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Dr L Michel

Centre Pierre Nicole

French Red Cross

CESP Inserm 1018, « Epidemiology of mental and physical health », « addiction science » unit

Paris

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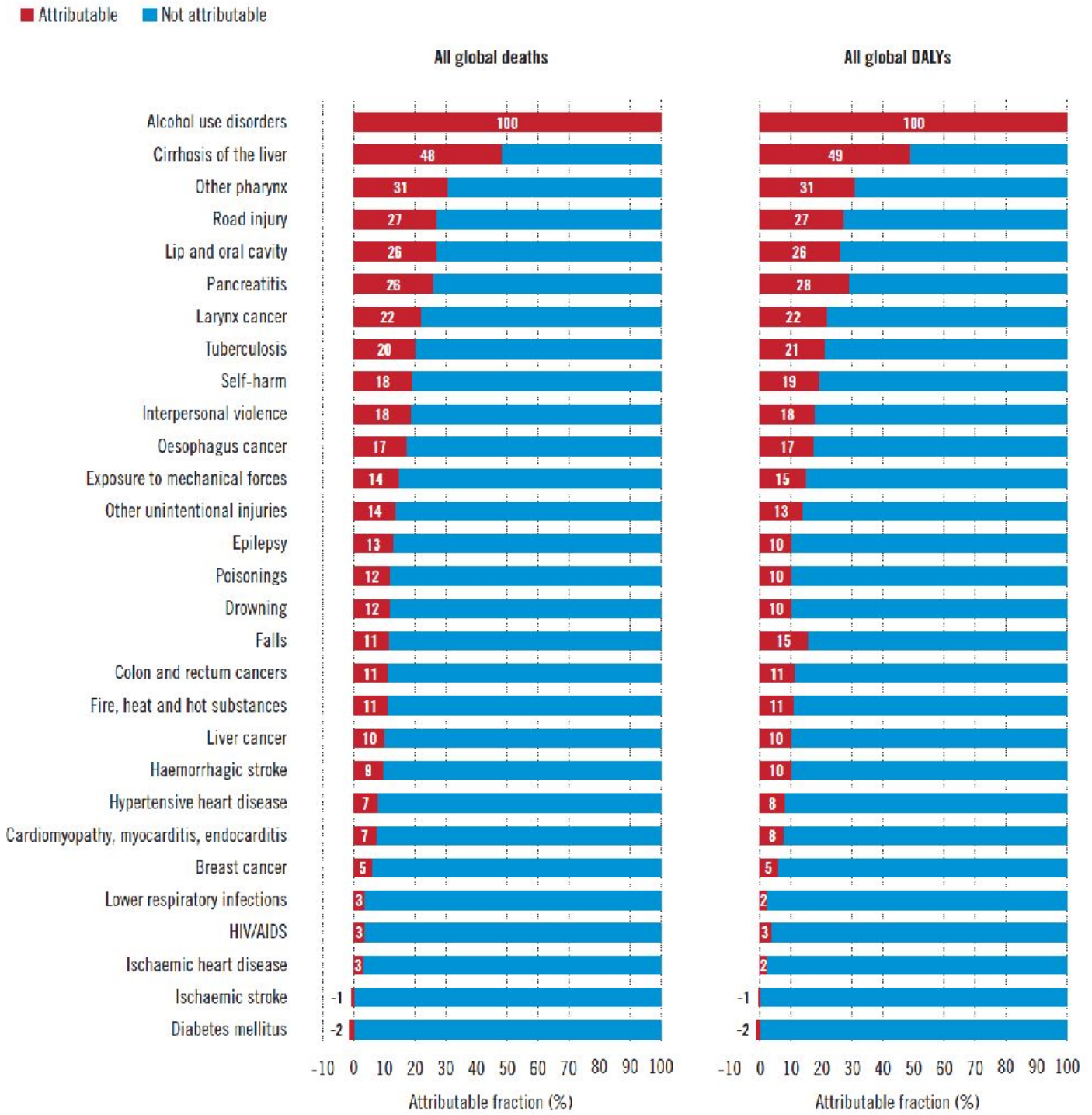
- Alcohol-attributable fractions for selected causes of death, disease, injury in 2016

- DALYs = Disability-adjusted life years



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Most harmful drugs (Lancet, 2010, UK)

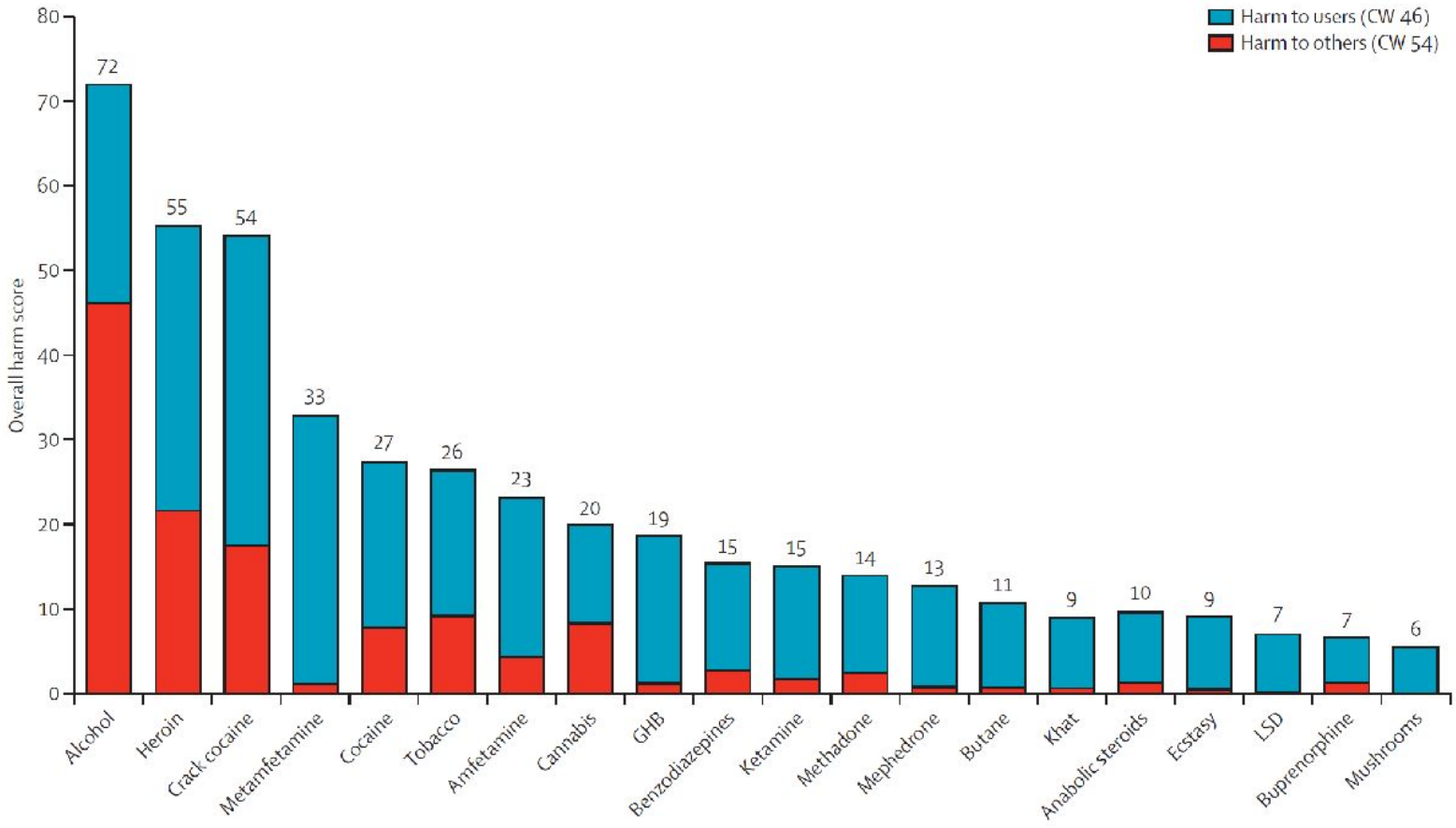

Figure 2: **Drugs ordered by their overall harm scores, showing the separate contributions to the overall scores of harms to users and harm to others**
The weights after normalisation (0–100) are shown in the key (cumulative in the sense of the sum of all the normalised weights for all the criteria to users, 46; and for all the criteria to others, 54). CW=cumulative weight. GHB=γ hydroxybutyric acid. LSD=lysergic acid diethylamide.

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Mortality (France)

- Tobacco : 70 000 deaths per year
- Alcohol : 49 000 deaths per year
  - 13% of the annual mortality
  - 1st factor associated with delinquency (25% of all convictions)

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CHILILAB Health and Demographic Surveillance System 2018 (Viet Nam)

- The level of alcohol consumption in Vietnam is currently high and has been steadily increasing over the past 10 years.
- Alcohol consumption at harmful levels leads to several health and social problems and is a serious public health concern.
- Alcohol consumption is more common in men than in women.
- People living in rural areas drink more than those in urban areas, but people living in urban areas tend to drink at a harmful level more.
- The results of this study reaffirm the need for public health strategies, including the formulation of laws and policies to reduce the harmful effects of alcohol consumption in Vietnam.

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WHO 2018

Whereas in the WHO African Region, the Region of the Americas and the Eastern Mediterranean Region alcohol per capita consumption remained rather stable, in the European Region it decreased from 12.3 litres in 2005 to 9.8 litres in 2016. The increase in per capita alcohol consumption is observed in the WHO Western Pacific and South-East Asia regions.

Prevalence of heavy episodic drinking* (%), 2016

	Population (15+ years)	Drinkers only (15+ years)	Population (15–19 years)	Drinkers only (15–19 years)
Males	25.1	50.2	18.2	55.5
Females	4.2	17.7	2.8	21.1
Both sexes	14.4	39.3	10.7	45.9

* Consumed at least 60 grams or more of pure alcohol on at least one occasion in the past 30 days.

Abstainers (%), 2016

	Males	Females	Both sexes
Lifetime abstainers (15+)	24.1	52.4	38.6
Former drinkers* (15+)	25.9	23.7	24.7
Abstainers (15+), past 12 months	50.0	76.1	0.6

* Persons who used to drink alcoholic beverages but have not done so in the past 12 months.

Prevalence of alcohol use disorders and alcohol dependence (%), 2016*

	Alcohol use disorders**	Alcohol dependence
Males	9.8	5.9
Females	1.2	0.1
Both sexes	5.4	2.9
WHO Western Pacific Region	4.7	2.3

* 12-month prevalence estimates (15+); **including alcohol dependence and harmful use of alcohol.

Global status report on alcohol and health 2018

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Alcohol dependence and psychiatric disorders

NESARC survey, *Hasin et al. 2007*.

	Alcohol dependence Last 12 months	Alcohol dependence lifetime
Dug abuse/dependence	**5,0 (3,59-6,94)**	**4,4 (3,81-5,03)**
Tobacco dependence	**7,5 (4,16-13,64)**	**3,3 (2,94-3,75)**
Mood disorder	**3,4 (2,78-4,19)**	**1,7 (1,47-2,07)**
Major depressive disorder	1,3 (0,92-1,93)	**1,4 (1,18-1,64)**
Type 1 bipolar disorder	**1,9 (1,13-3,01)**	**2,1 (1,57-2,86)**
Anxiety disorder	**1,5 (1,16-1,99)**	**1,7 (1,43-1,92)**
Personality disorder	**1,8 (1,45-2,20)**	**1,6 (1,40-1,90)**

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The cycle psychiatric disorders / alcohol use disorder

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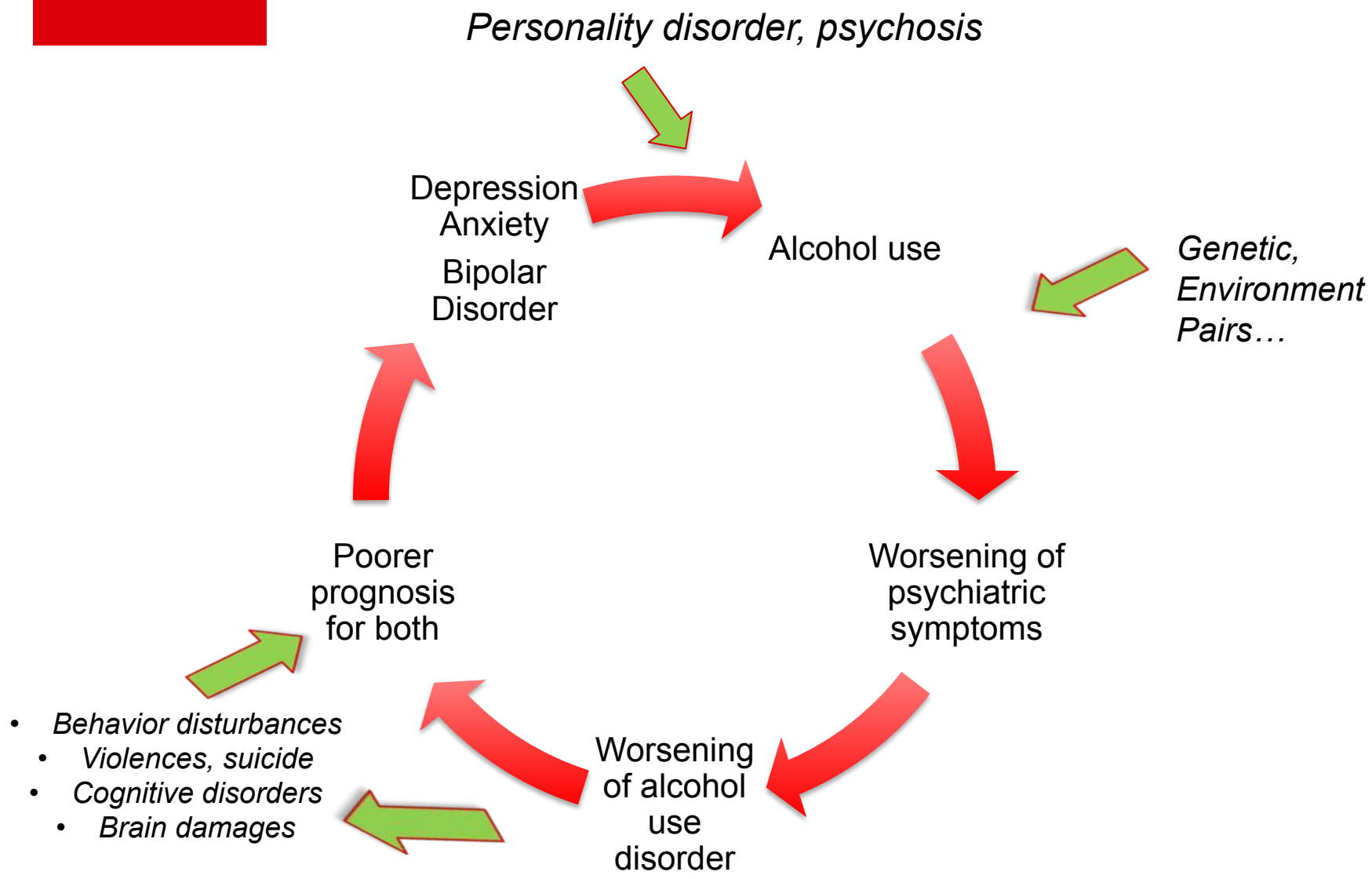

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Consequences Alcohol Abuse (Vietnam)

- Among PWID
  - Associated with presenting at least one psychiatric disorders (Pham Minh 2018),
  - Particularly when associated with methamphetamines (Le, 2020)
  - Association with high risk sexual activity among PWID (Michel, 2017)
- Among HIV PWID
  - associated with lower access to ART and virological suppression (Wagman, 2020)

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History of alcohol consumption

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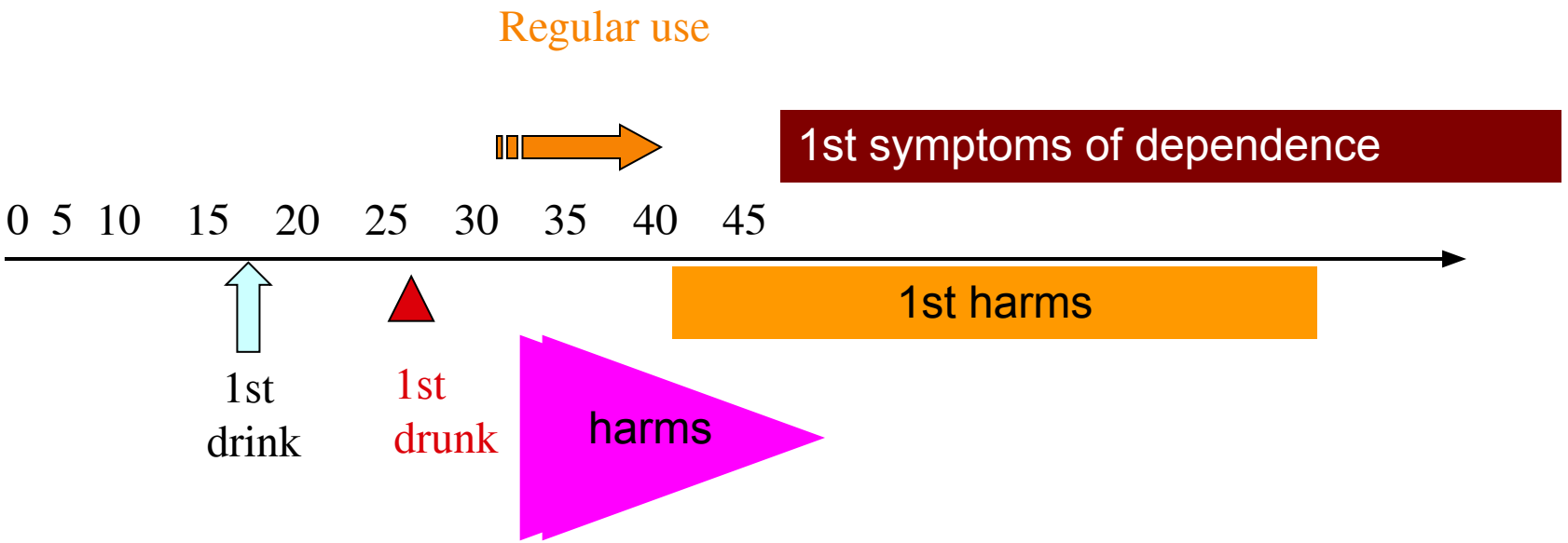

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Evaluation

- Alcohol use
  - Quantity, frequency, context
  - Questionnaires (Audit?)
  - Loss of control
  - At what time the first drink ?
- Social consequences
  - Family, work, friends
  - Budget
- Health status
  - Psychiatric disorders (depression)
  - Somatic problems: liver, mouth, skin…
  - Cognition

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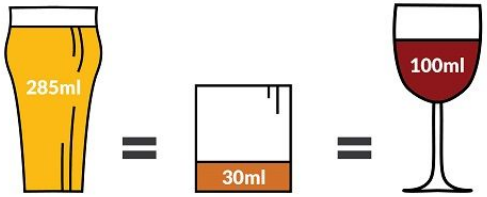

ONE STANDARD DRINK

A serve of full strength beer (285ml), a serve of distilled spirits (30ml), and a serve of red or white wine (100ml) contain the same amount of alcohol – one standard drink.

WHITE WINE
1.4 standard drinks
11.5% alcohol
150 ml average serving
(about half a glass)

RED WINE
1.5 standard drinks
13% alcohol
150 ml average serving
(about half a glass)

WINE
6-8 standard drinks
11-13% alcohol
750 ml bottle of wine

WINE
18-21 standard drinks
11-13% alcohol
2 litre cask of wine

FULL STRENGTH BEER
1.1 standard drinks
4.8% alcohol
285 ml glass (middy)

FULL STRENGTH BEER
1.6 standard drinks
4.8% alcohol
425 ml glass (schooner)

FULL STRENGTH BEER
1.4 standard drinks
4.8% alcohol
375 ml (can)

FULL STRENGTH BEER
34 standard drinks
4.8% alcohol
24 x 375 ml cans

HIGH STRENGTH SPIRITS
1 standard drink
40% alcohol
30 ml nip (shot glass)

READY-TO-DRINK SPIRITS
1.5 standard drinks
5% alcohol
375 ml (premix can)

READY-TO-DRINK SPIRITS
3.6 standard drinks
7% alcohol
660 ml (large premix bottle)

HIGH STRENGTH SPIRITS
22 standard drinks
40% alcohol
700 ml spirit bottle

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AUDIT questionnaire

Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

1 to 7: low-risk consumption
8 to 14: hazardous or harmful alcohol consumption
15 or more: alcohol dependence (moderate-severe alcohol use disorder).

The Alcohol Use Disorders Identification Test: Interview Version

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.

1. How often do you have a drink containing alcohol?
   (0) Never [Skip to Qs 9-10]
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily
   Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

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?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?
    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total of specific items here

If total is greater than recommended cut-off, consult User's Manual.

- Biological markers (Lancet, 2009)

	Suggested cut value
Gamma glutamyltransferase (GGT)	>35 u/L
Carbohydrate deficient transferin (CDT)	>20 G/L or >2·6%
Alanine aminotransferase (ALT)	>67 u/L
Aspartate aminotransferase (AST)	>65 u/L

Table 2: **State markers of heavy drinking**

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Example: Intermittent Paroxysmal Alcohol Use

Alcohol units

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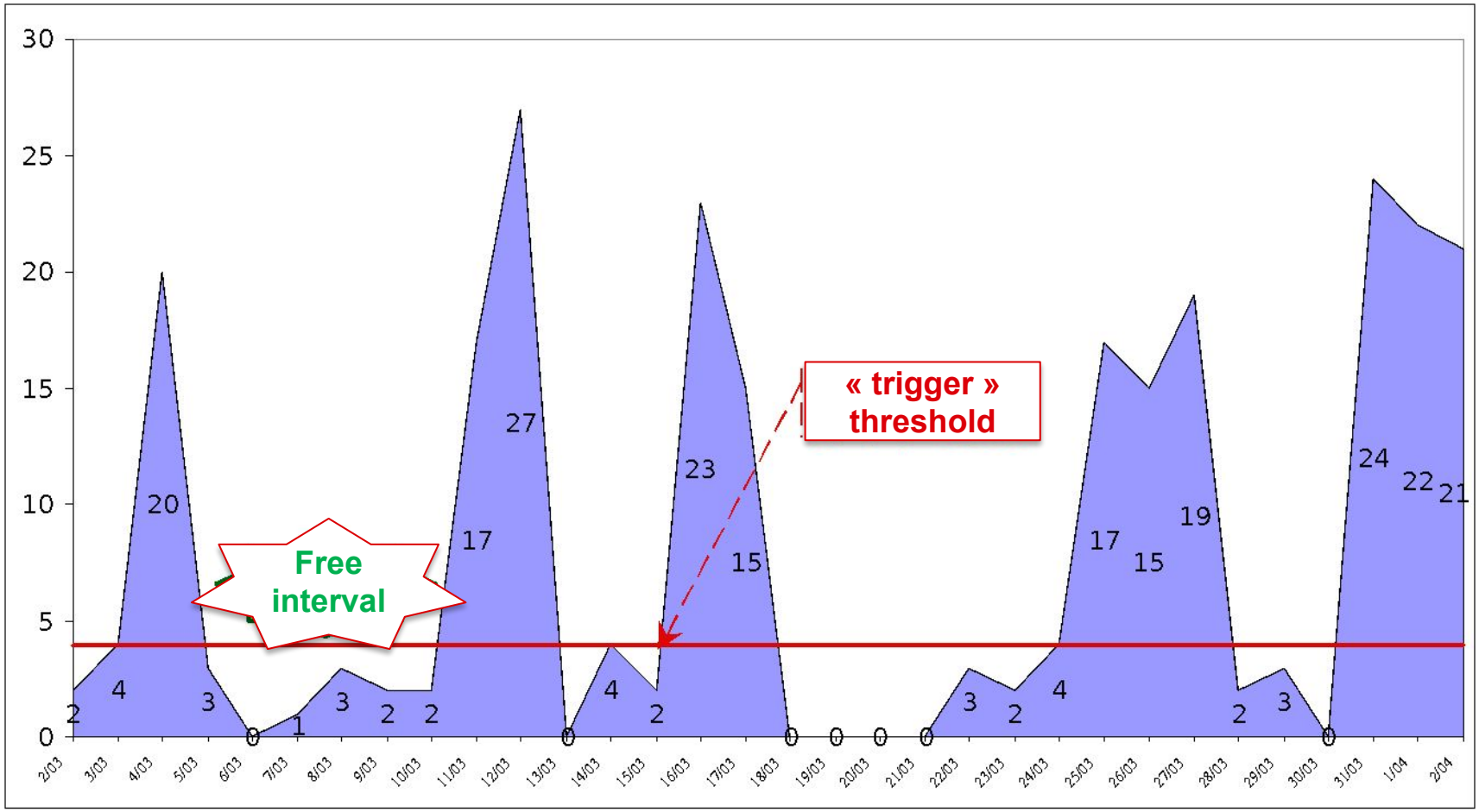

EUROPEAN MEDICINES AGENCY
SCIENCE MEDICINES HEALTH

Guideline on the development of medicinal products for the treatment of alcohol dependence

- **Goal of total abstinence**
  - Relapse prevention after withdrawal
- **Intermediate harm reduction goal**
  - Significant reduction without prior withdrawal
  - Target abstinence as soon as the patient is ready

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Alcohol Harm Reduction

- **Marlatt 2002**
  - *« Harm reduction offers a **pragmatic and compassionate approach** to the prevention and treatment of problem drinking that **shifts the focus away from alcohol use itself to the consequences of harmful drinking behavior***
  - *Many individuals experiencing problems related to their drinking (e.g., college students) are **not interested in changing their drinking behavior** »*

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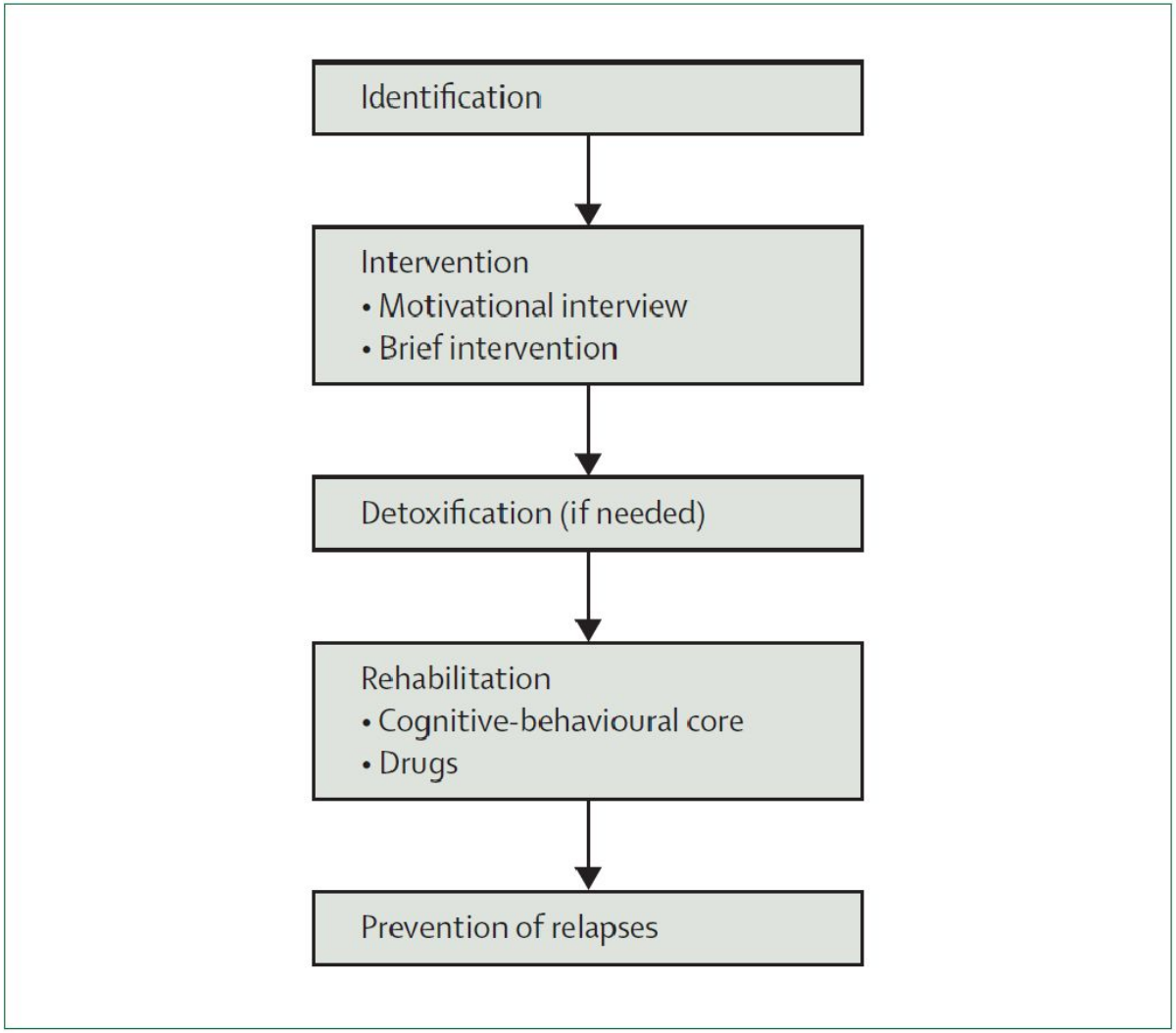
Alcohol Harm Reduction

Marlatt 2002 : objectifs

Harm reduction programs meet the individual "**where they are at**" to help them

- understand the risks involved in their behaviour and
- make decisions bout their own treatment goals.
- Instead of making abstinence from alcohol an objective, the harm reduction approach seeks to
  - **minimize the personal harm and adverse societal effects** that alcohol dependence can lead to,
  - provide an **alternative to zero-tolerance approaches** by incorporating drinking goals (abstinence or moderation) that are compatible with the needs of the individual, and
  - promote access to services by offering low-threshold alternatives, which enable clients to **gain access to services despite continued alcohol consumption**



Schuckit, Lancet 2009 **Figure: Stages of treatment**

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Clinical Challenges

- Abstinence
  - Withdrawal: prevent complications
    - Diazepam
    - Vitamine B1 IV if major withdrawal symptoms
    - Maintain abstinence with psychosocial interventions
- Harm reduction
  - Objective : Control consumption
  - Patient empowerment: motivational interviewing, CBT
    - Define pragmatic objectives
    - Meet regularly
    - Ask for a diary

	Usual dose*
Naltrexone	
Oral	50–100 mg per day[105,106]
Intramuscular injection	380 mg per month[107]
Acamprosate	666 mg three times per day[105,108,109]
Naltrexone+acamprosate	Same doses as above[110]
Disulfiram	250 mg per day[3,111,112]

*These drugs are usually prescribed for 3–12 months.

***Table 3:* Drugs for rehabilitation of alcohol-use disorders**

Schuckit, Lancet 2009

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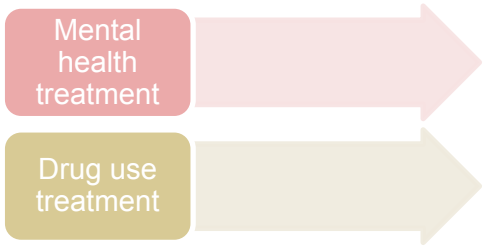
A new option: Baclofene

- Controversial: 4 meta-analyses in 2018 with different conclusions!
  (Andrade, J Clin Psy, 2020)
  - Baclofen found superior to placebo for abstinence rate
  - Borderline superior to placebo for amount of drinking
  - Outperform placebo for
    - Time to relapse
    - Endpoint abstinence rates
  - And to be not better than placebo or even worse in 1 meta-analysis
- Target abstinence as well as alcohol moderation
- Significant side-effects
  - Drowsiness, fatigue, insomnia
- Need to
  - Use it as second line treatment
  - Carefully introduce medication

Models of Services for dual disorders

- Sequential model
  - Networks independent and separate
  - Minimal link
  - Does not take into account interaction between disorders
    - High relapse rate on both disorders

- Parallel model
  - Simultaneous treatments are provided by 2 distinct, separate services
  - The 2 treatment needs often met with different therapeutic approaches
  - The medical model of psychiatry may conflict with the psychosial orientation of drug services
  - Requires a significant coordination work



- Integrated treatment
  - Treatment provided within a psychiatric or a drug treatment service or a special comorbidity programme
  - Cross-referral to other agencies avoided

Role of integrated still needs to be clarified (Tiet, 2007, ACER)

(1) *existing efficacious treatments for reducing psychiatric symptoms also tend to work in dual-diagnosis patients*

(2) *existing efficacious treatments for reducing substance use also decrease substance use in dually diagnosed patients, and*

(3) *the efficacy of integrated treatment is still unclear*

Dual disorders: principles of treatment *(Lancet psychiatry 2019)*

- Better results with integrated treatments
- Residential treatments tend to have better results than non-residential integrated treatments
- Pharmacological+psychosocial+behavioral interventions have better results than treatments alone
- Selective serotonin reuptake inhibitors (SSRIs)
  - Effective in treating mood disorders
  - Contradictory evidence exists regarding outcomes from drinking alcohol

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Exemple of the DRIVE-Mind cohort in Haiphong: ambulatory comprehensive care

- 233 people who inject drugs with severe psychiatric disorders included in a one year follow-up cohort
  - Psychotic syndrome or major depressive disorder
  - 30% with harmful alcohol use (Audit-C)
- Community-based intervention
  - Follow-up by trained CBO
  - Information, support for treatment, regular contact including with family, harm reduction for drug use, linkage to care for methadone, HIV
  - Psychiatric consultation on CBO site, free of charge
  - Free treatment provided on site
- Assessment after one year
  - 170 patients still on follow-up (12 deceased): 73% retention rate
  - 23% only with harmful alcohol use
  - 79% considered as very much ou much improved according to the psychiatrists (73% at M6 FU visit)

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IN FRANCE
EXEMPLE OF THE PIERRE NICOLE CENTER

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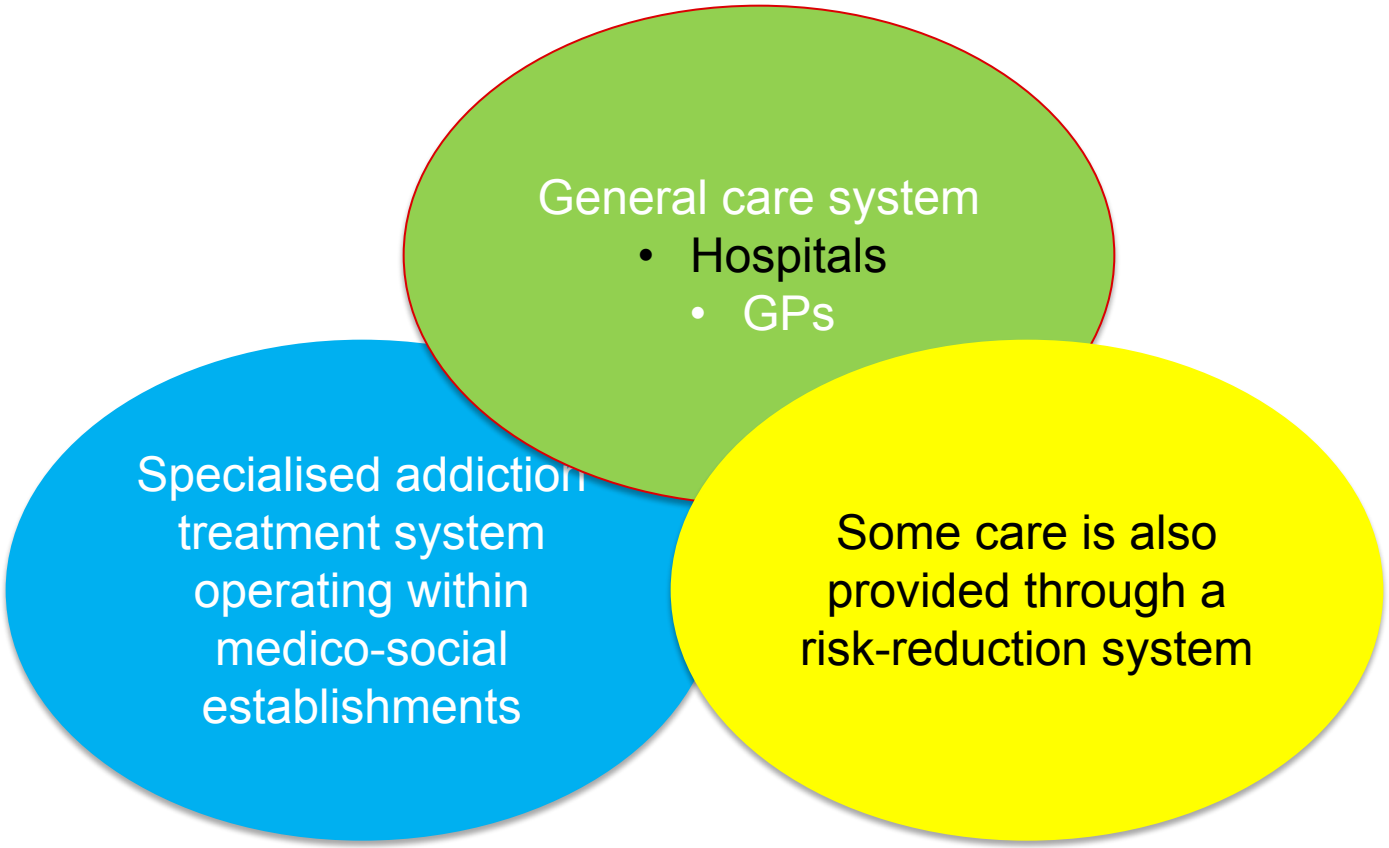
Addiction treatment: Care Organization

- Financed since 2003 by the French social security system



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Who is seeking for care ?

- Self-management
- General population
- Awareness

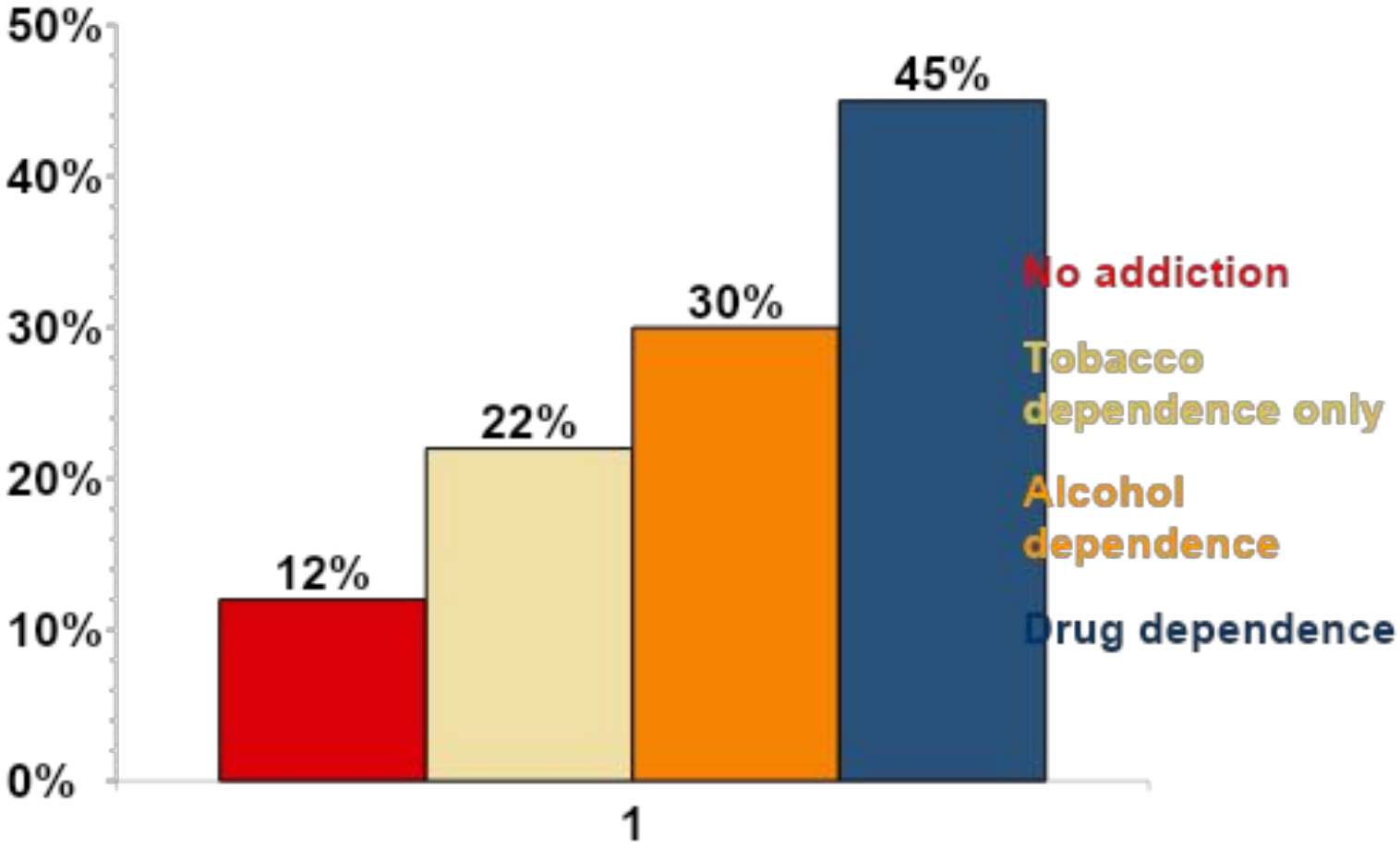
- Primary care
- Self-management failure : context, addiction severity…
- Brief intervention (counselling, support, evaluation, prescription…)

- Specialized settings (hospital, CSAPA/CAARUD)
- Severe addiction, psychiatric comorbidity, social impaiment
- Comprehensive approach, long term care

Psychiatric comorbidities

General population survey

Farrell et al (2001) Br J Psychiatry



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Specialised addiction treatment system

- 488 centres in France (CSAPA)
  - In the community
  - Free
  - No medical insurance required
  - Can be anonymous
  - Any addictive behavior

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Specialised addiction treatment system

- CSAPA
  - Consultations
  - Day clinics
  - Residential settings
  - Prison system

  - Activity (2016)
    - Total population : 308 000
    - Mediane number of patients per centre : 702
    - + 300 consultations for young people

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Specialised addiction treatment system

- Behavior motivating contact with drug addiction system
  - Alcohol 48%
  - Cannabis 20%
  - Opioids 13%
  - Tobacco 7%
  - Cocaïne/crack 3%,
    - > 10% in Paris area
  - Addiction without drug (pathological gambling, sex, anorexia/boulimia…)
    - And more and more frequently chemsex
- Drug Injection
  - Lifetime 9%
  - Last month 5%

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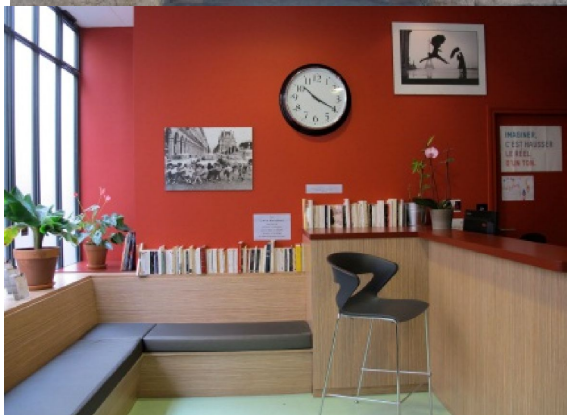
France: Centre Pierre Nicole



- A proximity setting
  - Red Cross setting downtown Paris
  - Around 1 800 patients/year, any addiction
  - Outpatient clinics + residential setting (70 places)
  - Interventions in prison setting
  - Youth clinic (prevention, assessment & care)
- Integrated care except for hospitalizatic
  - Multidisciplinary staff: 55 people
    - 4 psychiatrists/9 doctors
    - 5 psychologists
    - 4 nurses
    - Social workers

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In practice

- Often first line assessment with nurses/doctors
- Psychologist/nurses/GP/social worker may ask for a psychiatric assessment
- When psychiatric comorbidity identified, if previous follow-up
  - Contact with psychiatric setting to discuss parallel treatment
  - Some patients prefer being treated in addiction unit
    - Conflict with psychiatric staff
    - Or prefer being seen as a drug addict rather than psychiatric patient
      - stigma still present
  - Sometimes refusal to initiate care when psychiatric disorder is clearly the main concern (acute delusion, manic episode and refusal of any contact with mental health setting)

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In practice

- During the first contacts
  - Harm reduction first: OST, address urgent medical or psychiatric issues
  - OST if necessary the same day (interview, urine test)
  - Psychiatrist, psychologist, social worker
  - Rapid test: HIV, HCV, COVID
  - Medical status
  - Prescription for biological test, medication
  - Define a therapeutic project

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In practice

- When patient is naive of any previous follow-up
  - propose to meet a psychiatrist in mental health outpatient clinic in parallel with our follow-up
  - If refuse, comorbidity managed in the drug addiction unit
    - But frequent problem when acute phase of the psychiatric disorder (mainly schizophrenia and bipolar disorder)
    - Work with the patient to accept a psychiatric follow-up later

- Special focus on young people
  - Higher vulnerability regarding the consequences of drug use
  - The need to take into account family environment
    - Family intervention/therapy
  - Prevention is crucial

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OST

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180 000 on OST

112 000 buprenorphine (62%)
68 000 methadone (38%)

Prescription: Who ?

GP (63%)
Buprenorphine 80%
Methadone 36%

CSAPA (30%)
Buprenorphine 15%
(16 200)
Methadone 53%
(36 430)

Prison (7%)
buprenorphine 6%
Methadone 9%

Delivery: Where ?

Pharmacy
162 500 (90%)
Buprenorphine 89%
Methadone 90%

CSAPA 12%
Buprenorphine 3%
(3 400)
Methadone 27%
(18 500)

Prison

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OST

- OST initiation
  - DOT except Saturday and Sunday for at least 2 weeks
  - Starting a Monday
  - Daily clinical assessment + regular urine test

  - Then delivery for 2 days, 3 days, a week up to 2 weeks
  - DOT for the most vulnerable ones (homeless, severe psychiatric disorders…) or if misuse (injection, snorting, resell…)

  - When possible, pharmacy
  - Referral to GP possible when patient fully stabilized but GP often not interested

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- For dual diagnosis
  - DOT when necessary for psychotropic drugs/drug addiction treatment
  - Extended-release antipsychotics available
  - Psychosocial interventions
  - Daily therapeutic activities, daily contact with nurses possible
  - Social support
  - Link with psychiatric emergency setting
  - Link with psychiatric outpatient/inpatient clinics
  - Even if an integrated model of care is proposed, link with psychiatric settings is necessary, particularly to face acute disorders (schizophrenic disorder, bipolar disorder)
  - Regular contacts with professionals from psychiatry/meetings around patients are organized

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- Integrated care
  - Medical follow-up (GP)
  - Psychiatric follow-up
  - Addiction problem follow-up
  - Psychotherapy
  - Social support (health insurance, housing, …)
  - Therapeutic activities (art, psychodrama, videos, cognitive remediation…)
  - CBT
  - Rehabilitation (job, …)
  - Residential care
  - Harm reduction (including in the residential setting)