

Effect of lockdown following COVID-19 pandemic on alcohol use and help-seeking behavior: Observations and insights from a sample of alcohol use disorder patients under treatment from a tertiary care center

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India has been under nationwide lockdown since 25 March 2020. The lockdown includes prohibition on sale of alcohol, restrictions on movement, and limited availability of public transportation. The countrywide lockdown has posed unique challenges to those with alcohol use disorder: both active alcohol users and those seeking treatment to quit.¹

We contacted patients who were enrolled in an ongoing project assessing the impact of disulfiram among patients with alcohol use disorder. The research project was approved by the Institutional Ethics Committee and conformed to the provisions of the Declaration of Helsinki. The patients gave informed consent and their anonymity has been preserved. Telephonic reminder calls were made to the participants to ensure therapeutic adherence and to obtain updated information on alcohol use.

We were able to connect with 73 (76.7%) of the patients. All were male. The mean duration of alcohol use disorder was 8.66 (SD 6.20) years.

Alcohol and tobacco products were not included in the list of essential commodities during the lockdown. This has meant non-availability of these substances through authorized vendors. However, around 20% (*n* = 16) of the patients reported that they had tried to procure alcohol during lockdown and 10 of these (62.5%) had successfully procured alcohol at least once (Table 1). Most of them have done so through clandestine sources and at higher prices than normal. Additionally, alcohol procured by about 20% of these 10 patients had been sold in an unsealed bottle. This raised concern about the safety of these alcoholic beverages and the possibility of exposure to additional health risks from consumption of adulterated or surrogate alcohol (e.g., poisonous fungus, methanol toxicity).^{2,3}

Five patients (6.6%) reported having experienced alcohol withdrawal since the beginning of lockdown and one of these subjects reported experiencing withdrawal seizures. Only one patient of the five (20%) has been able to procure medicines to manage the withdrawals, and most of the subjects have not been able to access any medical help to manage their withdrawals.

The proportion of alcohol users across the country who would have experienced withdrawals is likely much higher than what we have observed in the current study. This is so because subjects in the present study had been offered treatment for alcohol use disorder in the past and it is likely that a significant proportion of them was no longer using alcohol, at least on a regular basis. While withdrawal symptoms among those physically dependent on alcohol are self-limiting, they are distressing and can even be lethal if left untreated. The added mental stress due to uncertainty about the future due to COVID-19, hardships faced due to lockdown, and economic and employment concerns would have made it even more challenging to bear the withdrawals. The bidirectional relation between coexisting psychological distress and increased alcohol

withdrawal symptom severity has been well established in the published literature.^{4,5}

Of the 15 patients (19.7%) who tried to procure disulfiram, only nine (60%) were able to do so. Lack of availability of disulfiram at pharmacies is a concerning observation. Similarly, medications for the management of alcohol withdrawal symptoms could be procured by just one of the subjects. Concerns about limited attention to the availability of such medicines have been reported in the literature.⁶

A total of 28 (36.8%) patients tried to attend follow-up at the treatment center. Only five of these (17.8%) were able to reach the center. Lack of transportation, restrictions by law-enforcement agencies, and fear of contracting COVID-19 infection during travel were the common barriers to treatment-seeking (Table 1). A reduced help-seeking behavior out of safety concerns has been reported during previous pandemics as well.⁷ While it is likely that the complete lockdown will be lifted in the coming weeks, the restrictions on movement are likely to continue further. Hence it is important to ensure the availability of public transportation as well as

Table 1 Alcohol use pattern and help-seeking behavior of persons with alcohol use disorder during the COVID-19 lockdown period (*N* = 73)

Alcohol use pattern and help-seeking behavior	<i>n</i> (%)
Tried to procure alcohol since lockdown	16 (21%)
Was able to procure alcohol since lockdown	10 (62.5%)
Source of procurement of alcoholic beverage (<i>n</i> = 10)	Gray market 7 (70%) Friends 2 (20%) Employee from work 1 (10%)
Pricing of the alcoholic beverage	Higher 9 (90%) Free 1 (10%)
Alcoholic beverage was sold in a sealed bottle	8 (80%)
Tried to attend follow-up at NDDTC since lockdown	28 (36.8%)
Could reach the treatment center	5 (17.8%)
Reasons for not being able to reach treatment center (<i>n</i> = 23)	Restrictions on movement 7 (30.4%) Could not arrange transport 10 (43.4%) Decided not to travel due to safety concerns 5 (21.7%) Could not get leave from work due to emergency duties 1 (4.3%)
Tried to procure disulfiram since lockdown	15 (19.7%)
Able to procure disulfiram since lockdown	9 (60%)
Source of procurement of disulfiram (<i>n</i> = 9)	Chemist 8 (88.8%) Physician 1 (11.1%)
Experienced alcohol withdrawals since lockdown	5 (6.6%)
Management of the alcohol withdrawals (<i>n</i> = 5)	Procured medicines from chemist 1 (20%) No intervention 4 (80%)
Used any tobacco product since lockdown	38 (50%)
Source of procurement of tobacco product (<i>n</i> = 38)	From vendor at higher price 33 (86.8%) From vendor at sale price 2 (5.2%) Had stocked before lockdown 1 (2.6%) From friends 2 (5.2%)
Family members could be contacted over the telephone	34 (44.7%)

NDDTC, National Drug Dependence Treatment Center.

support from the law-enforcement agencies to facilitate the movement of these patients to the treatment centers. Moreover, treatment-seeking will remain low despite the lifting of restrictions unless the safety concerns of this group are addressed adequately.

In a binary logistic regression model, number of days since last use of alcohol (odds ratio, 0.90 [95% confidence interval, 0.84–0.97], $P = 0.007$) was the only variable independently associated (inverse association) with attempt to seek alcohol during the lockdown period.

There is a need to address barriers to help-seeking going ahead as we continue to deal with COVID-19 in the coming months. A contingency plan should be put in place to ensure continuity of care for persons with alcohol use disorder in such extraordinary situations.

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Disclosure statement

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References

1. Poyyal S. The lockdown shows India's ill-preparedness to deal with rampant alcoholism. *Re:Set* 2020. [Cited 20 April 2020.] Available from URL <https://resetfest.com/the-lockdown-shows-indias-ill-preparedness-to-deal-with-rampant-alcoholism/>
2. Lachenmeier DW, Rehm J, Gmel G. Surrogate alcohol: What do we know and where do we go? *Alcohol. Clin. Exp. Res.* 2007; **31**: 1613–1624.
3. D'Silva J. India's problem with toxic alcohol. *BMJ* 2015; **351**: h4536.
4. Andersohn F, Kiefer F. Depressive mood and craving during alcohol withdrawal: Association and interaction. *Ger. J. Psychiatr.* 2004; **7**: 6–11.
5. Wetterling T, Junghanns K. Psychopathology of alcoholics during withdrawal and early abstinence. *Eur. Psychiatry* 2000; **15**: 483–488.
6. Balhara YPS. A curious case of the World Health Organization's (WHO) approach on alcohol use disorders: Inferences from the WHO list of essential drugs. *Addiction* 2013; **108**: 2030.
7. Feng S, Grépin KA, Chunara R. Tracking health seeking behavior during an Ebola outbreak via mobile phones and SMS. *NPJ Digit. Med* 2018; **1**: 51.

Yatan Pal Singh Balhara, MD, DNB, MNAMS  Swarndeep Singh, MD and Parul Narang, BDS

National Drug Dependence Treatment Center and Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, India
Email: ypsbalhara@gmail.com

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E-mental health options in the COVID-19 pandemic and beyond

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According to the United Nations, there is a high risk that the COVID-19 crisis will evolve into a mental health crisis if no immediate action is taken.¹ Potential causes of psychological distress during the pandemic are many, including fear of infection and consequences of physical and social distancing (e.g., loneliness) or economic turmoil (e.g., job loss). The United Nations recommends the widespread availability and use of mental

health care and psychosocial support as a means to minimize the psychological consequences of the COVID-19 crisis.¹ However, mental health care is often underfunded and structurally poorly prepared for the challenges ahead. Currently, there are also unique challenges to contact-based mental health services, such as risk of infection (or fear thereof) in inpatient settings or in community initiatives (e.g., self-help groups). Thus, the transmissibility of COVID-19 via direct contact hinders many forms of traditional treatment options in mental health care.

To date, there is common agreement that e-mental health provides valuable options for mental health care during the pandemic.^{1–4} E-mental health encompasses the use of digital technologies to deliver, support, or enhance mental health services.⁵ For example, during the pandemic in China, e-mental health options (e.g., online psychological counseling, online mental health education, and online psychological self-help interventions) were widely used.² In Germany, reimbursement possibilities for recently deregulated video consultations have been expanded in response to the COVID-19 outbreak. Thus, the pandemic may accelerate regulatory processes required for e-mental health services. As a quick emergency response, governments worldwide should expand the legal frameworks required for the application and reimbursement of e-mental health options.

The COVID-19 crisis does not only lead to short-term psychological difficulties, but negative long-term mental health consequences are also expected.¹ In light of the growing demand and expected economic turmoil, which may limit resources, sustainable, innovative, and cost-effective solutions in mental health care are needed in the long term. The current crisis provides an opportunity to align mental health-care policies with the current state of knowledge regarding the effectiveness of e-mental health options.⁶ National health policy-makers should further accelerate e-mental health options. To meet this aim, sustainable policy measures are needed that include adequate funding and reimbursement strategies, but also high standards of usability and rigorous quality control for e-mental health products. Importantly, not all available e-mental health options must necessarily be implemented or reimbursed. For example, thus far, the evidence for the effectiveness of standalone apps in mental health care is rather limited.⁷ Adequately funded research is needed to assess how the applicability and effectiveness of e-mental health options in routine practice and future crises can be further improved, taking into account users' perspectives.^{8,9} Many mental health professionals are gaining firsthand experience with e-mental health options in the current pandemic, which may positively influence attitudes towards their use in clinical practice. Specific training of mental health professionals will be necessary to meet quality standards for safe and effective use of e-mental health options. In sum, we support current calls for the upscaling of e-mental health options in the face of the COVID-19 crisis. Additionally, sustainable policy solutions, training capacities, and adequate research funding are imperative to ensuring the long-term uptake, acceptance, and quality of e-mental health options.

Disclosure statement

Professor Gaebel and Dr Stricker have nothing to disclose.

References

1. United Nations. Policy Brief: COVID-19 and the Need for Action on Mental Health. 2020. [Cited 18 Jun 2020.] Available from URL: https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf
2. Liu S, Yang L, Zhang C *et al.* Online mental health services in China during the COVID-19 outbreak. *Lancet Psychiatry* 2020; **7**: E17–E18.
3. Torous J, Myrick KJ, Rauseo-Ricupero N, Firth J. Digital mental health and COVID-19: Using technology today to accelerate the curve on access and quality tomorrow. *JMIR Mental Health* 2020; **7**: e18848.
4. Wind TR, Rijkeboer M, Andersson G, Riper H. The COVID-19 pandemic: The 'black swan' for mental health care and a turning point for e-health. *Internet Interv.* 2020; **20**: 100317.
5. World Psychiatric Association. WPA position statement on e-mental health. 2017. [Cited 18 Jun 2020.] Available from URL: https://3ba346defde6-473f-b1da-536498661f9c.filesusr.com/ugd/e172f3_6c100e940fbc4c6e91a79c9dd98193d.pdf