LETTERS

Intensive care unit guidelines for admission and discharge, 2023

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The Directorate General of Health Services (DGHS), India, has released guidelines for intensive care unit (ICU) admission and discharge [1] to guide intensivists and registered medical practitioners (RMPs) in an Expert Consensus Statement (ECS). This is based on the recommendations of 24 experts working in different ICU settings. This team deserves applause for their efforts in creating guidelines for clinicians working in ICU settings. The Delphi method [2], considered one of the most scientific methods for such statements, has been used for this ECS.

The authors have stated that critical care, intensive care, and intensive therapy are synonymous, probably with the intention that different terms used by different practitioners should not lead to confusion. However, this may create problems — for persons with mental disorders requiring intensive care — from the perspective of medical insurance coverage. Following the enactment of the Mental Health Care Act (MHCA) 2017 [3], the Insurance Regulatory and Development Authority of India (IRDAI) has mandated that all insurance companies should cover treatments for mental disorders on par with those for physical illness [4]. Such coverage includes admission to ICU or High Dependency Units (HDU) for acutely agitated or disturbed persons with mental illness (PMI), including substance use disorders, posing increased risks to themselves or others.

A closer examination of seven admission criteria listed in this ECS suggests that, while creating this document, health has been viewed from a physical perspective only, as there is no mention of any need for admission of PMI requiring admission in an ICU or HDU.

The statement, under point three, conveys that if a patient refuses to be admitted to the ICU, such a patient should not be admitted to the ICU. It is possible that PMIs with suicidal intent, persons with delirium tremens, or those with substance use disorders, including intoxication, may refuse ICU admission. In all such cases, clinicians should make decisions aligning with the MHCA 2017 and the patient's best interests. Inclusion of a statement that "intensivists or RMPs should decide upon the need for admission of patients in ICU settings based on the best interests of the patient and should consider medico-legal opinion when in doubt" would have been more apt.

Stand-alone psychiatric hospitals are likely to have critical care or ICU or intensive therapy units to address the needs of agitated persons whose behavioural or physiological disturbances may be related to underlying mental disorders, medical disorders, or substance use-related problems. It is also not uncommon to find admission of persons with alcohol withdrawal delirium or persons acutely agitated with a possible psychosis in regular medical intensive care units in small towns, where there is no access to nearby psychiatric care facilities. Therefore, any ICU admission guidelines should be from a complete health perspective, including both physical and mental health.

The lack of foreword and context for this ECS poses a danger to the utilisation of this document in a court of law against RMPs who might have admitted or discharged PMI from the ICU based on their clinical judgement, besides posing challenges to insurance coverage for PMI admitted in ICU settings as part of their mental illness treatment. The inclusion of background for the creation of the ECS, limitations in its scope, acknowledgement of the complexities involved in real-life admission and discharge of acutely ill patients, particularly of the mentally ill in ICU settings, and the provision of any evidence for backing the Statement, if included, could have made this ECS more relatable and valuable. Studying the "ICU Admission Guidelines" issued by the National Health Trust [5] United Kingdom, and "Guidelines for ICU Admission, Discharge, and Triage" [6] by the American College of Critical Care Medicine could be useful in this regard.

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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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