Psychiatric and Clinical Sequelae of Delirium and Competence to Stand Trial

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We present the case of a middle-aged defendant who had been incarcerated in a county jail and housed on the mental health unit. It was documented that he had been exhibiting fluctuating levels of alertness and responsiveness. The writers saw him in a forensic capacity, to conduct an evaluation of his competence to stand trial, and recognized that he was having a medical emergency, delirium that was most likely due to brain metastases from inoperable advanced cancer. We recommended an immediate transfer to a medical facility for treatment. The article serves to present an interesting case and to highlight the need for clinical vigilance despite the usual goal of an objective, noninterfering forensic role.

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Delirium is a neuropsychiatric syndrome that occurs frequently in cancer patients, especially in those with advanced disease. Recognition and effective management of delirium is particularly important in supportive and palliative care, especially in view of the increased mortality after delirium.[1] Because of the projected increase in the elderly population and the consequent potential increase in the number of patients diagnosed and living longer with cancer, care must be taken to rule out this condition in any encounter with the elderly or medically compromised psychiatric patient/evaluee.

Studies of delirium in a variety of settings have generated new insights into phenomenology, assessment tools, the psychomotor subtypes, potential patho-physiological markers, pathogenesis, reversibility, and the role of sedation in symptom control. Validated tools exist to assist in the assessment of delirium. Although our understanding of the pathogenesis of delirium has improved somewhat, there remains a compelling need for further elucidation of the underlying pathophysiology, especially in relation to opioid and other psychoactive medications that are used in supportive care. Further trials are needed, especially in patients with advanced disease, to determine predictive models of reversibility, preventive strategies, and outcomes and to assess the role of antipsychotic and other medications in symptomatic management.[1]

The core features of delirium due to a general medical condition, 293.00 (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision [DSM-IV-TR] criteria) are:

A. Disturbance of consciousness (i.e., reduced clarity of awareness of the environment) with reduced ability to focus, sustain or shift attention.
B. A change in cognition (such as memory deficit, disorientation, language disturbance) or the development of a perceptual disturbance that is not better accounted for by a preexisting, established, or evolving dementia.
C. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
D. There is evidence from the history, physical examination, or laboratory findings that the disturbance is caused by the direct physiological consequences of a general medical condition [Ref. 2, p 143].

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Case Example

Identifying information has been removed or altered in this case example. The Institutional Review Board of the SUNY Upstate Medical University determined that it was exempt from IRB review.

Mr. A. was evaluated for competency to stand trial for several charges pursuant to a court order. He had received a diagnosis of late-stage cancer with brain metastases. He was having disturbances of perception, including visual hallucinations (seeing smoke or fog) and auditory hallucinations (hearing noises). He had received palliative radiotherapy and was incarcerated one month later at the local county jail for his criminal charges. After his incarceration, mental health professionals at the county jail evaluated him on several occasions before his competency evaluation. According to the county jail mental health records, he exhibited fluctuating levels of alertness and responsiveness. He was lucid at times and disoriented at times. His thought process was tangential, confused, and bizarre, and he was often sobbing. His speech was pressured. On at least one occasion, he was noted to exhibit bizarre behavior: he started sobbing and walked away from the interviewer and kneeled on the floor and began to pray. At the county jail, Mr. A. was monitored in active supervision. He had initially refused his oncology appointment at the county jail, and it was rescheduled for the following week.

Mr. A. had no history of psychiatric treatment or hospitalization before the current incarceration. He had a history of using cannabis, and his most recent use was two days before his incarceration. He denied any history of alcohol use. He stated that he was not aware of any family history of mental illness.

During the competency examination, Mr. A. appeared to be confused, as he often glanced about the room. He was oriented to person and place but was disoriented to time. He knew the season and year, but could not state the month, date, or day of the week. His responses were irrelevant to the questions being asked. For most of the interview, his speech was pressured. He described his mood as "bad enough." His affect was labile. He was crying during most of the interview and was hard to interrupt at times. He admitted to experiencing visual hallucinations of smoke or fog and of red, blue, and green colors coming out of his cell walls and auditory hallucinations of noises. His thought process revealed tangentiality and loose associations. He did not report having suicidal thoughts or plan or intent, and he did not report having homicidal thoughts. However, he stated, "My family is in danger and my kids like to play with guns and I have many guns to protect them." On cognitive examination, his immediate and short-term memories were impaired. His attention span, calculation ability, and concentration were impaired. His abstract reasoning was impaired.

In the assessment of competence, Mr. A. seemed to try his best to attend to the interview. However, he was confused and often glanced about the room. Several questions had to be repeated to him before he offered a response. Sometimes he would pause and say "It just went away" before asking the examiners to repeat the question. At apparently arbitrary points during the interview he often interjected the exclamation, "Salu, salu!" He was lucid at times, responding with goal-directed responses but at times he was very tangential, illogical, crying, and uninterruptible. During the evaluation, his attention span was very limited and his concentration was impaired. His ability to testify relevantly was impaired.

Mr. A. responded correctly to several questions, displaying knowledge of the roles of the various courtroom personnel. He understood the difference between a felony and a misdemeanor and the concept of pleading guilty or not guilty and of making a plea bargain. He expressed a statement that his lawyer might be unable to help him this time, and reasonably justified that belief when he said "My lawyer did not get me out the first time." He further expressed paranoid ideations about potential witnesses and believed that the district attorney (DA) wanted him to do favors for her. Most of his responses were obtained only after the questions were repeated several times. His ability to attend to questions and to respond promptly and appropriately was severely impaired due to visual hallucinations that continually distracted him from the matter at hand.

Evaluators' Response

The authors informed the social worker who supervised the unit that Mr. A. was in the throes of a medical emergency and should be transferred immediately to a medical facility. The psychiatrists who work at the jail were contacted so that they could complete the requisite legal documents for requesting medical care/consultation outside the facility.

Mr. A. was sent to an emergency room for further medical care and was thereafter hospitalized.

Several factors led to our recommendation to the court that Mr. A. be found incompetent to stand trial. Because of his fluctuating level of awareness, his poor attention span, and labile mood, he could not attend to a reasonable discussion of his options or assist an attorney in planning legal strategy. These symptoms also severely impaired his ability to testify relevantly. He had paranoid beliefs concerning the DA and potential witnesses and thus could not rationally understand the proceedings against him. Because of his severely impaired memory and confusion, he lacked the ability to retain and recall matters discussed. Therefore, he could not have an ongoing factual understanding of the proceedings against him.

His symptoms of disorientation, fluctuating sensorium, and impaired attention span, concentration, calculation ability, and memory were not just seen as affecting his competence to stand trial, but more urgently were recognized as symptoms of delirium requiring immediate attention.

Discussion

Without careful assessment, delirium can easily be confused with other psychiatric disorders because many of the signs and symptoms are conditions present in dementia, depression, and psychosis.[3] Delirium is probably the single most common acute disorder affecting adults in general hospitals. It affects 10 to 20 percent of all hospitalized adults, and 30 to 40 percent of elderly hospitalized patients and up to 80 percent of patients in intensive care.[3] Management of delirium requires treatment of the underlying causes. In some cases, temporary, palliative, or symptomatic treatments are used to comfort patients or to allow better patient management (for example, a patient who, without understanding, is trying to pull out a ventilation tube that is required for survival).

We present this case report to highlight the importance of using a structured formulation to diagnose and treat the psychiatric and clinical sequelae of delirium. Further, the forensic psychiatrist, while not in the role of therapist/advocate, is not excused from exercising clinical skills in recognizing a medical emergency and responding to it. In this instance, the authors had to make a recommendation to the jail officials to have their staff psychiatrists arrange for the transfer of the defendant to a hospital for necessary acute medical care.

References

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