Original Article

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Comprehensive Evaluation of Drug De-addiction Centres (DDCs) in Punjab (Northern India)

Community Medicine Section

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ABSTRACT

Background: Drug addiction is on the rise in Punjab,India. There are 15 DDCs which are supported by the Indian Red Cross Society. There is alleged mushrooming of private Drug De-addiction Centres (DDCs) in the smaller towns, villages and cities of Punjab.

Objective: This study aimed to evaluate DDCs in Punjab.

Materials and Methods: A total of 10 DDCs were included in the study and scheduled visits were made to collect data by using a pre-tested questionnaire.

Results: The duration of treatment was 1 month at the Red Cross DDCs and it was approximately 6 months at private DDCs. The staff at the private DDCs were inadequate. The major drugs which were abused by patients were Propoxyphene, Alcohol, Bhukki and Cannabis. Patients were usually referred to the DDCs either by family members (35.3%) or social workers (29.8%). About 72.5% of patients were married, 36.3% had passed 10th standard and 54.4% were employed. A majority dropped out of the DDCs due to personal reasons and lack of family support. On comparison, more patients were found to be treated at Red Cross centres (75.3%) than at private centres (65.8%). All DDCs had conducted regular sessions of individual, group and family counseling for patients. Red Cross DDCs ensured that ex-clients received follow-ups and home visits. More patients were satisfied with the services which were provided by the Red Cross DDCs. On the contrary, more patients at the private DDCs complained about harassment fromstaff personnel (p>0.05).

Conclusion: It is recommended that all DDCs should be checked regularly, and that the private centres should be provided with additional support from the government, to help run them more efficiently.

Keywords: Drug de-addiction centres (DDCs), Details of drug abuse, Recovery of addicts, Indoor stay of addicts, Staff details at DDCs

INTRODUCTION

In the year 2004, the Indian Ministry of Social Justice and Empowerment (MSJE) conducted a national survey that indicated that drug abuse was quite common among males who were between 12 to 60 years of age. The results seen among this age group were as follows: tobacco use (55.8%), alcohol habit (21.4%), cannabis use (3.0%), opiate use (0.7%) and sedative use (0.1%). Punjab was ranked third out of all the Indian states, in having the largest percentage of drug users [1].

Another grave problem which was observed was that drug abuse was also associated with an increased risk of other diseases like HIV and sexually transmitted diseases (STDs). In India, among Injecting Drug Users (IDUs), HIV sero-prevalence was as high as 8.71% [2].

Under the "scheme for prevention of alcohol and substance (drugs) abuse", which was launched in 1985 by the MSJE, specific guidelines were set out for the DDCs to follow, according to their admission capacities. The MSJE is assisting 373 Non-governmental Organizations (NGOs) in maintaining 401 DDCs, which have now been renamed as Integrated Rehabilitation Centres for Addicts (IRCA), and 68 counselling and awareness centres all over the country [3,4].

Punjab currently has DDCs in the government medical colleges of Patiala, Amritsar and Faridkot and at district hospitals.

But, there is alleged mushrooming of private DDCs in the smaller towns, villages and cities in Punjab. There are many reports on human rights violations and financial exploitations in the media, with allegations such as mistreatment, overcharging and enslavement of the patients. Raids have been conducted at some centres over the past few years, and patients have been freed by the health authorities and police [5].

Particulars	DDCs									
	Indian Red Cross DDCs							Private DDCs		
	Patiala	Kharar	Nawan Shahar	Gurdaspur	Ludhiana	Faridkot	Bathinda	Dasuya	Qadian	Bhogra
Location*	U	R	U	U	U	U	U	U	R	R
No. of beds for which receiving grant-in-aid	30	15	15	30	15	15	21	0	0	0
No. of beds/durries actually in position	30	22	20	30	15	30	25	15	15	15
Separate female ward	Yes	No	No	No	Yes	No	No	No	No	No
Recommended minimum staff	15	11	11	15	11	11	11	11	11	11
Total staff in position	18	11	16	15	12	12	14	7	6	6

[Table/Fig-1]: Infrastructure and Staffing Details of Ddcs
(*U=Urban, R=Rural) (N. Shahar= NawanShahar)

Drugs Abused	DDCs										Total
	Indian Red Cross DDCs							Private DDCs			
	Patiala	Kharar	Nawan Shahar	Gurdaspur	Ludhiana	Faridkot	Bathinda	Dasuya	Qadian	Bhogra	
Capsules (Propoxyphene)	43	42	26	1081	77	14	247	10	20	0	1560 (29.3%)
Alcohol	52	198	49	199	45	40	175	10	6	19	793 (14.9%)
Bhukki	0	338	0	0	0	34	308	0	09	20	709 (13.3%)
Opium	48	26	18	55	33	2	10	10	10	15	227 (4.3%)
Cannabis	6	2	17	38	04	50	09	0	0	03	129 (2.4%)
Buprenorphine	8	15	0	27	30	2	0	0	0	20	102 (1.9%)
Brown Sugar	30	21	10	22	0	0	0	0	0	0	83 (1.6%)
Volatile solvents (Inhalants)	0	2	37	0	0	17	10	01	0	0	67 (1.3%)
Cocaine	0	0	0	0	0	17	39	0	0	0	56 (1.1%)
Heroin	0	0	23	1	7	15	0	0	0	0	46 (0.9%)
Morphine	0	0	0	0	0	1	20	0	0	0	21 (0.4%)
Hallucinogens	0	0	0	1	0	10	0	0	0	0	11 (0.2%)
Multiple drugs (not in above categories)	49	43	45	319	18	23	0	0	0	10	507 (9.5%)
Others	32	725	2	236	0	10	04	0	0	0	1009 (19%)
TOTAL	268	1412	227	1979	214	235	822	31	45	87	5320

[Table/Fig-2]: Details of drugs abused as per records of patients admitted in DDCs
(drug addiction records available for only n= 5320 patients)

Period of Indoor	DDCs										Total
	Indian Red Cross DDCs							Private DDCs			
	Patiala	Kharar	Nawan Shahar	Gurdaspur	Ludhiana	Faridkot	Bathinda	Dasuya	Qadian	Bhogra	
1-10 days	15	16	0	11	05	34	270	0	0	0	351 (15.2%)
11-20 days	20	27	0	25	0	51	523	0	0	0	646 (28%)
21-30 days	88	52	156	120	0	128	29	0	0	0	573 (24.9%)
31-40 days	15	26	0	336	206	19	0	0	0	0	602 (26.1%)
41-50 days	0	17	0	0	3	2	0	0	0	0	22 (1%)
51-60 days	0	0	25	0	0	0	0	0	0	0	25 (1.1%)
More than 60 days	0	0	0	0	0	0	0	31	20	35	86 (3.7%)
Total	138	138	181	492	214	234	822	31	20	35	2305

[Table/Fig-3]: Details of indoor stay of admitted patients as per records at DDCs
(N of Indoor patients = 2,305)

Reasons for drop-outs	DDCs										Total
	Indian Red Cross DDCs							Private DDCs			
	Patiala	Kharar	Nawan Shahar	Gurdaspur	Ludhiana	Faridkot	Bathinda	Dasuya	Qadian	Bhogra	
Poverty	0	30	4	6	20	20	0	0	02	0	82 (19.7%)
Lack of family support	10	15	2	07	10	14	80	0	0	18	156 (37.5%)
Unsatisfied with services	0	0	04	0	0	04	0	0	0	0	8 (1.9%)
Personal reasons e.g., ceremony/ grief	10	10	12	0	14	09	86	02	15	12	170 (40.9%)
Total	20	55	22	13	44	47	166	02	17	30	416

[Table/Fig-4]: Reasons for drop-outs of patients as per records at DDCs

OBJECTIVES

To comprehensively evaluate DDCs of Punjab.

MATERIALS AND METHODS

A cross-sectional study was conducted at 10 DDCs in Punjab. A total of 15 DDCs are being run by the Indian Red Cross Society [4]. There are multiple private DDCs which are being run by private registered societies. As has been shown in the tables, Seven Indian Red Cross DDCs and three private DDCs were studied. Those centres that were functional for more than a year were included. Necessary permission was taken and data was collected by using a pre-tested questionnaire. Only those patients (n=120) who were admitted to the DDCs on the day of the scheduled visits were interviewed. The interviews were conducted in person, after taking informed consents of the patients and giving an explanation about the purpose of the study. Strict confidentiality of the information which was provided was ensured. The data which was collected was then statistically analyzed by using Microsoft Excel and application of the Chi-square test.

Particulars	DDCs										Total
	Indian Red Cross DDCs							Private DDCs			
	Patiala	Kharar	Nawan Shahar	Gurdaspur	Ludhiana	Faridkot	Bathinda	Dasuya	Qadian	Bhogra	
Treated	83 (60)	72 (52.2)	86 (37.9)	303 (61.6)	150 (70)	151 (64.2)	493 (60)	11 (64.7)	20 (44.4)	45 (51.7)	1414 (58.5)
Relapsed	35 (25.5)	11 (8.0)	119 (52.4)	176 (35.8)	20 (9.4)	37 (15.7)	163 (18.8)	4 (23.5)	8 (17.8)	12 (13.8)	585 (24.2)
Dropped Out	20 (14.5)	55 (39.8)	22 (9.7)	13 (2.6)	44 (20.6)	47 (20.1)	166 (20.2)	2 (11.8)	17 (37.8)	30 (34.5)	416 (17.3)
Total	138	138	227	492	214	235	822	17	45	87	2415

(figures in parenthesis show percentage out of respective column; recovery records available for n=2415 patients)

[Table/Fig-5]: Recovery of admitted patients as per records at DDCs

(n=120)	Good		Average		Poor		Total	
	Red Cross	Private	Red Cross	Private	Red Cross	Private	Red Cross	Private
Staff Services and Staff Behaviour	10 (11.1%)	2 (6.7%)	40 (44.4%)	10 (33.3%)	40 (44.4%)	18 (60%)	90	30
Medical Services	10 (11.1%)	2 (6.7%)	45 (50%)	10 (33.3%)	35 (38.9%)	18 (60%)	90	30
Counselling Services	10 (11.1%)	3 (10%)	50 (55.6%)	8 (26.7%)	30 (33.3%)	19 (63.3%)	90	30

[Table/Fig-6]: Satisfaction of patients from services being provided (those who were admitted at time of study) at DDCs

(n=120)	Satisfaction from indoor services and recommendation of DDC to others by patients (who were admitted at time of study)	
	Indian Red Cross DDCs	Private DDCs
YES	37 (41.1%)	6 (20%)
NO	53 (58.9%)	24 (80%)
Total	90	30
Chi square: 4.36 ; p<0.05; Significant		

[Table/Fig-7]: Statistical analysis of satisfaction from indoor services and recommendation of DDC to others by patients between Indian Red Cross and Private DDCs

(n=120)	Harassment by Staff at DDC (as told by admitted patients at time of study)	
	Indian Red Cross DDCs	Private DDCs
YES	27 (30%)	13 (43.3%)
NO	63 (70%)	17 (56.7%)
Total	90	30
Chi square: 1.8 ; p>0.05; N.S.		

[Table/Fig-8]: Statistical analysis of reporting of harassment by patients between Indian Red Cross and Private DDCs

RESULTS

A majority of the DDCs (7 out of 10) were urban. The private DDCs were not receiving any type of financial aid [Table/Fig-1].

In the year 2010, the total Outpatients Department (OPD) patients were 12,548, including 17 females (OPD only), and 2,305 in patients (all males). Here, OPD patients were those who had either reported to out-reach camps which were organized by the DDCs and had taken treatment from the camp sites, and those who had reported directly to the OPDs of the DDCs. Indoor patients were those who had been admitted to the DDCs for any respective duration of time.

The major drugs which were abused were Propoxyphene, Alcohol, Bhukki, Opium, Cannabis and Buprenorphine, in descending order of abuse [Table/Fig-2].

The major routes of drug abuse were oral (86.2%), inhalation (4.3%) and intravenous (3%). The sources of referrals of the patients to the DDCs were family members (35.3%), social workers (29.8%), self (13.6%), friends (9.3%), ex-clients or their family members (6.7%) and counselling and awareness centres (4.1%).

A majority of the patients were married (72.5%), and 18.1% were unmarried. About 9.4% patients were separated/divorced due to drug abuse.

About 36.3% of the patients were educated up to higher secondary level, 18.43% were middle passed, 13.53% had only primary education, 11.8% were literate (read and write), 10.9% patients were illiterate, 5.64% were graduates and 3.4% were post graduates.

About 43.5% of the patients stayed at the DDCs for a period which was less than the recommended duration of 1 month. At the private DDCs, all patients stayed for more than 60 days [Table/Fig-3].

A majority of the patients left the treatment which was provided by the DDCs due to personal reasons (40.9%) and lack of family support (37.5%) [Table/Fig-4].

Out of the 82 patients who required additional treatment, the reasons for it were the following: Hepatitis B (n=24), Hepatitis C (n=10), TB (n=17), HIV (n=7), and Syphilis (n=2).

Out of the 2415 patients whose records were available, 58.5% were treated, 24.2% had relapsed and 17.2% had dropped out [Table/Fig-5].

Home visits were conducted by the counsellors at the homes of patients discharged from the Red Cross DDCs, but not at the homes of the patients who were discharged from the private DDCs.

All the centres organized out-reach camps in urban areas and villages for preventive education, spreading of awareness, registration of addicts, counselling, and detoxification/de-addiction treatment. No vocational rehabilitation was given at any of the DDCs.

On comparison, more patients were found to be satisfied by the services which were provided by the Indian Red Cross DDCs [Table/Fig-6].

DISCUSSION

The number of private DDCs is increasing in the rural areas of Punjab,India. The probable reason behind this is providing for the larger existing rural population.

According to the scheme for prevention of alcoholism and substance (drugs) abuse, DDCs should ordinarily have 15 bedded or 30 bedded facilities with specified staff, as per the norms. The centres receive financial assistance, with up to 90% of the approved expenditure. The project directors of the private DDCs were made aware of the fact that they could apply for a grant-in-aid after running the centre successfully for one year and fulfilling the requirements which were laid down by the MSJE [3,4].

DDCs at Kharar, Nawan Shahar, Faridkot, and Bathinda had more beds than were sanctioned, due to an increase in the number of patients and requests made by families of the patients to admit their family members at the DDCs by any possible means.

Separate wards for females were present at the Patiala and Ludhiana centres, but there was no indoor stay facility for female patients. Drug addiction in females was reported in the OPDs, but due to social stigma, they were not admitted.

A majority of the patients were referred to the DDCs by family members and social workers. Families play an important role in the motivation of addicts in getting treatment. Social workers can go and talk to the addicts and their families and motivate them to get treatment.

A majority (36.3%) of the patients at all the centres were educated up to higher secondary level, and this was followed by 18.43% patients, who were educated up to middle standard. Similarly, in Uttar Pradesh Singh et al., found that most of the drug abusers were educated up to primary and secondary levels (40.13% and 41.10% respectively). It was also found that those that fell into drug abuse habit at early ages produced an increased amount of school dropouts [6].

In the present study, 54.4% patients were employed in some form or the other. On the other hand, Singh et al., found 81.36% of the drug abusers were employed as drivers, labourers and rickshaw pullers. This difference probably occurred due to different socio-economic profiles of the people from the two states [7].

In a different study done on the long-term outcomes of in-patients who were suffering from substance use disorders in Chandigarh, Singh et al., found that patients who were followed-up had a significantly longer durations before relapse [8]. Thus, DDCs should stress on keeping patients on follow-ups, in order to achieve better outcomes.

A very small number of the staff had received training of any kind, which was probably the reason behind the patients being not satisfied by counselling and staff services.

A high rate of dissatisfaction was seen at the private DDCs. Various reasons given by the patients included verbal abuse, physical abuse and even torture by the DDC staff, especially when they didn't obey the orders of the staff. Medical services were mostly irregular as well. Many patients were forced to sleep on the ground. The treatment duration was 6 months.

A statistically significant finding was that most of the patients felt a positive change and that they were willing to recommend the Red Cross DDCs ($p<0.05$) to other people, probably due to their better services [Table/Fig-7].

No statistically significant difference was found ($p>0.05$) with respect to the difference in incidents of harassment from staff of both types of DDCs. Patients were interviewed in separate rooms, with a maintenance of full confidentiality, but 70% of patients at the Red Cross DDCs and 56.7% of patients at the private DDCs denied this [Table/Fig-8]. It could be due to the fact that the patients were afraid of the consequences of reporting, or that they may have been given a warning of being thrown out from the DDCs.

CONCLUSION

There is an urgent need for filling all vacant posts and improving the services and facilities which are provided to patients by DDCs. Private DDCs should be guided, supported and promoted by the government, so that these centres can be run more efficiently, in order to provide more beneficial facilities. All DDCs must be strictly checked and regulated by the concerned higher authorities for any human rights violations. It is highly recommended that these services should be provided free of cost to the poor.

A vocational rehabilitation program that provides training in tailoring, carpentry or computer courses must be financed and supported at all DDCs, in order to reintegrate the de-addicted persons into the social mainstream. Project directors must ideally be retired from the medical profession or from an allied subject, so that they can direct the centres in a more knowledgeable way.

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