

Profile of Women Seeking Treatment for Substance Use Disorder in Tertiary Care Government De-Addiction Centre

Abstract

Background: There is an increasing trend among women using substance. However, very few women seek treatment for substance use disorder in Government de-addiction centre. There is limited literature available regarding the same. **Aim:** To examine the profile of women seeking treatment for substance use disorder in Government De-addiction Centre, Bengaluru. **Methods:** The study was retrospective in nature. All the female patients who sought in-patient treatment from centre for addiction medicine, NIMHANS, Bengaluru from Apr 2015- Sept 2016 were included in the study. **Method of data collection:** Content analysis was used to collect the secondary data from the hospital record. **Descriptive statistics** such as mean, frequency distribution was used for statistical analysis. **Results:** Mean age of women who sought treatment for substance use disorder in the centre was 42 ± 14 years. The mean age at initiation of alcohol was 27 ± 9 years, alcohol dependence was 34 ± 10.6 years. Majority (65%) belonged below poverty line. 59% were married and living with their spouse. 55% of them sought treatment either on their own or brought by family members, 38% referred by the psychiatrist. More than one-third (36%) had primary school education. Nearly one-third (27%) of them had repeated admissions more than once. More than one-third of them (34%) were homemakers, nearly one-fourth (24%) of them were lost their previous job, 6% of them students and professionals respectively. **Conclusion:** The majority (68%) of women had diagnosis of alcohol dependence, nicotine (44%), benzodiazepine (14%), opioid dependence (11%), cannabis dependence (1.6%), less than 1% had other forms behavioural addictions.

Keywords: Drug Uses, Chemical Dependency, Alcohol, Help Seeking

Introduction

The prevalence of women's substance use is decreased in most regions globally, except in South-East Asia and Western Pacific Regions. However, the absolute number of currently drinking women has increased. Worldwide, women are more often abstainers than men. More than half of the world's female population aged 15 years or

older are lifetime abstainers (54.6%). Women consume less alcohol than men. When females drink alcohol, they drink less on average and engage less often in heavy drinking episodes. Globally, the prevalence of current drinking alcohol in men and women shows a decreasing trend from 2005. The percentage of decrease was 4.3% for men (57.9% to 53.6 %) and 5% for women (37.3% to 32.3%).

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Globally 32.28 million women had alcohol use disorder in 2017. The prevalence of current drinking in females is more in high-income countries (57%), followed by upper middle income (36.1%), lower middle income (19.8%), and low-income countries (16.9%). Leading contributors to the burden of alcohol-attributable deaths and DALYs among women were cardiovascular diseases, digestive diseases, and injuries.

Alcohol use among women in India

Alcohol use is not uncommon among women in India. Remarkable gender differences exist in alcohol use patterns; 27.3% of men use alcohol, and 1.6% of women use alcohol. One in sixteen alcohol-using women is dependent. In India, during 2017, the prevalence of alcohol use disorder in women was 0.51% and in men 1.73% (WHO, 2018). There was a decreasing trend in India as well, in line with the global trend. The decrease per cent was 0.5% in both sexes. Among women, states with the largest prevalence (>10%) of alcohol use are Arunachal Pradesh (15.6%) and Chhattisgarh (13.7%). The prevalence of cannabis among women was 0.6 %, opioid use of 0.2%, inhalants of 0.07%, and a tiny portion of women using cocaine 0.1% (Atul, 2019). Among women, those with more education and those with higher income/occupational status were more likely to report high-risk drinking, including heavy drinking episodes. Women who drink alcohol had a history of alcohol use in their family; 97% of rural women did not seem aware of treatment availability, alcohol use among the older women and widowed are more prevalent in the rural part of Telangana (Potukuchi and Rao 2010). Compared to men, women became dependent on alcohol more rapidly and had less social and more physical and psychiatric complications (Selvaraj V, 1997). Women, who sought treatment for their condition, were married and non-earning most of them from an urban background. The common substance of abuse was tobacco, followed by opioids, alcohol, and benzodiazepines (Nebhinani et al., 2013, Kanika 2017). Indian studies show that women with SUDs

who entered into treatment ground were married, homemakers, and common substance was prescription opioids along with benzodiazepines. Women were introduced to opioids by medical practitioners and husbands who used the substance for pain relief. Common comorbidity was depressive disorder, anxiety, cluster B personality traits/disorder, and somatoform disorder (Atul 2017, Dayal 2016, Grover 2015).

The association of alcohol consumption with engagement in unprotected sex has increased the risk of experiencing an unintended pregnancy. The global prevalence of alcohol use during pregnancy in the general population amounts to 9.8% (Popova et al 2017). Children of women using alcohol have chromosomal abnormalities, growth delays, intellectual, behavioural disorders, speech and language difficulties, visual and audiological impairments, cardiac deformities, urogenital problems, and fetal alcohol spectrum disorders (Popova et al 2016).

Psychosocial factors

Women with a history of adverse childhood experiences are at increased risk of developing alcohol use disorder in later life (Lee, 2008 and Liebschutz 2002). Traumatic experiences in life such as intimate partner violence, emotional abuse (Malik 2017, Devries 2014 and Yoshihama 2010) and relationship problems such as marital discord further increases the risk for alcohol use disorder among women with substance use disorder (Cranford et al 2010 and Blair, 2016). The prevalence of co-occurring mood and anxiety disorders is high among women. There is an association between depressive and anxiety disorders among women with substance abuse (Grant et al 2006). Childhood sexual abuse increased the risk for both substance abuse and dependence in women. Poor education status, lack of a job, young age at work, early marriage, and lack of social support increase vulnerability to substance use in females (Murthy 2008). Pregnant women with opioid use disorder

have psychiatric comorbidity, with depression and anxiety being widespread (Arnaudo 2017). Major depressive disorder and dysthymia, in most cases, comorbid disorders were secondary to SUDs (Malik 2017, Malik 2015, Nebhinani et al 2013 and Ray et al 2004).

Treatment seeking

Women are less likely to enter a treatment centre for substance abuse than men because of several reasons. Around four per cent of women attending the out-patient services of a general hospital had alcohol dependence and found to be pregnant. Several studies reported high rates of medical and psychiatric comorbidity and poor follow-up rate among women with SUDs. There is a gradual increase among the women with SUDs seeking treatment across centers in India (Selvaraj 1997, Prasad 1998, Grover 2014, Nebhinani 2013, and Potukuchi 2010). Women with substance use disorder were significantly low compared to men (Murthy et al 1995). Barriers to treatment-seeking women with substance use disorder include the lack of childcare, fear of stigma, lack of family or financial support, denial, worry of being identified as a drug addict, thinking they could quit on their own. Lack of information about treatment options and long waiting times were perceived barriers (Copeland 1997, Murthy 2002, Poole & Isaac 2001, Rabuffetti 2003, Nebhinani et al 2013).

Linkages and referrals to these services provide a coordinated continuum of care needed to improve their quality of life, after-care services, home visits, and telephone follow-ups (Taylor 2010). Higher education was associated with abstinent, easy to make a better understanding about their problems and follow-up. Most women patients come by self or family referral and are referred by a psychiatrist, with a limited referral from other medical professions (Nebhinani et al 2013). The specifically designed treatment program for women is more effective in their treatment completion, length of stay, decreased use of substances, reduced mental health

symptoms, improved birth outcomes, employment, self-reported health status, and high-risk reduction (Olivia 2009).

Methods

The retrospective study was conducted at the Centre for Addiction Medicine, National Institute of Mental Health and Neurosciences, Bangalore, (Institute of National Importance), a premier institute for mental health and neuroscience in southeast Asia, fully funded by the Ministry of Health and Family Welfare, Government of India. The Centre has separate premises for the out-patient department, women who seek treatment for substance use disorder. The out-patient consultation is available on (Mon, Thurs, Sat) between 9.00 am to 3.30 pm. All the women patients would be initially screened and evaluated by the post-graduate trainees in psychiatry, clinical psychologist, psychiatric social worker, and psychiatric nursing after the direct interview with the patient and their family members, followed by consultation with a senior consultant psychiatrist. A consultant psychiatrist would make the diagnoses. A tailor-made and individualized treatment plan would be devised according to the patient's needs in consultation with the multi-disciplinary team under the leadership of the senior consultant psychiatrist.

All the women patients would be preferred to undergo out-patient detoxification. In-patient care would be considered when the patient is not getting the benefit of out-patient treatment and their health condition warrants admission. Before admission, all the women patients would be given pre-admission counselling by the psychiatric social worker who explains ward rules and regulations during the in-patient care. Written informed consent would be obtained from the patient and their relatives during pre-admission counselling at the out-patient setting. As admission in the female ward is voluntary, patients would be prepared to stay for 21 days for the treatment completion. As a policy, the centre encourages out-patient detoxification for first-time

treatment seekers. In case out-patient detoxification fails, then in-patient care is considered depending on the availability of beds.

The center has separate 20 bedded facilities for women with substance use disorder, and it was commissioned in 2014. The women's wing has a full-fledged multi-disciplinary team comprising nursing, psychiatric social work, clinical psychology and psychiatry, occupational therapy, yoga therapy. The centre has an infrastructure facility for women to attend group therapy, yoga, recreational activities. The women's wing is fully funded by the Ministry of Health and Family Welfare, Government of India. The centre has male and female ward separately. The treatment services are provided separately for men and women. The center has full-fledged female nursing officers and female psychiatric social workers exclusively for female patients.

A multi-disciplinary team provides tailor-made intervention at different levels. A female therapist counsels the female patients. A psychiatric social worker acts as a case manager for each patient. They work with the patient from day one of in-patient care, including psychosocial assessment, intervention with their family members, keeping the patient in the treatment loop, and monitoring regular follow-up. If the patient failed to attend follow-up, social workers visit the patient's home to motivate the patient and family members to attend follow-up. Whenever a patient comes for follow-up, the therapist would review who had been counselled the patient earlier. Treatment charges are less for BPL cardholders and waived off financially restricted patients. Psychiatric social workers facilitate the shelter, placement, and legal remedies for homeless women, poor social support, or those abandoned by the family. Psychiatric social workers work along with the collaboration of various welfare agencies who are predominately working for women. Female psychiatric social worker conducts group therapy on weekdays. Patients attend group therapy after detoxification. Group therapy is

based on relapse prevention, and specific issues related to women would be discussed. Every Wednesday, psychiatric social workers conduct group therapy for caregivers, discuss a medical model of addiction, the importance of medication and regular follow-up, family role in recovery, and handling lapse/relapse. A separate waiting hall, baby care room, and consultation team for female patients have been initiated recently in the out-patient department.

Secondary data was collected from the respective patients' case records. There were 597 women patients' availed treatments for substance use disorder as an in-patient at Centre of Addiction Medicine from 1985 to 2019. The present study was conducted in Oct 2016. On average more than 100 women patients get admitted as an in-patient at the Women ward from 2015.

Results

Table 1
Profile of women with substance use disorder

Demographic profile	Category	Frequency N=86	Percentage
Education	Primary	31	36.0
	High School	25	29.1
	Hr. secondary	5	5.8
	Graduates	14	16.3
	Post-graduates	11	12.8
Employment	Unemployed	18	20.9
	Housewife	37	43.0
	Farmer	7	8.1
	Skilled worker	6	7.0
	Clerical work/	2	2.3
	Professional	6	7.0
	Business	1	1.2
	Student	8	9.3
	Retired	1	1.2
Socio-Economic status	BPL	56	65.1
	APL	30	34.9
Marital Status	Unmarried	18	20.9
	Married	51	59.3
	Separated	1	1.2
	Divorced	3	3.5
	Widowed	13	15.1

Table 1 reveals that more than one-third (36%) had primary school education, nearly one-third (29%) of them had education up to 6-10 years, 16% of them were graduates and 13% of them had post-graduates. The majority (65%) belong below the poverty line, 59% married, 21% never married, 15% widowed. More than one-third (34%) were homemakers, nearly one-fourth (24%) of them were lost their previous job, 6% of them students and professionals respectively.

Table 2
Clinical Profile

Clinical variable	N	Min	Max	Mean	S.D.
Age	86	15	78	41.79	13.97
Age at onset of alcohol use	52	12	50	27.25	9.23
Age at alcohol dependence	39	19	60	34.02	10.64
Age at onset of nicotine use	43	10	46	23.37	9.60
Age of nicotine dependence	36	10	45	24.75	8.93
Age at physical complications	14	19	75	37.50	14.63
Age at psychiatric complications	4	19	47	38.00	12.83
Age at complicated withdrawal	5	34	48	41.00	6.20
Age at First treatment	77	17	78	41.71	13.58

Table 2 shows the mean age of women who sought treatment for substance use disorder in the centre was 42 years (S.D= ± 14). Mean age at initiation of alcohol was 27 years (S.D= ± 9). Mean age at alcohol dependence was 34 years (S.D= ± 10.6). Mean age at initiation of nicotine use was 23 years (S.D= ± 9.6) and nicotine dependence was 25 years (S.D= ± 9). Minimum age of the women who sought first treatment for substance use disorders was 17 years and the maximum years being 78 years. Nearly one-third (27%) of them had repeated admissions more than once. Mean age of their physical complications and psychiatric complications started at 38 years respectively.

Table 3 reveals that, the majority (88%) had a primary diagnosis of nicotine dependence, 68% had alcohol dependence, 14% had benzodiazepine dependence, 11% had opioid dependence, 1.6% had cannabis dependence, and less than 1% had other forms

Table 3
Clinical profile

Clinical variable	Category	N	Percentage
Primary substance use	Alcohol	53	61.6
	Nicotine	12	14.0
	Opioid	4	3.5
	Sedatives	8	9.3
Secondary substance of abuse	Nicotine	33	38.4
	Opioid	1	1.2
	Cannabis	2	2.3
	Benzodiazepine	3	3.5
Poly substance abuse	None	38	44.2
	Yes	5	6
	None	72	84
Informants	No information	9	10
	Self	10	11.6
	Parents/Spouse	29	33.7
Motivation	Friend	47	54.7
	Contemplation	30	34.9
	Action	3	3.5
	Preparation	12	14.0
Psychiatric Co-morbidity	Pre-contemplation	14	16.3
	None	17	19.8
	Depression	22	25.8
	None	57	66.3
	OCD	2	2.4
	Schizophrenia	3	3.6
Family history of psychiatry illness	Postnatal Depression	1	1.2
	Somatoform Disorder	1	1.2
	Psychosis	1	1.2
	Mood	3	3.5
	Suicide	4	4.7
Family history of substance use	None	69	80.2
	Not Available	9	10.5
	Alcohol	40	48.6
	Nicotine	8	9.3
Source of Referral	Absent	29	33.7
	Missing	9	10.5
	Self/Family	47	54.7
	Physician	1	1.2
	Psychiatrist	33	38.4
	Ex-patient	1	1.2
	Others	3	3.5

behavioural addictions. 6% had polysubstance dependence. 55% of them sought treatment either on their own or brought by family members, 38% referred by the psychiatrist. The majority (80%) do not have a family history of psychiatric illness.

Nearly half (48.6) of them had a family history of alcohol use and nicotine use was 9.3%.

Discussion

The proportion of women availing of treatment services is less when compared to the prevalence of substance abuse among women. There is a considerable treatment gap among women compared to the number of men availing of treatment. A notable observation from the centre is that duration of in-patient stay among females is more, and many have less social support when compared to their male counterparts. One reason could be looking after school-going children at home, their spouses. Most often, female patients who have poor social support from their mother become the primary caregiver during their in-patient stay. They have more physical complications than men. Their spouses have more stigma in the neighbourhood and society. It is a shame for parents and husbands to reveal that their ward has alcohol use disorder. Female patients do have self-stigma to seek help and to continue follow-up service. Waiting for the hall is common for both male and female patients in the out-patient facility, whereas consultation is provided separately for female patients who come for follow-up.

The present study showed that socio-demographic variables of marital, employment and socio-economic status of women who sought in-patient care, majority of them were housewives, married and low socio-economic background; this finding was similar to results of previous studies (Atul 2017, Kanika 2017, Dayal 2016, Grover 2015). Most of them come by own or brought by family members, and some of them referred by a psychiatrist. This finding was in concordance with Nebhinani et al (2013). Family history of substance use plays a significant role in initiating and maintaining factors among the women with substance use in the present study, which was in concordance with previous study findings (Nebhinani et al 2013 and Grant et al 2020).

Primary substance use was alcohol, followed by nicotine, sedatives, and opioid in this study. This finding was similar to other studies (Malik 2015, Potukuchi and Rao, 2010). Whereas studies conducted in North, North West, and Northeast India showed the most common substance abuse was opioids among women who sought treatment for their conditions (Dayal 2016, Grover 2015, Atul 2017). The second most common substance use was nicotine, along with primary substance. In the present study, nearly half of them was not using more than one substance. Common co-morbidity psychiatric illness was depression in this study, similar to previous Indian studies (Dayal 2016, Arnaudo et al 2017, Nebhinani et al 2013 and Ray et al 2004). More than half of them did not have any psychiatric co-morbidity condition in the present study. Family history of substance use has a more significant association with initiation and maintaining factors among women with substance use disorder.

Conclusion

A women-centric treatment program should be designed to address the issues faced by women with SUD. Child care facilities need to be incorporated along with the treatment plan and ensuring easy access to treatment. Available treatment facilities for women with SUDs need to be popularised and destigmatized.

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