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Korsakoff Psychosis following involuntary treatment for alcohol use disorder

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Substance Use Disorders (SUDs) are a major cause of global mortality and morbidity. In India, Alcohol Use Disorder is among the most prevalent of these [1]. Inadequate knowledge about the illness and its treatment, lack of resources, and regressive government policies (criminalisation of drug use itself and lack of prioritisation for SUD treatment) are among the reasons for the large gap between the need for facilities and their availability [2]. Under Section 71 of the Narcotic Drugs and Psychotropic Substances Act, central and state governments are required to establish centres for identification and treatment of SUDs, but many states lack such rules [3]. This has led to the establishment of a large number of unauthorised "de-addiction" centres, most of which have not registered under the Mental Healthcare Act (MHCA), 2017, and do not possess government accreditation for good clinical practice [4]. These centres exploit the need for treatment, and the desperation of family members seeking care for their loved ones. They commit medical malpractice and ethical and human rights violations [5]. Instead of providing medical care, they mete out "punishments" to patients, inflicting suffering and in some cases causing irreparable harm to vulnerable people.

A young man was admitted to a tertiary care hospital in central India with hallucinatory and disorganised behaviour. The case was managed by the team of authors with TM being the lead physician. Previously, his relatives had forcibly admitted him to a private "de-addiction centre" or "nasha mukti kendra" after multiple failed attempts on their end to make him abstinent. According to the reported history, he was kept isolated at the centre and detoxified without any pharmacotherapy. He reported being tied to the bed and experiencing seizures, which were determined to be alcohol withdrawal seizures. After discharge, he started displaying disorganised behaviour such as disrobing in public, significant forgetfulness, perplexity with repeated mistakes in household chores, and impaired concentration. Family members then sought treatment with us and he was admitted for further evaluation. A detailed psychological evaluation revealed anterograde amnesia (inability to form new memories) and retrograde amnesia (inability to recall old memories), decreased inhibition, and difficulties with planning and problem solving. The patient was diagnosed with alcohol-induced persisting amnestic disorder (Korsakoff Psychosis) caused by the sudden stoppage of alcohol after a period of heavy drinking. This was the result of lack of appropriate medical treatment (evidenced by him experiencing seizures) aggravated by the involuntary nature of his treatment, which prevented him from seeking due care elsewhere. Korsakoff psychosis is a known consequence of inappropriate treatment of alcohol withdrawal [6]. The patient was treated with Risperidone and high dose thiamine supplementation and discharged when there was mild symptomatic improvement.

The coercive treatment he underwent raises many questions. Involuntary treatment for SUDs has always been considered unethical if not illegal. Yet, sufferers from SUDs are often coerced into treatment. Although the MHCA allows involuntary treatment for mental illness, most experts agree that treatment for SUDs should be voluntary. The MHCA as well as the guidelines from the Ministry of Health and Family Welfare and the Ministry of Social Justice and Empowerment assert that voluntary treatment and pharmacotherapy are key aspects of SUD treatment [7]. Yet as our case highlights, there exist many facilities in our country that offer involuntary treatment with scant regard for the rules. Some states like the National Capital Territory of Delhi have adopted minimum standards of care for preventing such violations [8]. However, clearly this has not been enough and more states need to come up with such measures to prevent these violations.

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Group Antenatal Care (G-ANC): A way forward to improve Afghanistan's utilisation of maternity care

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In Afghanistan, maternal mortality and infant mortality — two key indicators of population health — are among the highest in the developing world, partly because of nearly a half-century of conflict and persistent socioeconomic instability [1]. The latest data in 2017 show that Afghanistan's maternal mortality ratio (638 per 100,000 live births) and infant mortality rate (36 per 1,000 live births) are much higher than other countries with comparable economic development [1]. Poor health infrastructure, political upheaval, reductions in donor funding and corresponding disruptions in health services, insecurity, climate change, and escalating humanitarian crises further intensify these issues [1].

Antenatal care (ANC), a core intervention of the safe motherhood initiatives, anticipates improved maternal and neonatal outcomes [2]. For instance, it is estimated that utilisation of high-quality ANC services could reduce 20% of pregnancy-linked maternal deaths [2]. A public health challenge faced by most low-and middle-income countries (LMICs), including Afghanistan, is poor utilisation of ANC services associated with inadequate resources, poverty, and cultural and traditional practices [3,4].

In Afghanistan, only 22% of pregnant women receive the previously recommended 4 or more ANC visits, with the updated World Health Organization (WHO) recommendation of eight visits not yet implemented [3]. Moreover, 55.8% of pregnant women initiate ANC at the recommended time (during the 1st trimester), and only 1.3% of those with ANC utilisation receive all the required ANC services [4,5]. As this challenge is expected to continue, policymakers need to explore solutions that improve antenatal care utilisation.

The research in LMICs has highlighted the crucial role the group-ANC (G-ANC) model can have in helping expectant mothers with the provision of essential health services, including screening, nutritional guidance, health promotion, and early detection of complications [6]. This model of care organises similar cohorts of 8-12 pregnant women to increase discussion among participants and to ensure community-building (peer support) during the antenatal care period, and may be an effective strategy for improving the quality of maternal care and outcomes in LMICs [6,7]. A recent systematic review by Sharma et al identified that the G-ANC model has a positive impact on quality and attendance at ANC and the uptake of health facility delivery [6]. Additionally, higher client satisfaction rates and substantial long-term cost reductions were observed in G-ANC compared with standard care, as reported in other systematic reviews [7,8].

The G-ANC model of care can be considered an essential step towards improving the quality of ANC services in Afghanistan. However, the capacity of health systems to support the G-ANC model of care is not a given. The resilience of Afghanistan's healthcare system, already grappling with the rigors of conflict, combating the Covid-19 pandemic and environmental calamities, has been further compromised by natural disasters that have highlighted its vulnerabilities [1,3]. Healthcare workers may be unaware of what activities for the G-ANC model exist [5]. The health system might fail to provide the necessary resources or even discourage the training of healthcare workers for effective implementation of the G-ANC model [5]. Furthermore, low literacy rates among Afghan women, poor health infrastructure, communication barriers stemming from linguistic differences, recent restrictions imposed on women's movements, and ingrained sociocultural norms and values might be seen as threats to the G-ANC model adaptation in Afghanistan.

To appropriately tackle these barriers, we present a set of policy recommendations that should enable the healthcare system to more readily understand, support, and promote the G-ANC model of delivery in the country.

1. Before policymakers begin implementing the G-ANC model across a large number of health centres, pilot studies are needed to examine the feasibility and effectiveness of the model under the Afghan healthcare system.