Delirium Assessment and Management in Geriatric Psychiatry under Prevailing Indian Laws (MHCA 2017)

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ABSTRACT

The Indian Mental Health Care Act of 2017 (the Act) focuses on the human rights of persons with mental illness. It is based on the individual's dignity, autonomy, and independence with a client-centered approach. Delirium is frequently seen in the hospitalized geriatric population, more commonly in medical and surgical wards, and much less frequently in psychiatry wards. Delirium is covered under the Act as a "substantial disturbance of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, (and) capacity to recognize reality or ability to meet the ordinary demands of life." The Act provides provisions for capacity assessment, emergency treatment, supported admission, advance directive, and the role of nominated representative in such cases.

Keywords: Delirium, MHCA, capacity, advance directive, nominated representative

Delirium is a disorder of consciousness[1] and is associated with impaired attention, disturbances in global cognition, psychomotor functioning, sleep–wake cycle, and emotions. It is characterized by a rapid onset and fluctuating course of the symptoms for less than six months (F05, ICD-10 1992).[2] The risk factors for developing delirium are older age, cognitive impairment, pre-existing medical condition(s), polypharmacy, surgery, acute medical emergency, and trauma.[3]

The Mental Health Care Act 2017[4] (MHCA 2017, hereby referred to as Act), which came into force on 29th May 2018, resulted from India's ratification to the United Nations Convention on Rights of Person with Disability to safeguard the rights of persons with mental illness. The Act places the human rights and rights of equality of persons with mental illness at the forefront. It includes the concepts of capacity, nondiscrimination, community living, confidentiality, access to medical records and release of information about the mental illness, and protection from cruel and degrading treatment.

Delirium is characterized by "dream-like consciousness" (Fish psychopathology),[5] which blurs the distinction between the external reality and the patient's inner world, affecting the capability to make informed decisions, including their health, thus requiring legislative safeguarding under the rubric of the Act.

Case Summary

An 82 years old, retired government doctor was living an independent life with his wife. The gentleman managed his activities and finances such as pension and bills without assistance; the only help he required was a chauffeur to drive him everywhere since having a cataract operation about ten years ago. The medical history included hypertension and benign prostate hypertrophy, for the last 35 and 10 years, respectively, and appropriate medications controlled both the illnesses.

A week ago, he developed high-grade fever, and on the advice of the family doctor, was admitted to a private hospital. The first suspect diagnosis was COVID-19 infection, but RT-PCR was negative, and the characteristic blood and thorax imaging changes were absent. The neutrophils were raised above the normal value, and urine had pus cells

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on microscopy and significant E.coli growth on culture. While the lab results were awaited, intravenous antibiotics were given along with symptomatic management for fever. Upon receiving the urine culture report, the diagnosis was of urinary tract infection, and the antibiotics were changed for which the organism was highly sensitive.

On the 3rd day of admission, the fever disappeared, but the patient changed sleep and interaction with significant others. He was awake for most of the preceding night, interspersed with short periods of dozing. In the morning, there was marked drowsiness, which persisted throughout the day. He could not identify place or time; speech was rambling and incoherent with an irritable mood and interspersed with episodes of physical aggression towards family members.

The symptoms worsened over the next 24 hours. On the second night, the patient was sleepless and repeatedly attempted to go out for his "morning walk" or "to meet his brother." The following day, he slept most of the morning and afternoon and was awake only by 5 pm; the pattern of the previous nights was repeated.

The provisional diagnosis of delirium was made following the International Classification of Diseases-10 (ICD-10) diagnostic criteria (rapid onset of impaired consciousness, disturbance in cognition, and psychomotor activity with altered sleep–wake cycle and fluctuating course).

We now discuss the following: First, we cover the relevant sections of the Act with quotes from the interaction we had on the topic with a legal expert (see acknowledgment, and the opinion is marked as RK). We then discuss its relevance concerning the management of delirium in the preceding case. Double quotes ("") are used when the text is directly quoting the Act.

Mental Health Care Act 2017

The MHCA 2017 is classified under 16 chapters and 126 sections with their own sets of subsections and clauses. The Act covers the definition of mental illness and its purview, mental health establishment, capacity and assessment, advanced directive and the nominated representative (NR) to carry out the wishes of the patient, review board, or monitoring bodies to safeguard rights of persons with mental illness.

Mental Illness (Section 2 [1.S])

The Act defines mental illness as follows:

> "Mental illness means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behavior, (and the) capacity to recognize reality or ability to meet the ordinary demands of life, mental conditions associated with the abuse of alcohol and drugs but does not include mental retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by subnormality of intelligence".

For the determination or diagnosis, the Act states that the "Mental illness shall be determined by such nationally or internationally accepted medical standards…(including ICD)" (section 3 [1]).

Though delirium is seen predominantly in the medical or surgical wards, in patients without any current psychiatric disorder, because of significant brain dysfunction, it is subsumed under chapter V of ICD-10 and chapter 6 of ICD-11. It should also be emphasized that the Act does not exclude subjects based on reason or etiology or the place where a patient is being treated—be it a mental hospital/clinic or a general hospital setting.

> **Does delirium come under the purview of the Act?** *Delirium is a disease where the normal functioning of the brain is adversely affected. The name of "Delirium" disease may not find a specific mention in the Act of 2017. Still, in its wisdom, the legislature has defined mental illness, which is widely worded and exhaustive in itself, embodying the probable contingencies of mental illness. The patient's condition is required to be taken into consideration for extending him the benefit of MHCA 2017, not the reason or etiology for giving the benefit of the Act. The ingredients of definitions are attracted in the case of delirium, a disease that impairs the patients' capacity to make decisions. So long as the impairment of judgment-making power continues, there appears prima facie no legal impediment in protecting MHCA 2017. The Act would be attracted in cases where all or anyone condition of mental illness is attracted.* (RK)

Capacity to Make Decisions About Own Health (Capacity) (Sections 4 (1) and 89 [1.A])

The Act mentions, "the determination of a person's mental illness shall alone not imply or be taken to mean that the person is of unsound mind unless he has been declared as such by a competent court" (section 3 [5]). This implies that a person with mental illness is deemed to have the capacity to decide on his/her treatment unless proven otherwise. The components for assessing the capacity are given in **Table 1** (section 4 [1]), and this has to be undertaken independently by 1 Psychiatrist and 1 Mental Health Professional/Medical Practitioner (sections 2 (n), (r) & (y)) (**Table 2**). The assessment should take place on the day of admission, or within preceding seven days of the assessment, and both (should) independently conclude… that the person has a mental illness of such severity that the person—(i) has recently threatened or attempted or is threatening or attempting to cause bodily harm to himself; or (ii) has recently behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him; or (iii) has recently shown or is showing an inability to care for himself to the degree that places the individual at risk of harm to himself. (Section 89 [1.a])

Emergency Treatment Scenarios (Section 94)

In emergencies, patients can be treated up to 72 hours with the least restrictive care, subject to the informed consent of the NR (discussed later).

Admission, Treatment and Discharge (Sections 85–99)

There are two different categories for admission based on the person's capacity.

TABLE 1.

Capacity as Defined in MHCA 2017

The Mental Capacity of a Person is Intact if He/She Has the Ability to-
1. Understand the information that is relevant to decide on the treatment or admission or personal assistance; or 2. Appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or 3. Communicate the decision using speech, expression, gesture, or any other means.

TABLE 2.

Definition of Psychiatrist and Mental Health Professional

The psychiatrist is a medical practitioner	1. Possessing a postgraduate degree or diploma in psychiatry awarded by University Grant Commission recognized university; or 2. Awarded or recognized by the National Board of Examinations, or recognized by the Medical Council of India, or 3. Any medical officer who is declared as a psychiatrist by the government of the state.
Mental health professionals	1. A psychiatrist as defined above; or 2. A professional registered with concerned state authority under section 55; or 3. A professional having postgraduate degree (Ayurveda) in Mano Vigyan Avum Manas Roga or postgraduate degree (Homeopathy) in Psychiatry, or postgraduate degree (Unani) in Moalijat (Nafasiyatt) or a postgraduate degree (Siddha) in Sirappu Maruthuvam.

Note: "Clinical psychologist," "mental health nurse," and "psychiatric social worker" are not included as mental health professionals.

For supported admission patients, the capacity has to be reviewed every seven days either by the medical officer in charge of the case or a Mental Health Professional (section 89 [8]).

To discharge such patients, the current treating psychiatrist has the responsibility to coordinate and plan the discharge process and follow-up care in consultation with all the other concerned persons **(section 98 [3])**.

At times, some proportionate and reasonable steps are required to protect patients and others from the immediate risk of significant harm, warranting the use of seclusion or restraint. But it should be used as the last option, with well-documented authorization, periodic review, and for the shortest duration possible **(section 97).**

Advance Directive (AD) (Section 5)

An Advance Directive (AD) is a legal written document prepared by an adult, irrespective of any past mental illness and treatment, where she/he can state

1. **Independent Admissions (Sections 85 and 86)** are for those who can retain (AND) weigh information as part of decision making, (AND) communicate it as such to the treating physician. These patients are treated as per their informed consent. Such patients can request discharge by themselves (section 88). However, the treating mental health professional can withhold the discharge for 24 hours for assessment and transfer of the patient for supported admission if he/she is of the opinion that the decision made for discharge is not in a lucid state. The patient can be a threat to self or others or is not in a state to take care of oneself (section 88 [3]).
2. **Supported Admission (Sections 89 and 90)** is used where a person has made a threat or tried to harm self or others or has shown an inability to take care of themself. The person requires very high support from his/her NR and cannot be admitted as an independent patient. The requirements which apply to such admission are listed in **Table 3**.

TABLE 3.

Requirements for Admission, Treatment, and Discharge Under Supported Admission

Admission	1. The person has to be independently examined by one psychiatrist on the day of admission or in the preceding seven days, the other being a mental health professional or a medical practitioner. Based on their examination independently and, if appropriate, on information provided by others, both have to conclude that the person has a mental illness of severity enough to require admission. 2. The person is ineligible to receive care and treatment as an independent patient because he cannot make mental health-care and treatment decisions independently and needs very high support from his nominated representative in making decisions.
Duration of admission	The admission under this is for a maximum of 30 days (section 89 [2]).
Information to review board	All supported admission have to be informed to the review board within seven days, except in the case of women and minors where this timeframe is three days (section 89 [9]).
Treatment	The treatment is based either on advanced directives if it exists or informed consent of the nominated representative. It should be the least restrictive care option under the given circumstances.
Discharge	If the treating mental health professional/medical officer thinks that the patient no longer requires supported admission, he/she can terminate the admission under section 89. If he/she is of the opinion that there is a need for further supported admission he/she can request for admission under section 90.

any or all of the following for care and treatment of a mental illness:

1. How to be cared for and treated
2. How to be NOT cared for and treated
3. Individual(s) who may be his/her NR

The document is maintained by the Mental Health Review Board **(sections 7 and 82 [1.a]).**

AD can only be formulated when the patient can do so. Thus, AD cannot be formulated in situations where the person was brought for admission when unwell.

Nominated Representative (NR) (Section 14)

A NR is a person who the patient has so designated to look after his/her welfare when he/she becomes incapacitated. The NR is appointed by the patient when the latter can do so, that is, when the patient is well **Table 4** lists the requirements for one to be appointed as NR and the hierarchy of others who can be considered as NR by the review board in situations when there is no appointed NR **(sections 14 (3) and 14 (4)).**

It is important to note that when he/she regains the capacity, the patient can change any or all aspects of the previously formulated AD, including the name of the NR.

Delirium and MHCA 2017

In the case scenario above, at the time of admission, the patient was suffering from physical illness and had capacity to consent for the admission and make decisions related to the prescribed treatment. On the third day, the symptoms of delirium appeared, and the Act came into play. In such a case, the medical officer in charge of the case should proceed as described further.

Confirming the Presence of a Psychiatric Disorder, viz Delirium

In the case described above, the patient was managed as in-patient by an internal medicine specialist. In an ideal situation, the physician in charge should assess the capacity of the subject admitted. In case of any indecision, they can seek urgent psychiatry referral, preferably from a geriatric psychiatrist.

TABLE 4.

Requirements to Be Nominated as NR and Order of Precedence While Deciding NR

1. Nominated representative appointed by the patient in the advanced directive	
	a. Should be an adult b. Should be capable of discharging the duties assigned
2. When there is no NR mentioned in advanced directive, the following is the order of precedence in which people are considered as NR	
	a. a relative b. a caregiver c. any other person appointed by the review board d. Director of Department of Social Welfare

Capacity Assessment

With the diagnosis of delirium, it is important to establish whether the subject has the ability to make decisions about his/her line of treatment with an emphasis on the capacity to consent[6] for admission, treatment, and discharge:

1. Capacity is always specific to the task, that is, the capacity to consent for admission is separate from the capacity to take treatment.
2. Having the capacity to consent is a dynamic entity, that is, it can change over time.

Hence, it is important to mention the task for which the capacity was assessed and when.

The above point (2) is especially relevant to delirium, where the illness can have lucid intervals. Thus, during the lucid intervals, the patient will be free from the symptoms and assumed to have the capacity. However, the Act states that consecutive capacity assessments should not be more than seven days apart. In our opinion, this time interval is justified for other major psychiatric disorders like schizophrenia or bipolar disorder. Still, it is too long for a short illness with abrupt onsets, like delirium.

Treatment (Sections 88, 94)

Section 88 (3)—physicians can hold the patient in the hospital for 24 hours if the patient is demanding immediate discharge against the medical advice.

The Act states that an emergency treatment supersedes everything else in the Act, which can be "provided by any registered medical practitioner… either at a health establishment or in the community." and includes "transportation" of the patient "to a nearest mental health establishment for assessment" **(section 94).**

Until a formal capacity assessment is carried out and the patient's status changed from independent to supported admission, the physician in charge can place the patient on an emergency treatment order. Under this section, the least restrictive care options can be exercised for the next 72 hours.

Search for AD and NR

As the status of this patient is now changed to "Supported Admission," it is "the duty of every psychiatrist in charge to propose or give treatment following any advance directive if present". Additionally, let us suppose that the psychiatrist does not follow the AD. In that case, he/she should "make an application to the (Mental Health Review) Board to review, alter, modify or cancel the advanced directive" as and when the need arises **(section 82).**

Thus, the psychiatrist should inquire energetically from all possible sources about any AD the patient may have formulated and seek consent from the NR to continue the treatment.

If No AD, Can the Person Formulate AD

In this and similar situations where the patient's capacity is in question, a capacity assessment should be undertaken to formulate AD.[3,4]

Written Consent by NR

Following the Act, under the provision of Supported Admission, patients can

get admitted and treated by the written consent of NR. However, this consent is considered as temporary as it is rescinded once the patient regains the capacity. The consent of NR is to be properly recorded in treatment documents.

Informing the NR at Every Step of the Treatment, Preferably in Writing

Though the consent from NR is temporary, it is advisable to keep NR informed about every step of management, preferably in writing to avoid any future legal consequences. A suggested way here is that the NR gets a signed copy of the treatment plan as and when it is formulated or edited.

Move the Patient to Independent Admission as Soon as Possible

It is the duty of treating physicians to periodically assess the patient's capacity and move to independent admission as soon as he/she regains their capacity to understand their condition, appreciate the need for care, and communicate their decision by any means possible.

Conclusion

This Act emphasizes the "rights-based care" making capacity and its assessment pivotal in treating a person with mental illness. We concluded that the Act should be followed in its entirety, as it deals with admission, treatment, and discharge of a person with mental illness lacking capacity.

The Mental Health Care Act, 2017, in conjunction with the Rights of Persons with Disability Act, 2016, has underlined the need for clearer legislation to govern/guide decisions about treatment(s) in persons lacking capacity.

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