Facilities and Care In De-Addiction Centers

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I. Introduction

The World Health Organization estimates that as of 2010 there are 208 million people with alcoholism worldwide. (4.1% of the population over 15 years of age)The National Mental Health Survey of India (2016) noted that the prevalence of alcoholic use disorder is significantly high (4.6% for alcoholic use disorder). NMHS of India (2016) reported that there is a very high prevalence of disorders due to misuse of alcohol and treatment gap is 86.3%. Alcoholism is a complex problem having medical and social ramifications which impacts all social strata. Controlling addictive disorders requires programmes like provision of treatment services, care and facilities.

More and more de-addiction centers are opened because high demand and lack of facilities. Minimum norms in these facilities are governed by state mental health rules. We examined 45 de-addiction centers regarding man power and facilities.

Karnataka is an top of the charts in drugs abuse amongst kids, followed by Andra Pradesh, Alcohol consumption and use od tobacco by children is light in Meghalaya, accordingly to a 2012 study.

II. De-addiction facilities

De -addiction facility' means a place where persons diagnosed to have dependence on alcohol and other drugs are treated and cared. (Karnataka Mental Health Rules, 2012)

Addiction is an illness which is progressive, incurable and often fatal. There are psychological consequences to the disease of chemical dependency. As the need for alcohol use increases and as impairments to body organs and the nervous system occur, addicts alter the way they view themselves & others, and the rest of the world. They begin to see things as they must to live with their addictive.

Recovery from alcoholism unfolds in phases. It is a progressive movement through specific developmental periods. This means that each phase of recovery requires the completion of specific recovery tasks that must be accomplished in order to prepare the recovering person for the next phase of recovery.

III. Alcoholism

The term alcoholism is commonly used amongst laypeople, but the word is poorly defined. The WHO calls alcoholism "a term of long-standing use and variable meaning", and use of the term was disfavored by a 1979 WHO expert committee.

IV. Definition

Misuse, problem use, abuse, and heavy use of alcohol refer to improper use of alcohol, which may cause physical, social, or moral harm to the drinker. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines binge drinking as the amount of alcohol leading to a blood alcohol content (BAC) of 0.08, which, for most adults, would be reached by consuming five drinks for men or four for women over a two-hour period. According to the NIAAA, men may be at risk for alcohol-related problems if their alcohol consumption exceeds 14 standard drinks per week or 4 drinks per day, and women may be at risk if they have more than 7 standard drinks per week or 3 drinks per day. It defines a standard drink as one 12-ounce bottle of beer, one 5-ounce glass of wine, or 1.5 ounces of distilled spirits.

V. Facilities and care to be provided in De-Addiction Centers

Substance abuse is a complex problem having medical and social ramifications which impacts all social strata. Controlling addictive disorders requires programmes like demand reduction, provision of treatment services. In patient services will need to follow guidelines as per regulations, etc.

State mental health rules-2012 was notified by government of Karnataka vide GO No.HFW 148 CGE 2012, Dated: 03/12/2012. As per the above rules de-addiction centre's are included under acute care centre as per rule 22, accordingly every de-addiction centre has to obtain valid license. Deputy Commissioners of the district are designated as licensing authority.

Following are the minimum norms to be provided in such centres as per rule 22 of KMHR 2012

(i) Staff.-

(a) Psychiatrists: patient to be 1:100
(b) Mental health professional assistant Clinical psychologist or Social worker:
Patient to be 1:50.
(c) Nurse: Patient to be 1:10.
(d) Medical practitioner with recognized M.B.B.S Degree: patient to be 1:50.

(e) Attenders in the attendant: patient ratio of 1:5
(f) The functioning of nurses and doctors should be such that at any given time (all 24 hours) at
least one doctor and one nurse are available in a ward.

(ii) Physical Features.-

a) There will be one bed and mattress per patient along with 3 sets of bed linen (i.e. a pair of bed sheets and a pillow cover). One pillow, one blanket.

(b) The psychiatric in-patient facility should be located in a safe area

(c) The minimum distance should be maintained between the cots is 3 feet.

Living accommodation could be, double, multiple bedded or single bedroom or cottages.

(d) The accommodation shall be separate for males and females.

(e) The dormitories and multiple bedded rooms shall have Bath rooms
and toilets on the following scale - one toilet for every five residents, one bathroom for
every ten residents.

(iii) Support/ Facilities.-

Adequate medical as well as non-medical modes of intervention must be available to all patients. The psychiatrists in consultation with other faculty must devise a particular schedule/regimen for each patient.

a). Each facility should be adequately equipped to look after emergencies.

b). Pro forma of case record for each patient must be maintained in form-VI. (Show)

c). A discharge summary must be given to each patient or guardian at the time of discharge,
and a copy of the same must be maintained by the hospital. If families or consumer is
interested in changing to another consultant, he/she must be provided with a discharge
summary.

d) Adequate facilities to ensure safety of the patient should be provided.

e) Other Facilities:

f) Adequate facilities should be provided for dining, recreation and entertainment.

g) Visiting Team as per the Mental Health Act and the rules there under

While providing residential treatment programmes it is also essential to ensure quality of services provided through qualified professionals. It is also important to safe guard the human rights of subjects taking treatment in such centers.

It is also mandatory to follow provisions of mental health act 1987 section 16-30 and Mental Health Care Act 2017, Mental Health Care (State Mental Health Rules 2018) while admitting patients with substance use disorders. Knowledge of others acts like the drugs and cosmetic act 1940, the Narcotic drugs and psychotropic Substance (NDPS) act 1985 is important in running drug de-addiction centers.

VI. Objective

- To know whether licensed de-addiction facilities have minimum norms as rules.
- To know about the psychosocial interventions in De-addiction centers

VII. Methodology

Data collected from these de-addiction centers when evaluated by inspecting officer . Facilities and care in each centre is noted in a semi structured proforma. Findings were tabulated, analyzed. Conclusions were drawn based on findings.

VIII. Results

45 centers were evaluated, 73%. Of them had procured license. 44% of them had psychiatrists. 51.1 % of them Social Workers, 42.2 % of them clinical psychologists, over all 77.8% of them had one or other deficiencies.

IX. Conclusions

Private de-addiction in centers in the community have deficiencies of Infrastructure and man power. More than 1/3 had not employed social workers. There is a need for good quality studies for establishing effective of the psychosocial interventions. Valid license to de-addiction centers required. Majority of De-addiction centers had fulfilled minimum norms as per rules. There is a need for good quality studies for establishing effective of the care and facilities.

Keywords: De-addiction centers, Alcoholism, Facilities and Care

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