



Profile of Psychosocial Rehabilitation Centres for Persons with Substance Use Disorders in Bengaluru: A Cross-Sectional Study

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Abstract Substance use disorder is a major global health problem. There is limited information available about the pattern of utilization of psychosocial rehabilitation services (de-addiction service centres) for persons with substance use disorder. To study the profile of psychosocial rehabilitation centres (de-addiction service centres) for persons with substance use disorder in Bengaluru. To assess the staff profile, organisation profile, to examine the nature, types of treatment and psychosocial rehabilitation services offered by the de-addiction centers. Cross-sectional study design was used. Sample size: Out of 43 private organizations, 32 were eligible to participate. Out of 32, one-third (N=10) of the organizations participated in the study. Based on minimum standards of care manual for substance use disorders, an online questionnaire regarding organizational profile, staff pattern, nature and type of treatments, range of psychosocial rehabilitation services offered. Data was collected through online using google forms. Descriptive statistics such as frequency was used to analyse the data collected. All 10 organizations have a

minimum one social worker, psychologist, nursing staff, and other supportive staff in the psychosocial rehabilitation centers. All the organizations have basic infrastructure and amenities as per minimum standards of care. Most organizations provide recovery oriented services, almost all organizations provide telephonic follow-up and home visit services. Most organizations provide psychosocial rehabilitation services. Most organization expressed need for training their counsellors on group therapy and family therapy techniques. Most organisations possibly comply with a minimum standard of care and service, follow a twelve-step treatment approach, reintegrate the recovered clients in the community, provide an opportunity to work in their respective organisations. Most organisations have self-help (AA) groups, offer assistance programmes for family members, supportive educational groups and halfway-home care services.

Keywords De-addiction centre · Alcohol use disorders · Minimum standards of care · Drug dependence treatment centre

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Introduction

Substance use disorders (SUDs) is a significant public health problem in India and Worldwide. More than

five per cent of people suffer from alcohol use disorders, and more than 5.7 crore people need treatment for the same in India. One in five alcohol users' needs urgent treatment [1]. There are only 9000 + psychiatrists are available to treat 5.7 crore people with alcohol use disorder and two crore people with other drug use disorders in India. There is a massive disparity between substance use problems and available treatment services. India has a high 'treatment gap' for substance use disorders. The treatment gap is more tobacco use disorder (92%), alcohol use disorders (86%) as compared to other drug use disorders (73%). Although most persons with alcohol use disorder (69%) received treatment from a government physician in the recent past than any other mental illness [2], about one in 37 people with alcohol use disorders and one in 20 persons with drug use disorders have not received any treatment^[1].

Treatment for Substance Use Disorders

Presently, there are three sectors involved in treating SUD in India. In the Government sector, the Ministry of Health and Family Welfare has 122 de-addiction centres to treat SUD. These are located in medical colleges and district hospitals across different states in the country. In the Non-Government (NGO) sector, there are about 400 NGOs funded by the Ministry of Social Justice and Empowerment for treatment and rehabilitation. Private organisations play a significant role where several persons seek help for SUD. However, no data are available about these private hospitals [3]. Very few people affected by alcohol or drug dependence receive treatment from NGO de-addiction centres such as IRCA supported by the Ministry of Social Justice or a government de-addiction centres, those supported by the Drug De-Addiction programme, Ministry of Health & Family Welfare. Most of these treatment centres are located near cities and towns. Very few alcohol users receive comprehensive treatment in India [4].

Treatment for SUD consists of pharmacological treatments such as detoxification and craving management, psychological treatment consists of cognitive-behavioural therapies, biofeedback, motivational interviews and psychosocial treatment involves psycho-education, group therapy and family therapy [5]. In India, the number of rehabilitation facilities

providing such treatment is minimal. Currently, treatment for SUD is mainly available in government-run de-addiction centres. Several alcohol users who live in rural and underserved areas, receive inadequate treatment [6]. The de-addiction camps are a successful model in India. Treatment is provided at no cost and tailored to clients' individual needs. The camps encourage people to seek help for alcohol problems [7].

Rationale

Most addiction research studies stem from addiction treatment centres. However, there is no research on these treatment centres' evolution, staffing, funding source, and utilisation of psychosocial rehabilitation services, contributions, and achievements in India. Information on substance use treatment utilisation and preferences of treatment settings are limited. There is a paucity of information about the psychosocial rehabilitation services (de-addiction service centres) for persons with substance use disorder. There are no studies on compliance of minimum standards of care for substance use disorder, the profile of private organisations and the non-governmental organisations providing the rehabilitation services for SUD, their staff profile. The study would be helpful in understanding the nature of the treatment, range of psychosocial rehabilitation services available to persons with SUD in the private rehabilitation centres, to make appropriate policies, strengthening the available services, reporting, and training purposes, making recommendations to the concerned authorities (Fig. 1).

Hence, the present study investigated the psychosocial rehabilitation services provided by private and non-governmental organisations in Bengaluru for persons with substance use disorder. Specific objectives were to assess the staff profile and examine the nature and type of treatment, range of psychosocial rehabilitation services offered to individuals with substance use disorder.

Methods

A cross-sectional study design was used. There are 43 de-addiction centres in and around Bengaluru urban and rural areas. About 32 organisations details were

Flowchart showing sample recruitment

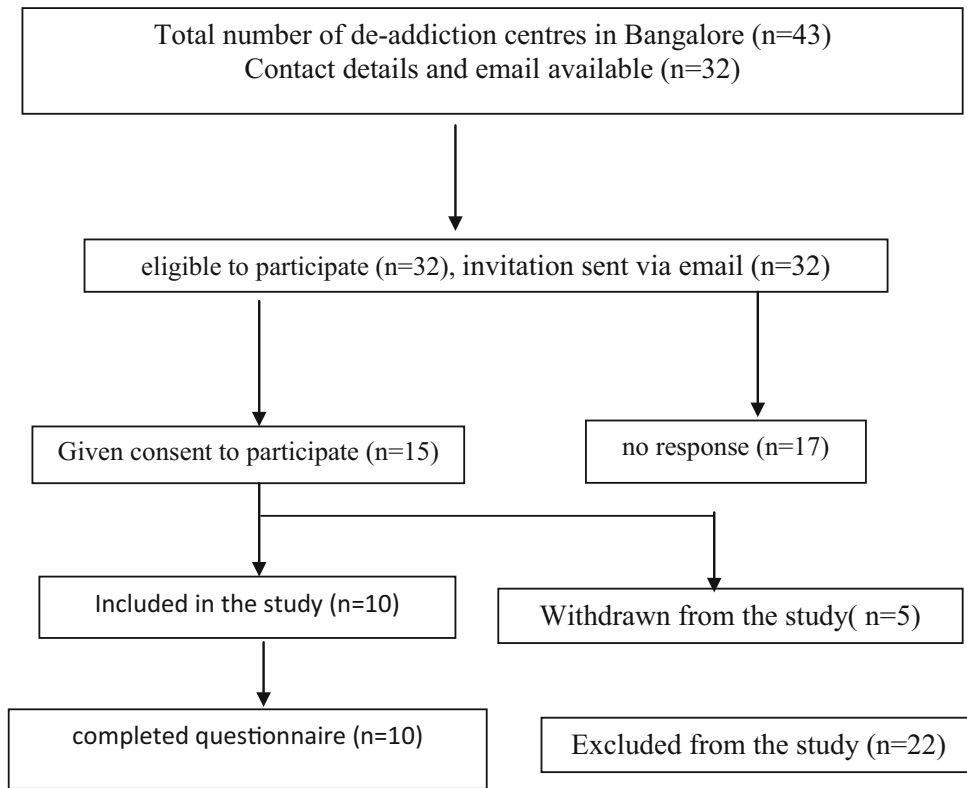


Fig. 1 Flowchart showing sample recruitment

collected from the state mental health authority [8], and other secondary sources. Out of 43 centres, contact details (email and telephone) were unavailable for 11 organisations. Invitation to participate in the study was sent via email to the remaining 32 organisations using google forms in November 2020. Out of 32, 15 centres gave online consent to participate in the study after three months (March 2020). Five of the organisations withdrew from the study after giving consent. Using census method of sampling, remaining 10 centres were considered. Data was gathered using google forms (online questionnaire method). Data were received in March 2020. Tools used: Online questionnaire was developed in the English language on organisation’s profile (5 items; name, address, contact details, registration details, funding source), staff profile (3 items; the number of staff, designation, qualification), infrastructure (9 items based on minimum standards of care for SUD manual) [9] documentation (3 items), type of psychosocial

rehabilitation services (8 items), follow-up activity (4 items), recovery-oriented rehabilitation services (10 items) and training needs (21 items). CHERRIES (Checklist for reporting results of internet E-surveys) [10] guidelines were used for reporting purpose. The online questionnaire had 63 items. Approximately it takes 45–60 min to complete. Face validity of the questionnaire was established with two subject experts in the field. The questionnaire underwent repeated revisions. e-questionnaire was pre-tested by authors before sending it to the rehabilitation centres. Online informed consent was obtained from the respective administrative in-charge of psychosocial rehabilitation centres.

Study procedure: Inclusion criteria: Private Institutions, non-governmental organisations, and other charitable trusts involved in the treatment and psychosocial rehabilitation services of individuals with SUD in and around Bangalore (urban & rural areas) were eligible to participate in the study. As the

questionnaire was sent to via e-mail, whoever has the access to respective organizations' email can have the access to the questionnaire. Participants can have complete access to the questionnaire after filling the required/mandatory items in each page. Announcement and advertisement regarding the study was sent in the form of e-invitation to the 32 organizations who had email. In this email questionnaire the responses were captured in an automated method. After participants submit the completed questionnaire, the researcher would get an intimation mail and summary of responses would be visible in a Google sheet. There was no incentive provided to participate in the study. Bias was not preventable as items in the questionnaire were not randomized. Adaptive questioning was used to reduce the number and complexity of the questions. Questions were framed using simple language. There were six screen pages in the e-questionnaire; each page displaying 10 items. The respondents had the option to review and change their responses using back button. Duplicate items were not preventable as cookies and computer IP address were not used. Telephone calls were made and emails were sent to get the missing data.

Confidentiality and anonymity of the information collected would be maintained. The nature and purpose of the study were explained in the informed consent. About 22 rehabilitation centres refused consent to participate. Descriptive statistics such as frequency and percentage were used to analyze the data. The study obtained Institute Ethical clearance in September 2020.

Results

Table 1 shows that half of the rehabilitation centres' license was active, all ten organisations' funding source was self, all ten centres have a minimum of one social worker, psychologist, nursing staff, and other support staff member in the rehabilitation centres. All the rehabilitation centres possibly have basic infrastructure and amenities and comply with minimum standards of care. Six rehabilitation centres provide psychosocial rehabilitation services for less than 25 clients in a month.

Table 2 shows that all ten organisations provide detoxification services. Six organisations provide residential care treatment for 21–30 days. All ten

organisations provide individual, family counselling for clients' family members and group counselling. All the organisations refer clients to other treatment services on a need basis and have a daily activity schedule. Nearly five organisations reported that 26 to 50 clients recovered fully after availing psychosocial rehabilitation services from the centres and completing a required number of follow-up services in a year. All the organisations provide telephonic follow-up and home visits for persons with substance use disorder.

Table 3 indicates that eight organisations most likely reintegrate their recovered clients into the community. All the organisations have community outreach programs. Nine organisations follow the self-help (AA) group approach and provide family members assistance, offering educational and supportive group services and halfway home services. Eight organisations did not provide drop-in centre services (places where people can obtain food and other services). Six organisations offer vocational training to their clients; Eight organizations provide an opportunity to work in their respective organisations.

Some observations: All staff members received orientation, training and detoxification, documentation procedure in the SUD. Few rehabilitation centres provide innovative therapeutic programmes such as music, art therapy, yoga, meditation, recreational activities, in-door and out-door games for clients, horticulture and occupational therapy. Most personnel in rehabilitation centres expressed the need for training in family therapy and group therapy techniques. One rehabilitation centre has five bedded separate facilities to treat women with SUD and behavioural addictions (Table 4).

Discussion

A cross-sectional study examined the profile of psychosocial rehabilitation centres available for persons with substance use disorder in Bangalore. There is a substantial growth of psychosocial rehabilitation centres for persons with substance use disorders in Bangalore. The present study was carried out with a limited sample size ($n = 10$). There are few studies on the profile of de-addiction centres in other states covering aspects of organisation profile, staff pattern, services provided with similar sample size and using single case study design [11].

Table 1 Profile of Psychosocial Rehabilitation Centres

Sl.No	Organization Profile	Category	f (n = 10)
1	Registration of organization/ License	Registered	05
		Awaited	05
2	Funding Source	Self	10
		State Govt	0
		Central Govt	0
3	Contact details available	Yes	10
		No	0
4	Number of staff members	Below five	03
		6–10	05
		10–15	02
5	Availability of multi-disciplinary team	Social Workers	10
		Psychologist	10
		Nursing officers	10
		Others	10
6	Infrastructure	Basic amenities	10
7	Bed occupancy	≤ 25	06
8	Number of clients availing psychosocial rehabilitation services in a month	≤ 25	06
		26–50	03
		51–75	01
9	Number of clients registered in a month	≤ 50	08
		≥ 50	02

As per minimum standards of care[9], all the Government and private, non-governmental organisations that run de-addiction centres must register the organisation in the concerned state mental health authority. The study showed that five rehabilitation centres in Bangalore registered in-state mental health authorities. Whereas in Kolkata, 22 registered organisations provide rehabilitation services for substance use disorders [12,13], Maharashtra has the highest number (68) of IRCA's for psychosocial rehabilitation services for persons with SUD in India [14].

All rehabilitation centres provide detoxification services; however, the number of patients detoxified in a month differs across centres. This finding was similar to several studies [15–23]. The funding source of all ten organisations was self-generated. The treatment charges collected from the patients' families are the major funding source for all organisations. This finding was in concordance with the previous study [24]. The present study revealed that all the ten rehabilitation centres perhaps have social workers, psychologists, nurses and support staff. Previous

studies support this finding [25–29]. The study revealed that the duration of residential care for treatment of SUD ranges from 21–30 days in six rehabilitation centres. This finding was in concordance with a previous study [29], whereas the duration of stay in IRCAs is 90 days [12], residential care treatment was 30–90 days in six rehabilitation centres, Kolkata[13] and few other centers reported three weeks to eight weeks treatment duration [30].

The present study revealed that all rehabilitation centres offer individual, group and family counselling services. This finding was concomitant to previous studies [15,17,21,24]. Most organisations possibly provide group counselling in the form 12 step approach (Alcoholic anonymous). All ten organisations possibly provide referral services to other rehabilitation and treatment centres. This finding was in contrast to the previous studies [30,36]. Kattimani et al. [30] reported that a cross-referral system between the non-governmental and government organisations almost do not exist due to lack of public–private partnerships and poor networking.

Table 2 Infrastructure (Minimum Standards of Care)

Sl.No	Minimum Standards of Care	Category	f (n = 10)
1	Bed Strength	≤20	06
		21–40	02
		41–60	02
4	Type of accommodation	General ward	10
		Single Room	05
		Double Room	01
		Special ward	02
3	Locker facility for each patient	Yes	08
		No	02
4	Sitting room for patients and/or Visitors room for family	Yes	10
		No	0
5	Reception, enquiry, registration counter waiting space for person	Yes	10
		No	0
6	Medical check-up room and for clients who are in delirium or any emergencies	Yes	10
		No	0
7	Counselling room	Yes	10
		No	0
8	Storage facilities in your organization	Yes	09
		No	01
9	Outdoor recreational facilities	Yes	09
		No	01
10	Rest rooms available in your organization	≤10	09
		≥10	01

Grover et al. [15] reported that drug dependence treatment services include liaisons and networking with other governmental and non-governmental agencies.

Results revealed that all the rehabilitation centres provide possible telephone follow-up services and home visits. Previous studies reported similar findings [15,17,22,28,31]. Treatment seekers who received follow-up or home visits at the end of the year showed a better outcome [32].

Most rehabilitation centres do not provide vocational training and livelihood skills for persons with SUD. This finding was in concordance with the UNESCO study [33]. The present study revealed that most organisations successfully reintegrated their recovered clients into the community. All organisations have outreach programmes. Gupta et al. [17] report similar findings. Most rehabilitation centres do not provide drop-in centre services. None of the previous studies investigated the availability of drop-

in service in the rehabilitation centre, an essential service for homeless persons with SUD and those who have poor social support, rejected by kith and kin owing to SUD.

In 2000, Ministry of Social Justice and empowerment carried out nationwide survey on Drug Abuse Monitoring System (DAMS) in India. Totally 164 NGOs and 25 Government organizations providing treatment for SUD participated in the study. Overall, participation rate was low; 57 percent for NGO's, seven percent for Government Organization. The study faced difficulty in contacting the NGOs and addresses of the most non-governmental organization were incomplete as a result many NGOs unable to participate in the study and postal questionnaire were returned back [34]. There was no information about these 164 organizations' profile, staff pattern and the type of treatment services, provided in the study.

It is a challenge to study the functioning of de-addiction centres. In 2002, NDDTC had evaluated the

Table 3 Psychosocial Rehabilitation Services

Sl.No	Psychosocial Rehabilitation Services	Category	f (n = 10)
1	Detoxification services provided by the organizations in a month	≤50	04
		51–100	04
		≥101	02
2	Duration of Residential Care services	11 to 20 days	0
		21 to 30 days	06
		31–60 days	04
3	Individual counselling services	Yes	10
		No	0
4	Frequency of Individual counselling sessions are offered	Daily	08
		Weekly	02
5	Availability of family counselling services	Yes	10
		No	0
6	Frequency of family counselling sessions	Daily	05
		Weekly	03
		Monthly	02
7	Group counselling services offered	Yes	10
		No	0
8	Frequency of group counselling sessions	Daily	07
		Weekly	02
		Monthly	01
9	Referral services to the other treatment centres	Yes	10
		No	0
10	Daily Programme Activity Schedule	Yes	10
		No	0
11	Number of clients recovered after psychosocial rehabilitation services	≤25	02
		26–50	05
		≥51	03
12	Number of letters sent to ex-clients in a year	≥25	05
		≥26	05
13	No. of ex-clients who visited the centre after recovery	≤25	09
		≥26	01
14	Telephone follow up & home visits	Yes	10
		No	–

functioning of 104 de-addiction centres commissioned under the Ministry of Health through on-site visit and postal questionnaires. Results showed that only 41% of the centre were functional, staff were inadequate, most centres did not have medicines. In 2006–2007, NDDTC and NIMHANS together carried out another evaluation of 44 government-run de-addiction centres through onsite visit. Results revealed that one-third were functional and another one-third were partially

functional, detoxification was available as pharmacological treatment. The documentation and psychosocial interventions were inadequate. Most rehabilitation facilities face issues like uneven funding, the state government's low priority for de-addiction treatments, a lack of dedicated staff, nurse, social worker, or counsellor, a high patient load, and an inconsistent supply of medications. There are almost no community-based activities, inadequate collaboration with

Table 4 Recovery-Oriented Psychosocial Rehabilitation Services

Sl.No	Recovery-Oriented Psychosocial Rehabilitation Services	Category	f (n = 10)
1	Recovered clients provided linkage for reintegration into the community	Yes	08
		No	02
2	Outreach programmes, camps,	Yes	10
		No	0
3	Self-help (AA) group	Yes	09
		No	01
4	Halfway-home care service	Yes	09
		No	01
5	Drop-in centre service	Yes	02
		No	08
6	Family Assistance program	Yes	09
		No	01
7	Vocational training	Yes	06
		No	04
8	Educational and Supportive group services	Yes	09
		No	01
9	Providing opportunity for individuals to work in organizations	Yes	08
		No	02

NGOs, insufficient record-keeping, and minimal support for substance using women and adolescents [35].

Most cited reasons for non-participation in the study were the unavailability of administrative in-charge to give consent. Most questions looked like monitoring and evaluation of their centre; most rehabilitation centres were unconvinced with study purpose and uncomfortable to furnish the sensitive administrative and service details about their centre such as licensing, information about the availability of mental health professionals, doctors, nurses, and fear of cancellation of license. It was the time the new mental health care act was implemented in the State, and the State mental health rules were framed, license fees were revised, and procedures for obtaining/renewing license was taking place with a new set of rules. The previous year, the Ministry of Social Justice & Empowerment carried out a *service provider survey* that collected similar information on the nature and range of treatment services available to substance users as part of a national-level survey on the pattern of substance use in India. A couple of years before the study, a social worker from State mental health authority visited these organizations to collect

information related to services available, charges levied, and their service location details were uploaded on its website. During the study period, the COVID-19 pandemic broke, most of the organisations temporarily stopped their services. Hence, the organizational visit was not possible to collect the data in person. There are 34 IRCAs (Integrated rehabilitation centre for addicts) in Karnataka funded by the Ministry of Social Justice and Empowerment, four out of 34, IRCAs were in Bangalore gave consent to participate and later withdrew from the study.

Limitations

The study has several limitations. The major study limitation was the small sample size. Hence, study results cannot be generalised. An independent evaluator should have done this type of study. The data solely relied on information given by the organisations' administrative in-charge. Hence, there could be information bias in the study. Due to COVID-19, interviews were not allowed due to fear or infection. Few organisations stopped the de-addiction treatment

services during the pandemic. The study did not explore the charges levied by NGOs, years of service, domicile of clients availed services, major diagnostic categories.

Future Directions

Future research studies can examine the minimum standards of care, challenges encountered by the de-addiction centres in obtaining the license and getting it registered under the state mental health establishment.

Conclusion

Most organizations possibly comply with a minimum standard of care and service, follow a twelve-step treatment approach, successfully reintegrate the recovered clients in the community, provide an opportunity to work in their respective organizations. Most organizations possibly have self-help (AA) groups, offer assistance programmes for family members, supportive educational groups and halfway-home care services.

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Declarations

Conflict of interest Nil.

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