

BARRIERS TO SEEK DEADDICTION SERVICES IN SUBJECTS WITH ALCOHOL USE DISORDER – A CROSS SECTIONAL STUDY

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ABSTRACT

Background: Kerala consumes 8.3 liters of liquor per person annually, the highest in India. Various factors have been identified as barriers among subjects with Alcohol Use Disorder (AUD) in approaching psychiatric care centers for deaddiction treatment.

Aims & Objectives: (1) To identify barriers to seek alcohol deaddiction treatment in subjects with AUD. (2) To assess their perception about the new alcohol regulation policy of the Government of Kerala.

Methodology: A purposive sample of 100 people with AUD at two government run alcohol outlets of Kannur district were interviewed with a self-rated questionnaire (Barriers Questionnaire v.1.0A–CASAA Research Division) over a period of one month. Their sociodemographic variables were also collected.

Results: The main treatment barriers were lack of need (79%), confidence of handling problem on their own (77%), risk of losing job and friends (70%), privacy concerns (71%), lack of time (53%), embarrassment to patient and family (51%), financial burden (59%) and fear of treatment (59%). Majority (68%) supported new regulations by the government, but pointed out the need to create awareness among public regarding ill effects of substance use and to check the rise in usage of illicit drugs.

Conclusion: Several barriers prevent people in Kerala from seeking deaddiction for AUD. These need to be considered during making of policies and implementation of treatment strategies.

Keywords: alcohol, barriers, deaddiction treatment

INTRODUCTION

In ancient India, alcohol use was restricted to certain occasions like war, religious activities and festivals. After the long British rule, India witnessed a slow and steady rise in alcohol consumption, and there was a gradual change in the attitude of society towards the habit. Even illicit alcohol making

became a cottage industry in various parts of India.¹ Better fermentation and distillation processes and good transport facilities made alcohol easily available in all parts of the nation.

CURRENT INDIAN SCENARIO

India, the largest democracy in the world, is well known for its culturally diverse and extremely

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varying populations. The quantity and pattern of alcohol use in India depends on the attitude and perception of these cultural sects towards alcohol. In India, the two types of liquors available are Indian Made Foreign Liquors (IMFL) and country liquor. Studies conducted in different parts of the nation showed a prevalence of alcohol use ranging from 23% to 74% among males.² Alcohol use among women was significantly less, but common among tribal groups and tea plantation workers.²

KERALA SCENARIO

Current alcohol use among populations in southern India show a prevalence ranging from 33% to 50%.³ Annual alcohol consumption among the population of Kerala was found to be 8.3 liters per person; thrice the national rate. This led certain sections of the media to term Kerala the “alcohol capital of India”.⁴ Alcohol use among teenagers is also on the rise. A study conducted in coastal Kerala found the prevalence of alcohol use among children and teenagers to be 3%.⁵

Alcohol sale in Kerala is regulated by the Kerala State Beverages Corporation (KSBC), a public sector company owned by the Government of Kerala. It controls the sale of IMFL and beer in the state. KSBC has 22 warehouses and 337 retail outlets throughout the state.⁶

Arrack consumption has been banned in Kerala since 1st April 1996. Kerala has implemented prohibition of alcohol in a phased manner from August 2014. Government has ordered the shutdown of all bars except five star hotels. It was proposed that the retail liquor outlets of the KSBC, which has a complete monopoly in selling liquor in the state, will be reduced by ten percent every year so that in ten years, the state would be alcohol free. These regulations met with mixed responses from the state’s population.

BARRIERS IN SEEKING TREATMENT FOR ALCOHOL USE

Several deaddiction centers, both registered and unregistered, function in Kerala. Treatment

involving different systems of medicine, and religious and pseudo-religious modalities, is available in the state. Though the state never met the demand for deaddiction facilities, the available facilities are not adequately made use of by our population. Many barriers prevent alcohol users from seeking deaddiction treatment.

Barriers to treatment are events or characteristics of the individual or system that restrain or serve as obstacles to the person for receiving health care or drug treatment.⁷ People tend to have significant problems in availing treatment for addiction, especially alcohol. Deaddiction services have been associated with significant positive outcomes among substance users.⁸ But, for this, the subject has to present before the medical team. Melnyk had identified five main classes of barriers: relationship, site-related aspects, cost, fear, and inconvenience.⁹ According to Andersen and Newman, factors related to the individual and the health care system interact in influencing health care facilities, including substance abuse treatment. Health care system factors include policy issues, financial burden, stigmatization and misconceptions about treatment.¹⁰ Individual-related factors include perception about the drinking pattern, realization of the need, sex, age, ethnicity, education and marital status.

The best way to find out about details of various barriers to seek substance abuse treatment is to ask the patients themselves. A large population study demonstrated that lack of confidence about the effectiveness of treatment, stigmatization by public, and denial served as significant interferers with treatment.¹¹ Injection drug abusers considered the need to hide their behaviour from the spouse and lack of adequate time as important barriers.¹² Lack of insurance aid, fear of treatment, previous experience of ineffective treatment and aversion to certain treatment modalities along with dislike in sharing their problems and stigma served as significant treatment barriers.⁷ In another study where problem drinkers were asked to identify their own problems, they came up with four main areas of

concern: privacy, necessity of treatment, practicality and financial concerns.¹³

INDIAN DATA ON BARRIERS TO SEEK DEADDICTION TREATMENT

Limited data are available from Indian population regarding barriers in seeking deaddiction treatment. A study conducted among substance abusers in rural population detected lack of time (51.2%) as the major barrier in seeking treatment, along with other factors like absence of problem (48.8%) and fear of treatment (40.3%).¹⁴ Majority of the participants in a study conducted among alcohol users in a community outreach deaddiction center considered alcohol as a social problem, and the main barriers cited were “ashamed to admit problems” and “treatment does not help”.¹⁵

The facts that most of the available data are from clinical populations and that almost no data are available from South India make the present study relevant. Here, we target a specific population with alcohol use disorders (AUD) from community who did not present for any deaddiction help. Subjects were selected from people standing in queue to purchase alcohol from government-owned beverage outlets. Such a group was never considered in earlier studies.

AIMS & OBJECTIVES

- To identify barriers to seek alcohol deaddiction treatment in subjects with AUD
- To assess their perception about the new alcohol regulation policy of the government

MATERIALS AND METHODS

This was a cross-sectional study which used purposive sampling technique. A team comprising of residents, postgraduate students and interns from Dept. of Psychiatry was formed under the leadership of primary investigator and divided into groups to interview subjects. Study was conducted in the months of April–May 2015 at two Government owned beverage outlets in Kannur district. People standing in the queue were selected

for study. Strict confidentiality was maintained regarding identity of participants. Study was conducted on three days in a week, with each team visiting beverage outlets separately. Our target sample size was 100, and about 300 people were approached. Study concluded once the sample of 100 was obtained. The data sheet included basic sociodemographic details and relevant tools. Data sheet was administered, after personal interview with the subject, by a member of the team who was given training on administering the questionnaire.

SAMPLE

Study was conducted among people who met the criteria for AUD according to DSM 5. Subjects were selected from people standing in the queue to purchase alcohol from government-owned beverage outlets. Alcohol users who met the following criteria were included:

- Over 18 years of age and consented for the study
- People who met the DSM 5 diagnostic criteria for AUD¹⁶
- Not on any psychiatric treatment

TOOLS

Barriers questionnaire 1.0 A, a tool to assess the barriers in treatment seeking for alcohol users, was developed by research division of Centre on Alcoholism, Substance Abuse and Addictions (CASAA), University of New Mexico; and asks people why they had not previously sought treatment. It has 50 self-report questions, assessed using Likert scale of 0-3 (0=Not Important, 1=Somewhat Important, 2=Important, 3=Very Important). The questionnaire has not been scaled, and interpretation is therefore at the item level.¹⁷ Though the questionnaire is in English, members of our team who administered the tool explained its contents to our sample in Malayalam. Perceptions of our sample regarding the new alcohol regulations were assessed using the closed- ended questions included in Table 1.

Table 1: Questions regarding alcohol regulation law by Government (Each had to be answered in “Yes” or “No”

1. Are you aware of the recent alcohol regulation laws by the government?
2. Do you think it is a right way to check the use of alcohol?
3. If the laws were implemented, would you expect a change in the quality of life?
4. Do you think it is possible to successfully implement the legal restriction of alcohol?
5. Do you think the use of illicit liquor will increase with implementation of these laws?
6. Do you think these restrictions could lead people to turn to other drugs of abuse?
7. Do you think educating people about healthy drinking would have been a better step?

ETHICAL ASPECTS

Approval was obtained from the Institutional Ethics Committee. Permission was also obtained from the Managers of the beverage outlets. Written informed consent was obtained from the subjects. Nature of the study was explained and confidentiality was promised. Subjects were allowed to participate anonymously. Subjects who required treatment for alcohol abuse or dependence were offered treatment. The study was not funded by any external agency and has no conflict of interests.

ANALYSIS

SPSS Software package (Version 17 for windows) was used for analysis. Descriptive statistics were used.

RESULTS

A total of 100 subjects between ages 23 and 68 took part in the study. Age distribution of the sample is shown in Figure 1. The initial proforma filled by them contained questions on identification data and questions regarding the recent government

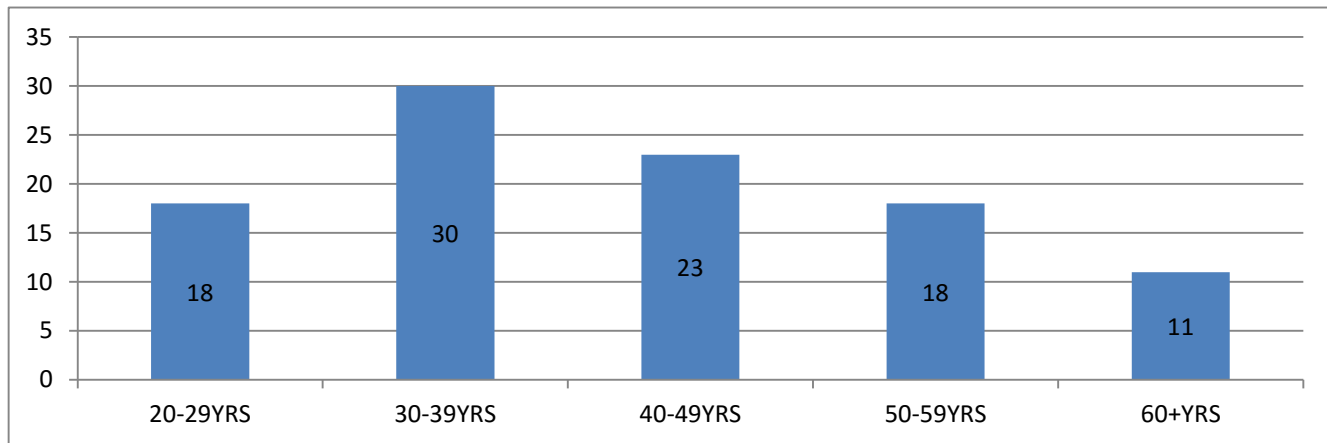
regulations on sale of alcoholic beverages in Kerala. All participants were male. 29% of the subjects were Below Poverty Line (BPL) as determined with their ration card status.

92% of the respondents said they were aware of side effects of alcohol consumption and 97% were aware of the various steps being taken by the government of Kerala to regulate sale of alcohol. 68% of the subjects believed that the government orders were the right way to check the use of alcohol, 58% believed that these steps, if implemented, would result in an improved quality of life, and 57% said it is possible to successfully implement these laws. 51% believed that such restrictions would certainly increase the sale of illicit liquor and 66% believed that restriction of sale of alcohol would eventually lead people to turn to other drugs of abuse. 73% of the respondents believed that educating people about healthy drinking would have been a better option. 59% was of the belief that alcohol is the main cause of family issues in the current scenario and 91% said they have faced some kind of financial difficulties due to their drinking habit. 41% said that consumption of alcohol has led to problems with their partners and 25% believed that the share of income they spent on alcohol denied their children adequate resources for education.

For convenience, the responses “Important” and “Very important” given to items of the Barriers Questionnaire were taken together as Significant Barriers, and responses “Not important” and “Somewhat important” were taken as Not Significant barriers. The percentages of respondents who found the various items of the Barriers Questionnaire as Significant Barriers are as follows:

79% said that they did not feel the need to seek deaddiction therapy because their drinking seemed fairly normal to them and 64% said that no one told them that they had a problem with alcohol or encouraged them to seek help. 74% felt they didn't have a serious problem with alcohol and 77% felt that they could handle it on their own. 50% worried about what others might think of them if they sought

Figure 1: Age distribution of study population



treatment. 42% felt too embarrassed or ashamed to seek help to stop their drinking habit, while 51% felt that such a step would embarrass their families. 63% believed that seeking deaddiction treatment would put their jobs in danger. Only 9% of the respondents did not know where to go for the treatment. 52% did not want to be told to stop drinking and 45% felt that treatment wouldn't do any good. Importantly, 75% of the respondents considered the cost of modern day deaddiction therapy as an important barrier to seeking the same. Only 2% felt transportation issues were a barrier. 77% considered time constraints as a significant barrier. While only 19% responded that they were afraid of being put into a hospital, 59% said that the fear of what may happen in treatment was a significant barrier that stopped them from availing deaddiction therapy.

62% did not like being asked personal questions. 39% considered the fear of failure of treatment a significant barrier. 55% didn't want somebody telling them what to do with their life. Only 6% of subjects considered a previous bad experience with treatment as a significant barrier. 47% said that they liked drinking and didn't want to give it up. 70% felt they would lose friends if they went for help. 38% believed that the bad feelings of going through withdrawal from alcohol stopped them from seeking help. 48% felt it all seemed like too much trouble to

go for help and 37% said they like to get drunk and thus did not want to seek help.

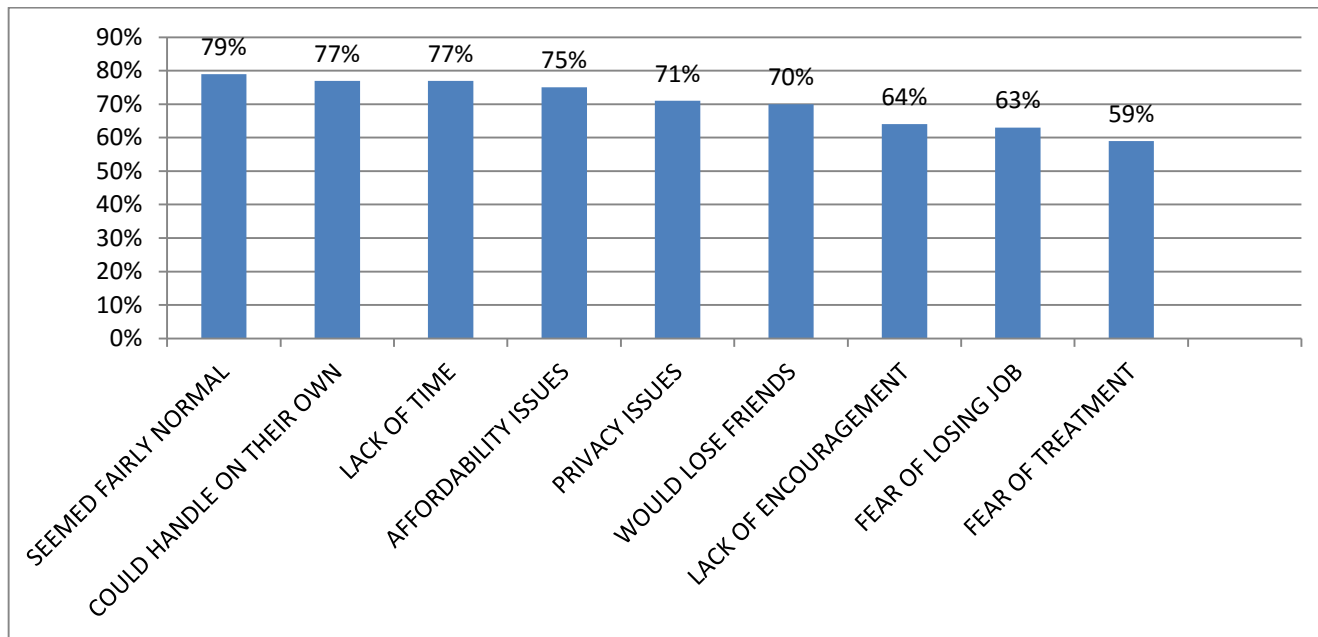
48% people felt drinking had not really caused much trouble or problems for them. 32% people said they were afraid of the people they have to see during therapy and 32% also said that they didn't feel safe at the centers for treatment. 41% felt that drinking was not their main problem.

71% did not like to talk about their personal life to other people and 40% felt people would make fun of them if they were to seek help. 32% said they did not want to go to Alcoholics Anonymous (AA) or other twelve step groups, while 39% felt that "help" was for people who had worse problems than theirs. 59% considered issues with insurance companies that cover their treatment as a significant barrier.

The barriers identified as significant by most number of the participants are shown in Figure 2. The barriers identified by the major age groups was also assessed and is described in Table 2.

Subjects who required treatment for alcohol abuse or dependence were offered treatment, and till now four of them have sought treatment from our department.

Figure 2: Significant Barriers identified



DISCUSSION

As the present study targeted a population of persons with AUD who have not sought treatment but are waiting in queue to procure alcohol, the barriers they reported to us are valid indicators of what prevents such a population from seeking deaddiction care. Since the literacy standards in Kerala are higher than the national standards, it was not surprising to find that almost the entire study population was well aware of the ill effects of alcohol and of the various steps being taken by the state government to curb the excessive use of alcohol. However, though 92% of the study population was aware of the ill effects of alcohol, the group as a whole was not well informed about the various solutions available to them to tackle this menace, as evidenced by the fact that they were still drinking and the finding that they reported multiple barriers to seeking deaddiction treatment.

Our results are consistent with those of previous studies on the topic. Like previous studies, realization of need, perception about drinking pattern, financial burden of treatment, stigmatization, misconceptions about treatment and

inconvenience were identified as significant barriers in our study.^{7, 10, 13, 14}

The main barrier highlighted by the study population was a belief that their drinking seemed fairly normal and that they could handle the problem on their own. This could be a result of the absence of a clear cut demarcation between healthy drinking and excessive use in their minds. This should be also seen in the background of the recent arguments that the term “healthy drinking” is an oxymoron and that even a small amount of alcohol cannot be considered safe and can increase the risk for cancer.¹⁸

While 42% of the subjects felt that they would be embarrassed and ashamed to avail deaddiction services, 51% were concerned about their families being embarrassed. This is mostly a result of the stigma attached with seeking psychiatric help. Such stigma also leads people to consider alternate methods of treatment like pseudo-religious procedures, unscientific drugs and those promoted by misleading advertisements in media.

Table 2: Prevalence of Barriers among different age groups

AGE GROUP	MAJOR BARRIERS IDENTIFIED
20-29	Fear of losing friends Affordability issues Lack of time
30-39	Lack of time Drinking seemed fairly normal Could handle on their own
40-49	Lack of time Could handle problem on their own Privacy issues
50-59	Lack of time Could handle problem on their own Privacy issues
More than 60	No serious problem Fear of treatment Embarrassment to family

Our results (lack of encouragement – 64%, fear of treatment in the family and patient – 59%) also highlight the importance of the role played by the family in encouraging a person to seek deaddiction treatment. Mental health professionals should sensitize the family members in particular and the public in general regarding ill effects of alcohol, and create awareness about the illness model of addiction and the various scientific treatments available. If these components are incorporated in treatment protocols, it will encourage the families to be more supportive to the patient than being ashamed.

A significant number of respondents were concerned about the risk of losing their job if they were admitted for treatment. If the job providers themselves take the initiative to encourage their employees to get rid of their drinking habit, and even allowed paid leaves for the period of treatment, this would result in improved work performance.

Another significant concern among the study population was the fear of losing their close friends. A large number of the subjects consume alcohol in

the company of their peers. Successful deaddiction treatment for one of them could start a chain reaction and encourage their peers also to avail deaddiction services. Clinicians may also encourage patients to involve in self-help groups like AA to prevent the boredom that would be created by staying away from friends who use alcohol.

71% of the respondents said they were not comfortable about discussing their personal life during treatment. Patients should be explicitly educated that all information they reveal will be strictly considered confidential, and the clinicians should take all care to ensure confidentiality.

More than half of the study population reported a fear of what might happen during treatment. This is a direct result of people not being well aware of the procedures and protocols of deaddiction treatment. Community based programs should educate the population regarding the procedures undertaken during treatment and their scientific basis.

A common barrier indicated by the subjects was the cost of modern day deaddiction treatment. Deaddiction treatment usually requires a long term hospital stay. The patients must be informed that the cost of deaddiction treatment is very minimal when compared to the financial burden incurred on their families by their drinking habit and its after effects. Government can also consider providing deaddiction services and appointing sufficiently trained persons including doctors, addiction counsellors etc. in government hospitals. Insurance companies can also start covering deaddiction services.

Most previous studies targeted clinical populations that had already overcome the various barriers in front of them. Our study is significant because the target population required deaddiction treatment or would likely require it if their current drinking patterns continued. The questionnaire we used covered almost all the barriers one could possibly face when he decides to avail deaddiction treatment.

The theme of this study is also currently undergoing heavy scrutiny in various circles as the government takes various stringent measures to curb excessive alcohol use in the state. Almost 97% of the study population is well aware of the alcohol regulations by the government, which is not surprising in a state with high literacy standards and where citizens are well informed about decisions by the government. Majority of our participants believed the government's steps to be the right way to reduce the use of alcohol. Their optimism is supported by some available research, like a study which found that a ban on alcohol reduced alcohol use, heavy episodic drinking, and associated secondhand effects in college students.¹⁹

LIMITATIONS

- Our sample size was only 100. This is because our resources in terms of time, finance and logistics were limited. Similar studies involving larger populations, conducted in different regions across the length and breadth of the state, would yield more valid results.
- Social stigma and fear could have influenced the responses given by the participants.
- Since the sampling was purposive, the sample selected may not be representative of the degree of alcohol consumption among the abusers.
- Barriers Questionnaire was developed in western context. Consumption patterns of alcohol vary in different parts of the world, and in this context, the validity of the instrument in our context could be questionable.

CONCLUSION

The onus of providing deaddiction services in the state lay predominantly on the government and the practicing psychiatrists. 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. Though the new regulations regarding sale of alcohol have been successfully implemented and positively accepted by the public, it should also be ensured that the use of illicit alcohol and other drugs of abuse do not go on the rise. Most importantly, the government should ensure ample participation of psychiatrists and their organizations during policy making regarding regulation and control of abuse of alcohol.

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