Original Research

FROM DEPENDENCE TO DIGNITY: EFFECTIVENESS OF A COMMUNITY-BASED SOCIAL PSYCHIATRY MODEL IN SUBSTANCE USE DISORDER REHABILITATION

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ABSTRACT

Substance Use Disorders (SUDs) represent a major public health concern worldwide, contributing significantly to morbidity, mortality, and psychosocial impairment, particularly in low- and middle-income countries. Conventional biomedical models of addiction management primarily focus on detoxification and pharmacotherapy, often neglecting the broader social determinants that influence relapse and long-term recovery. Social psychiatry emphasizes the role of social context, family systems, and community structures in mental health outcomes. Community-based rehabilitation (CBR), endorsed by the World Health Organization, aims to restore dignity, participation, and social inclusion among individuals with chronic health conditions.

This prospective longitudinal interventional study evaluated the effectiveness of a community-based social psychiatry rehabilitation model among patients with SUDs admitted to a tertiary care–affiliated rehabilitation centre. Seventy-two adults diagnosed with SUDs were assessed at baseline and at discharge/6-month follow-up using standardized tools for recovery outcomes, psychosocial functioning, and quality of life. Statistically significant improvements were observed in abstinence rates, treatment adherence and quality of life across all WHOQOL-BREF domains, and psychosocial reintegration. Strong family and community support emerged as a significant predictor of sustained recovery.

The findings support the integration of social psychiatry principles into addiction rehabilitation services to promote sustainable, dignity-oriented recovery.

Keyword: Substance Use Disorders, Social Psychiatry, Community-Based Rehabilitation, Psychosocial Reintegration, Quality of Life.

INTRODUCTION

Substance Use Disorders are chronic, relapsing conditions that contribute substantially to the global burden of disease and disability.[1] The harmful use of alcohol and psychoactive substances is associated with increased morbidity, premature mortality, and significant social and economic consequences.[1,2] In India, epidemiological evidence indicates that nearly one-fourth of the population is affected by some form of substance use, with a treatment gap exceeding 70%.[2]

Despite advances in pharmacological management, relapse rates remain unacceptably high following conventional detoxification-focused interventions.[3] This limitation is largely attributed to persistent social exclusion, stigma, unemployment, fractured family relationships, and lack of community reintegration.[4,7] Addiction is increasingly recognized as a biopsychosocial condition requiring interventions beyond symptom control.[5]

Social psychiatry expands the understanding of mental illness by examining the interaction between psychological distress and social structures, cultural norms, and community environments.[5,8] Recovery-oriented models emphasize not only abstinence but also restoration of identity, autonomy, and social belonging.[9,10] Community-based rehabilitation operationalizes these principles by promoting empowerment, participation, and inclusion within natural community settings.[6]

Integrating social psychiatry and CBR into addiction rehabilitation may enhance long-term outcomes by addressing both clinical and social dimensions of recovery.[10,11] This study evaluates a community-based social psychiatry rehabilitation model

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implemented at a tertiary care–linked rehabilitation centre in central India.

AIM AND OBJECTIVES

Aim: To assess the effectiveness of a community-based social psychiatry rehabilitation model in improving recovery and quality of life among patients with Substance Use Disorders admitted to SETU Rehabilitation Centre, Chirayu Medical College and Hospital.

Objectives

1. To evaluate recovery outcomes in terms of relapses, abstinence, and treatment adherence.
2. To assess changes in psychosocial functioning and quality of life before and after rehabilitation.
3. To study the role of family and community support in sustained recovery.

METHODOLOGY

Study Design

A prospective, longitudinal, community-oriented interventional study was conducted.

Study Setting

SETU Rehabilitation Centre, under Chirayu Medical College and Hospital, Bhopal.

Study Population

Adults aged 18 years and above diagnosed with Substance Use Disorders as per ICD-10/DSM-5 criteria were included.[3]

Sample Size

Sample size was calculated using the following formula: $n = (Z\alpha + Z\beta)^2 \times 2\sigma^2 / d^2$ Where:

$Z\alpha = 1.96$ (95% confidence interval)

$Z\beta = 0.84$ (80% power)

σ = Standard deviation of WHOQOL-BREF scores from previous studies

d = Expected mean difference

Based on pre- and post-intervention comparisons of WHOQOL-BREF scores, an estimated sample size of 60–80 participants was calculated, accounting for attrition.

Inclusion Criteria

Patients aged 18 years and above, diagnosed with Substance Use Disorder (including alcohol, opioids, cannabis, or polysubstance use) as per standard diagnostic criteria, who were admitted for inpatient rehabilitation at the SETU Centre and were willing to participate and provide informed written consent were included in the study.

Exclusion Criteria

Patients with severe cognitive impairment or active psychosis that interfered with study participation, those who were critically ill and required emergency medical care, and patients who were unwilling to participate or unable to provide informed consent were excluded from the study.

Procedure of Data Collection

Data collection was carried out in a structured manner beginning with a baseline assessment at the time of admission, during which information on socio-demographic characteristics, substance use history, quality of life using the WHOQOL-BREF, psychosocial functioning, and family and social support was obtained. This was followed by a comprehensive inpatient rehabilitation intervention, which included pharmacotherapy and detoxification, individual and group psychotherapy, family counseling, vocational and life-skills training, peer-support sessions, and community linkage activities as per standard treatment protocols.

A post-rehabilitation assessment was conducted at the time of discharge and/or during a 3–6 month follow-up, assessing relapse or abstinence status, treatment adherence, quality of life (WHOQOL-BREF), psychosocial functioning, and indicators of social reintegration. Additionally, a qualitative component was included, wherein in-depth interviews were conducted with selected participants to explore experiences related to dignity, stigma, and community reintegration.

Intervention

Participants received a structured rehabilitation programme comprising pharmacotherapy, psychotherapy, family counseling, vocational training, peer support, and community linkage activities.[6,8,10]

Outcome Measures

Quality of life was assessed using the WHOQOL-BREF, while recovery outcomes included abstinence status, treatment adherence, and relapse rates.[7,11]

Ethical Considerations

The study was conducted after obtaining approval from the Institutional Ethics Committee, and written informed consent was taken from all participants prior to enrolment. Confidentiality of participant information was strictly maintained throughout the study, and participants were informed of their right to withdraw at any stage without any consequences to their treatment. Additionally, psychological support and appropriate counseling services were made available to participants in case of emotional distress during the course of the study.

Statistical Analysis

Statistical analysis was performed using descriptive statistics, with continuous variables summarized as mean and standard deviation and categorical variables expressed as proportions. Paired t-test or Wilcoxon signed-rank test was used for pre- and post-intervention comparisons as appropriate, while the chi-square test was applied to assess associations between categorical variables. Multivariate

regression analysis was conducted to identify independent predictors of sustained recovery.[7]

RESULTS

Socio-Demographic Profile

A total of 72 participants were included in the analysis. The majority were male (83.3%), and most belonged to the economically productive age group of 31–50 years. Alcohol was the most commonly used substance (52.8%), followed by opioids and polysubstance use

Table 1: Socio-Demographic Profile of Participants (N = 72)

Variable	Frequency (n)	Percentage (%)
Age Group (years)		
18–30	18	25.0
31–40	26	36.1
41–50	20	27.8
>50	8	11.1
Gender		
Male	60	83.3
Female	12	16.7
Marital Status		
Married	46	63.9
Unmarried	20	27.8
Separated/Widowed	6	8.3
Primary Substance Used		
Alcohol	38	52.8
Opioids	14	19.4
Cannabis	8	11.1
Polysubstance	12	16.7

Recovery Outcomes

At the 6-month follow-up, abstinence was achieved in 58.3% of participants, while treatment adherence improved significantly from baseline to 76.4%. These changes were statistically significant ($p < 0.001$), indicating meaningful clinical improvement following the intervention.

Table 2: Recovery Outcomes Pre- and Post-Rehabilitation

Outcome	At Admission	At 6-month Follow-up	p-value
Continuous abstinence (%)	0%	58.3%	<0.001
Relapse (%)	—	27.8%	—
Good treatment adherence (%)	31.9%	76.4%	<0.001

Interpretation: Statistically significant improvement in abstinence and adherence following intervention.

Quality of Life Outcomes

All four domains of the WHOQOL-BREF—physical, psychological, social relationships, and environmental—showed statistically significant improvement following rehabilitation ($p < 0.001$). The largest gains were observed in psychological and social domains, reflecting enhanced emotional well-being and interpersonal functioning.

Table 3. WHOQOL-BREF Domain Scores Before and After Rehabilitation

Domain	Pre-intervention Mean ± SD	Post-intervention Mean ± SD	p-value
Physical Health	42.6 ± 6.8	63.9 ± 7.4	<0.001
Psychological	38.4 ± 7.1	61.2 ± 6.9	<0.001
Social Relationships	36.1 ± 8.3	59.4 ± 7.6	<0.001
Environmental	40.7 ± 6.5	62.8 ± 7.1	<0.001

Interpretation: All four domains of quality of life showed statistically significant improvement.

Role of Social Support

A strong positive association was observed between higher levels of family and community support and sustained recovery. Participants with high social support demonstrated significantly lower relapse rates compared to those with low support (χ^2, $p < 0.01$).

Table 4. Association between Social Support and Sustained Recovery

Social Support Level	Sustained Recovery n (%)	Relapse n (%)	p-value
High	28 (77.8)	8 (22.2)	<0.01
Moderate	10 (55.6)	8 (44.4)	
Low	4 (22.2)	14 (77.8)	

Interpretation: A strong positive association was observed between family/community support and sustained recovery (χ^2 test, $p < 0.01$).

Intervention Components: The rehabilitation programme incorporated multiple psychosocial and community-oriented components addressing clinical stabilization, social reintegration, and skill development.

DISCUSSION

The present study demonstrated that a community-based social psychiatry rehabilitation model significantly improved recovery outcomes and quality of life among individuals with Substance Use Disorders.[3,6] Improvements in abstinence and adherence align with evidence emphasizing the importance of psychosocial interventions in addiction management.[6,7]

Enhanced quality of life across all domains highlighted the role of social reintegration and dignity restoration in recovery processes.[9,11] The strong association between family support and sustained recovery underscores the centrality of social networks in relapse prevention.[8,12] These findings are consistent with recovery-oriented frameworks that conceptualize addiction recovery as a social as well as clinical process.[10]

CONCLUSION

A community-based social psychiatry rehabilitation model offered a holistic and sustainable approach to addiction recovery by addressing both clinical symptoms and social determinants.[6,10] Integration of family involvement, community participation, and psychosocial rehabilitation significantly enhances long-term outcomes and quality of life. Scaling up such models within national de-addiction programmes may reduce relapse rates and improve public health outcomes.[12]

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