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Challenges Faced and Their Management During Drug De-Addiction Programme

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Abstract

Recovering from addiction is a long road and stopping the substance abuse is just the first part. Getting sober is just the stepping stone for fully taking back the control of life. There are so many rehabilitation facilities and programs to help people through the rehab process. However, challenges faced during the de-addiction process are of concern. There is a wide array of reasons that contribute to these challenges, both treatment and patient related, the most fundamental and important being lack of adequate infrastructure, workforce crisis, recruitment issues, negative attitude of the patient and that of the society towards him, lack of job opportunities and the list goes on. This interferes with the quality of treatment and supporting services for recovery of patients from addiction. A proper de-addiction plan should consider all these challenges and other complications that may come across during management. Various management steps, at government/legal, institutional and individual level are possible to overcome these problems are available and surely make the process of drug de-addiction better and smooth to ensure improvement and quality of life.

Keywords: de-addiction, rehabilitation, challenges

Introduction

Chronic drug use is overpowering and it decimates an individual's life as the medications assume responsibility for your life. Shaking off an illicit drug use isn't simple. It requires a ton of boldness to initially concede that you have an issue and a lot of exertion is required to look for help and recuperate from fixation. [1, 2]

It was reported globally that 246 million people (1 out of every 20 people) between the age of 15 and 64 years abused the drugs in 2013. It was reported that around 27 million people faced various complications because of drug abuse. Around half of the people who are abusing drugs administer the drugs through injection and around 1.65 million people who were taking the drugs through injection were suffering from human immunodeficiency virus. [3] Similarly, a large proportion of the population (around 38%) consume alcohol globally, among whom, about 16% engage in heavy episodic drinking. In 2012, it was estimated that alcohol was responsible for 5.9% deaths worldwide. [4]

In India, alcohol (21.4%) was found the primary substance of abuse and other substances commonly abused were cannabis (3.0%) and opioids (0.7%) in the National Household

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Survey. The survey estimated that more than one crore people in the country were suffering from alcohol or drug dependence. [5]

Drugs of abuse are responsible imbalance in the level of neurotransmitters in the brain and these changes remain there even long after an individual quitting the substance of abuse. This imbalance in the level of neurotransmitters makes the relapse more frequent, therefore treatment is an essential part of the rehabilitation process. [6]

Recouping from addiction is a lengthy, difficult experience and halting the substance misuse is only the first step. Getting calm is only the venturing stone for completely reclaiming the control of life. There are such a significant number of recovery offices, centres and projects to help individuals through the recovery procedure. [7]

However, challenges faced during the de addiction process are of concern. The most common challenge encountered is inadequate manpower that is an essential part of the treatment and support through the recovery process. Among other challenges are inadequate salary, making the people realize that they are facing problem and convincing them to be part of the treatment. Among the other issues are selection, retention and professional development of staff. Together all these issues ultimately affect the quality of the treatment offered to the person undergoing de-addiction process. [8, 9]

Initiation and Evolution of the Drug Addiction Programme

The time of 1980 saw some significant advancements in India, in light of the rising issues of medications use. Alongside the plan of MoSJE, there was a felt need among the specialists and arrangement producers to address the therapeutic treatment of SUDs through the medicinal services frameworks of the nation, including the MoHFW, Government of India. It was chosen that treatment arrangement will be the command of MoHFW, while counteractive action and restoration will be the focal point of the MoSJE. Following the proposals of a Cabinet subcommittee, the Drug De-Addiction Program (DDAP) was propelled in 1988. The program conceived building up 30-bedded de-addiction centres (DACs) in every one of the six head clinics/foundations in the nation for giving inpatient treatment to patients with SUD. Within the next few years, the program additionally extended in 1992–93 under a plan for foundation of DACs in therapeutic schools/area clinics in different states. Through a coordinated effort between the central and state governments, the one-time costs for foundation of DACs were borne by the central government, while the common cost of running the DAC administrations was visualized to be borne by the state governments. The plan between the focal and state government was made thinking about that "well-being" subject is a mutual order between the association and state governments under the Constitution of India. Along these lines, the focal government help was to a great extent constrained to arrangement of one-time award for framework, while staff, supplies, and other repeating costs were to be borne by the particular state governments. [10]

For the north-eastern states, however, there was a provision of an additional recurring assistance of up to Rs. 200,000 per year per centre by the central government. Under the scheme, about 122 DACs have been established by the MoHFW, of which 43 are in the north-eastern states. Besides, the DACs in the north-eastern states, few others were also

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Vol-22-Issue-16-August-2019

supported by the MoHFW through provision of one-time infrastructure support as well as almost 100% of recurring expenses for staff and supplies. These were located in the following central government institutes: Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry; and Ram Manohar Lohia Hospital, New Delhi. Out of these, the DAC at AIIMS, New Delhi, was designated as the 'National Drug Dependence Treatment Centre' (NDDTC) in 2002, with an expanded mandate of working as a national level resource centre. Apart from the clinical, academic, and training activities, NDDTC has been tasked with the responsibility of playing an advisory role to the DDAP, MoH, and FW as well as coordination of several activities on behalf of the Ministry. [11, 12]

The 'DDAP' is a modest-sized program coordinated by the MoHFW through a section in the Ministry where the day-to-day affairs are managed by a Director, DDAP, who in turn, reports to a Joint Secretary. In most of the state governments, there are no state-level counterparts for DDAP. There is also provision of an additional staff in the form of an assistant program officer/under-secretary. However, none of the senior administrative officials are responsible exclusively for this program and they have many other responsibilities as well. Thus, there is no senior official at the Union Health Ministry in Government of India, tasked exclusively with looking after the addiction treatment issues. The budget allocated to the DDAP is also modest; the approved budget outlay for 5 years in the 12th 5-year plan from 2012 to 17 was Rupees one hundred and fifty-one crores. [13]

Challenges faced during the Drug De-Addiction process

Treatment related problems:

- **Workforce crisis**

High turnover rates, deficiency of the specialized people, less young people, insufficient pay, inadequate fulfilling of training requirements, absence of characterized vocation ways and stigma as of now challenge the field. These inadequacies directly affect labourers and the patients/customers under their consideration. Drug de-addiction programme involves the people from various fields - mentors, doctors, medical caretakers, social specialists, clinicians, marriage and family advisers, effort and admission labourers, caseworkers and clergy.

In 2003, SAMHSA (Substance Abuse and Mental Health Services Administration) identified five specific needs under the environmental scan:

i. Number of the people involved
ii. Educational qualifications and workforce credentialing;
iii. Training to upgrade the skills of present workforce
iv. Inputs to reduce stigma among people
v. Inputs to involve more young people

- Outcomes of Current Trends

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Vol-22-Issue-16-August-2019

People entering treatment are giving progressively mind boggling and extreme issues while assets have remained generally rare. Private well-being plan inclusion in general well-being plan inclusion over the previous decade, putting considerably more prominent requests on a framework that was at that point deficiently financed to satisfy need. In 1991, private protection represented 24 percent of substance misuse treatment uses, though, in 2001, it represented just 13 percent. Simultaneously, the profile of the freely subsidized addictions treatment persistent/customer has changed. Clinicians and projects must be set up to address the necessities of both an all the more seriously weakened populace, with issues that are progressively various and increasingly obstinate, and a less debilitated populace that is being alluded before in the movement of an addictive issue. To keep up abilities that will keep pace with the quickly evolving condition, the workforce must be strong, clinically skilful and versatile. Tending to these difficulties will require progressing information and ability advancement at the official, the executives and expert levels, and will likewise require enhancement of the workforce through specialization among advocates and through the expansion of a bigger number of partnered experts. Specific ability is required in zones, for example, brief treatment, medicine helped treatments and co-happening issues.

- **Infrastructure Development Issues**

A sound addictions treatment framework guarantees the accessibility of a certified workforce fit for meeting the treatment and recuperation needs of assorted populaces. Proper infrastructure equipments and materials required should be available, which is currently not the scenario. This framework must incorporate components to draw in, instruct, prepare and hold staff and to help the dynamic limit of the treatment conveyance framework. The foundation additionally should incorporate data frameworks that help and upgrade labourers' capacities to oversee treatment benefits and guarantee responsibility and nature of care.

- **Recruitment Priorities**

Treatment offices rival different divisions of the economy that regularly pay higher wages and spot less requests on labourers' time. The requirement for staff with more significant levels of instruction and preparing is more noteworthy now than it was even a couple of years prior due to the (1) expanding multifaceted nature of the patient/customer populace entering treatment and (2) logical advances in treatment. The pool of prepared specialists is neglecting to stay aware of interest. Exacerbating these issues is the constrained stockpile of new labourers. With the present pattern in see, somewhere in the range of 2000 and 2030, the all-out populace of working-age people (18 to 64 years) is anticipated to develop by just 16 percent.

- **Addictions Education and Accreditation Priorities**

New requests are being put on the advanced education framework as the requirement for scholastic training develops inside the addictions treatment field. Truly, preparing for addictions treatment would in general look like a student model. This model emphasizes experience over formal education. An apprentice model can best be portrayed as training in which most of information, aptitudes and capacity to rehearse are conferred through supervision. With the need to treat and oversee complex patients/customers and execute confirm based practices in the work environment, the call for progressively formal instruction

ISSN: 0971-1260
Vol-22-Issue-16-August-2019

to supplement supervision is changing the workforce culture. Progressively, states are finding the need to require formal instruction through credentialing and licensure gauges.

- **Study Issues**

Information on the addictions treatment workforce has been restricted. The surveys, which contrast in substance and procedure, centre on issues, for example, scholarly preparing and expert experience, enrolment and maintenance, treatment models, preparing interests and representative fulfilment. While educational, such examinations don't yield information to direct the advancement of the addictions treatment workforce. [14]

Patient/addict related issues:

- **Irregular Follow Up due to financial problems:**

The greater part of the patients coming into government establishment in the developing nations are from lower financial strata and a large portion of them are day by day workers. They are living hand to mouth presence. The procedures of recovery start with medicine. In any case, because of absence of cash they can't desire customary development. They can't bear the cost of transport charge or train-passage. Once in a while disease of earning individual from families guarantees that they don't have cash to eat, let alone for transport toll or train-charge. Now and again hospital needs to arrange for transport charge or train toll from the poor patient's fund. So patients can't come to take drug normally. They can't take medication structure outside on the grounds that cost of medication is high. What's more, medications need to proceed for long time or even for a lifetime. This prompts relapse of diseases and illnesses.

- **Lack of medicines in governmental Institute:**

There is not adequate supply of medicines in government hospital. Since the cost of the medicines are high so people cannot afford from outside. People who are undergoing de-addiction process has to take medicines for long period or in some cases even for lifetime.

- **Difficulties in a Vocational Rehabilitation:**

In some instances the patients want to undergo vocational training on daily basis. Because of their financial condition, they cannot afford. In the developing countries even the government cannot support because insufficient fund.

- **Lack of Job Opportunities:**

Even in developing countries, there are not enough job opportunities. Unemployment is also one the common reason for the people to undergo drug addiction. If these people are facing the same issue again which is common in present scenario that may be a reason for relapse.

- **Hospital as a dumping site:**

Since the relatives of the addicted people start facing mental and financial problems and the patient becomes a huge liability for them. They want to get rid of the patient at any cost.

ISSN: 0971-1260
Vol-22-Issue-16-August-2019

Under these circumstances, sometimes they give a wrong address while admitting the patient in hospital.

- **Negative attitude of society:**

The Negative attitude of society is one of problems in providing rehabilitation. Existences of this challenge can intensify addiction and limits the addicts and their families of participation and attendance in society.

- **Negative attitude of providers:**

The Negative attitude of providers that engage in providing of rehabilitation services cause lack of ability in treatment and withdraw process of rehabilitation. [15 16,17,18,19,20]

- **High cost of rehabilitation:**

The high cost of rehabilitation is one of the major challenges and causes of discontinuation of rehabilitation for the addict and their families. Existence of this barrier can disrupt receiving rehabilitation services.

Other problems include problem of access to centres of rehabilitation services, problem of transportation, lack of communication ability etc.

Management of drug de-addiction challenges

At legal or governmental level:

- For better functioning of established de-addiction institutions, the government has taken steps and prescribed staff and infrastructure norms which will be applicable for all centres.
- The centres are required to hire an adequate number of qualified health professionals
- Audit of these establishments is conducted by state authority comprising of various officials from social security department, human rights department etc.
- For conducting these audits the state government will charge a fee which will be notified from time to time.

At institutional level:

Following steps are incorporated at institutional level to take care of the patients:

- Cognitive-behavioural therapy, which helps to cope up the current situation by changing the thinking pattern
- Multi-dimensional family therapy, that is designed for well-being of both the patient and the family.
- Motivational interviewing, which concentrates on the will power of the patient in helping quitting the substance of abuse.
- Motivational incentives that encourage positive participation in the drug de-addiction programme.

ISSN: 0971-1260
Vol-22-Issue-16-August-2019

At individual level:

Nothing is more effective than setting personalised goals to improve at individual level and overcome the addiction problem both mentally and physically.

Such goals include:

- Practicing self-care: Making time for things like regular exercise, personal hobbies and medication to help maintain balance in life.
- Eating and consuming nutritiously: Regularly eating nutritious food can help the body to recover from negative effects of substance abuse.
- Setting and achieving personal goals: This helps the healing process, increases self-efficacy and requires self-examination which are great in recovery.
- Maintaining a clean living space: A clean environment promotes feeling of security, safety and comfort while also improving personal hygiene.
- Managing finances: Saving and spending money wisely can help to reduce stress and sustain sobriety.
- Building healthy relationships: Relationships based on honesty, trust and good communication can help maintain sobriety even in stressful times.
- Finding and maintaining employment: Sustainable employment in recovery is essential in building confidence and achieving goals.
- Managing time responsibly: Managing time effectively increases efficiency, reduces boredom and anxiety and provides a sense of fulfilment.

Addressing the problem

Diverse government divisions and services work together to resolve the problems. Like somewhere else on the planet, three expansive approaches are pursued to address the issue of medication use – supply reduction, demand reduction and harm reduction. The 'supply reduction' segment of the administration attempts to lessen the accessibility of unlawful medications through usage of pertinent medication laws and approaches and is overseen to a great extent by the Department of Revenue, Ministry of Finance, the Narcotics Control Bureau, Ministry of Home Affairs, Government of India and an assortment of different organizations in the focal or state governments. The 'demand reduction' segment, then again, manages diminishing the interest for drugs in the populace through avoidance, treatment, and restoration. The Ministry of Social Justice and Empowerment (MoSJE), Government of India, is the nodal service for request decrease and has a 'Plan for Prevention of Alcoholism and Substance Abuse' set up since 1985–86. This plan of the MoSJE is actualized by the nongovernmental associations (NGOs), who run 'Incorporated Rehabilitation Center for Addicts' for treatment and restoration of individuals with SUD. The well-being part of the nation additionally assumes a significant job in sedate interest decrease by treatment of SUDs through government human services offices, which is the focal point of this article. 'Harm reduction' in India is chiefly observed as counteractive action of HIV among individuals who infuse drugs and different methodologies for this are executed by the National AIDS Control Organization, Ministry of Health and Family Welfare (MoHFW).[21]

ISSN: 0971-1260
Vol-22-Issue-16-August-2019

Conclusion

Considering all the challenges and the limitations they pose on the de-addiction process, it is necessary that they must be addressed to improve the life of addict and ensure its quality. Various measures have been taken at legal or governmental level such as mandatory auditing of de-addiction centres, role of MoHFW in 'supply reduction', 'demand reduction' and 'harm reduction'. Also, more importantly, setting personal goals and focussing on personal improvement with an undeterred goes a long way. Emphasis should be laid on constantly improving the available options to treat and rather prevent the addiction and other related complexities from growing. This will definitely ensure betterment of society as a whole and make the world a better place to live in.

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ISSN: 0971-1260
Vol-22-Issue-16-August-2019

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