ISSN: 2249-894X IMPACT FACTOR : 3.8014 (UIF)

REVIEW OF RESEARCH
UGC APPROVED JOURNAL NO. 48514
VOLUME - 6 | ISSUE - 9 | JUNE - 2017

PSYCHO-SOCIAL INTERVENTIONS IN THE WAY OF ALCOHOLIC USAGE MALADIES IN SELECT DE-ADDICTION CENTRES

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ABSTRACT

Psychosocial interventions that have been shown to be effective in studies are not routinely used in clinical practise or taught in educational programmes for mental health professionals who deliver psychosocial interventions. There is no standard system in place to ensure that patients/consumers receive effective psychosocial interventions. (2015, Mary Jane England, Adrienne Stith Butler, and Monica L. Gonzalez). While there is a substantial research base for the efficacy of treatments to cure these conditions, there is a significant difference in what is proven to be successful and what is currently delivered in clinical treatment. Furthermore, as transparency and success evaluation become more important, methods to encourage and assess the quality of psychosocial interventions would be required. This article focuses on the mechanism for optimising the effects of psychosocial services offered by selected de-addiction centres for alcoholic use disorders. The impact of psychosocial treatments on patients is also discussed in the article.

KEYWORDS: *Alcoholic use Disorders, Psychosocial Interventions, Addiction Treatment Centers.*

INTRODUCTION:

Addiction issues have an effect on every aspect of Indian culture (Benegal, 2005; Murthy, 2008). To get enjoyment or relax, people start using different drugs such as cigarettes, alcohol, hemp, opioids, and so on. Pleasurable behaviours will be replicated, according to behavioural and learning hypotheses. The most of them pick up these behaviours from their peers. Later on, it has serious negative effects. When an individual begins to use drugs to relax, he will eventually be unable to survive without them. This is analogous to driving a gasoline vehicle with kerosene. The advantages of use would be appreciated for a short time, but the engine would soon be spoiled. Substance abuse has the same effect on a person's physical, psychological, and social functioning.

Family members play an important part in both avoiding and recovering from alcohol problems (Pandian, 1999; Lakshmi, 2007). Socialization by families, peers, education, faith, and work environment plays an important role in developing an anti- or pro-substance use mentality in people's lives. A individual suffering from addiction could benefit from relearning or changing their mindset. Structured psychosocial services delivered to individuals, families, groups, and communities have been shown to be successful in the treatment of addiction.

EXTREMITY OF THE PROBLEM

In India, addiction has been a biopsychosocial problem. Substance misuse leads to societal, economic, physical, and psychiatric problems in society (Murthy, 2008; Benegal, 2005). In India, prevention is the primary aim or strategy. However, for a variety of reasons, this was not possible. Psycho-Social Interventions are critical in preventing the onset of drug abuse and assisting people in quitting. According to the World Health Organization (WHO, 2010), there are 208 million individuals suffering from alcoholism worldwide. (approximately 4% of the population above the age of 15) According to the National Mental Health Survey of India (2016), the incidence of alcoholic use disorder is significantly high (5.0 percent), and there is a very high prevalence of illnesses caused by alcohol consumption, with an 86.0 percent treatment distance.

Alcoholism is a complex disorder with medical and social implications that affects people from all walks of life. Controlling addictive conditions necessitates programmes such as medication, care, and equipment. Because of the high demand and shortage of services, more and more de-addiction centres are opening. State mental health regulations regulate the minimum standards of these hospitals. Karnataka leads the way in terms of substance addiction among children, followed by Andhra Pradesh. Alcohol use and cigarette use among children are poor in Meghalaya (KMHR, 2012).

Amenities and care to be provided in De-Addiction Centers

Substance misuse is a complicated epidemic with medical and societal consequences that affects people from all walks of life. To control addiction disorders, programmes such as demand reduction and recovery facilities are needed. In patient care, procedures must be followed in accordance with legislation, among other things. The government of Karnataka published the State Mental Health Rules-2012 in GO No.HFW 148 CGE 2012, dated 03/12/2012. As a result of the aforementioned laws, de-addiction centres are classified as urgent care centres under rule 22, and each de-addiction centre must receive a valid licence. The licencing power is delegated to the district's Deputy Commissioners. As per rule 22 of the KMHR 2012, the following are the minimum standards to be given in such centres. The De-Addiction Centers must adhere to the following standards and guidelines:

I. Personnel -Psychiatrists shall be on staff, in a patient-to-psychiatrist ratio of 1:100, one mental health professional, one assistant clinical psychologist, or one psychiatric social worker: Patient to be 1:50, Nurse to be 1:10, Medical Practitioner with a recognised M.B.B.S Degree to be 1:50, and so on. The number of attendants to patients in the attendant:patient ratio is 1:5. Nurses and doctors can work together to ensure that at any given time (24 hours), at least one doctor and one nurse are present in a ward.

II. Functional Features - Each patient has one bed and mattress, as well as three sets of bed linens (i.e. a pair of bed sheets and a pillow cover). a single pillow, a single blanket In-patient psychiatric hospital, A reasonable gap of three feet should be kept between the costs. Living quarters may be a twin, multiple bedded, single bedroom, or cottage; housing for males and females must be different, and dormitories and multiple bedded rooms must have a bathroom. The following scale applies to toilets and bathrooms: one toilet for every five inhabitants, one bathroom for every ten residents.

III. Provisions and amenities-All patients must have access to adequate medical and non-medical interventions. Psychiatrists must formulate a specific schedule/regimen for each patient in conjunction with other faculty. The guidelines stipulate that each facility must be properly prepared to handle emergencies, that each patient's case record must be kept in form VI, and that each facility must maintain a proforma of case record for each patient. At the time of discharge, each patient or parent must be issued a discharge report, and the hospital must keep a copy of it. If a family or client wants to switch consultants, he or she must be given a discharge outline, adequate facilities to ensure the patient's welfare, adequate facilities for eating, exercise, and entertainment, and a Visiting Team as required by the Mental Health Act and the laws that govern it.

It is also important to ensure the continuity of care delivered by trained providers while delivering residential recovery programmes. It is important to protect the civil rights of those receiving care in such facilities. When admitting patients with alcohol use disorders, it is therefore necessary to meet the provisions of the Mental Health Act of 1987, Section 16-30, and the Mental Health Care Act of 2017, Mental Health Care (State Mental Health Rules, 2018). Knowledge of other laws, such as the Narcotics and Cosmetics Act of 1940 and the Narcotic Drugs and Psychotropic Substances (NDPS) Act of 1985, is important when maintaining opioid rehabilitation facilities.

Precis of Addiction, De-Addiction and Psycho-Social Interventions

Addiction is a disease that progresses, is incurable and sometimes leads to death. The condition of chemical dependence has neurological ramifications. Addicts' perceptions of themselves and others, as well as the rest of the environment, change as their desire for alcohol grows and as impairments of body organs and the nervous system arise. They start to see life the way they have to in order to cope with their addiction. Alcoholism recovery takes place in stages. It is a gradual progression through specific developmental stages.This ensures that each step of rehabilitation necessitates the execution of particular recovery activities in order for the recovered individual to progress to the next stage of recovery. A de-addiction centre is a facility where people who have been diagnosed with an addiction to alcohol or other substances are monitored and cared for. (Karnataka Mental Health Rules, 2012)

Psychosocial treatments for behavioural wellbeing and drug use disorders are therapeutic or informational behaviours, approaches, or methods that seek to improve health performance and well-being by addressing biological, behavioural, cognitive, emotional, interpersonal, social, or environmental causes.Psychotherapies (e.g., psychodynamic therapy, cognitive-behavioral therapy, interpersonal psychotherapy, problem solving therapy), community-based treatment (e.g., assertive community treatment, first episode psychosis interventions), vocational rehabilitation, peer support services, and an array of other interventions are all used in the term "psychosocial interventions." **(**Mary Jane England, Adrienne Stith Butler, Monica L. Gonzalez (2015).Hundreds of randomised controlled clinical trials and several meta-analyses have shown the effectiveness of a wide variety of psychosocial treatments (Barth et al., 2013; Cuijpers et al., 2010 a, b, 2011, 2013; IOM, 2006, 2010).

The major Psycho-Social interferencescan be dividedas

INDIVIDUAL BASED INTERVENTIONS

Motivation Boosting Therapy: Motivation has been discovered to be an important factor in alcohol abuse treatment. It has been interpreted as a wish or compulsion to move from a user to a non-user. The individual's thoughts and behaviour are used to classify the intensity of their inspiration. Each stage has its own set of motivations. The most important aspect of the transformation process is to increase enthusiasm. Motivational interviewing strategies should be used to reduce the possibility of starting, halting, or reducing use.

Deterioration: Relapse/ Deterioration is a normal aspect of the healing process. It can be triggered by a variety of high-risk scenarios (Martino, 2007), including a strong desire to use, social pressure, trouble coping with feelings and challenges, and boredom. Relapse does not mean that the efforts are over. That is also not the conclusion of the method of assisting. Individuals who continue to put in more work will be able to regain repairs. Professionals and clients must all be ready to tackle this stage at any point of assistance.

Deterioration Prevention (Individual and Group based)

Individualized interventions can be beneficial in dealing with personal and private problems. Karen and Murthy (1998) saw group-based interventions as a source of encouragement, information, and a stage for attitude change and ability training (Moos et al., 2008). Person and community workshops will cover the following topics.

Psycho-Education: Individuals and families seeking care are also unaware of the essence of the condition, the treatment process, the steps of transition, and the prognosis. This could lead to early therapy discontinuation. Psycho-education from mental health providers would encourage people to stay on track with their care, which has been shown to improve healthcare outcomes.

Myths and Misconceptions: Drug use is linked to a number of stereotypes and beliefs. “It relaxes me,” “I gain courage to do things,” “I won't have anxiety if I use and do,” “I will work even more often with high concentration,” “night for sleep, it is helpful,” “drinking is good for the heart,” “little use is a sexuality booster,” and “for my poor mood, this is a solution,” are just a few of them. These misconceptions can be changed by peer interaction-based learning and abstinence practise.

Uncertain Situations: Peer group involvement has been identified as a key factor in the onset and maintenance of addiction (Martino et al., 2006). Even after treatment, old friends can pressurise the person to use. Individuals receive environmental signals that are linked to feelings of use. It can occur during holiday celebrations, family gatherings, or significant life events such as marriage, childbirth, or death. Problems or tough life circumstances are being listed as potential risk factors for resuming use. Individuals should plan for post-treatment relapse by identifying different high-risk situations, as well as individual, family, and community preparation.

Longing Management: Though craving/ longing is described as an overwhelming desire to use a drug, it has psychological and social aspects. Cravings can be triggered by a variety of factors, including social cues. The risk of relapse would be reduced if those cues were avoided. Patients are typically assisted in identifying flagging craving thoughts such as "just for now, let me have my last beer," "I haven't had in two years, but let me," "I won't have, let me just sit with my friends when they eat," and "alcohol is a soft drink, it isn't dangerous." Individuals must be able to recognise social and physical signals. Then, with knowledge of the sea wave dynamics of craving, they should use 4-D diversion strategies. Cravings come and go like a tide at the beach, and they need balance throughout that period. Individuals should treat cravings by using distraction, deep breathing, drinking water, and delay (4-D techniques).

Substance Refusal Skills: Substance refusal skills are taught through role plays. This is essentially assertiveness teaching. This will allow a person to say "No" when pressed by a mate, relative, or others to use. Assertive abilities rely heavily on tone of voice and nonverbal gestures. These will be given task training by enacting a party or a roadside scenario. People are allowed to abandon as soon as possible, while others are forced to use.

Handling Skills: Coping/ Handling skills are trained in two aspects, emotion based coping and problem based coping. In emotion based coping individuals are taught temporary nature of emotion, how emotions can be reduced using relaxation techniques. Individuals are educated not to take any hasty decisions or to negotiate with others while they are in emotions. The need for waiting while they are emotionally up would be discussed with life examples. Problem solving techniques has been used in problem based coping.

Problem Solving Structure: Addiction has been both a catalyst and a consequence of issues. To break this vicious circle, it is important to teach problem-solving patterns. Identifying the key challenge, recognising the problem, identifying resources, identifying alternatives, introducing the best available solution when considering personal resources and social help, assessing the outcome, and if the problem is not solved, trying again or attempting the next best solution are all steps in the problem solving process. This teaching can be carried out by evaluating some of their issues. It will assist people with not turning to drugs as a solution to their problems.

Optimistic Addiction and Lifestyle modification: Individuals' focus should be diverted to healthy addictions such as sports and games, workouts, yoga, therapy, recreational events, spiritual activities, and interests such as watching television. Positive addiction will provide an alternate source of enjoyment while still keeping the person occupied with some form of activity. As a result, the probability of relapse is reduced.

Rest, Money and Time Management: Relapse is caused by a variety of causes, including sleep difficulties, financial constraints, and an abundance of free time. As a result, sleep care and money management skills in

terms of investing must be taught. To prevent boredom, which has been identified as a leading cause of resumption of usage, free time should be scheduled ahead of time.

Relapse Management and Follow up: In alcohol therapy, relapse is a risk. Anticipating relapse and being ready to cope with it as soon as possible in a stable treatment model will ensure healing. Long-term follow-up has been cited as a key factor in patient effectiveness. During a relapse, family members should be taught how to assist the client in a non-critical way.

FAMILY BASED INTERVENTIONS

In alcohol therapy, family dynamics and other associated aspects are crucial. In the lack of individual support, addicts should be assisted in ventilating their suppressed feelings. Family attitudes will be changed with proper teaching and positive psycho-education. Family practises (Shankaran 2007) and the quality of marital and family life (Pandian, 1999) have been shown to be positive factors in the dynamics of restored or resilient individuals' families. This would improve the standard of human social support. It has been established that social reinforcement is an important factor in rehabilitation (Gillfford, et.al, 2006; Ashok, 2008; Kiran &Muralidhar, 2004). Healthy family contact (Shankaran, 2007; Pandian, 1999; Thirumoorthy, 1995; Veela, 1994) and frequent care follow-up with family support (Rajaram, 1990) have been shown to be the most important factors in maintaining abstinence after treatment.

COMMUNITY BASED INTERFERENCES

In order to ensure long-term abstinence, community-based approaches (Pandian and Sinu, 2007) have been shown to be successful. Strengthening self-help groups including Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), as well as having an effective network with other service organisations in the community, may be useful in addressing substance use disorders in case identification, diagnosis, and referral of treatment.

OBJECTIVES

1. To check how the de-addiction centres obey the government's rules and regulations.
2. To learn more about the status of Psycho-Social Interventions in the De-Addiction Centers that have been chosen.
3. To find out how satisfied the patients are with the psychosocial treatments that are part of the research.

RESEARCH DESIGN

The descriptive research design has been adopted for the study

STATEMENT OF THE PROBLEM

The aim of the research was to learn more about the Psycho-Social Interventions that are carried out in approved de treatment centres, as well as the support and facilities offered for people with opioid use disorders and how they benefit from the programmes. In addition, the report highlights the importance of identifying how the government's norms and recommendations are being followed by de addiction centres while performing psychosocial treatments. It is essential to review the compliance rules on a regular basis and to provide continuing assistance to the de-addiction centres. It's past time for alcohol therapy to become a part of routine medical care.

Universe of the Study: The study's scope was limited to selected approved de addiction centres in Karnataka State that provided psychosocial interventions.

Research Methodology

When the data from the chosen de-addiction centres were analysed by the inspecting officer. In a semi-structured proforma, each center's facilities and treatment are noted. The data was tabulated, examined, and hypotheses were drawn as a result of the results.

Sampling: There are 45 registered and unlicensed private de addiction centres operating in Karnataka, out of a total of 150 recovery institutions. Around 22 approved de addiction centres were chosen, and the remaining 23 unlicensed centres were not considered for the study's purpose of learning about the treatment and services offered by the study's selected centres. Just 50 people were selected for the survey in order to get their feedback about how satisfied they were with the treatment and services offered by the de-addiction centres. Purposive sampling and basic random sampling were used in the study to determine the efficacy of psychosocial treatments in these centres.

Sources of Data: For the purpose of data collection the researcher has used both primary data from the respondents and secondary data from the government survey reports.

Tools of Data Collection: The Tools of Data collection used by the researcher were structured questionnaire/ Interview schedule which were distributed to the authorities and the inmates of the selected de addiction centres.

Scope of the Study: The research wants to know about the psychosocial treatments used in Karnataka's approved de-addiction centres.

Analysis and Discussion

Table No.1: Table showing the number of Mental Health Establishments in Karnataka

Sl.No.	Category	No of Institutions N (%)
1	Psychiatric Establishments	13 (09.00)
2	De-addiction Centers	45 (30.00)
3	General Hospital psychiatry units	54 (36.00)
4	Rehabilitation Centers	38 (25.00)
	Total	**150 (100.0)**

According to the table above, approximately 36.00 percent of general hospital Psychiatry units are operational, a sizable number of 30.00 percent of De-addiction centres are operational, just 25.00 percent of detox centres are operational, and a very small percentage of 9.00 percent of Psychiatric institutions are operational in Karnataka.

Table No.2:De-Addiction Centers in Karnataka

Sl.No.	Name of the District	No.of De-Addiction Centers	Licensed		No of Beds	Psychiatrists		Social Workers		Psychologists		Facilities		Deficiencies	
			Yes	No		Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1	Bengaluru	20	16	4	924	16	4	16	4	16	4	16	4	10	10
2	Chickabalapur	1	1	0	24	1	0	1	0	1	0	1	1	1	0
3	Chikkamagalur	1	1	0	30	0	1	0	1	0	1	0	0	0	1
4	Chitradurga	1	1	0	30	0	0	0	1	0	1	0	0	1	0
5	Dakshina	3	2	1	150	3	0	1	1	0	3	3	0	0	3

	Kannada														
6	Dharwad	1	1	0	30	0	1	1	1	1	0	0	1	0	1
7	Davanagere	2	2	0	40	0	2	1	1	0	2	0	2	0	2
8	Hassan	2	2	0	45	0	2	0	2	0	2	0	2	1	1
9	Kolar	3	2	1	122	1	2	0	3	0	3	1	2	1	2
10	Kopala	1	1	0	30	1	1	0	1	0	1	1	1	1	0
11	Mandya	3	1	2	320	1	2	1	2	1	2	1	2	0	3
12	Ramanagara	3	1	2	120	1	2	0	3	0	3	1	2	0	3
13	Shivamogga	4	2	2	150	1	3	1	3	0	4	1	3	0	4
	Total	**45**	**33**	**12**	**2015**	**25**	**20**	**22**	**23**	**19**	**26**	**25**	**20**	**15**	**30**

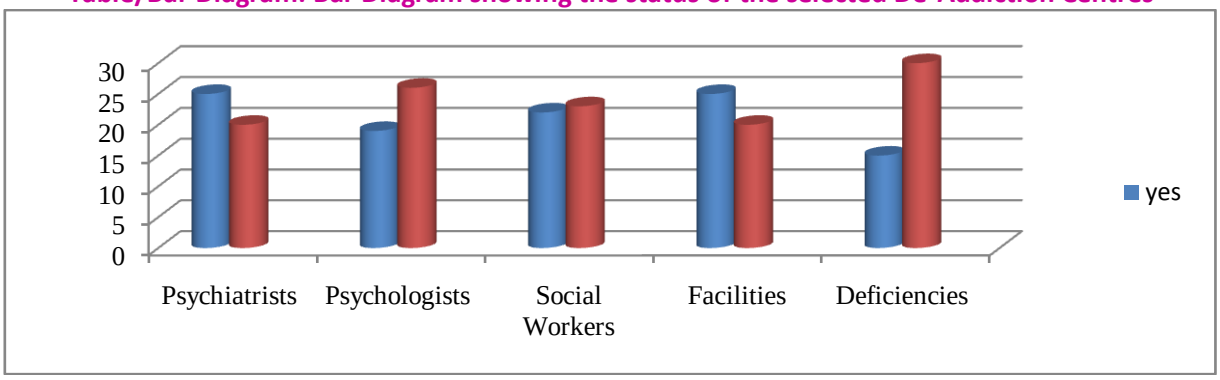
As seen in table No.2, Bangalore has the highest number of De addiction centres, with 20 total, 16 of which are licenced and four of which are unlicensed. In Bengalore, there are 924 beds, with 320 in Mandya coming in second. There are 16 psychiatrists and social workers, and the services are available in 16 centres, with only four deaddiction centres lacking adequate facilities. Since the number and scale of the districts are few, the description in some districts would be of no use, and it is self-explanatory as seen in the chart.

Table-3: Table showing the Details of Staff members in the selected De-addiction Centers

Sl.No	Appointment of Requisite Staff members	Yes N / (%)	No N / (%)
1	Psychiatrists	20 (45.0)	25 (56.0)
2	Psychologists	19 (42.0)	26 (58.0)
3	Social Workers	22 (49.0)	23 (51.0)
4	Facilities	25 (56.0)	20 (45.0)
5	Deficiencies	15 (33.0)	30 (67.0)

The following table shows that there is a net deficit of about 67.0 percent in terms of staff members. According to the results, as many as 58.00 percent of respondents believe they need psychiatrists, and a sizable proportion of respondents (56.00 percent) believe they do. Psychiatrists account for about 51.00 percent of the respondents, while 45.00 percent of the respondents believe that the services required by the government are not being delivered. These data can be linked to the current information in the table's column 3.

Table/Bar Diagram: Bar Diagram showing the status of the selected De-Addiction Centres



Results: As seen in the bar graph, 73.00 percent of the 45 centres analysed had obtained a licence. Psychiatrists were present in 44.00 percent of the cases, social workers were present in almost 51.00 percent of the cases, forensic psychologists were present in 42.00 percent of the cases, and a preponderating majority of 78.00 percent of the cases had one or more defects.

Key Findings of the Study

- More than 1/3rd of the de addiction centres do not have social services on staff.
- In order to determine appropriate treatment and services, high-quality research are needed.
- To work in de-addiction centres, you must have a valid licence.
- The preponderanceof de-addiction centres have met the required minimum standards.

Infrastructure and manpower shortages plague community-based private de-addiction centres. Social workers were not working in 51% of the centres. To work in de-addiction centres, you must have a valid licence. The majority of de-addiction centres have met the required minimum standards.

SUGGESTIONS

There is a need for high-quality research in the areas of nursing and services. According to the Mental Health Care Act of 2017 and the Mental Healthcare (State Mental Health Authority) Regulations of 2018, de-addiction centres must be licenced. In order to provide reliable and specialised care, it is necessary to hire a larger number of staff members, as required by the state mental health laws of 2018.

CONCLUSION

Psychosocial interventions use therapeutic or social behaviour that affect psychological, social, biological, and/or practical effects. Psychosocial approaches may be used alone or in combination with other therapies, such as medicine, to treat a variety of conditions and issues. Addiction's biopsychosocial elements affirm the need for multidisciplinary care. Many sources of support ensure rapid and stable transition. Psychiatric social workers are critical in reducing the likelihood of regression due to social conditions by encouraging patients to deal with social and environmental threats. Infrastructure and manpower shortages plague private de-addiction facilities in the community. Medical services, psychosocial interventions, vocational training, behavioural interventions, family education and skills instruction, and other psychosocial interventions for alcoholic use disorders must be provided at frequent intervals. Facility to transfer to an intensive care unit in a general hospital/Psychiatric ward when necessary.

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