



Assessment of quality of life of substance abusers in a de-addiction centre

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ABSTRACT **Aim:** - The aim of this study is to assess the substance abuser in a de-addiction centre to improve the poor quality of life by reducing their habituated substances.

Methods: - The world health organization quality of life assessment- BREF was used in the study to assess the quality of life of a patient in de-addiction centre.

Statistics: - The work is validated by the t-test assay, and the frequency was measured for all the parameters used by the patients.

Results: - From the list of different substances, most commonly used was alcohol (by 37.2 % of participants), followed by Heroin (by 34.6 % of participants) and Cannabis (by 26.4 % of participants).

Conclusion: - Quality of life can be increased by reducing the substance abuse. The poor quality of life persists in the more substances abuser due their lack of knowledge and other factors for substance use disorder.

KEYWORDS : QoL, SUD, de-addiction, depression

Introduction

Among several desires quality of life (QoL) is a basic one to fulfil the liveliness in a good state of mind. It is to feel good and live well in a community. QoL is a subjective appraisal of a patient's life in that instant: World Health Organization's four emphasized domains to calculate the QoL of patients are (i) how satisfied the patient is with their current physical health, (ii) mental health, (iii) social relationships, and (iv) environment [1]. Several factors may interfere which can consequently affect life satisfaction, including the problems that arise from the use of substances [2]. Today, there is a great deal of interest in health-related quality of life indicators as important measures of treatment effectiveness and patient satisfaction. The substance use disorder (SUD) treatment field has until recently less systematically collected and prioritized the QoL of patients, in comparison with other medical fields [3]. In reports of SUD from various patients from various centres it is indicated that poorer QoL has significant value and associated with other serious psychiatric disorders than the general population QoL value [4,5]. Actually QoL is predicted from the different characteristics of SUD, but consistently it has not been predicted by these characteristics of frequencies of substances use, type of substances and length of problematic usage [6, 7]. Measuring changes in quality of life, such as physical, mental, and social health, can provide a common yardstick to measure outcomes and determine the human life new interventions [8, 9]. In the medical field, assessing quality of life involves more than a simple description of a patient's health; rather, quality of life is seen as how patients perceive and react to their health status as well as to other nonmedical areas of their lives [10]. In world, about 190 million people consume one drug or addition to one [11]. Several epidemiological surveys revealed that the subjects above 15 years are 20-40% users of alcohol and from them 10% are regular or excessive [12,13].

In a survey of National Institute on drug abuse estimated that 6.4% of Americans (roughly 17 million adults) abuse or are dependent on alcohol. In a study from India regarding the substance abuse stated that alcohol was the commonest substance used (60-98%) followed by cannabis use (4-20%) [14, 15, 16]. Quality of life has become

increasingly recognized as an important outcome measure in treatment studies and health service research [17]. The evaluation of QoL is also widely used in clinical trials and in observational studies of health and disease with the aim of evaluating interventions as well as adverse effects of treatment and the impact of the disease process itself [18]. The subjective aspect of QoL, especially in the field of mental health, has achieved importance in the measurement of therapeutic results, which facilitated a gradual shift in clinical focus from identifying a cure to enhancing QoL [19]. In the area of substance abuse, the concept of QoL has been applied to evaluate functioning, well-being and life satisfaction [20, 21]. Some studies have focused preferentially on health-related factors, which overshadows the complexities of drug dependence or personal factors that may hinder effective treatment [22]. A recent generation of assessment tools is currently focusing on areas specifically related to substance use. Poor QoL may also be a predictor of treatment readiness; two qualitative studies have shown that the desire to restore the negative effects of a substance use disorder (SUD) on a patient's life and improve their QoL is a more explicit goal of treatment among patients than is reducing substance use itself [23, 24]. In this study substance abuser were assessed from a de-addiction centre to improve the poor quality of life by reducing their habituated substances.

Materials & Method

Sample

This study evaluated 30 adults recruited from inpatient treatment facilities within the de-addiction centre Bhubaneswar, Odisha from April to October 2016. Potential participants presenting for treatment were randomly invited to respond to the questionnaires at research site, SUM Hospital Bhubaneswar. The inclusion criteria comprised (a) being above the age of 18; (b) fulfilment of the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) criteria for any disorder related to substance use and (c) the ability to understand the aim of the study as well as the content of the questions in both questionnaires, which entailed a satisfactory command of English. Exclusion criteria comprised of presentations exclusively due to alcohol abuse and/or involuntary admission for

inpatient treatment. Prospective participants were provided with a written protocol pertaining to the study and a verbal explanation about the purpose of the study for their informed consent. They were also informed that participation was voluntary, confidential and anonymous.

Instruments

The world health organization quality of life assessment- BREF (WHOQOL-BREF) The World Health Organization Quality of Life Assessment- BREF (WHOQOL-BREF), is a questionnaire developed by the WHO as an abbreviated 26-item version of the WHOQOL-100 instrument for the assessment of quality of life across various settings. The WHOQOL- BREF is divided into four domains: Physical, Psychological, Social Relationships, and Environment. Each domain score reflects an individual's perception of his or her quality of life in that particular area. The WHOQOL-BREF has been validated across a wide range of languages. The demographic information including age, gender, ethnicity, highest level of educational attainment, employment status, and most frequently consumed drugs were also collected from the study participants.

Databank configuration

WHOQOL-BREF questionnaires given to all inpatient and 1st they are little bit of confusing then the research and psychologist give a brief introduction how o fill up the questionnaires all patient were 1st completed all demography data sheet and after that hey properly completed the WHOQOL-BREF questionnaire and therefore given full statistical consideration.

Statistical analysis

t-tests analyses were tested the individual association of each independent variable with overall QoL. The outcome measure was using the category neutral/good/very good as the reference with significant level.

Result

As displayed in Table 1 and Table 2, maximum samples were polysubstances users and had previous SUD treatment experience (95.65 %). The samples were of different age groups, most abused (46.66%) were found from the group of 31-43 years old. Most reported being single (56.6 %), unemployed (87.2 %), and having less than a secondary education (59.4 %). Symptoms of clinical depression (76.66 %) were diagnosed, as symptoms of clinical anxiety (63.33 %) were common and additional somatic chronic illnesses. From the list of different substances, most commonly used was alcohol (by 37.2 % of participants), followed by Heroin (by 34.6 % of participants) and Cannabis (by 26.4 % of participants) (Table-2).

Table-1, Sample descriptive of patients in a de-addiction center

Sl No.	Parameter		Frequency (%)
1	Age	18-30	12 (40%)
		31-43	14 (46.66%)
		44-56	4 (13.33%)
2	Marital Status	Married	17 (56.66%)
		Unmarried	13 (43.33%)
3	Educational Qualification	Illiterate	5 (16.66%)
		10th Pass	14 (46.66%)
		Graduation & Above	12 (40%)
4	Occupation	Employed	16 (53.33%)
		Unemployed	14 (46.66%)
5	Area	Urban	13 (43.33%)
		Rural	17 (56.66%)
6	Clinical diagnosis	Anxiety	19 (63.33%)
		Depression	23 (76.66%)

Table-2, Most Substance used by the patients

Sl No.	Substance Used	Frequency
1	Alcohol	37.2 %
2	Cannabis	26.4 %
3	Heroin	34.6 %
4	Methadone/buprenorphine	23.5 %
5	Benzodiazepine	8.2 %
6	Amphetamine	12.4 %

Table 3, Quality of life of patients in a de-addiction center

Sl no	QoL	Percentage
1	Very poor (Raw Score 65-75)	17 (76.66%)
2	Poor (Raw Score 76-85)	10 (33.33%)
3	Good (Raw Score 86-95)	3 (1%)

Discussion

Quality of life

Most men who reported very poor, poor and good were defined by the raw score which was calculated by four domains physical health, psychological, social relationships & environment. From the studied group the quality of life of very poor was 76.66%, followed by poor quality of life (33.33%) and very few were in good quality of life (Table-3). Activities of daily living, dependence on medicinal substances and medical aids, energy and fatigue, Mobility, Pain and discomfort are the questioner to the physical health. Bodily image and appearance, Negative feelings, Positive feelings, Self-esteem is from the psychological questioner. In social relationships; personal relationships, social support and sexual activity were the questioner for the patients. In the domain of environment; financial resources, freedom, physical safety and security, health and social care: accessibility and quality, home environment were the questioner to the patients.

The study results are very much consistent with the other studies [3, 25, 26, 27]. The correlation of QoL is established after finding in the literature among general population and the chronic disease patients as well as among the SUD population after in consideration with mental health problems [6, 28, 29]. Few large studies have explored SUD patients' QoL in connection with other physical well-being indicators, including exercise behavior, and our data show that being physically active improves the likelihood that male patients report higher QoL. Exercising behavior is frequently found to correlate with better QoL among other chronic disease populations and to improve QoL [30, 31]. This should prompt the SUD research field to utilize existing exercise research and QoL research from non-SUD groups when developing evidence-based treatment options, as well as to measure and exploit the potential for exercise to be used as a QoL-boosting activity within treatment. Exercise should be integrated into treatment for the very reason that this population presents with such impaired QoL. The significant QoL improvements can be seen even after modest doses of exercise in a smaller study [32]. As with physical inactivity, men's concerns with broader physical self-perceptions have been negatively correlated with quality of life among other populations.

Assessing QoL at intake can be an opportunity to learn about patient vulnerabilities which may not be uncovered through more objective questioning of various pre-determined domains, or a focus limited to substance use patterns. Our findings also support the continued measurement of QoL during treatment to guide further treatment plans as well as to be an outcome measure of treatment, which for a chronic condition must be monitored and addressed during the course of the disorder, at various phases, inclusive of during treatment

[33]. Knowing the variables that influence patients' well-being can help target treatment toward patient identified goals, and such patient improvement may improve treatment engagement, retention and success. If treatment's goal of recovery and improved well-being is to be achieved, services must be offered on multiple levels and empower patients to improve numerous areas of their life, without focusing only on substance-use outcomes [22, 34]. One such tool may be opportunities and support for physical activity as well as developing supportive social networks. Indeed, group-based exercise as part of treatment would likely improve both physical and social outcomes and improve QoL both directly and indirectly, thereby enhancing recovery.

Conclusion

According to the study; the poor quality of life persist in the more

substances abuser due their lack of intelligence and substance use disorder developed due to several factors. These finding provides importance to address mental health and providing support for physical and social well-being during treatment and also a reminder that SUD patients are vulnerable to many of the same situations and conditions as those without a SUD.

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