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Treatment of Substance Abuse & Mental Health illnesses leading to suicide based on client centred Bio-Psycho-Social treatment modality in middle to low income countries- A Case Study

The case study is compiled by Mr Omer Rafique who is a Public Health Consultant with specialization in Mental Health, Certified Clinical & Research Professional and a Microbiologist.

BACKGROUND:

The burden of mental health disorders in middle to low income countries is still underestimated (WHO World Health Report 2001). Limited awareness, promotion and treatment services available in a community to national level play a major role. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates diagnosis, and treatment.

In developing countries like Pakistan, immense stigma is attached to mental health or substance abuse (Afridi, 2008). Chronic substance abuse is still struggling to get acknowledged as an illness rather it is considered to be a deviant behaviour. Since these domains are a taboo, the clients are suffering in silence. There is a huge unmet need for creating awareness regarding mental health and substance abuse at national level in Pakistan. The government and private sector mostly focus on the poverty reduction, community development as well as communicable illnesses with a very little work being done to promote and create cognizance regarding non-communicable illnesses.

I would like to highlight the case study of Client A, as it serves as an example to understand how imperious it is to implement needs assessed, client centred, Bio-Psycho-Social treatment model (UNODC launches treatment protocols, 2012) as currently the main focus is still the biological treatment mostly.

There are close to none community outreach services in the domain of mental health or substance abuse treatment. The strong stigma attached to it has limited the services to territory care government hospitals, private hospitals or clinics.

I specialized in Mental Health / Social Care Services Management at Care4u- Home Support Services, Communities Portfolio, of Sheffield City Council. UK. It was mandatory for me to get trained as a counsellor along with several other areas to provide support to clients in clinical settings or at their homes. After shifting to Pakistan, home country, in January, 2012 I started to see clients at their homes. A while back, I received a call from a new client requesting to pay a visit to him as he needed help regarding his drug addiction problem. After asking where he got my contact number from it was clarified that a colleague of mine had referred him so there were no personal security issues.

CASE STUDY:

On a first visit to Client A, who is 29 years old gentleman, married and has a 3 years old daughter. He is a software engineer as well as runs his family business, and belongs to a sound socio-economic class. Three years ago, in January 2012, he suffered a brutal car accident which gave him four fractures on left leg below the knee joint. He was hospitalized for nearly 8 months and went through several surgeries to restore his mobility. While he was admitted in the hospital, he was given Nalbuphine (HCl) for the acute pain management then it was replaced by front line pain killers gradually. He does not remember if he was seen by any Psychologist / Psychiatrist while he was admitted in the hospital and after he was discharged he skipped follow ups neither the hospital had provision of checking up on discharged clients. There is a law in place regarding not to sell prescription medicines without prescription and

heavy penalty is attached with it if caught. However, the practise of getting any medicine without prescription is quiet common.

The Client started to inject Nalbuphine (HCL) on his own one month after getting discharged from the hospital without discussing it with any healthcare professional as he was still in colossal pain, could not get back to his pre- accident life routine or fulfil his family / social obligations. The dependency on Nalbuphine (HCL) developed the feeling of helplessness and severe depression which made him to attempt suicide two times. However, he did seek help from a psychiatrist when the situation got out of control which, as he mentioned, was one of the hardest decision he ever had to make in his life because of the stigma attached to substance abuse and mental health issues. Unfortunately, as he said that the psychiatrist could only give him 5 minutes consultation and prescribed him few medicines, and asked him to keep coming in for group drug detoxification & rehabilitation counselling sessions.

He went to one group sessions and left after 10-15 minutes as he did not want anyone to know about his condition and continued to inject 7-8 ampules of 20mg / ml Nalbuphine (HCL) per day. Meanwhile, his mother was diagnosed with the late stage of breast cancer while his father had to go through Coronary Artery Bypass Surgery. Being the only child, he struggled heavily to cope with his parent's illnesses as well as his own addiction problem. His wife could not be a support for him as she refused to stay in marriage with a drug addict. His intake of Nalbuphine (HCL) during this time was not enough for him so he added benzodiazepines as well and later switched to injecting morphine 15mg / ml. No history of alcohol use was mentioned initially. However, it was highlighted that he was a social drinker but stopped it as he made himself totally isolated from the outside world and spent all his time at home.

Mother passed away in the middle of 2013 and he blames himself for her death as his mother, when alive, told him out of severe concern to seek help for his drug dependency but he could not after his first experience with the psychiatrist. Father is usually in and out of hospital and since they have 3 in-house servants and 2 drivers at home so they look after the father and his mobilization as well as house work and run Client's outdoor errands. The marital issues went from bad to worst which further made him more isolated and he fell into self- victimisation because the wife, still in the house, starts arguing and yelling at him and degrades him over his addiction problem.

The combination of morphine and benzodiazepines gave him severe side effects and he switched to Fentanyl (Citrate) 0.05 mg along with 20-40 tablets of 0.5 mg Alprazolam and an antibiotic, Amoxicillin and clavulanate potassium 600mg orally, as the veins in his both arms are totally collapsed and injecting via IM has caused severe abscess and the pus is dripping from several locations and whenever he injects via IM, the injection content, Fentanyl (Citrate), comes out from one or another side. He has been cleaning both arms using spirit and saline water then puts bandages on.

TREATMENT:

This case was quiet complicated and he needed to be hospitalized after the initial assessment and by the result of Addiction Severity Index (ASI) assessment (Drug Dependence Treatment, 2012). However, the client was totally against to this idea. Case management approach (SAMHSA, 1998) was the only way to deal with it but the client was also not ready to have other people find it out and did not want to go see a Medical Specialist and a Psychiatrist.

First step was to make sure that he is not imposing life threat to himself or someone else. The first session started with the information on harm reduction, potential lethal

side effects of the cocktail drugs he was taking as well as the secondary infections on his arms. With the help of behaviour change communication (BCC), client gave consent to have him seen by a medical specialist for his arms and get the medication given by the doctor rather than self-medication as well as get his diagnostic tests done for HIV / AIDS, Hep B & C, TB. Next step was to have a psychiatrist see him and assess him for psychopathology as well as management during detoxification phase while he tapers off all the other medicines he was taking and stick to the ones the psychiatrist prescribed. The detoxification was done at his home and upon his consent the wife was taken on board for few sessions of counselling to educate her that his current condition is not a deviant behaviour, rather a chronic illness and how important it is for him to have support network.

Meanwhile, he was asked to put forward the names of friends or extended family members or servants he trusts or feels comfortable with to provide support. Initially he did not like the idea but with few sessions he realized that it is necessary as there are no community based services to provide help neither any hospital nor clinics have outreach services to visit him and look after him as well as being a counsellor I, personally, cant not be available around the clock. Total of four people were identified including his wife and were given two sessions on basic care.

Currently, he is out of detoxification phase and according to his treatment plan, which was made in collaboration with him, rehabilitation process started which includes integrative Therapies to help him reduce his anticipation and fear about the pain which got him busy always to the point where his injections and other medicines would be ready beforehand the pain would start. Small goals were focused in his treatment plan, which included helping him learn new coping mechanism with the stressors as well as physical activity was included. He goes out for a walk every

morning for 25-30 minutes with his wife followed by physiotherapy at a private hospital nearby.

At this moment in time, his arms are 80 % better then seen first time and he is regularly following up with the medical specialist and psychiatrist. The treatment is still going on and the ultimate goals are to provide support to him over his mother's loss as he is still going through the grievance and to re-integrate him back into society so he can start his life once again as a productive and responsible individual.

LIMITATION:

- One of the major limitations faced is the cultural stigma against drug addiction and it creates hindrance when it comes to having family / community engaged as a support network.
- There are no safeguarding policies for such vulnerable population therefore substance abuse being considered an aberrant behaviour and if they get involved in some legal cases, they have no credibility or protection.
- The limited / lack of mental health and substance abuse awareness at national level had made it difficult for the clients to come out and seek help as they are afraid of losing their respect and dignity among their peers.
- This particular case is a mainstream case seen in non- emergency environment. If such case is to be identified in an emergency hit area, it would get quite difficult to treat 1 client as in disasters the number of people in crisis is huge and if there is no awareness, promotion, trainings of front line medical staff on Bio-Psycho-Social treatment modality in general then it can have severe negative impact in emergency settings when Mental Health Psycho Social Support (MHPSS) needs to be implemented as well as helping affected people to increase resilience or preventing suicides.

References:

1. WHO World Health Report 2001. Mental health: new understanding, new hope. Geneva: World Health Organization, 2001
2. Afridi, M (2008). Mental health: Priorities in Pakistan. *Journal Of Pakistan Medical Association, Vol. 58, No. 5, May 2008.*
3. United Nations Office on Drugs and Crimes. (2012, November 9). *UNODC launches treatment protocols for drug use in Pakistan website:* http://www.unodc.org/unodc/en/frontpage/2012/November/unodc-launches-treatment-protocols-for-drug-use-in-pakistan.html
4. United Nations Office on Drugs and Crimes and Treatnet (International network of drug dependence treatment and rehabilitation resource centre). (2012). Drug Dependence Treatment: Training Package website: http://www.unodc.org/ddt-training/treatment/general.htm
5. Center for Substance Abuse Treatment. Comprehensive Case Management for Substance Abuse Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1998. (Treatment Improvement Protocol (TIP) Series, No. 27.) Chapter 2 - Applying Case Management to Substance Abuse Treatment. Available from: http://www.ncbi.nlm.nih.gov/books/NBK64857/