Alcohol and cannabis: what responses are available in the French addiction care plan?

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No conflict of interest for this communication

History

The addiction care plan (prevention/treatment) has been gradually developed over time as a function of:

- the problems raised (alcohol, illicit drugs, smoking, non-substance addictions)

- and local opportunities (behaviour/substance, medico-social/hospital, etc.)

$\Rightarrow$ Fairly extensive plan, but qualitatively and quantitatively heterogeneous and sometimes competitive, still insufficiently coordinated, and often fairly poorly visible for patients or even healthcare partners

Changes since the end of the 1990s

Evolving ideas concerning the concept of addiction, from a substance-based approach to a global addiction medicine approach.
Reorganisation of the addiction care plan since the 2007-2011 Ministerial plan.
Development of a complete and coherent plan adapted to all of the population's varied needs.
Improvement of the territorial distribution of the care plan.

Advantages:
- Improved recognition of addiction medicine
- Improved organisation and clarity of the addiction care plan
- Allocation of increased resources
- But also development of prevention, training and research, etc.

Presentation of the addiction care plan organised according to 4 poles

- **Office medicine**

  Essentially general practitioners. First line of non specialized care

- **Health and medico-social structures**

  . CSAPA (*Centres de Soins, d'Accompagnement et de Prévention en addiction medicine*)
  [addiction medicine care, support and prevention centres]
  . CAARUD (*Centre d'Accueil et d'Accompagnement à la Réduction des Risques pour Usagers de Drogues*)
  [drug user risk reduction centers]

- **Hospital structures**

- **Mutual aid associations**

First-line management

(non-addiction medicine specialists)

- **Office medicine**

  . Especially general practitioners

  . GPs with a particular interest in addiction medicine

  . *Microstructures*: assist GPs by part-time non-medical personnel: psychologist, health educator, social worker…)

  . Development of CSAPA outreach clinics in health care centres (nurses)

  Detection, approach, referral, coordination ± management

  Long-term follow-up.

- **Personnel, teams, non-specialised structures**

  * Pharmacists

  * Other: social welfare structures

Medico-social structures

System developed since the 1970s

- **Centres de Soins, d'Accompagnement et de Prévention en Addictologie** (CSAPA)
  = fusion of alcohol rehabilitation and illegal drug addiction centres, now devoted to all forms of addictive behaviour

  - Multidisciplinary teams
  - Low to moderate medicalisation
  - Long-term patient support
  - Coordination with partners
  - Specific national health insurance funding

Development of outreach clinics as close as possible to patients who find it difficult to travel / allocation of personnel to microstructures.

CSAPA

Mandatory missions

- Reception
- Information
- Medical, psychological, social evaluation
- Referral
- Medical, psychological, social management
- Risk reduction actions = limit health and social risks related to psychoactive substance use
  + integration into health care
  + maintenance and restoration of social interactions

Optional missions

- *Young user consultations* (early intervention +++)
- Prevention
- Teaching
- Research
- Interventions directed towards offenders, homeless persons, etc.

Participation in the health surveillance and alert system

CSAPA

These centres can comprise inpatient facilities

- Short stay

  Emergency or transition facilities

- Intermediate and long stay

  - Residential therapeutic centres (up to 1 year)
    Low level of medicalisation, focussing on rehabilitation/return to work and social integration
  - Therapeutic apartments (1 month to 1 year)
  - Host families (several days to several months)

- Therapeutic communities (1 to 2 years)

  Experimental establishments

  Can subsequently become CSAPA

  Therapeutic project + social integration

Centres d'Accueil et d'Accompagnement à la Réduction des Risques pour Usagers de Drogues (CAARUD)

Focussed on risk reduction, initially in relation to heroin and injected drugs (syringe exchange programmes, information, etc.)
However, alcohol and tobacco are the leading substances encountered.

Indicated for people not yet engaged in a management plan and/or exposed to particular risks (infectious, etc.)

Missions: reception, information, advice, assistance with access to care, assistance with access to rights (housing, etc.), return to work, provision of prevention material (Stéribox, etc.).

Hospital addiction medicine

A weak link

Emergency or crisis intervention

(especially for alcohol-dependent patients)

- What type of intervention?
- What responses?
- What types of referral?

Opportunity to approach addictive behaviours
Benefit of brief intervention in emergency wards, specially for young people received for drunkenness
Difficult because of the functioning of these structures

Drunk teen agers arriving in emergency ward : an hospitalization is recommended for 2 or 3 days : evaluation (alcohol consumption, psycho-social risks, suicidal risk…) and referral to care if needed

Hospital addiction medicine

Restructured in the framework of the 2007-2011 plan into 3 levels

- **Level 1, local**

  Consultation, liaison, access to beds for simple withdrawal

- **Level 2, backup**

  = level 1 + inpatient unit (full-time or day-time) allowing simple withdrawal and especially more complex care

  Addiction medicine aftercare and rehabilitation
  Prolonged residential care for 1 to 3 months
  Level of medicalisation between hospital and medico-social structures
  Multidisciplinary teams

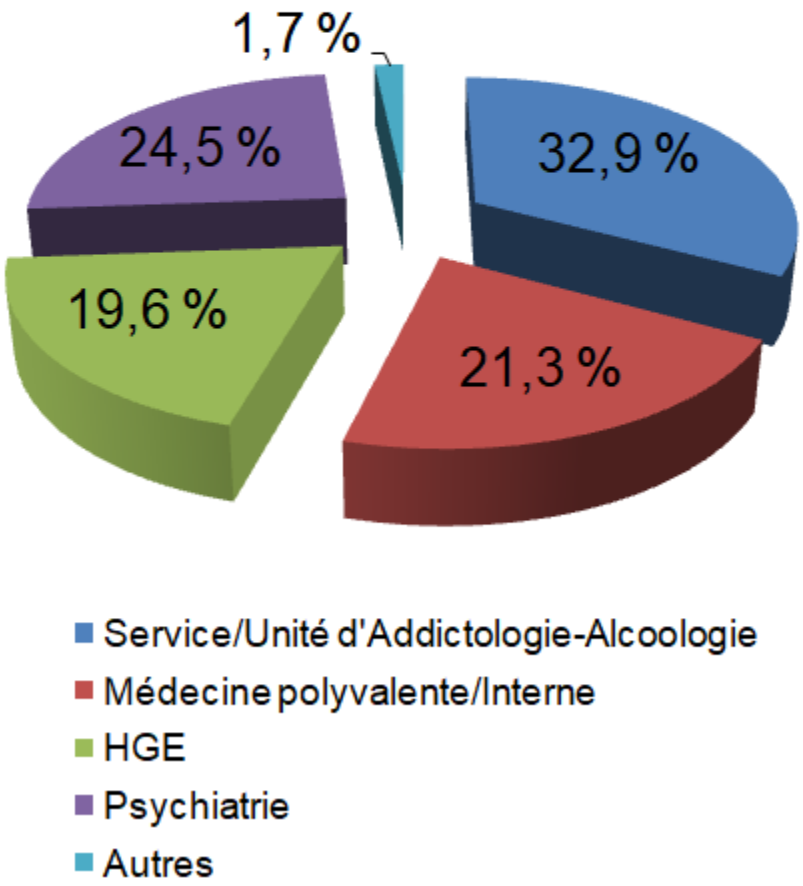
- **Level 3, regional expert centre**

  = level 2 + teaching + research (university hospital)

Medical specialities of hospitalization units

(mainly alcohol)

N = 286



The patient’s care pathway

Improve the coordination between the various addiction medicine professionals

The patient circulates in the health care plan

=> The patient's pathway must be fluid within this health care plan according to his or her needs and choices at a given point in time (network).

Networking

Networks are evolving towards a coordination support function to help GPs and facilitate therapeutic coordination of different professionals

But : this coordination of various actors, GPs, medico-social structures and medical institutions in the same region remains insufficient

For example the important relationships between addictologists and psychiatrists sometimes encounter difficulties functioning

Generally speaking, in young people problems are different from adults

- Less dependent
- More acute complications (binge drinking)
- Few somatic complications
- Mainly psycho-social problems
- Cognitive disorders
- Few hospitalizations or other residential cares (More frequent with adults 30-50 years old)
- Ambulatory follow-up

Alcohol and cannabis

- Essentially outpatient follow-up
- First-line care = general practitioners. Patients approach often difficult
- Consultations: CSAPA, hospital outpatient departments
- Day hospital
- Full-time hospitalisation or aftercare and rehabilitation: rare

  But: co-addictions are common in patients hospitalised for other addictive behaviours => cannabis must also be taken into account, especially in young patients.

  More frequent for alcohol

  . Severe addiction

  . Comorbidities

RECAP 2016

Common Data Collection on Addictions and Treatments

This system collects data about clients seen in National Treatment and Prevention Centres for Addiction (CSAPA)

375 structures

. CSAPA « all addictions »
. CSAPA « alcohol »
. CSAPA « illicit drugs »

308 000 patients

Young user consultations

Survey

253 structures / 34-35 000 young people

Rising

133 persons received on average per year. Great disparity

Mean number of consultations = 3.2

Breakdown according to addictive behaviours leading to treatment

Product	%
Alcohol	**10.7**
Tobacco	6.1
Cannabis	**70.6**
Addictions sans produit	6.6

Importance of family reception

Often worried. Need for informations

CSAPA

Breakdown of patients received in different CSAPA according to age

Age (years)	CSAPA illicit drugs %	CSAPA alcohol %	All CSAPA %
< 18	**6.4**	**3**	**4,1**
18-24	**16.6**	**9.1**	**11.5**
24-29	13.8	9;4	10.9
30-39	28.8	24.3	25.8
40-49	21.9	25.5	24.3
50-59	10.1	18.7	15.9
≥ 60	2.5	10	7.5

23%

12.1%

15.6%

Psycho-active substances breakdown according to CSAPA

Produit	CSAPA illicit drugs %	CSAPA alcohol %	All CSAPA %
alcohol	**20.7**	**61.6**	**48.4**
Tobacco	4.4	8.9	7.4
Cannabis	**32.7**	**14.0**	**20.0**
Opioids	23.9	7.6	12.8
Cocaine/crack	6.6	1.8	3.3

Breakdown of consumed products according to age

Age (years)	Cannabis %	Opioids, cocaine others %	Alcohol %
< 20	**27.1**	1.4	**2.5**
of which < 18	13.2	0.5	1.3
20 - 24	**26.2**	5.6	**4.6**
25 -29	18.0	13.2	7.5
30 -39	19.8	38.0	22.7
40 -49	6.8	28.9	27.7
50 -59	1.8	11;1	22.6
≥ 60 ans	0.3	1.7	12.3

Breakdown according to the number of products consumed last month

Number of products	Cannabis %	Opioids, cocaine other %	Alcohol %
1 product	**45.7**	29.4	**47.5**
2 products	**32.8**	28.5	**38.8**
3 products	**17.9**	24.7	**11.3**
4 products or more	**3.6**	17.5	**2.4**

As among adults, polyconsumption / polyaddiction is very frequent among young people

Alcohol – tobacco ; tobacco – cannabis and alcohol – cannabis = most frequent associations

Illicit drugs associations = opioids, cannabis, tobacco ± cocaine

Hospital addictology settings
Which patients?

The most severely ill patients:

- severity of addictive behaviour(s)
- and/or severe comorbidities

Survey (2010)

3,000 patients interviewed – 143 healthcare institutions

Hospitalisations essentially for alcohol-related problems

Results:

- ¾ of men
- Mean age = 46.9 years
- About 1/3 presented social difficulties
- ½ presented a mental illness (anxiety and mood disorders)

  Higher prevalence among women (53% vs 36%)
- Almost 4/10 presented a chronic somatic illness. This proportion increased with age.

Overall, 60% of hospitalised patients presented a chronic somatic illness or a mental illness or both

- 79% were smokers. 12 to 13% smoked cannabis (but 32% of patients under the age of 40). Higher proportion of men.
- Patients under the age of 40 were more often multiple psychoactive substance users
- ¾ of hospitalised patients had already been hospitalised

Strong points

- A specific and coherent addiction medicine plan, currently being reinforced, facilitating access to care.
  . Emphasis on outpatient follow-up
  . General practitioners – Microstructures – Local clinics
  . Telemedicine (early phase)

- Possibility of early local interventions
  Young user clinics (especially cannabis, but also alcohol and tobacco)

- Possibility of global evaluation and management of all addictions (high rate of multiple substance use among dependent patients)

- Creation of liaison teams in hospitals to facilitate the management and referral of patients hospitalised in units not specialised in addiction medicine

- Several mobile multisite / multi-institution teams

Weak points

- Cannabis and alcohol are the 2 substances about which it is most difficult to speak in France.
  . The illegal status of cannabis does not facilitate access to care
  . The place of alcohol in French society and the representations of alcohol-dependent subjects also do not facilitate access to care

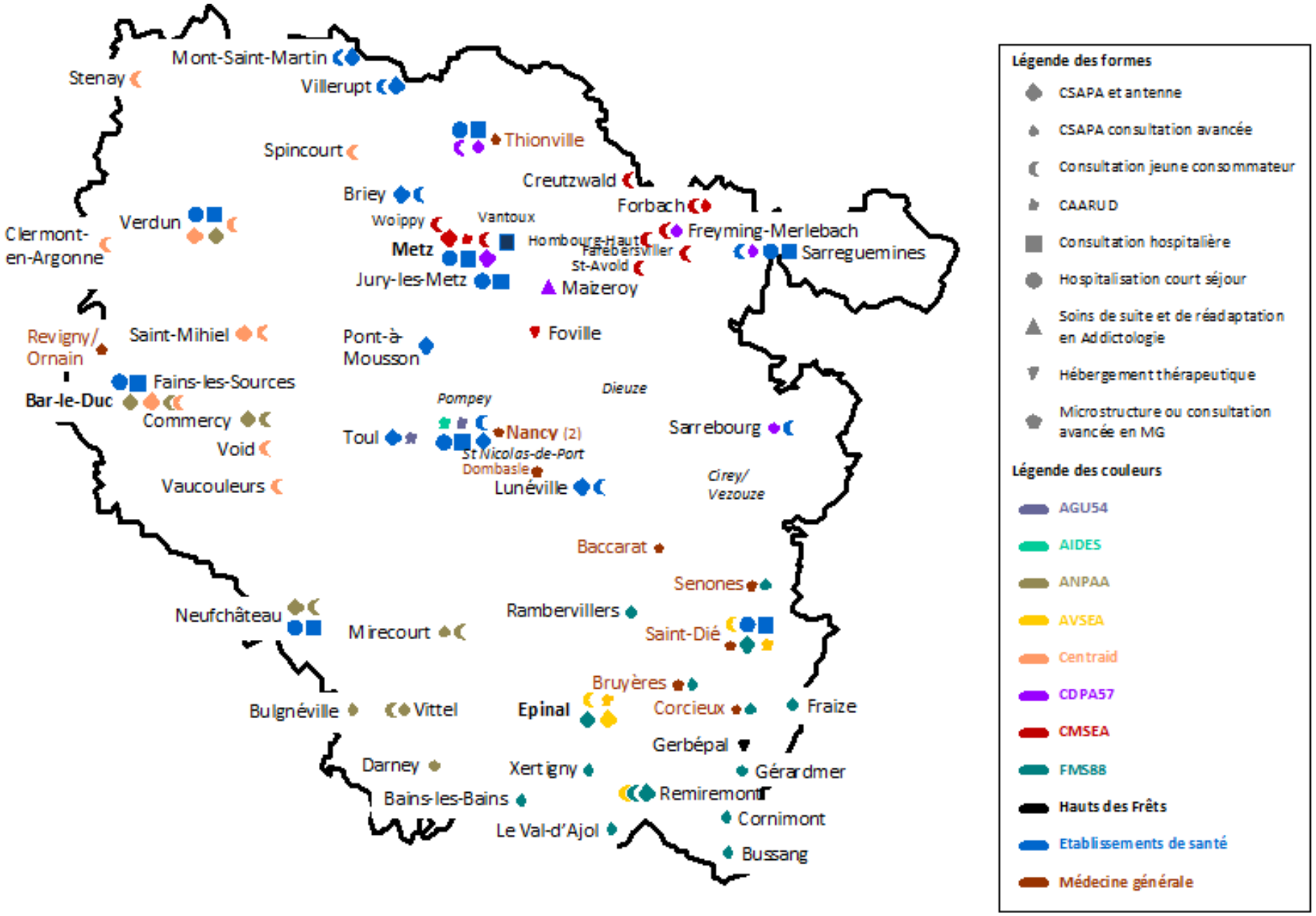
- Access to specialised care is sometimes difficult (rural zones with few specialists and even few general practitioners). Only 15 to 20% of patients are managed…

- Private practitioners are not sufficiently concerned by these problems, especially alcohol and cannabis. Smoking is easier to deal with.
  . Insufficient training (early detection, brief interventions, etc.)
  . Lack of time
  . Do not feel rightful to address these issues
  . ***Problem of representations***
  => Patients are referred to specialised centres too late, at a stage of severe abuse associated with complications

- Complications are well managed in hospital, but ***the underlying behaviour addictive is rarely addressed*** despite the creation of liaison teams, who are insufficiently called upon and inadequately funded.
  Emergency or crisis management constitutes a very inadequate response to dependent, usually alcohol-dependent, people.

- ***Coordination between the various professionals***, office medicine, health and social welfare structures and hospitals in the same territory ***still insufficient***.
  Referral to addiction medicine specialists ↔ psychiatrists, although essential, is not always straightforward
  Formal networks are still too rare and not always fully operational.

- ***Complex plan that is sometimes difficult to understand*** for patients and health care professionals


Mont-Saint-Martin
Stenay
Villerupt
Thionville
Spincourt
Creutzwald
Briey
Forbach
Woippy
Vantoux
Verdun
Clermont-en-Argonne
Metz
Hombourg-Haut
Freyming-Merlebach
Farebersviller
Sarreguemines
St-Avold
Jury-les-Metz
Maizeroy
Revigny/Ornain
Saint-Mihiel
Pont-à-Mousson
Foville
Fains-les-Sources
Bar-le-Duc
Dieuze
Pompey
Commercy
Sarrebourg
Toul
Nancy (2)
Void
St Nicolas-de-Port
Dombasle
Vaucouleurs
Lunéville
Cirey/Vezouze
Baccarat
Senones
Neufchâteau
Rambervillers
Mirecourt
Saint-Dié
Bruyères
Bulgnéville
Vittel
Epinal
Corcieux
Fraize
Gerbépal
Darney
Xertigny
Gérardmer
Bains-les-Bains
Remiremont
Cornimont
Le Val-d'Ajol
Bussang
Légende des formes
CSAPA et antenne
CSAPA consultation avancée
Consultation jeune consommateur
CAARUD
Consultation hospitalière
Hospitalisation court séjour
Soins de suite et de réadaptation en Addictologie
Hébergement thérapeutique
Microstructure ou consultation avancée en MG
Légende des couleurs
AGU54
AIDES
ANPAA
AVSEA
Centraid
CDPA57
CMSEA
FMS88
Hauts des Frêts
Etablissements de santé
Médecine générale

Conclusion