taking in, sheltering and aiding the social and professional rehabilitation of socially excluded individuals.

**Cirrhosis (of the liver)**
Liver damage that may constitute progression of *alcoholic liver disease*. It is characterised by the development of irreversible fibrosis leading to progressive impairment of liver function and other possible complications, including *hepatocellular carcinoma* in particular.

**CIWA-Ar scale**
The ‘Clinical Institute Withdrawal Assessment for alcohol’ (CIWA-Ar) scale is an instrument used to measure the severity of *alcohol withdrawal* in the form of a score out of 67 points. The CIWA-Ar takes longer but is more complete and better scientifically validated than the *Cushman score*. 
<table>
<thead>
<tr>
<th>NAUSEA AND VOMITING</th>
<th>TACTILE DISTURBANCES</th>
<th>AUDITORY DISTURBANCES</th>
<th>VISUAL DISTURBANCES</th>
<th>ANXIETY</th>
<th>HEADACHE, FULLNESS IN HEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>-- Ask 'Do you feel sick to your stomach? Have you vomited?' Observation.</td>
<td>-- Ask 'Have you any itching, plits and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?' Observation.</td>
<td>-- Ask: 'Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?' Observation.</td>
<td>-- Ask: 'Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing thing you know are not there?' Observation.</td>
<td>-- Ask 'Do you feel nervous?' Observation.</td>
<td>-- Ask: 'Does your head feel different? Does it feel like there is a band around your head?' Do not rate for dizziness or light headedness. Otherwise, rate severity.</td>
</tr>
<tr>
<td>0 no nausea and no vomiting</td>
<td>0 none</td>
<td>0 not present</td>
<td>0 not present</td>
<td>0 no anxiety, at ease</td>
<td>0 not present</td>
</tr>
<tr>
<td>1 mild nausea with no vomiting</td>
<td>1 very mild itching, pins and needles, burning or numbness</td>
<td>1 very mild harshness or ability to frighten</td>
<td>1 very mild harshness or ability to frighten</td>
<td>1 mild anxious</td>
<td>1 very mild</td>
</tr>
<tr>
<td>2</td>
<td>2 mild itching, pins and needles, burning or numbness</td>
<td>2 mild harshness or ability to frighten</td>
<td>2 mild harshness or ability to frighten</td>
<td>3 moderately anxious, or guarded, so anxiety is inferred</td>
<td>3 moderate</td>
</tr>
<tr>
<td>3</td>
<td>3 moderate itching, pins and needles, burning or numbness</td>
<td>3 moderate harshness or ability to frighten</td>
<td>3 moderate harshness or ability to frighten</td>
<td>4 moderately severe</td>
<td>4 moderately severe</td>
</tr>
<tr>
<td>4 intermittent nausea with dry heaves</td>
<td>4 moderately severe hallucinations</td>
<td>4 moderately severe hallucinations</td>
<td>4 moderately severe hallucinations</td>
<td>5 severe</td>
<td>5 severe</td>
</tr>
<tr>
<td>5</td>
<td>5 severe hallucinations</td>
<td>5 severe hallucinations</td>
<td>5 severe hallucinations</td>
<td>6 extremely severe</td>
<td>6 extremely severe</td>
</tr>
<tr>
<td>6</td>
<td>6 extremely severe hallucinations</td>
<td>6 extremely severe hallucinations</td>
<td>6 extremely severe hallucinations</td>
<td>7 continuous hallucinations</td>
<td>7 continuous hallucinations</td>
</tr>
<tr>
<td>7 constant nausea, frequent dry heaves and vomiting</td>
<td>7 continuous hallucinations</td>
<td>7 continuous hallucinations</td>
<td>7 continuous hallucinations</td>
<td>7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</td>
<td>7 extremely severe</td>
</tr>
</tbody>
</table>
Cochrane (Evaluation)
The ‘Cochrane Collaboration’ is an international, independent, non-profit organisation that aims to provide high-quality, up-to-date information related to the efficacy of healthcare interventions. More information: http://www.cochrane.fr.

Cognitive behavioural (therapy, interview, technique, approach, components)
Heterogeneous group of psychotherapy methods assuming that some disorders are the result of cognitive and behavioural patterns that can be modified by repeated training of the subject.

Compulsory treatment order
A compulsory treatment order is one of the three measures that exist in France concerning treatments ordered by a magistrate, along with a therapeutic injunction and a care injunction. The compulsory treatment order is pronounced by a judge, who orders the subject to ‘undergo medical examination, treatment or care measures’ (Art 132-45 of the French Penal Code). Enforcement of the compulsory treatment order is ensured by the sentencing judge and the prison rehabilitation and probation services (SPIP). In contrast with a therapeutic injunction, the treatment is managed solely by the healthcare professional met by the subject.

Coping
English term.
The set of processes that an individual adopts in response to a stressful event in order to control or reduce its impact on his/her physical and psychological well-being.

Craving
A conscious and intense desire to consume a substance. Craving is one of the main subjective symptoms of addictions.

Cushman score
The Cushman score is a clinical instrument used to measure the severity of alcohol withdrawal in the form of a score out of 21 points. Translated into French by B. Rueff, it is sometimes called the Rueff score in France. The Cushman score is quicker to perform but less complete and less scientifically validated than the CIWA-A scale.
Alcohol misuse: screening, diagnosis and treatment

<table>
<thead>
<tr>
<th>Points</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart rate</td>
<td>&lt; 80</td>
<td>81 to 100</td>
<td>101 to 120</td>
<td>&gt; 120</td>
</tr>
<tr>
<td>Systolic blood pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 to 30 years</td>
<td>&lt; 125</td>
<td>126 - 135</td>
<td>136 - 145</td>
<td>&gt; 145</td>
</tr>
<tr>
<td>31 to 50 years</td>
<td>&lt; 135</td>
<td>136 - 145</td>
<td>146 - 155</td>
<td>&gt; 155</td>
</tr>
<tr>
<td>&gt; 50 years</td>
<td>&lt; 145</td>
<td>146 - 155</td>
<td>156 - 165</td>
<td>&gt; 165</td>
</tr>
<tr>
<td>Respiratory rate</td>
<td>&lt; 16</td>
<td>16 to 25</td>
<td>26 to 35</td>
<td>&gt; 35</td>
</tr>
<tr>
<td>Tremor</td>
<td>0</td>
<td>Hand</td>
<td>Upper limb</td>
<td>Generalised</td>
</tr>
<tr>
<td>Sweating</td>
<td>0</td>
<td>Palms</td>
<td>Palms and forehead</td>
<td>Generalised</td>
</tr>
<tr>
<td>Agitation</td>
<td>0</td>
<td>Slight</td>
<td>Generalised and controllable</td>
<td>Generalised and uncontrollable</td>
</tr>
<tr>
<td>Sensory disturbances</td>
<td>0</td>
<td>Phonophobia</td>
<td>Photophobia</td>
<td>Pruritus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hallucinations with insight</td>
<td>Hallucinations without insight</td>
<td></td>
</tr>
</tbody>
</table>

Score < 7: clinical condition controlled
Score 7 to 14: moderate withdrawal
Score > 14: severe withdrawal

**Dependence** (on a substance)
The most severe stage of misuse in the categorical classifications for substance use, characterised by the subject’s inability to stop using the substance (DSM-IV and ICD-10).

**Detection**
Process of detecting a disorder from a set of data resulting from interview, clinical assessment or paraclinical tests on a patient. In contrast with screening, detection is not standardised.

**DSM-IV**
Fourth version of the Diagnostic and Statistical Manual (DSM), American psychiatric classification valid from 1994 to January 2013. DSM-IV proposed a categorical classification of substance-related disorders in two stages of increasing severity: abuse and dependence.

**DSM-5**
Fifth version of the Diagnostic and Statistical Manual (DSM), American psychiatric classification applied since January 2013. DSM-5 proposes a dimensional approach to substance use disorders.

**Early antenatal interview**
Interview offered, but not compulsory, after a declaration of pregnancy, often during the fourth month. An early antenatal interview is conducted by a midwife or physician (general practitioner, gynaecologist/obstetrician). It is an opportunity for discussion, listening to the patient, detection, referral not only for medical problems, but also psychological and social ones that might interfere with the pregnancy, delivery and post-partum period. The objective is to be able to offer management methods at the earliest possible stage. Psychoactive substance use is covered in this interview.
**Equipe de liaison et de soins en addictologie (French addiction liaison and care team) (ELSA)**

Multidisciplinary team intervening primarily in medical, surgical and emergency departments. Their main missions are to facilitate access to treatment for individuals with addiction problems and raise health personnel awareness of these types of conditions.

**Executive functions**

Set of cognitive functions enabling an appropriate immediate response to the context. Executive functions include capacities such as anticipation, planning, organisation, problem-solving, logical reasoning, working memory or selective attention.

**Experimentation (of a substance)**

Term indicating that a person has consumed a substance at least once during his/her lifetime.

**FACE questionnaire**

The FACE questionnaire is a French 5-item clinical instrument based on a simplified version of the AUDIT questionnaire, and which can be helpful to detect harmful use in the general population. Misuse is suspected for a score greater than or equal to 5 in males, and 4 in females.

The FACE questionnaire of the ‘Boire moins c’est mieux’ (Drinking less is better) programme

The following five questions should be asked in their original format and rated according to the patient’s spontaneous responses. In the event of hesitation, suggest types of responses, asking the patient to select ‘the answer that is the closest to reality’.

The first two questions refer to the last 12 months.

<table>
<thead>
<tr>
<th>Score</th>
<th>1/ How often do you drink alcohol-containing beverages?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Never</td>
</tr>
<tr>
<td>1</td>
<td>once a month or less</td>
</tr>
<tr>
<td>2</td>
<td>2 to 4 times per month</td>
</tr>
<tr>
<td>3</td>
<td>2 to 3 times per week</td>
</tr>
<tr>
<td>4</td>
<td>4 or more times per week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>2/ How many standard drinks to you consume in an ordinary day when you drink alcohol?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>One or two</td>
</tr>
<tr>
<td>1</td>
<td>three or four</td>
</tr>
<tr>
<td>2</td>
<td>five or six</td>
</tr>
<tr>
<td>3</td>
<td>seven to nine</td>
</tr>
<tr>
<td>4</td>
<td>ten or more</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>3/ Have your friends or family ever made comments on your alcohol consumption?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>4/ Have you ever consumed alcohol in the morning to make you feel better?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>5/ Do you ever drink to the point where you no longer remember what you said or did?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No</td>
</tr>
<tr>
<td>4</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Total
Alcohol misuse: screening, diagnosis and treatment

Interpretation:
→ For women, a score of 4 or higher indicates dangerous consumption.
→ For men, a score of 5 or higher indicates dangerous consumption.
→ A score of 9 or higher indicates addiction for women and men.

**Hepatocellular carcinoma (HCC)**
Primary cancer of the liver usually developing in patients with prior liver cirrhosis.

**ICD-10**
Tenth version of the international classification of diseases (ICD), a public health classification system that has been applied since 2006. ICD-10 proposes a categorical approach to the impact of substance misuse, by progressive level of severity, harmful use and dependence: a diagnosis of harmful use is no longer authorised if the subject presents a dependence syndrome.

**Level of evidence**
Level of scientific validity of a result or piece of data. Numerous different international classifications for levels of evidence exist. In France, the reference tool is the one published by the Haute Autorité de Santé in 2000, defining five levels of evidence of decreasing validity (HAS, 2000): 1 (randomised controlled trials with methodologically sound results); 2 (properly conducted non-randomised controlled trials); 3 (properly conducted, non-controlled prospective trials, such as cohort follow-ups); 4 (case-control studies or controlled trials presenting biases); 5 (highly biased study, case series, clinical case reports). For more information, refer to the table on page 111: ‘Level of evidence classification method’.

**Maison départementale des personnes handicapées (French departmental centre for disabled people) (MDPH)**
The departmental centre for disabled people is a departmental structure used as a contact point for people with disabilities or who consider themselves to be disabled. The role of the MDPH is to handle applications for recognition of disabled worker status (RQTH), which are submitted using a specific form (cerfa 13788 01). If RQTH status is granted, the MDPH sets up a multidisciplinary team responsible, in particular, for assessing the compensation requirements of the disabled person and proposing a personalised disability compensation plan.

**Marketing authorisation (MA)**
A marketing authorisation is an authorisation officially granted to a pharmaceutical company for a medicinal product to be marketed and prescribed in a specific indication and at defined doses. In France, an MA may be granted by the Agence Nationale de Sécurité du Médicament et des produits de santé (ANSM), or directly on a European level by the European Medicines Agency (EMA). Any use of a medicinal product outside its indication and/or authorised doses is described as ‘off-label’.

**Medical file**
A physician's archive of physical or computer documents (clinical notes, medical correspondence, paraclinical test results) assembling the main information relative to a
person's health during the course of monitoring carried out by the physician. The content and proper management of the medical file are important in medical and legal terms.

**Misuse** (of a substance)
Misuse includes all types of use that cause negative consequences and those at risk of causing them. 
By definition, alcohol misuse includes at-risk use and alcohol use disorders.

**MoCA**
The ‘Montreal Cognitive Assessment’ (MoCA) is a screening instrument for moderate cognitive disturbances not specific to a disease type, performed on the basis of a score calculated out of a possible 30 points. The MoCA instrument has been validated to screen patients with substance use disorders for cognitive disorders.

**Motivational** (interview, therapy, approach, intervention)
A directive, patient-focused intervention style, based on exploration and resolution of ambivalence, designed to facilitate behaviour change.

**Neuropsychological impairments**
Impairments identified using specific measuring instruments or paraclinical tests affecting basic cognitive functions, such as language, memory, executive functions, management of social relationships.

**NICE**

**Open/closed question**
An open question is a question that does not lead to a set answer and therefore gives the person being asked the question the opportunity to express him/herself in his or her own words.
The opposite of this is a closed question, in which the subject can only give a set answer (for example ‘yes’ or ‘no’).

**Pancreatitis**
Inflammation of the pancreas consecutive to alcohol misuse, which may develop suddenly (acute pancreatitis) or more gradually (chronic pancreatitis). In acute cases, an increase in the concentration of certain pancreatic enzymes in the blood is observed (blood amylase, blood lipase).

**Perinatal medicine**
Prevention and specific care covering the period from the 26th week of pregnancy to the eighth day after delivery.
Personality disorders
Personality disorders are a heterogeneous category of psychiatric disorders characterised by maladaptive relational, emotional or cognitive functioning, leading to lasting social and behavioural problems.

PHARES
Video programme offering cognitive behavioural help to alcohol-dependent patients who have stopped drinking and are motivated to maintain their abstinence.

Pre-conception consultation
Non-compulsory consultation with a general practitioner, medical gynaecologist, gynaecologist/obstetrician or midwife, by a woman or couple wishing to undergo a health check with a view to a potential pregnancy. A pre-conception consultation is an ideal opportunity for detection, education and prevention.

Primary care
‘Primary care’ or ‘primary health care’ covers all first-stop health services that must be easily accessible and capable of meeting the majority of individual health needs, as part of a long-term relationship with individuals, families and the community. Primary care therefore includes prevention, screening, immediate management of the simplest situations or appropriate referral for complex situations, dispensing medicinal products.

Reduction in alcohol use
A reduction in alcohol use is one of the possible goals that a subject presenting alcohol misuse may opt for. Ideally, the reduction should aim not to exceed the thresholds for at-risk use, or even to achieve abstinence. However, any lasting reduction in alcohol use has a significant impact on the mortality risk and should be preferred to no change at all.

Relapse
Relapse after detoxification was formerly defined as having the first drink. More recently, relapse has been defined by the resumption of high-level use (greater than or equal to 5 units/day on a single occasion for males aged under 65 years; greater than or equal to 4 units/day for males aged over 65 years and females). It should be noted that these levels were defined by the US Food and Drug Administration, with a unit corresponding to 14 grams of alcohol, whereas a standard unit in France corresponds to 10 grams.

Residential (treatments, care)
Patient treatment within a fully residential structure.

Screening
Presumptive identification of a diagnosis using a standardised method (questionnaire, paraclinical test). Screening methods may be used following detection of suggestive signs, or directly in specific prevention situations or in the event of identified vulnerability factors.

Silent assumption
Used in cognitive therapy, this is a cognitive dysfunction, also known as a ‘cognitive pattern’ or ‘dysfunctional attitude’.
Silent assumptions are deeply held fundamental attitudes - generally unconscious - that underlie negative thoughts, themselves a source of (excessively) strong negative emotions. We can discover our silent assumptions by asking ourselves the question: ‘So what? If it's true in what way does it bother me?’.

**Soins de suite et de réadaptation addictologique (French addiction aftercare and rehabilitation units)**
Medical or sociomedical structures designed to prevent or reduce the functional, physical, cognitive, psychological or social consequences of deficiencies or limited capacities of patients and to promote their rehabilitation and reintegration.

**Standard unit (of alcohol)**
Reference unit to measure a subject's alcohol consumption. In France, a standard unit contains 10 grams of alcohol. The number of standard units consumed by a subject can be calculated using the formula: *quantity of alcoholic beverage drunk (ml) x alcohol percentage of the beverage x alcohol density (0.8).*

**Temporary recommendation for use (TRU)**
A ‘temporary recommendation for use’ is an official, exceptional measure granted by the *Agence nationale de sécurité du médicament et des produits de santé* (ANSM), governing the off-label prescription of a medicinal product awaiting an official MA. The objective of TRUs is to ensure the safe use of the medicinal products via implementation of patient monitoring organised by the concerned pharmaceutical companies. This is a temporary measure that may not exceed 3 years.

**Therapeutic injunction**
A therapeutic injunction is one of the three measures that exist in France concerning treatments ordered by a magistrate, along with a compulsory treatment order and a care injunction. A therapeutic injunction applies specifically to users of narcotics or alcohol (Art L 3413-1 of the French Public Health Code). It is pronounced by a prosecutor during the police investigation or by a judge during or after the judicial procedure. In contrast with a compulsory treatment order, the treatment is coordinated by a contact physician who refers the subject to an appropriate treatment structure.

**Transaminases**
Enzymes partially secreted by the liver that may be present in abnormal quantities in the blood in the event of liver damage, particularly in the case of *alcoholic liver disease*. There are two types of transaminases: alanine aminotransferases (ALAT) and aspartate aminotransferases (ASAT).

**Use disorders (of a substance)**
Term used by the Diagnostic and Statistical Manual (DSM) psychiatric classification system to designate types of substance use resulting in a number of social or medical consequences on the subject's current life.
**Varices**
Permanent dilation of veins. Oesophageal and gastric varices are a sign of cirrhosis resulting from a blood flow blockage in the liver with the establishment of an alternative network.

**Wernicke's encephalopathy**
Neurological disorder attributed to a thiamine deficiency and occurring, in particular, following sudden withdrawal of alcohol and carbohydrate intake. It is initially characterised by the development of balance problems (ataxia with nystagmus), oculomotor paralysis and confusion (Wernicke's syndrome). It may progress to an irreversible state characterised by short-term memory impairment, false memories and confabulation (Korsakoff’s syndrome).
APPENDIX 2. LABORATORY TESTS AND ALCOHOL MISUSE: OVERVIEW

Biological markers are widely used in the detection, assessment and monitoring of subjects with alcohol use disorders.

**Detection and monitoring of people who misuse alcohol**

A number of biological markers have been tested with a view to detecting and monitoring people who misuse alcohol. Today, three are widely used while the others are still experimental. These three biological markers are useful for identifying chronic excessive alcohol use. They are Gamma-Glutamyl Transferase (GGT), Mean Corpuscular Volume (MCV) and Carbohydrate Deficient Transferrin (CDT). None of these markers provide an indication of the level of severity of the drinking behaviour.

**Gamma Glutamyl Transferase (GGT)**

Gamma-Glutamyl Transferase is an enzyme responsible for amino acid transport in the cell membranes (in particular cysteine). It is present in numerous different tissues and organs: kidney, liver, heart, pancreas, bile ducts, etc.

It is mainly the hepatic fraction of GGT that is measured. The measurement is quick, inexpensive and accurate.

Its normal value is generally <50 IU/l in men and <40 IU/l in women. An elevation in GGT generally occurs after around two weeks of regular excessive intake (more than 60 g of pure alcohol per day). However, this is not the case in people under the age of 30, in whom GGT is particularly insensitive.

If an individual cuts down on, or stops, drinking the level falls by around a half every two weeks approximately. GGT is not a very sensitive marker and its specificity is not very high (approximately 60% specificity) because numerous other causes apart from alcohol can contribute to its elevation, such as obesity, diabetes, enzyme-inducing medicinal products and any liver disease causing cholestasis. There is no between-individual comparison of GGT values, but a good level of within-individual correlation.

It should be remembered that GGT is not very useful for detecting alcohol problems in a non-targeted population and that its value lies in the monitoring of its evolution in patients during the drinking reduction or abstinence maintenance phase, as an additional element to clinical assessment.

**Carbohydrate Deficient Transferrin (CDT)**

Transferrin is the substance that transports iron. It exists in several isoforms depending on the number of carbohydrate nuclei that are associated with it. When 60 g or more of alcohol per day is drunk for at least 10 days, the fraction of carbohydrate-deficient transferrin (CDT) increases. Its elimination half-life is around 2 weeks. CDT has a sensitivity equivalent to that of GGT but a generally greater specificity (approximately 80 to 90%). Other causes of elevated CDT are pregnancy, congenital abnormalities affecting certain glycoproteins, genetic variants of transferrin, and certain forms of severe liver disease. The assay is still expensive and relatively difficult to perform.

Combination with GGT increases its sensitivity (up to 80%).
Mean Corpuscular Volume (MCV)
An elevation in MCV develops after around 2 months at least of regular excessive alcohol use. A return to normal volume is generally very slow, taking around 3 months following a reduction in alcohol use due to the half-life of red cells. The sensitivity of MCV is poor (30 to 40%) and its specificity much higher (90%). The GGT-MCV combination has a sensitivity of around 70% to 80%.

In practice, these markers can be used in addition to clinical assessment in order to detect regular excessive alcohol use, monitor therapeutic management and use objective instruments to talk about alcohol use in an ambivalent patient. They must not become a main issue in the doctor-patient relationship.
APPENDIX 3. ALCOHOL TREATMENT SYSTEMS AND SERVICES IN FRANCE

Specialised alcohol abuse treatment structures can be outpatient or residential. Outpatient treatment can take place in different places depending on the severity of the abuse: patient consultations with a general practitioner, psychiatrist or addiction specialist, multidisciplinary consultations in a Centre de soins, d’accompagnement et de prévention en addictologie (CSAPAs, or national treatment and prevention centres for addiction) or a Centre Médico Psychologique (CMP, or medical and psychology centre), home visits by a nurse, social worker or general practitioner and hospital or outpatient treatment.

Residential treatment involves 24/7 management in a structure that provides housing and treatment for a duration varying from a few days to several months. It should be noted that the general practitioner referring patients to such specialised structures may encounter significant delays in treatment that can be difficult to manage.

1/ National treatment and prevention centres for addiction (CSAPAs)

CSAPAs have different missions:
- Manage the alcohol abuser or help the abuser's family or friends. This involves counselling, establishing initial contact to create the basis of a relationship and providing first-line attention to requests and needs.
- Inform the patient or his/her family and friends in compliance with the rules of ethics and confidentiality. This may be information on the patient's rights or treatment methods.
- Provide a medical, psychological and social evaluation of the patient and/or his/her family/friends to propose the most suitable treatment and support for his/her needs.
- Referrals: anyone seen in a CSAPA must be offered treatment organised by the Centre or be referred to a structure that is better adapted to his/her needs (practitioner, psychiatry, hospital, other medico-social structure).
- Provide medical treatment with a pharmacological component.
- Provide psychological treatment in addition to the medical evaluation. It includes psychological follow-up and appropriate support to the situation and personal needs.
- Provide social and training support to help the patient gain, or return to, independence in order to support treatment. More specifically, it involves assistance in exercising and maintaining entitlements as well as social integration actions or referrals.
- Institute harm reduction measures for people being treated.

There are two types of CSAPA:
- non-residential treatment centres,
- residential treatment centres.

Residential treatment centres provide medium-term treatment and group housing for people addicted to one or more psychoactive substances who require intensive medical and social treatment in a protected, contained environment for a given period of time.
2/ Hospital structures

There are three types: local, last resort and reference. The purpose of this organisation is to offer accessible treatment to the population and adjust the complexity of the sometimes-required treatment with better territorial coverage.

 ✓ The local level includes:
- an addiction consult with a hospital that can handle various types of addiction,
- a hospital addiction treatment and liaison team to help identify and treat patients within various hospital treatment services and the emergency counselling department,
- a hospital department to supervise simple cases of withdrawal.

This department is most often part of the general health care system (internal medicine, general medicine, hepatogastroenterology and/or psychiatry).

 ✓ The last resort level is comprised of:
- a hospital department with personnel specially trained in addiction medicine who provide specific treatment. It admits patients whose condition requires specialised, complex treatment. In addition to consultations and the liaison team seen at the local level, there is outpatient or inpatient hospitalisation for simple withdrawal (an approximate seven-day stay) or complex withdrawal (two- or three-week stay). These addiction structures admit those people in dire situations as a result of the severity of their addiction, the significance of their somatic and psychiatric comorbidities, or the level to which their cognition is affected. They provide an in-depth somatic, social and psychiatric addiction evaluation and report as part of a comprehensive treatment and management programme.
They also offer specific addiction treatment such as group therapy, group or individual psychotherapy, family therapy or couples' therapy.
- Addiction follow-up and rehabilitation centres (SSRAs), which constitute an important phase in post-acute, prolonged residential patient treatment to help integrate abstinence.

These centres offer a medical and psychosocial programme, of which rehabilitation is a key objective. It is necessary for certain addiction follow-up and rehabilitation treatment centres to treat patients whose cognitive function disturbances are predominant.

 ✓ The last resort level is comprised of university hospital addiction units.

Other hospital departments not specialised in addiction, such as psychiatric departments (for patients with dual diagnoses) or departments of internal medicine, hepatogastroenterology or infectious diseases (for HIV- or HCV-positive patients) participate in treatments for psychoactive substance users.

A special category exists for involuntary hospitalisation: psychiatric treatment at the request of a third party and psychiatric treatment decided by a representative of the state. Such treatment is administered in a public psychiatric establishment, and is administered to patients addicted to alcohol in 10 to 30% of cases.63
In addition to these specialised treatment structures, the following measures should be mentioned.

1/ Health networks

Professional coordination is the central mission of the network. This is a major challenge for improving quality of care. This coordination through the network must be distinguished from direct patient treatment and treatment provided by addiction treatment measures.

2/ Mutual aid associations (see Question 19)

There are numerous mutual aid associations in France of varying origin and size. They sometimes employ very different resources to achieve their objectives, which are apparently common and unifying. The objectives are to help people dependent on alcohol to become and remain abstinent. They also help the friends and family of people in difficulty. In addition to helping to reinforce abstinence, mutual aid associations help forge non-judgemental friendships, identify models and rid themselves of the feeling of social stigma. Some associations use a spiritual approach to achieve these objectives. There are also efforts within corporations and associations (e.g., SNCF, La Poste, Orange). Some of these associations opened and managed treatment and rehabilitation centres. They can operate within hospitals, clinics and outpatient alcohol addiction treatment centres, and often develop prevention activities.

3/ Occupational medical and social support

The attention often focuses on the heaviest drinkers. However, there are safety risks even with the intake of small quantities of alcohol or psychotropic medications. The less involved the workplace is in such alcohol use, the more difficulty drinkers experience. The workplace (in the general sense of the term - not just colleagues) can contribute to identify and raise awareness on abuse and provide support to help people change. Occupational health services are bound to patient secrecy, and represent specialist participants in these efforts. Occupational health services have a decisive role to play: on the one hand, they facilitate access to care and professional support and/or they support efforts of people experiencing difficulties with alcohol, and on the other hand, they take part in prevention. The objective in this case is not abstinence, but rather managing the occupational risks related to alcohol use, whether banal or harmful, while preventing abuse from worsening. An important part of the work of specialised interventions is offering the patient the ability to contact an occupational physician or a specialised occupational illness service in the event that difficulties are encountered related to alcohol at the workplace. It should be reiterated that that the reasoning behind this measure is to protect people at the workplace.
# APPENDIX 4. MESA GRANDE: SUMMARY TABLES

Summary scores for treatment modalities with three or more studies$^{80}$

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>All studies, regardless of population severity</th>
<th>Clinical populations only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank order</td>
<td>CES</td>
</tr>
<tr>
<td>Brief intervention</td>
<td>1</td>
<td>280</td>
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<tr>
<td>Motivational enhancement</td>
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<td>173</td>
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<tr>
<td>GABA antagonist</td>
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<tr>
<td>Opiate antagonist</td>
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<tr>
<td>Social skills training</td>
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<td>Community reinforcement</td>
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<td>Behavior marital therapy</td>
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<td>Self-monitoring</td>
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<td>25</td>
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<td>Cognitive therapy</td>
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<td>21</td>
</tr>
<tr>
<td>Client-centred counseling</td>
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</tr>
<tr>
<td>Disulfiram</td>
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<td>20</td>
</tr>
<tr>
<td>Aversion therapy, apneic</td>
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<td>18</td>
</tr>
<tr>
<td>Covert sensitisation</td>
<td>14.5</td>
<td>18</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>16.5</td>
<td>14</td>
</tr>
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<td>Aversion therapy, nausea</td>
<td>16.5</td>
<td>14</td>
</tr>
<tr>
<td>Self-help</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Self-control training</td>
<td>19</td>
<td>9</td>
</tr>
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<td>Minnesota model</td>
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<td>-3</td>
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<tr>
<td>Exercise</td>
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<td>-3</td>
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<td>Stress management</td>
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<td>-4</td>
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<tr>
<td>Family therapy</td>
<td>23</td>
<td>-5</td>
</tr>
<tr>
<td>Aversion therapy, electric</td>
<td>24.5</td>
<td>-13</td>
</tr>
<tr>
<td>Twelve-step facilitation</td>
<td>24.5</td>
<td>-13</td>
</tr>
<tr>
<td>Antidepressant, SSRI</td>
<td>26</td>
<td>-16</td>
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<tr>
<td>Lithium</td>
<td>27</td>
<td>-32</td>
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<td>Marital therapy, other</td>
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<td>-33</td>
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<td>Functional analysis</td>
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<td>-36</td>
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<td>Hypnosis</td>
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<td>-41</td>
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<tr>
<td>Psychedelic medication</td>
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<td>-44</td>
</tr>
<tr>
<td>Calcium carbimide</td>
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<tr>
<td>Serotonin antagonist</td>
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<td>-68</td>
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<td>Anti-anxiety medication</td>
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<tr>
<td>Relapse prevention</td>
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<td>Metronidazole</td>
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<td>Antidepressant, non-SSRI</td>
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<td>-104</td>
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<tr>
<td>Milieu therapy</td>
<td>38</td>
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Alcohol misuse: screening, diagnosis and treatment

<table>
<thead>
<tr>
<th>Treatment modality</th>
<th>CES</th>
<th>%+</th>
<th>N</th>
<th>Mean MQS</th>
<th>% clinical</th>
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<tr>
<td>Alcoholic anonymous</td>
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<td>14</td>
<td>7</td>
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<td>Video self-confrontation</td>
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<td>-108</td>
<td>0</td>
<td>8</td>
<td>10.5</td>
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<tr>
<td>Relaxation training</td>
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<td>17</td>
<td>18</td>
<td>10.56</td>
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<td>11</td>
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<tr>
<td>Psychotherapy</td>
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<td>18</td>
<td>10.94</td>
</tr>
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<td>10</td>
<td>20</td>
<td>11.15</td>
</tr>
<tr>
<td>Educational lectures, films, groups</td>
<td>46</td>
<td>-343</td>
<td>27</td>
<td>23</td>
<td>8.74</td>
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</tbody>
</table>

CES: cumulative evidence score

%+: percent of studies with positive finding for this modality

N: total number of studies evaluating this modality

MQS: methodological quality score of studies

% clinical: percent of studies conducted with treatment-seeking populations.

Summary scores for treatment modalities with 1-2 studies
### Alcohol misuse: screening, diagnosis and treatment

<table>
<thead>
<tr>
<th>Treatment</th>
<th>CES</th>
<th>N</th>
<th>%+</th>
<th>MQS</th>
<th>% clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapy</td>
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<td>0</td>
<td>1</td>
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<td>100</td>
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<tr>
<td>Tobacco cessation with nicotine gum</td>
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<td>0</td>
<td>1</td>
<td>12</td>
<td>0</td>
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<tr>
<td>Tobacco cessation with exercise</td>
<td>-12</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Dopamine agonist</td>
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<td>0</td>
<td>1</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>Dopamine precursor</td>
<td>-16</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>100</td>
</tr>
<tr>
<td>BAC discrimination training</td>
<td>-24</td>
<td>0</td>
<td>2</td>
<td>12</td>
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<td>Beta blocker</td>
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<td>0</td>
<td>1</td>
<td>13</td>
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<tr>
<td>Client choice among options</td>
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<td>1</td>
<td>14</td>
<td>0</td>
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<tr>
<td>Psychotherapy, group process</td>
<td>-30</td>
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<td>2</td>
<td>10</td>
<td>100</td>
</tr>
<tr>
<td>Electrical stimulation of the head</td>
<td>-34</td>
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<td>2</td>
<td>11.5</td>
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<tr>
<td>Anti-psychotic medication</td>
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<td>100</td>
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<td>Placebo</td>
<td>-48</td>
<td>0</td>
<td>2</td>
<td>12</td>
<td>100</td>
</tr>
</tbody>
</table>

**CES:** cumulative evidence score

%+: percent of studies with positive finding for this modality

**N:** total number of studies evaluating this modality

**MQS:** methodological quality score of studies

% clinical: percent of studies conducted with treatment-seeking populations.
APPENDIX 5. WORKING METHOD

In the health field, Good Practice Recommendations (GPR) are defined as ‘methodically developed proposals to help practitioners and patients find the most suitable treatment in given clinical circumstances’.

These are part of an objective to improve the quality and safety of treatment. They aim to provide the various health system players (professionals, patients and users, decision-makers) with a rigorous summary of the current state of the art and scientific data, intended to:
- provide decision-making aid when choosing healthcare;
- harmonise practices;
- reduce needless or risky treatments and procedures.
The development of a GPR should not be an objective in its own right, but fit within a good practice programme ranging from identification of points for improvement for a treatment to assessment of this programme. A good practice programme may be incorporated within the framework of continuing professional development.

➤ Choice of working theme
The objective is to propose recommendations perceived as relevant and usable by professionals.
The theme choice must therefore be based on knowledge of needs expressed by professionals (ad hoc interviews and feedback from the field) and on real practices (on the basis of facilitated access to existing national databases), as well as a first analysis of the literature. The bodies responsible for development of the GPR may delegate this task to one or more people and incorporate it within a multi-year programme.

➤ Methodology
A rigorous and explicit approach must be applied in order to develop valid and credible good practice recommendations.
The objective of the Clinical Practice Recommendations (CPR) method is to draft a small number of recommendations that are:
- concise;
- classified on the basis of identified levels of evidence or, in the absence of scientific evidence, on the basis of expert consensus;
- unambiguous;
- and answering the questions asked.
### Level of evidence classification method

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td><strong>Established scientific evidence</strong></td>
<td>- randomised comparative trials with a high power and no major biases,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- meta-analysis of randomised comparative trials,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- decision analysis based on properly conducted studies</td>
</tr>
<tr>
<td>B</td>
<td><strong>Scientific assumption</strong></td>
<td>- randomised comparative trials with low power,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- properly conducted, non-randomised comparative studies,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- cohort studies.</td>
</tr>
<tr>
<td>C</td>
<td><strong>Weak level of evidence</strong></td>
<td>- case-control studies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- retrospective studies,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- case series</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- comparative studies with major biases</td>
</tr>
<tr>
<td>AE</td>
<td><strong>Expert consensus</strong></td>
<td>If no studies are available, the recommendations are based on a consensus</td>
</tr>
<tr>
<td></td>
<td></td>
<td>between working group experts, after consulting the review group.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The absence of classification does not mean that the recommendations are not</td>
</tr>
<tr>
<td></td>
<td></td>
<td>relevant and useful.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>However, this should prompt additional studies.</td>
</tr>
</tbody>
</table>

The CPR method is a rigorous method for the development of GPR, based on:
- the participation of professionals and representatives of patients and users concerned by the theme of GPR;
- transparency, with access to:
  - the critical analysis of the literature;
  - the essential points of the discussions and decisions taken by the working group members;
  - the classifications and comments of the review group members;
  - a list of all the participants in the various groups;
- editorial independence;
- management of interests declared by the working group experts.

### General process for development of this Good Practice Recommendation

Initiated by a steering committee, which forms a working group and a national & European review group, GPR is developed in 4 stages.
GROUPS

✓ The working group
Multidisciplinary and pluriprofessional, it ideally consists of 15 to 20 health professionals, working in the public or private sector, of different geographic origins or schools of thought, including the chairman of the working group and representatives of patient and health service user associations (mutual support groups, in the present case).

Since the present GPR has an international dimension, the working group was coordinated by two co-chairmen, the President of the Société Française d’Alcoologie (SFA) and the President of the European Federation of Addiction Societies (EUFAS).

The working group develops draft recommendations for submission to the review group. In the case of good practice recommendations on alcohol misuse, given the size and diversity of the working group composition, two group members were appointed as session secretaries to ensure that the recommendations were drafted in a uniform manner.

Health professionals must be familiar with professional practices in the field corresponding to the study theme and be capable of assessing the relevance of published studies and the various clinical situations examined.

The bibliographic data available are critically analysed and summarised in the form of a scientific rationale.

At the end of the review phase, the working group finalises the recommendations on the basis of the classifications and comments of the review group.

✓ The review group
Qualitatively similar in composition, this group consists of 30 to 50 health professionals and patient and health service user representatives, extended to include representatives of medical specialities, professions or civil society not present in the working group.

It returns a formal opinion relative to the content and format of the initial version of the recommendations, in particular their applicability, acceptability and clarity.

Its members provide their own individual consultative opinion and do not meet.

The international dimension of the present good practice recommendations was validated by a second consultative opinion requested from an expert group of EUFAS members, proposed by the President of the EUFAS and the joint chairman of the working group. The working documents have been translated into English and the final version of the Good Practice Recommendations is available in English on the EUFAS website.

THE 4 PHASES IN THE CPR PROCESS

✓ Systematic review and synopsis of the literature phase
This phase leads to, in the case of this GPR, the production of a scientific file and a list of 19 draft questions to be submitted to the working group.

The scientific file realisation is preceded by a literature search and critical analysis of the literature, enabling a level of evidence to be allocated to the studies.
Drafting phase of the initial version of the recommendations

The members and chairman of the working group work together to draft the initial version of the recommendations to be submitted to the national and European review group. During working group meetings, the scientific rationale and classified draft recommendations are discussed on the basis of existing data and practices. For expert consensus, a draft recommendation is included in the recommendation text submitted to the review group for its opinion if it receives the approval of at least 80% of the working group members.

Review phase

This culminates in the production of an analytical report collating all the classifications and comments of the review group members and, if applicable, participants in public consultation processes. Each member returns an individual opinion. The instrument used for assessing the quality of the clinical practice recommendations is the French translation of the AGREE instrument (Appraisal of Guidelines for Research and Evaluation Instrument). For each draft recommendation, there is a 7-point numerical rating scale, along with a comment box.

Finalisation phase

It leads to the production of the final version of the scientific rationale, recommendations and their synthesis (as a set of key messages), followed by the dissemination of the documents. After analysis and debates regarding classifications and comments of the review group, recommendations are altered by the working group according to specific rules.

Management of conflicts of interest and working group composition

Methods

Working group composition methods

The composition of the working group, determined by the steering committee, was defined on the basis of the method presented in the HAS methodological guide for the CPR method: involvement of stakeholders in the field (learned societies, national specialist professional bodies, general medicine college, user associations) with a view to obtain the names of interested professionals and user representatives.

The various experts identified were then approached to give their agreement to participate and collect their statements of interest.

A total of 18 experts were approached to join the working group and send back their statements of interest.

Management of conflicts of interest

The interests declared by these experts were analysed by the steering committee members and deemed to be compatible with their inclusion in the working group for these good practice recommendations.
The public statements of interest can be consulted on the website of the Société Française d’Alcoologie (sfalcoologie.asso.fr) in the ‘Good Practice Recommendation’ section.

➢ **Updates**

Updating this Good Practice Recommendation will be envisaged if relevant data were published in the scientific literature or if significant changes in practices were to occur after this publication.

**NB**

In the context of the present recommendation, the Société Française d’Alcoologie chose the Transferase Consulting & PR agency to help with practical logistics as well as general organisation and coordination of the project.
APPENDIX 6. LITERATURE SEARCH

The literature search was systematic, hierarchized and structured. The members of the Steering Com helped to design the literature search strategy. The search was carried out over a period appropriate to the theme and updated until publication of the recommendations.

A very large proportion of the literature search is based on the methodical analysis work carried out by international learned societies.

A bibliographic selection of references on the basis of the criteria defined was performed by the members of the Steering Committee following the latter’s first meeting.

Each article selected was analysed in accordance with critical literature review principles, first assessing the study method used then the results.

The analysis of the literature specifies the level of evidence and the studies.

➤ Literature search method

The search concerned the subjects and study types defined during the scoping phase by the Steering Committee members and was limited to publications in English and French.

Information sources

Bibliographic databases

• Medline (National Library of Medicine, USA)
• The Cochrane Library (Wiley Interscience, USA)
• Science Direct.

Other sources

• Websites of learned societies competent in the field studied
• Bibliography of articles and documents selected.

Search strategy

The bibliographic database search strategy was constructed using, for each subject, either thesaurus terms (descriptors) or free text terms (in the title or abstract). These are combined with terms describing the study types.

This search was supplemented by the bibliography of the Working Group experts and the references cited in the analysed documents.

Literature monitoring

In addition, monitoring of the websites indicated previously in the ‘Information sources’ paragraph was performed until February 2014.
Alcohol misuse: screening, diagnosis and treatment

Table 1: Literature search strategy

<table>
<thead>
<tr>
<th>Terms used</th>
<th>Search period</th>
<th>Number of references</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 1 ‘Alcohol’ OR ‘Alcoholic’ OR ‘Drinkers’ OR ‘Problem drinking’</td>
<td>01/1994 - 02/2014</td>
<td></td>
</tr>
<tr>
<td>Step 2 Practice Guideline OR Government Publication or Consensus Development Conference OR ConsensusDevelopment Conference NIH</td>
<td></td>
<td>165</td>
</tr>
<tr>
<td>Meta-analyses, literature reviews</td>
<td>01/1994 - 02/2014</td>
<td>11,849</td>
</tr>
<tr>
<td>Randomised controlled trials</td>
<td>01/1994 - 02/2014</td>
<td>16,328</td>
</tr>
<tr>
<td>Step 1 and Meta-analysis OR Review [publication type]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step 3 Randomised Controlled Trial OR Multicentre</td>
<td></td>
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</tr>
<tr>
<td>Step 4 Randomised Controlled Trial OR Multicentre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study OR Controlled Clinical Trial OR Comparative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Study OR Clinical Trial, Phase III</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Article selection criteria

The systematic literature review was limited to studies, concerning the efficacy or safety of the proposed interventions, capable of bringing added scientific value relative to the experts' opinion. The following publications, in French or English, were included in the systematic literature review:

- Original studies;
- Complete publications (abstracts and conference proceedings were not retained);
- French and international good practice recommendations (systematic reviews, multidisciplinary expert opinions, user representative opinions);
- Systematic reviews of controlled trials, with or without meta-analysis;
- Randomised controlled trials (RCTs) or otherwise, published subsequent to the systematic reviews addressing the same question;
- Cohort studies and comparative studies, published subsequent to the systematic reviews addressing the same question;
- Practice theses to study current practices.

Inclusion criteria

- Objective: to study the efficacy of a treatment or strategy in helping people reduce their alcohol use or stop drinking completely.
- Study design: 1) systematic reviews, RCT meta-analysis or with at least one control group; 2) epidemiological and observational studies.
- All alcohol using populations.
- Reference measurement of alcohol use on inclusion.
• Comparator groups: 1) placebo and/or other treatment; 2) drinker vs non-drinker; 3) misuse vs non-misuse.
• Endpoint: 1) abstinence, 2) reduction in alcohol use, 3) controlled use.

**Exclusion criteria**
• Case studies, clinical case reports.
• Stakeholder reviews, general reviews, etc.
• Absence of comparator group.
• Very specific population that cannot be extrapolated to the French population.

**Article sorting method**
The articles were selected independently by Prof. H.J. Aubin, co-chairman of the working group, and by Prof. F. Paille, chairman of the steering committee. An initial article selection was made by reading titles and abstracts. Some articles were eliminated simply by reading the title if they did not meet the inclusion criteria. In the event of any doubt, if the title was not explicit enough, the abstract was read. The selected articles were then read in full, and only those meeting inclusion criteria were retained for analysis and are presented here. A level of evidence was allocated to the studies on the basis of their methodological quality (Agence Nationale d’Accréditation et d’Evaluation en Santé. Guide d’analyse de la littérature et gradation des recommandations. Guide méthodologique. Paris: ANAES; 2000.)

**Results**
Number of references analysed: 629.
Number of references retained: 192.
REFERENCES


Alcohol misuse: screening, diagnosis and treatment


61. HAS. Critères diagnostiques et bilan initial de la cirrhose non compliquée. Paris; 2009 Updated.


65. Sobell MB, Sobell LC. Controlled drinking after 25 years: how important was the great debate? Addict Abingdon Engl. 1995 Sep;90(9):1149–1153; discussion 1157–1177.


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78. Dawson DA, Li T-K, Chou SP, Grant BF. Transitions in and out of alcohol use disorders: their associations with conditional changes in quality of life over a 3-year follow-up interval. Alcohol Alcohol Oxfs. 2009 Feb;44(1):84–92.


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PARTICIPANTS

- **Professional bodies, patient and user support groups**
  The institutional and professional bodies, together with the patient and user support groups (mutual support groups, in this case) stated on page 3 agreed to act as partners for this good practice recommendation.

- **Working group**
  The participants to the different meetings submitted their declarations of interest to the Société Française d’Alcoologie. These were analysed and taken into account so as to avoid conflicts of interest.
  The list of the 18 participants is described in detail on pages 3 and 4 of the document.

- **National review group**
  Participants: 37 persons.
  - Mrs Christine ARVOIS, midwife - Reims
  - Prof. Marc AURIACOMBE, psychiatrist - Bordeaux
  - Dr Bernard BASSET*, public health physician - Paris
  - Prof. Amine BENYAMINA, psychiatrist - Villejuif
  - Mrs Véronique BONY*, Adalis - Paris
  - Dr Anne-Marie BRIEUDE, general practitioner - Blois
  - Dr Georges BROUZE, psychiatrist - Clermont-Ferrand
  - Dr Frédéric BROUZES, general practitioner - Pointe Noire
  - Mrs Ludivine BUZIT, nurse - Reims
  - Mrs Micheline CLAUDON, psychologist - Paris
  - Prof. Olivier COTTENCIN, psychiatrist - Lille
  - Dr Général DEMORTIERE*, occupational physician - Cergy
  - Dr Annabel DUNBAVAND, public health and social medicine physician - Paris
  - Dr Benoît FLEURY, hepato-gastroenterologist - Bordeaux
  - Dr Claudine GILLET, occupational physician - Nancy
  - Dr Marie GRALL-BRONNEC, psychiatrist - Nantes
  - Dr Morgane GUILLOU LANDREAT, psychiatrist - Morlaix
  - Dr Anita HERCEND, general practitioner - Paris
  - Prof. Dominique HUAS*, general practitioner - Vendôme
  - Dr Olivier KANDEL*, general practitioner - Poitiers
  - Dr Paul KIRITZE-TOPO, general practitioner - Angers
  - Dr Yann LE STRAT, psychiatrist - Colombes
  - Prof. Michel LEJOYEUX, psychiatrist - Paris
  - Dr Jean-Noël MICHE*, general practitioner - St Denis
  - Mr Jacques MORCHOISNE, Al-Anon and AA - Clamart, Mrs Nathalie FREMAUX, Pôle Aide, Accompagnement et Bénévolat, Association Amitié La Poste France Télécom - Paris, Mrs Françoise BRULIN, La Croix Bleue - Paris
  - Mr François MOUREAU, Camerup* - Aubagne
  - Prof. Mickaël NAASSILA, research professor in neuro-pharmacology - Amiens
  - Prof. François PAILLE, internist - Nancy
  - Prof. Pascal PERNEY, gastroenterologist and hepatologist - Nîmes
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- Dr Eric PEYRON, psychiatrist - Lyon
- Dr Didier PLAYOUST, general practitioner - Andernos les Bains
- Dr Cécile PREVOST, general practitioner - Sèvres
- Dr Alain RIGAUD, psychiatrist - Paris
- Dr Isabelle ROCHER, general practitioner - Luçon
- Prof. Florence THIBAUT, psychiatrist - Paris
- Dr Nathalie WIRTH*, general practitioner - Nancy
- Mr Gabriel ZIMMERMANN*, FNESA - Maizeroy

(*) Member of a partner body and/or organisation.

European review group
Participants: 4 persons proposed by Prof. K. Mann, chairman of the European Federation of Addiction Societies (EUFAS) and co-chairman of the working group for the present good practice recommendation.

Prof. Colin DRUMMOND, psychiatrist - London, United Kingdom
Prof. Conor FARREN, psychiatrist - Dublin, Ireland
Prof. Emanuele SCAFATO, gastroenterologist - Rome, Italy
Prof. Friedrich WURST, psychiatrist and psychotherapist - Salzburg, Austria

Other people consulted as part of this project
- Dr Philippe CASTERA, general practitioner - Bordeaux

ACKNOWLEDGEMENTS

The Société Française d’Alcoologie would like to thank all the members cited above for their assistance, as well as:
- Dr Corinne DANO and Dr Benjamin ROLLAND, working group session secretaries;
- Dr Gisèle GILKES, Princeps Editions, responsible for the overall coordination of the project.

The SFA extends its thanks to the French Department of Health (DGS), which supported the original project.

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## DESCRIPTIVE DATA SHEET

<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Alcohol misuse: screening, diagnosis and treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Working method</strong></td>
<td>On the basis of Clinical practice recommendations (CPR).</td>
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<tr>
<td><strong>Objectives</strong></td>
<td>To improve the quality of management of adult patients who misuse alcohol.</td>
</tr>
<tr>
<td><strong>Patients or subjects concerned</strong></td>
<td>All individuals who misuse alcohol.</td>
</tr>
<tr>
<td><strong>Professionals concerned</strong></td>
<td>Although many professionals are potentially concerned by addictive behaviour (health, social, judicial, educational fields, etc.), these recommendations are mainly intended for general practitioners, addiction specialists and, generally, all healthcare professionals, physicians (notably internists, hepatogastroenterologists, occupational physicians, neurologists, psychiatrists, etc.), along with nurses, psychologists, midwives, pharmacists, support groups, etc., involved in managing patients who misuse alcohol.</td>
</tr>
<tr>
<td><strong>Requesting party and sponsor</strong></td>
<td>Société Française d’Alcoologie</td>
</tr>
</tbody>
</table>
| **Co-sponsors** | - Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA)  
- European Federation of Addiction Societies (EUFAS) |
| **Partners** | - Addictions Drogues Alcool Info Service (Adalis)  
- Alliance Prévention Alcool  
- Collège de la Médecine Générale  
- Collège Universitaire National des Enseignants d’Addictologie  
- Coordination des Associations et Mouvements d’Entraide Reconnus d’Utilité Publique (CAMERUP)  
- Fédération Française d’Addictologie (FFA)  
- Fédération Nationale des Établissements de Soins et d’Accompagnement en Addictologie (FNESAA)  
- Société Française de Médecine du Travail (SFMT)  
- Société Française de Tabacologie |
| **Funding** | Public and private. |
| **Project management** | Steering committee chaired by Prof. François Paille. |
Alcohol misuse: screening, diagnosis and treatment

<table>
<thead>
<tr>
<th><strong>Literature search</strong></th>
<th>A very large proportion of the literature search is based on the methodical analysis work carried out by international learned societies. The detailed literature search strategy is described in appendix 2 of the scientific rationale.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rationale authors</strong></td>
<td>The 18 members of the working group.</td>
</tr>
<tr>
<td><strong>Participants</strong></td>
<td>The members of the working group, the national review group and the European review group.</td>
</tr>
<tr>
<td><strong>Conflicts of interest</strong></td>
<td>The participants in the working groups communicated their statements of interest. These were analysed by the steering committee members and deemed to be compatible with their inclusion in the working group for this Good Practice Recommendation. The public statements of interest can be consulted on the website of the Société Française d’Alcoologie (sfalcoologie.asso.fr) in the section on ‘Good Practice Recommendation’.</td>
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<td><strong>Updates</strong></td>
<td>Updating this Good Practice Recommendation will be envisaged if relevant data were published in the scientific literature or if significant changes in practices were to occur after this publication.</td>
</tr>
</tbody>
</table>
| **Format** | Good Practice Recommendation, available for download on the:  
  - SFA website  
  - ANPAA website  
  - EUFAS website |