

TREATMENT OF ALCOHOL AND DRUG ABUSE IN CAMP SETTING

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ABSTRACT

Community based de-addiction is the need of today, but in India it is done inside the hospitals. Camp detoxification is one of the alternative approaches.

The process of camp detoxification was divided into two phases. In phase I, arrangement for admission of 22 patients of drug and alcohol abuse was made, in phase II, 20 patients were admitted & were given treatment which consisted of pharmacological, psychoeducative groups & recreational & religious activities. All the patients completed 10 days treatment among them 18 patients were symptom free while 2 patients were having significant withdrawal symptom. The results of 10 days camp treatment showed better retention rate, good outcome & no use of illicit drugs during camp treatment.

Key words : Drug abuse, camp setting, detoxification.

The problem of traditional drug abuse is in existence in most of the societies over the world since the time immemorial. However, the problem has become more complex and alarming in the recent years. This may be attributed to: a) Magnitude of problem has increased many fold. b) New synthetic and more addictive substances have been added to the list of abusable drugs. c) More and more individuals have shifted from traditional oral/smoking to injectable drug use. d) Children have started abusing dependence producing substances. e) The age-old social control measures have become ineffective.

Most of the de-addiction treatment centres providing outpatient and inpatient care are located in the major hospitals in the urban areas. Community based de-addiction approaches are not very popular. Large number of patients do not seek treatment from these de-addiction centres. Additionally, hospital based treatment is very expensive and there is acute shortage of hospital beds. In India, majority of the de-addiction centres are located inside the

psychiatry wards and are looked after by psychiatrists. Stigma attached to psychiatry might discourage many patients from seeking admission into these treatment centres.

In view of the above facts i.e. shortage of hospital beds, hospital based treatment is expensive and stigmatising and large number of patients are not utilising these services, health professionals and policy planner have perceived a need to explore alternative approaches. Camp detoxification is one of the alternative approach. The feasibility of addressing alcohol and drug issue through camp has already been documented by many clinicians. In India, eye and family planning camps are very common. The first opium detoxification camp was organised in Feb.1979 in a village of Jodhpur district of Rajasthan (Purohit and Razdan, 1988). Subsequently they have treated 640 patients of opium dependence between 1979-1983. The results of these camps were very satisfactory. Shanthy Ranganathan (1994) from Tamil Nadu treated 105 patients of alcohol dependence through camp approach between 1989-1992.

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The results of these camps were highly successful and five factors, were identified for effective outcome i) Inspiration, hope and confidence provided by a recovering alcoholic, ii) reasonably good agricultural earning throughout the year, iii) organisers were teachers who are highly respected, iv) strong faith in God, v) motivation to take disulfiram was high. We will like to share our experience of a recently organised detoxification camp.

MATERIAL & METHOD

Department of Psychiatry has been providing community outreach services for drug and alcohol dependent patients as well as mentally ill patients for the last 2 years. These services are located at village Palsaura, about 10 kms from the main hospital and services include early identification, health education, detoxification, agonist maintenance and follow-up. The community team consists of consultant, social worker and a staff nurse. Community catchment area has a population of 20,000. Population is heterogeneous in nature, as they have migrated to Chandigarh from neighbouring states in search of a job. Majority belongs to lower socio-economic status and are engaged in skilled or semiskilled jobs.

The process of camp detoxification can be divided into two phases:

PHASE I : (Activities before the camp):

In the month of May 1997, the panchayat of village Palsaura approached the community team to admit about 22 patients of drug and alcohol abuse. These patients were identified by the community leaders and motivated jointly by them and social workers of the community team. As there was shortage of beds in hospital, alternative treatment approach through camp was discussed with the community leaders. The community team of the hospital agreed to provide manpower, and medicines. With mutual agreement, a Gurudwara in the village was selected for the camp. The Gurudwara management committee consisted of village

sarpanch, a private practitioner and priest of gurudwara for making decisions and motivating patients. Patients agreed to bring their own beds and linen. The village Panchayat and other community leaders provided security arrangements and also acted as motivation promoters. A month prior to holding the camp, social worker made home visits to discuss with the families about the proposed activities during the camp and to motivate them for joining family session.

PHASE II (activities during the camp) :

Twenty patients of drug and alcohol dependence (alcohol 11, opium 2, other opiate 4, cannabis 1 and poly drug abuse 2) were admitted for 10 days. Additionally, a group of 4 patients requested night admission as they were working during day and did not have any leave. They reported in the morning for collecting their medicines and came back for night stay after finishing their work. Night admission was requested as most of the craving occurred in the evening after the work. Patients who were unwilling for admission were treated on outpatient basis.

STAFF : Regular staff consisted of a resident doctor, a staff nurse and a security person. One social worker was available from 9.00 to 5.00 PM for running the psychosocial groups and family sessions. Consultant was available for 2-3 hours in the morning to oversee the arrangement, to boost up the morale of the staff and for psycho-educative groups.

TREATMENT : Treatment component consisted of :

- i) **Pharmacological :** Opiate dependent patients were detoxified with either dextropropoxyphene or clonidine or buprenorphine and nitrazepam. Alcohol dependent patients received benzodiazepines (diazepam) and vitamins. Patients with mild withdrawal received only symptomatic treatment like analgesics, antidiarrhoeal, hypnotic and antiemetics.

- ii) **Psycho-educative groups :** Eight

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sessions of one-hour duration were attended by all the camp patients. Each session consisted of a specified topic which covered harmful effects of drug, high risk situations, coping strategies, alternative high (pleasure), harmful effects of injectable drugs and relapse prevention. The sessions were didactic in nature but became interactive in the end. The topic of each session was displayed on the notice board well in advance and each patient came prepared for contribution and discussion.

- iii) Recreational and religious activities : Each patient participated in one hour session of daily yoga. Television, playing cards, carrom boards and other indoor games were made available. One of the community team members participated and supervised group interactions. Religious teachings and songs were played most of the time highlighting faith in the God and hope for recovery.
- iv) Family session : Four family sessions were held and theme of these sessions was primarily focussed on the nature of illness (remitting and relapsing) and role of family members in preventing relapse.

RESULTS

All the patients were male and mean age was 41.45 years (S.D.±14.27). About 50 percent of subjects were illiterate and only 15 percent were matriculate. All but one was employed full time. Majority (80 percent) were married and belonged to Sikh religion. Average duration of drug use was 16.35 years (S.D.± 11.66). Majority (90 percent) were smokers.

All the patients completed 10 days treatment. None of the patients smoked during camp stay. There was no clinical evidence of use of illicit drugs, which was corroborated by random urine screening for drugs. There was no violence or treatment related complaints as commonly seen in hospital based detoxification.

Most predominant opiate withdrawal symptoms were anxiety and restlessness (100 percent), aches and pains (88 percent), yawning and lacrimation (75 percent), craving for drugs (50 percent) and insomnia (50 percent). Common alcohol withdrawal symptoms were anxiety (60 percent) tremors (54 percent), headache (54 percent) and insomnia (45 percent). None of the patients had complicated withdrawal. Routine investigations including X-ray chest did not reveal any other medical complications.

At the end of 10 days, 18 patients were symptom-free while 2 patients (opiate dependence) still had significant withdrawal symptoms and they were transferred to hospital for further inpatient treatment

DISCUSSION

Research has shown that large number of alcohol and drug dependent patients do not seek treatment from hospital based de-addiction services. A recent survey by the principal author, (unpublished) of patients reporting to community clinic who did not seek treatment in the past has shown that these patients knew about the availability of the treatment facilities in a hospital located about 3 kms away from their place of residence. The reasons reported by these patients for not seeking treatment from hospital based de-addiction services were: i) a lot of time is wasted to see a doctor, ii) hospital has a very structured and rigid programme and drug dependent patients find difficulty in fitting in, iii) attitude of some of the staff members is very uncooperative and discriminatory, iv) cost of treatment and inadequate transport facilities were other reasons. Thus, if we want that large number of drug & alcohol dependent persons should be enrolled into treatment, we must move out of the hospital and see them in their own communities.

Drug and alcohol treatment facilities are still very scarce and are located in major hospitals of bigger cities. Cost of treatment and lack of trained manpower are, the major factors for shortage of treatment facilities. Thus cost-

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effective alternatives, particularly by the developing countries, must be explored. Camp treatment is one of the alternatives which needs to be explored.

Purohit & Razdan (1988) treated patients of opium dependence through camp approach. The findings showed that camp based detoxification is more acceptable, affordable, cost effective and conducive for group interaction and health education as compared to hospital based treatment. Active community participation was another important finding. Shanthi Ranganathan (1994) reported high recovery rate among alcohol dependent persons who were treated in a camp setting. Closely knit community structure, full time engagement in work, involvement of community leaders in treatment and faith in the God played crucial role in high recovery rate.

In the present camp treatment, retention rate was very high as none of the patients was discharged prematurely. Purohit and Razdan (1988) reported 5 to 10 percent dropouts. Dropouts were more when camps were larger. Santhi Ranganathan (1994) has not mentioned about dropouts. The premature discharge in hospital based de-addiction centres is very high. Several researchers from U.S.A have reported that 30-35 percent patient do not complete treatment (Baekland & Lundwell, 1975; Millman et al., 1981; Copeland & Hall, 1992). Studies from India have reported 36 to 69 percent premature discharges from hospital based treatment (Nigam et al., 1990; Samantaray et al. 1997). In the present camp treatment, very strong social influence by the Panchayat, family and community leaders probably played an important role in keeping them in the treatment. Active participation by the community in terms of encouragement, moral support, taking responsibility of patient's work and family, providing financial support and recreational and religious activities were important and crucial factors which lack in hospital based treatment.

Faith in religion also played an important role in the treatment outcomes. Pre-treatment assessment of patients revealed that 90 percent

of them were heavy smokers. None of the patient smoked during 10 days camp stay. This is quite contrary to experience with hospital based de-addiction centres where smoking on the bed is one of the most common problems and many patients are discharged on disciplinary grounds because of smoking. Gurudwara is a Sikh religious place where smoking is not permitted and all the patients adhered to it. Earlier camp approaches (Purohit & Razdan 1988; Shanthi Ranganathan, 1994) did not mention about smoking.

Clinical assessment and random urine screening showed that none of the patients used drugs inside the camp premises. In hospital based de-addiction centres, use of illicit drugs is common. On most of the occasions, drugs are smuggled into the ward by close relatives of patients and patients themselves during admissions and visiting other departments for investigations and consultation. Illicit drugs are smuggled inside the ward despite strict rules including body search. Non-availability of drugs and social pressure might have checked drugs smuggling inside the camp. Purohit and Razdan (1998) who detoxified opium dependent patient have not mentioned about drug use inside the camp.

Group cohesiveness was another significant observation during the camp treatment. All the patients were seen supporting and helping each other. Elderly patients were looked after by younger patients. Everyone participated in all the daily activities without any resistance. Treatment in camp setting is also very cheap. Most of the facilities were provided by the community and religious organisations. Treatment in the camp cost Rs. 15/- (fifteen) per patient per day to the hospital whereas cost of treatment in hospital based de-addiction centres will be very high.

In conclusion, treatment of drug and alcohol in camp setting is acceptable, feasible and cost-effective. The results of 10-day camp treatment showed better retention rate, good outcome and no use of illicit drugs during camp treatment. Community participation is very high. Religion and social pressure are significant

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variables effecting treatment outcome. The results of the present camp detoxification support the observations of Purohit & Razdan (1998) and Shanthi Ranganathan (1994).

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