Improving Treatment of Substance Use Disorders through Community Drug Treatment Clinics: An Experiential Account

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Abstract

India has a huge burden of substance use disorder (SUD). The national response to the problem of SUD has been to support addiction treatment centers either in government hospitals or in nongovernmental settings. The existing number of addiction treatment facilities is less compared to the burden of substance use in India. The existing models of treatment in India place undue emphasis on inpatient treatment of SUD. Community-based treatment aims to bring the treatment of SUD closer to the patients in their community. Community-based treatment of SUD utilizes existing services available in the community by establishing an integrated network of community-based services. There have been different models of community-based care for the management of SUD in India. Most of them, however, address short-term withdrawals and do not provide long-term treatment in community. National Drug Dependence Treatment Centre, AIIMS, New Delhi, has been providing community-based treatment for SUD since the 1990s. Two of the three community drug treatment clinics (CDTCs) are in operation for more than 5 years now and cater to the population residing within a defined catchment area. The CDTCs use infrastructure available in the community to operate the clinics. The clinics are run daily by a team of nursing staff, while the doctor is available only twice a week. A menu of options, ranging from short-term treatment to long-term agonist maintenance treatment is provided in the clinic. Both pharmacotherapy and psychosocial interventions are provided. Each clinic caters to hundreds of patients through these facilities. There is a need to expand CDTCs in India considering their cost-effectiveness, acceptability, and overall effectiveness, especially in urban colonies with higher substance-related problems.

Keywords: Community-based care, community drug treatment clinics, model of care, substance use disorder

Introduction

Substance use disorders (SUDs) have a significant bearing on the individual users, their family members, and the society at large. As per the global status report on alcohol and health, 43% of the world population (2.3 billion) had consumed alcohol in the past 12 months in 2016.[1] As per the World Drug Report, in 2017, there were an estimated 271 million people aged 15–64 years who had used illicit drugs at least once in the previous year. Of these, about 35 million were estimated to be suffering from SUD.[2] India, too, has a significant problem of SUD. The national survey to assess the extent and pattern of substance use in India, 2019, showed that about 7.5 crore individuals suffer from different SUD in India.[3] The survey reported that alcohol is the most common psychoactive substance used in India, followed by cannabis and opioids. The survey estimated 5.7 crore individuals with alcohol use disorder, 90 lakhs with cannabis use disorder, and 77 lakhs with opioid use disorder in India.

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Treatment of substance use disorder in India: Existing systems and gaps thereof

The Ministry of Social Justice and Empowerment (MoSJE) and the Ministry of Health and Family Welfare (MoH and FW) are responsible for reducing the demand for psychoactive substances in India. MoSJE provides financial assistance to NGOs for setting up and running Integrated Rehabilitation

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Centre for Addicts (IRCAs).[4] At present, more than 400 IRCAs are supported by the Ministry. The "Drug De-addiction Programme (DDAP)" launched by MoH and FW established "De-Addiction Centres (DAC)" for inpatient treatment of SUD in different medical colleges and district hospitals. Currently, there are more than 120 DDAP-supported DACs. Various privately run facilities also exist which are operated by players ranging from highly qualified psychiatrists to those who have recovered from SUD.

The existing number of addiction treatment facilities is clearly less compared to the burden of substance use in India. The national survey, 2019, showed that only 25% of those who tried to quit alcohol received treatment.[3] Similarly, among patients with drug use disorders, only 25% of those who tried to quit received treatment ever. The existing models of treatment in India place undue emphasis on inpatient treatment of SUD. Both the DACs and IRCAs are modeled around the provision of inpatient care. The current understanding is that all patients suffering from SUD do not require inpatient treatment. In fact, outpatient treatment works as well as inpatient treatment of SUD.[5,6]

A variety of treatment services should be made available for people who use drugs.[7] The most common types of services needed are informal community care and primary health-care services, followed by specialized drug dependence treatment services. The top of the pyramid is occupied by long-stay residential services. In India, the opposite is true. There is a plethora of long-stay residential services, while the availability of SUD treatment in primary care services is minimal. Community drug treatment clinics (CDTCs) can be an answer to plug this gap in the availability of treatment of SUD in India.

Community-based Treatment for Substance use Disorder

Community-based treatment aims to bring the treatment of SUD closer to the patients in their community. This treatment setting helps in responding to a wide variety of client needs. These needs can include psychological and pharmacological treatment of SUD, recovery management, general health and mental health care, social assistance and protection, HIV prevention and treatment services, and family, community, and peer support. Community-based treatment of SUD utilizes services available in the community by establishing an integrated network of community-based services. Community-based SUD services ultimately aim to reduce the need for long-term residential treatment and custodial services for clients with SUDs.

There can be multiple benefits of community-based treatment of SUDs. There is a close collaboration between the health sector, other service providers in the community, and social welfare support for reintegration and rehabilitation. The entire process of treatment is embedded into the community setting and is implemented using assistance from the community resources. This may, in turn, increase social support for the patients and help in promoting healthy public opinions about SUD and its treatment, which may also help reduce stigma and social marginalization. Furthermore, the active participation of the patient and family helps to promote responsibility and ownership. Most importantly, treatment provided in the community disrupts the family, social, and occupational life of an individual to a lesser extent than long-term residential care.

Community-based treatment of substance use disorder in India

A variety of approaches have been utilized in India for providing community-based treatment of SUD. The drug de-addiction and treatment center (DDTC) of PGIMER, Chandigarh, has been running a community outreach clinic at Kharar Civil Hospital, Kharar, Mohali, Punjab, wherein services are provided once a week.[8] Special Outreach Outpatient Clinics are also operated by the institute which are organized at different locations in premises provided by the village panchayats.[9] A team of psychiatrists, social workers, and nursing staff holds the clinic on a given date to provide free consultations and medications for acute withdrawal management. The clients are then advised to follow-up at the DDTC located in the main hospital for continuing their treatment.

Another approach which has been used in some states of India is a camp approach.[10-14] In this approach, a village or a locality is chosen to provide treatment for acute withdrawal symptoms in a camp for a period of 7–10 days, along with psychosocial interventions. This approach too is less resource intensive in terms of human resources and utilizes facilities provided by the local community to conduct camps. This approach has been used for treating acute withdrawal symptoms of various substances, including alcohol and opioids, and has met with fair amount of success. This approach, however, caters to the immediate needs of the patient in terms of withdrawal management and does not provide long-term treatment of SUD in the community.

Community Drug Treatment Clinics: Experience of National Drug Dependence Treatment Centre, AIIMS

The National Drug Dependence Treatment Centre (NDDTC), AIIMS, New Delhi, has been providing community-based treatment for SUD since the 1990s. These treatment facilities are aimed at providing substance use treatment services to the locals as well as at developing a low-cost model of SUD treatment for India. Currently, NDDTC provides community-based treatment through its three CDTCs located in different parts of Delhi. Of these, two clinics are in operation for more than 5 years now. Both these clinics are in North-East Delhi and cater to the population residing within a catchment area of 5–7 km of each clinic. The clinics are in areas where there is a sizeable presence of patients with SUD. Thus, the

clinics are based on the principle of increasing the availability of treatment for SUD in the patients' vicinity. These localities were chosen after conducting assessments by the social officers working with NDDTC.

Physical amenities and staffing

The CDTCs use the spaces already available in the locality. The space for one of the clinics (Trilokpuri clinic) is donated by the Rotary hospital. The other (Sunder Nagri) clinic runs in a community marriage hall managed by the Delhi Urban Shelter Improvement Board, Government of NCT of Delhi. These clinics contain one room for doctor and counselor, one room for dispensing medications, a room/area for registration and record-keeping, and a waiting area for patients to be seated while receiving consultations or medicines. No new construction was done for operating these clinics. The clinics primarily use the resources available in the community in terms of space.

The doctors (one faculty, 1–2 senior residents, one MD student) and one counselor visit the clinic twice a week and provide outpatient care. They assess new patients presenting to the clinic, prescribe appropriate medications, conduct psychosocial interventions, and regular follow-up of patients retained in treatment. Two nursing staff are present in the clinic daily along with ancillary staff for dispensing the medicines. Thus, staffing is modest in the CDTCs. The Trilokpuri clinic runs from Monday to Saturday, while the Sunder Nagri clinic runs 7 days a week. The timing of the clinics is generally from 8 am to 3 pm.

Treatment of substance use disorder

The Trilokpuri clinic provides treatment for all psychoactive substances (including alcohol, opioid, cannabis, tobacco, and benzodiazepines). The Sunder Nagri clinic focuses primarily on the treatment of opioid use disorder. Both clinics provide acute and long-term treatment of SUD. Both pharmacological and nonpharmacological treatments are provided. The medicines include medications for the treatment of withdrawal symptoms, long-term treatment of alcohol (disulfiram and naltrexone), and long-term treatment of opioids (agonists – buprenorphine and antagonist – naltrexone). The Sunder Nagri clinic also provides methadone as long-term opioid agonist treatment. The nonpharmacological treatment includes brief intervention, motivational enhancement therapy, psychoeducation, relapse prevention therapy, family interventions, etc., Thus, a menu of options is available at the clinics which are utilized based on the patient's condition and need. In severe cases and in cases where outpatient-based treatment is not successful, the patient is referred to NDDTC located about 15–20 km from the clinics, where the patient is admitted for a period of 2–4 weeks. The patient is then referred to the respective clinics. A continuity of treatment is maintained between inpatient and outpatient treatment in this manner.

For other health-related conditions, the clinics have a tie-up with existing hospitals in the locality. Patients are referred to the general outpatient departments situated in the vicinity for minor medical ailments. The recently initiated Mohalla clinics run by the Delhi government are utilized for routine laboratory investigations. Linkages have also been established with the nearby antiretroviral treatment (ART) centers and tuberculosis treatment centers. A general hospital located 5 km from each clinic is utilized for other medical services. Thus, the local resources are utilized for providing other health-care services required for patients with SUD.

Other services

The counselor at the community clinics assesses the occupational need of each patient and counsels the patient to start working soon after the initial treatment. There have also been attempts at providing microfinance for patients to start their own work.[15] The clinics have tied-up with local skill development agencies for providing skill training to some patients in need of the same. Attempts have been made to provide food and shelter from local institutions, including religious institutions. Thus, local resources are utilized for providing other supportive services for the patients.

Family involvement

Many patients at the community clinics are accompanied by their family members. When family members do not come by themselves, attempts are made to contact them telephonically and if required, home visits are also made (with due permission from the patient). Family members, thus, become an integral part of the assessment and treatment. Not only are they helpful in supporting the patient during the entire treatment process, but they are also included in the shared decision-making regarding the patient's overall treatment. Their own concerns and issues related to patient's substance use are also addressed simultaneously. Family interventions are provided as and when feasible and necessary. The family members are found to be extremely helpful in retaining clients in treatment (for example, attending the sessions and ensuring follow-up). They also are utilized for arranging the required resources for living a substance-free life (for example, supervision of medications or proper vocation).

Patient recruitment and treatment process

The clinics had to invest time and efforts in the initial days to recruit patients in the treatment. The counselors attached to the clinics met potential patients and educated them about treatment availability. The local leaders of the community were also informed about the availability of treatment in their vicinity. Once sufficient patients were recruited, they themselves became advocates for the CDTCs. The families of the patients who benefitted from the treatment also became advocates of the community clinics. At times, a potential patient would simply visit the clinic with his treatment-seeking friends and witness the clinic "in action". They realized that they can easily get treatment without having to be admitted and subjected to torture, which they otherwise were subjected to sometimes in the private "rehabilitation centres". The community clinics helped in reducing the stigma attached to the treatment of SUD in this manner.

The clinic follows an "open door" policy for the treatment of SUD. No prior appointment is required to see a doctor or counselor. The patient registration at the clinics follows flexible time schedule. Those who have dropped out of treatment are also restarted on treatment on the day they revisit the clinic. The clinics do not subject the patients to urine screening to confirm abstinence. Rather, the clinics rely on patient's version and cross-check with families as required. On any consultation day, about 5–10 new patients are registered in the clinic. The Sunder Nagri clinic dispenses medicines (where daily dispensing is followed) to about 500 patients on any given day, while 300–400 patients visit Trilokpuri clinic in a week (where take-home dispensing of up to 1 week is followed). Thus, a sizeable number of patients are serviced through these clinics using minimal resources from the center.

Learning from the Community Drug Treatment Clinics Model

CDTCs are an effective option for the management of SUD in India. The NDDTC experience suggests that CDTCs can provide quality care at a low cost with minimal infrastructure, staff, and other resources. Since the treatment services are at the doorstep of the patients, they are more ready to access and accept treatment. Family plays an important role in the entire treatment process starting from the assessment. Local resources are made use of in providing other health-care services as well as social support services. CDTCs adhere to most principles of effective community-based treatment advocated by international agencies. There is a need to expand CDTCs in India considering their cost-effectiveness, acceptability, and overall effectiveness, especially in urban colonies with higher substance-related problems. Our experience suggests that the psychiatry departments in medical colleges can play an important role in setting up such CDTCs. These community clinics can help in service delivery and for training postgraduate psychiatry students. Since community-based treatment facilitates treatment-seeking, the CDTCs can enhance the clinical caseload for treatment services in the hospital which are underutilized.

Conclusions

CDTCs can shift the treatment focus from long-term inpatient care for a few to low-intensity outpatient treatment for many. From a public health perspective, such an effort would be a positive step toward filling the treatment gap for SUDs and in reducing stigma for treatment of SUD in India.

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Conflicts of interest

There are no conflicts of interest.

References

1. World Health Organization. Global Status Report on Alcohol and Health 2018. Geneva: World Health Organization; 2018. Available from: http://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf?ua=1. [Last accessed on 2018 Oct 26].
2. United Nations. World Drug Report, 2019; 2019. Available from: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_1_EXECUTIVE_SUMMARY.pdf. [Last accessed on 2020 May 15].
3. Ambekar A, Agrawal A, Rao R, Mishra AK, Khandelwal SK, Chadda RK, *et al*. Magnitude of substance use in India. New Delhi: Ministry of Social Justice and Empowerment, Government of India; 2019.
4. Dhawan A, Rao R, Ambekar A, Pusp A, Ray R. Treatment of substance use disorders through the government health facilities: Developments in the "Drug De-addiction Programme" of Ministry of Health and Family Welfare, Government of India. Indian J Psychiatry 2017;59:380-4.
5. Institute of Medicine. Bridging the Gap Between Practice and Research: Forging Partnerships with Community-Based Drug and Alcohol Treatment. Washington, D.C.: National Academies Press; 1998. Available from: Available from: http://www.nap.edu/catalog/6169. [Last accessed on 2021 Jan 06].
6. Proctor SL, Herschman PL. The continuing care model of substance use treatment: What works, and when is "enough," "enough?" Psychiatry J 2014;2014:1-6.
7. UNODC, WHO. International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing. Geneva: World Health Organization and United Nations Office on Drugs and Crime; 2020. License: CC BY-NC-SA 3.0 IGO." Available from https://www.who.int/publications/i/item/international-standards-for-the-treatment-of-drug-use-disorders. [Last accessed on 2020 Dec 20].
8. Giri OP, Bharadwaj R, Misra AK, Kulhara P. Impact of drug awareness and treatment camps on attendance at a community outreach de-addiction clinic. Ind Psychiatry J 2015;24:202-5.
9. Singh SM, Giri O, Misra A, Kulhara P. Deaddiction services in the community by a team from a tertiary hospital: Profiles of patients in different settings. Indian J Prev Soc Med 2012;43:288-94.
10. Chavan BS, Gupta N. Camp approach: A community-based treatment for substance dependence. Am J Addict 2004;13:324-5.
11. Purohit D, Razdan V. Evolution of community camp approach of opium detoxification in North India. Ind J Soc Psychiatry 1988;4:5-21.
12. Purohit D, Vyas B. Opium addiction treatment camp – A follow-up study. J Clin Psychiatry 1982;6:55-61.
13. Raj L, Chavan BS, Bala C. Community "de-addiction" camps: A follow-up study. Indian J Psychiatry 2005;47:44.
14. Sidana A. Community psychiatry in India: Where we stand? J Ment Health Hum Behav 2018;23:4.
15. Yadav D, Dhawan A, Balhara YP, Yadav S. Occupational rehabilitation of opiate users on maintenance treatment in India: A microcredit-based approach. J Soc Work Pract Addict 2010;10:413-22.