

Correspondence

Referral patterns in de-addiction services: an experience from a single centre

Sir,

India has a large unmet need for de-addiction services¹. The government through the Ministry of Health and Family Welfare (MoHFW) provides de-addiction services in the psychiatry or medicine departments attached to medical colleges which are pharmacotherapy oriented, and the Ministry of Social Justice and Empowerment (MoSJE) provides de-addiction services through non governmental organizations (NGOs), which emphasize psychosocial rehabilitation rather than medical management. Apart from these, many individual private sectors/agencies also provide de-addiction services. These services are complementary when used according to individual needs, but patients are deprived of such an opportunity due to the working styles of these agencies.

There is a proposal for 'Developing a Network of De-addiction services from Government, NGO and Private Sector', an initiative under the WHO regional branch, coordinated by National Drug Dependence Treatment Centre (NDDTC), All India Institute of Medical Sciences (AIIMS), New Delhi which is likely to bridge this gap in services, besides increasing their accessibility. As part of this initiative the modified Drug Abuse Monitoring System (DAMS) proforma² was used to collect data from all de-addiction service providers. The objectives of this study were to identify the mode and route of patients' arrival for the purpose of availing de-addiction services, and to study the pattern of further referrals to other service providers. This study was conducted in the De-Addiction Centre at Jawaharlal Institute of Postgraduate Medical Education & Research (JIPMER), Puducherry, India.

Data were collected on new cases attending the psychiatry OPD for de-addiction services over a period of one year (June 2011 to May 2012), using the

modified DAMS proforma provided by the project co-ordinating centre (NDDTC, AIIMS, New Delhi). The original DAMS proforma was used to collect data from de-addiction service providers all over India (mainly government service providers), and keeps track of the current drug abuse pattern and notes change in pattern of drug abuse over years². It contains service provider's identification, basic socio-demographic data of the patient, a checklist of drugs of abuse ever used and drugs currently being used in the last one month, questions on injection drug use and on high risk behaviour. The modified version has additional questions related to (i) previous drug treatment taken, and (ii) if treatment was taken, from which set up, (iii) if any referrals were made during the previous treatments, (iv) for what reasons referral was made at that time, and (v) current plans after assessment for referral to other agencies along with reason for the same.

A total of 166 male patients, with a mean age of 41.61 ± 9.39 yr were screened during the study period. Of these, 140 (84.3%) were literate with education level ranging from primary to postgraduation, and 145 (87.3%) were married. The most common substance use in the preceding one month was alcohol in 157 (94.6%) followed by nicotine in 97 (58.4%) patients. Sedative hypnotics (2.4%) and cannabis (1.8%) were the other substances. None reported stimulant, opioid or intravenous drug use. Medical co-morbidity was seen in 32 (19.3%) patients. Common medical conditions were hypertension, seizure disorder, hepatitis and gastritis. Psychiatric illness (psychosis and mood disorder) was noted in nine (5.4%) patients.

Most patients (155, 93.4%) who sought treatment from this De-addiction Centre came on their own. Nine (5.4%) were referred from other government centres and two from private set up. No referrals were made from NGOs. Those who were referred to this centre were

sent for investigations, pharmacological management or for alcohol associated medical problems. Further referrals after current assessment (n=5) were made to Government agencies only. Only 18 (10.8%) had sought any previous treatment and only three (1.8%) were referred to governmental agencies during those previous visits.

Analysis of the data revealed that most of our patients were self-referred and that cross-referral was almost non-existent between governmental and non-governmental organizations, showing an absence of public-private partnership. Networking can be improved by outlining the responsibilities of each sector and establishing a proper system of referral for cases that require care from other agencies. Part of this problem can be solved by public-private partnership that leads to accreditation programmes for de-addiction services with minimum facilities³. All de-addiction services providers in the region can be identified and brought under a single linkage system by providing unique identification to each treatment seeker in the region. All these services may be integrated into the district mental health programme (DMHP).

Interpretation of the current data is subject to consider certain caveats in methodology, reporting bias by patients (NGO may not be identified, as these are considered as private set up by treatment seekers who

may not want to disclose previous treatment taken), and referrals during the first visit may not in all cases. The assessment of physical and psychological barriers for networking of de-addiction services needs further exploration.

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