**A DESCRIPTIVE STUDY TO ASSESS BARRIER IN SEEKING DEADDICTION
TREATMENT IN SUBJECTS WITH ALCOHOL USE DISORDER (AUD) IN
SELECTED DEADDICTION CENTRES OF PUNJAB.**

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ABSTRACT

Introduction: Alcohol is one of leading causes of death and disability globally and in India. About 2 billion people worldwide consume alcoholic beverages and one third (nearly 76.3 million) to have one or more diagnosable alcohol use disorder.

Material and method: A descriptive research design was used present study. Total sample for the study used were 60 subjects with alcohol use disorder by convenient sampling technique. The data was collected from subject in selected deaddiction centre, after explaining them the purpose of study.

Results: The result of study showed that majority of subjects had average high number of barriers 13% of subjects had high number of barriers and 7% of subjects had low number of barriers. The data revealed that the mean of barrier score in subjects with alcohol use disorder was 82.42 followed by standard deviation 13.33. Chi square values have shown that there is no significance association between the level of barrier scores and other demographic variables (Age, gender, residential area, religion, educational status, type of family, monthly income, duration of drinking).

Conclusion: it was concluded that the authorities should make use of the media to reach out to the population and to make them more aware of the reality and effectiveness of de-addiction treatment. The government should act as a role model to the private sector in showing ways of providing treatment at affordable costs.

Keywords: Alcohol use disorder, Barriers, De-addiction centre.

INTRODUCTION

Alcohol is one of leading causes of death and disability globally and in India. About 2billion people worldwide consume alcoholic beverages and one third (nearly 76.3million) to have one or more diagnosable alcohol use disorder. Alcohol is attributed to nearly 3.2% of all deaths. It is acknowledged that countries which had low alcohol consumption are now witnessing and increasing consumption pattern WHO estimates for the South East Asian countries indicate that one fourth to one third of male population drink alcohol (Global status report on alcohol 2004) with increasing trends among women. In India the estimated numbers of alcohol users are 62.5 million, with 17.4% of them being dependent users and 20-30% of hospital admissions are due to alcohol related problems (2005). The Global Information System on Alcohol and Health (GISAH) is an essential tool for assessing and monitoring the health situation and trends related to alcohol consumption, alcohol-related harm, and policy responses in countries. In 2005, the world wide total consumption was equal to 6.13 liters of pure alcohol per person 15years and older.

Unrecorded consumption accounts for nearly 30% of the world wide total adult consumption. National Survey on Drug Use and Health (NSDUH) reported that 86.4 percent of people ages 18 or older reported that they drank alcohol at some point in their lifetime; 70.1 percent reported that they drank in the past year; 56.0 percent reported that they drank in the past month. Substance Abuse and Mental Health Services Administration, (SAMHSA)

Alcohol Use Disorder (AUD) is a chronic relapsing brain disease characterized by an impaired ability to stop or control alcohol use despite adverse social, occupational, or health consequences. AUD can range from mild to severe, and recovery is possible regardless of severity. The fourth edition of the Diagnostic and Statistical Manual (DSM-IV), published by the American Psychiatric Association, described two distinct disorders-alcohol abuse and alcohol dependence-with specific criteria for each. The fifth edition, DSM-5, integrates the two DSM-IV disorders, alcohol abuse and alcohol dependence, into a single disorder called alcohol use disorder, or AUD, with mild, moderate, and severe sub

classifications. The RTI query with the Punjab and Excise department has revealed that the state's liquor consumption has gone almost double in the last ten years. According to sources, the number of liquor vendts have also gone up from around 7,100 including 2,529 English liquor vendts to nearly 10,000 vendts including 3,500 English vendts in the same corresponding period. There was also a sharp rise between 2011 to 2014, around 59 per cent, in liquor consumption in the state.

Collins SE, Kirouac M stated that alcohol is also known by its chemical name ethanol, is a psychoactive substance that is the active ingredient in drinks such as beer, wine, and distilled spirits (hard liquor). It is one of the oldest and most common recreational substances, causing the characteristic effects of alcohol intoxication ("drunkenness"). ("10th Special Report to the U.S. Congress on Alcohol and Health: Highlights from Current Research"). Alcohol consumption is rewarding and reinforcing and can result in addiction to alcohol, which is termed ALCOHOLISM.

Discontinuation of alcohol after extended heavy use and associated tolerance

development (resulting in dependence) can result in withdrawal. Alcohol withdrawal can cause confusion, anxiety, insomnia, agitation, tremors, fever, nausea, vomiting, autonomic, seizures, and hallucinations. In severe cases, death can result. Delirium tremens is a condition that requires people with a long history of heavy drinking to undertake an alcohol detoxification regimen.

Yost DA Opined that death from ethanol consumption is possible when blood alcohol levels reach 0.4%. A blood level of 0.5% or more is commonly fatal. Levels of even less than 0.1% can cause intoxication, with unconsciousness often occurring at 0.3–0.4%. The oral median lethal dose (LD50) of ethanol in rats is 5,628 mg/kg. Directly translated to human beings, this would mean that if a person who weighs 70 kg (150 lb.) drank a 500 mL (17 US Fl oz) glass of pure ethanol, they would theoretically have a 50% risk of dying. Symptoms of ethanol overdose may include nausea, vomiting, central nervous system depression, coma, acute respiratory failure, or death.

Lukas SE, Orozco S Opined that in combination with cannabis, ethanol increases plasma tetra hydro cannabinol

levels, which suggests that ethanol may increase the absorption of tetra hydro cannabinol Disulfiram inhibits the enzyme acetaldehyde dehydrogenase, which in turn results in buildup of acetaldehyde, a toxic metabolite of ethanol with unpleasant effects. The medication is used to treat alcoholism, and results in immediate hangover-like symptoms upon consumption of alcohol.

Boyle P opined that alcohol is legal in most of the world. However, laws banning alcohol are found in the Middle East and some Indian states as well as some Native American reservations in the United States. In addition, there are strict regulations on alcohol sales and use in many countries throughout the world. For instance, most countries have a minimum legal age for purchase and consumption of alcohol (e.g., 21 years of age in the United States). Also, many countries have bans on public drinking. Drinking while driving or intoxicated driving is frequently outlawed and it may be illegal to have an open container of alcohol in an automobile.

Butcher JN, Hooley JM, Mineka SM stated that alcohol causes a plethora of

detrimental effects in society, both to the individual and to others. It is highly associated with automobile accidents, sexual assaults, and both violent and nonviolent crime. About one-third of arrests in the United States involve alcohol abuse. A 2002 study found 41% of people fatally injured in traffic accidents were in alcohol-related crashes.

OBJECTIVES OF THE STUDY

1. To identify frequency of alcohol among the subjects seeking de-addiction treatment with alcohol use disorder.
2. To identify the barrier in seeking de-addiction treatment in patient with alcohol use disorder.
3. To find out association between the barriers in de addiction treatment and alcohol use disorder with their selected demographic variables.

MATERIALS AND METHODS

In this study a descriptive research design was used to assess the barrier in seeking de-addiction treatment in subjects with Alcohol use disorder in selected de-addiction centres of Punjab. Total sample for the study used were 60 subjects with alcohol use disorder by convenient sampling

technique. Two tools were used to collect the data in the study i.e. demographic profile sheet and structured barrier questionnaire. Validity of research tool was established under the guidance of various experts from the field of Mental Health (Psychiatry) Nursing. The pilot study was conducted for the feasibility of study. Permission to conduct the study was taken from ethical committee and superintendent of de-addiction centres. Analysis of the data was done by using both descriptive and inferential statistics.

RESULTS

Table Showing barrier Scores in subject with alcohol use disorder seeking de-addiction treatment.

Barrier Scores	N= 60	%	Frequency
High Barriers. (101-150)		13%	8
Average Barriers. (51-100)		80%	48
Low Barriers. (0-50)		7%	4

Maximum =150

Minimum=0

The result of study showed that majority of subjects had average high number of barriers 13% of subjects had high number of barriers and 7% of subjects had low number of barriers. The data revealed that the mean of barrier score in subjects with alcohol use disorder was 82.42 followed by standard deviation 13.33. 87

The significant treatment barriers were feeling of trouble to go for help (74%), confidence of handling problem by its own (72%), don't like to talk in group (70%),

worry about indulge in legal trouble (70%), not to believe as an addict (68%), fear of treatment (68%), embarrassment of what others thinking (67%), liking the drug consumption (67%), Fear of losing the job (66%), privacy concern (66%), safety concern (66%), lack of encouragement (65%), felt embarrassed or ashamed (65%), don't want others suggestions for treatment (65%), fear to lose friends (65%).

CONCLUSION

Hence it was concluded that the authorities should make use of the media to reach out to the population and to make them more aware of the reality and effectiveness of deaddiction treatment. The government should act as a role model to the private sector in showing ways of providing treatment at affordable costs. Government authorities should also ensure that deaddiction services are available to their employees without them having to risk their jobs, and the private sector should follow suit. Most importantly, the government should ensure ample participation of psychiatrists and their organizations during policy making regarding regulation and control of abuse of alcohol. Moreover, the

awareness camps should be organized for community to aware about deaddiction treatment and centers, as well as prevention of alcohol abuse and other substance use.

REFERENCES

1. WHO Expert Committee on Problems Related to Alcohol Consumption: second report (PDF). Geneva, Switzerland: World Health Organization. 2007. p. 23. ISBN 9789241209441. Retrieved 3 March 2015. ...alcohol dependence (is) a substantial risk of regular heavy drinking.
2. Vengeliene V, Bilbao A, Molander A, Spanagel R (May 2008). "Neuropharmacology of alcohol addiction". *British Journal of Pharmacology*. 154 (2): 299–315. doi:10.1038/bjp.2008.30. PMC 2442440. PMID 18311194. (Compulsive alcohol use) occurs only in a limited proportion of about 10–15% of alcohol users.
3. Stogner JM, Eassey JM, Baldwin JM, Miller BL (September 2014). "Innovative alcohol use: assessing the prevalence of alcohol without liquid and other non-oral routes of alcohol administration". *Drug and Alcohol Dependence*. 142: 74–8. doi:

10.1016/j.drugalcdep.2014.05.026. PMID 25012895.

4. Proudfoot H, Teesson M. (2002) who seeks treatment for alcohol dependence? Findings from the Australian National survey of mental health and well-being. Soc Psychiatry Psychiatric Epidemiology. 37:451–6. [PubMed]

5. Hanpatchaiyakul K, Eriksson H, Kijssompon J, Ostlund G. (2014) Thai men's experiences of alcohol addiction and treatment. Glob Health Action. 7:23712. doi: <http://dx.doi.org/10.3402/gha.v7.23712>. [PMC free article] [PubMed]

6. Van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen (2013) HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: systematic review. Drug Alcohol Depend; 131:23–35. [PubMed]

7. Brett J, Lee KS, Gray D, Wilson S, Freeburn B, Harrison K, (2016). Mind the gap: what is the difference between alcohol treatment need and access for Aboriginal and Torres Strait Islander Australians? Drug Alcohol Rev. 35:456–60. doi:

<http://dx.doi.org/10.1111/dar.12313>. [PubMed]

8. Gilman JM, Ramchandani VA, Crouss T, Hommer DW (January 2012). "Subjective and neural responses to intravenous alcohol in young adults with light and heavy drinking patterns". Neuropsychopharmacology. 37 (2): 467–77. doi:10.1038/npp.2011.206. PMC 3242308. PMID 21956438.

9. Gerdner A, Holmberg A. (2000) Factor affecting motivation to treatment in severely defendant alcoholics. J Stud Alcohol Drugs. 61:547–60. [PubMed]

10. Mäkelä P, Keskinen IT, Koskinen S. (2003) what underlies the high alcohol-related mortality of the disadvantaged: high morbidity or poor survival? J Epidemiol Community.; 57:981–6. [PMC free article] [PubMed]