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The Incapacity and Legal Status Assessment Algorithm and Clinical Case Narratives

1 Introduction

This book is written for physicians, medical students, and mental health professionals in South Africa, providing the Incapacity and Legal Status Assessment Algorithm (ILSAA) by which the assessment of someone's legal status in terms of the South African Mental Health Care Act (MHCA) may be practised among actual patients as well as on a set of clinical case narratives published in this book. 'Practise' in the title of the book thus invokes two senses of the word. First, it refers to professional practice for which the algorithm is meant to aid and bring about legally and ethically accountable and sequential decision-making. Second, it refers to exercising and improving professional assessment skills and knowledge through application of the algorithm on clinical case narratives that capture a variety of authentic clinical presentations.

The MHCA requires that all treatment, care, or rehabilitation services for mental healthcare users (MHCU) be rendered in accordance with an assessment of an individual's legal status as being a voluntary, involuntary, or an assisted MHCU. The care, treatment, and rehabilitation intended by the MHCA include hospitalisation but are neither confined to hospitalisation nor to a hospital setting.

This assessment is in pursuance of the main aim of the MHCA providing for mental health services in the least restrictive ways possible. In addition to its legal imperatives, the assessment is crucial ethically in preserving the rights of individuals by which they may make decisions on their mental healthcare autonomously when they have the capacity to do so, yet to ensure that individuals who are incapable of giving consent to mental healthcare may still be provided with treatment, care, or rehabilitation. Pivotal in this assessment is thus whether an individual is incapable of giving consent to the proposed treatment, care or rehabilitation owing to a mental illness.

The ILSAA comprises decision-making paths and captures in an operationalised format the requirements of the MHCA in deriving the suitable legal status within which terms treatment, care or rehabilitation service should be provided for an individual. Available as annexure at the back of this book, we recommend that this algorithm be copied freely and used extensively.

Much of this book contains a variety of clinical case narratives that were purposively developed in articulating the diverse clinical and ethical aspects that are key in the assessment of incapacity and legal status. Although a few of these relate to psychotic disorders, most describe various ways in which mood disorders may present clinically, including psychotic features and cognitive impairment, thereby providing sufficient variety for using these in practising legal status assessments as would be relevant to most, if not all, mental illnesses. The solutions regarding the most appropriate legal status and decision path for each case narrative are provided in Chapter 3, against which readers may compare and verify their application of the algorithm.

As it is not reasonable to expect that health practitioners consult the MHCA in its details when urgent decisions are required in a challenging clinical situation, the algorithm affords a concise and practical decision-making guide, all captured on a single page instead of the 40 pages of the MHCA written in legal terms. Even with the algorithm as an aid, the assessment of incapacity and legal status for purposes of the MHCA is rather complicated and challenging, both practically and intellectually. It requires that one applies a professionally trained mind through a thorough interpersonal engagement with a MHCU, even when this engagement is very difficult practically when a MHCU is, for example, aggressive, violent, or mute.

Nonetheless, the algorithm is meant as an aid in applying the MHCA, specifically in assessing the legal status of an individual. The MHCA is about much more than this, however, meaning that the algorithm does not replace the MHCA, and its use remains accountable in terms of this law. For some clinical cases in practice or in the set of case narratives, the legal status for a specific MHCU or case narrative may be apparent for the seasoned practitioner even without applying the algorithm. For these cases, however, applying the algorithm may nonetheless serve two purposes: first, as a confirmation, and second, as a clinical record of the decision-making process and paths at the time of the assessment, thus

pre-empting that an individual's capacity and the suitable legal status may change over time.

By applying the algorithm, medical and other mental health care practitioners should be enabled to make better decisions and be more accountable in making these. It may also reduce the strain and effort required to deal with the complexities and difficulties posed by the nature and presentations of mental illnesses and the resource-constrained circumstances in which these often present in South Africa. Rather than being trapped by these, the algorithm provides a systematic way to expedite the assessment required by the MHCA in an ethical and legally sound way.

2 Requirements of the Mental Health Care Act (Act 17 of 2002)

The MHCA aims to protect a person's rights to dignity, equality and liberty as guaranteed by the South African Constitution. The MHCA and its regulations make specific mention of 'restrictions and intrusions' on the 'right to movement, privacy and dignity of the mental health care user'. The Act recognises that the person with mental illness or disability (and his or her property) may at times require protection. Members of the public and their property may similarly at times require protection from a person with mental illness or disability. However, this protection of the various parties should not be done unfairly and must be based on the mental health status of the MHCU. The Constitution of the Republic of South Africa, Sections 9 and 10, guarantees equal dignity to MHCUs. The MHCA, Section 10, accordingly prohibits unfair discrimination of persons living with a mental illness or disability. The MHCA recognises that there is a need to 'promote the provision of mental health care services in a manner that promotes the maximum mental well-being of the users of these mental health care services and the communities they reside in'.

The MHCA makes provision that a person may receive care, treatment and/or rehabilitation (CTR) as a voluntary, assisted, or involuntary MHCU. These three categories will be referred to as the legal status of the MHCU. For voluntary CTR, Section 25 of the MHCA requires that the MHCU submit voluntary and willingly to a health establishment. The MHCU must be able to make an informed decision on the need for CTR, free from coercion or undue influence, and must not decline the CTR.

For assisted CTR, sections 26 and 27 of the Act require a written application indicating a reasonable belief that the user is suffering from a mental illness or severe mental disability. Furthermore, the user must have been assessed as being incapable of making an informed decision regarding this need at the time of application and not be refusing CTR.

For involuntary CTR services, sections 32 and 33 of the Act in require the same as for the assisted category, except that, at the time of application, the MHCU declines the proposed CTR. To further distinguish between the assisted and involuntary categories, the Act stipulates that assisted CTR must be required for the health or safety of the MHCU or others. For involuntary CTR, the Act requires that the MHCU be at risk of inflicting serious harm on himself or herself or others; or require the protection of his or her financial interests; or require protection of his or her reputation. The risk to health, financial interests or reputation should be as a consequence of the mental illness.

The legal forms required for the hospitalisation of assisted or involuntary MHCUs are established by the MHCA and its regulations. The forms set out the legal requirements for assisted and involuntary mental health care services. The various grounds for assisted CTR (requiring CTR for one's own health and safety or the health and safety of others) and involuntary CTR (likely to inflict serious harm on oneself or others or CTR being necessary for the user's financial interests or reputation) are set out in the forms. Additionally, provision is made for the assessment of the presence of a mental illness (necessitating CTR) and for incapacity assessment. An opinion is also sought on whether the (prospective) MHCU has homicidal or suicidal 'tendencies' or is 'dangerous'. A provisional diagnosis (of mental illness) must be provided, based on the description of the 'mental health state' of the (prospective) MHCU.

These forms should be available widely and freely. At the very least, the documents should be at each district hospital which, by policy, is the first health establishment for admission of MHCUs. The forms should also be available at all primary health clinics, community health centres and specialist psychiatric hospitals in both the private and public health sectors in South Africa. It should be possible to obtain the necessary documents electronically from the website of the National Department of Health or the Government Printing Works (http://www.gpwonline.co.za/Pages/default.aspx), through their eGazette site (http://www.

gpwonline.co.za/Gazettes/Pages/default.aspx) as it was published in the Government Gazette.

Although the forms are legally required and provide the opportunity to document the presence of the minimum legal requirements for assisted or involuntary CTR service, using the forms is not sufficient to ensure that the process is carried out adequately and ethically. For example, neither the forms nor the MHCA detail the requirements of an incapacity assessment. The ILSAA adds to these forms in meeting the further requirements of the MHCA.

3 Incapacity to give informed consent to care, treatment and/or rehabilitation must be assessed clinically

Against presuming either capacity or incapacity to give informed consent, the MHCA requires a clinical assessment of this in deciding on the suitable legal status. Capacity to give informed consent is the key consideration on which the application of the MHCA hinges.

The MHCA specifies that an assessment must be made regarding the user's capacity to make 'an informed decision on the need for the care, treatment and rehabilitation services' in order to decide on the most applicable legal status. Section 25 of the MHCA requires that an MHCU who 'submits voluntarily' does so after making an informed decision and in doing so, provides informed consent.

This requirement of the MHCA is an expression of the Constitution of the Republic of South Africa.

In Section 1, it declares that the Republic of South Africa is founded inter alia on the values of human dignity, the achievement of equality and the advancement of human rights and freedoms. Furthermore, the Bill of Rights in Chapter 2 of the Constitution guarantees the right to human dignity (Section 10) and freedom and security of the person (Section 12). Section 12 explicitly stipulates that 'everyone has the right to bodily and psychological integrity, which includes the right to security in and control over their body'.

The assessment of incapacity referred to in the MHCA pertains to incapacity to give informed consent rather than assessment of criminal or any other kind of incapacity. Criminal incapacity refers to proceedings in terms of sections 77, 78 and 79 of the Criminal Procedure Act in relation to the individual's ability to understand and contribute to his or her defence in a criminal case. It furthermore pertains to possible

exculpation by virtue of mental illness as a legal defence. The assessment of capacity to give informed consent, in contrast, has a bearing on preserving the human dignity and legal rights of the individual, irrespective of the application of the Criminal Procedure Act.

The MHCA requiring a clinical assessment regarding the capacity of a MHCU to give informed consent rejects a categorical approach whereby a MHCU is rendered incapable of giving informed consent merely by virtue of belonging to a particular diagnostic category such as being diagnosed with schizophrenia or an acute psychosis. This categorical approach is no longer a tenable legal and clinical position.

Instead, the MHCA makes a functional approach an imperative in recognising that capacity to give informed consent (i) is neither necessarily affected, nor necessarily affected to a sufficient degree when belonging to a particular diagnostic category (for example, when in an acute psychotic state), (ii) may change over time (even in the same day); and (iii) is specific to a particular proposed intervention (that is, one may be incapable of consenting to one but not another intervention). Accordingly, the MHCA requires the assessment of capacity to give informed consent to the CTR.

4 Good process and criteria for assessing incapacity to give informed consent

Captured in the Incapacity and Legal Status Assessment Algorithm, four key questions should guide the assessment of incapacity to give informed consent:

(i) Does a mental illness prevent the patient from understanding the proposed intervention?

(ii) Does a mental illness prevent the patient from choosing decisively for or against the proposed intervention?

(iii) Does a mental illness prevent the patient from communicating his or her choice regarding the proposed intervention (despite substantive attempts to communicate with the patient)?

(iv) Does a mental illness prevent the patient from accepting the need for the proposed intervention?

An ethically and clinically accountable answer to each of these key questions in the assessment, is dependent on good process of which details are described elsewhere.

Good process in the assessment of incapacity to give informed consent is required for all three phases in the assessment. These phases captured in Figure 1 entail:

(i) all that is required for making a clinical diagnosis of mental illness and establishing whether and what the need is for an intervention;

(ii) assessing the patient's understanding, choosing, communicating and acceptance of the need (specified in the key questions above); and

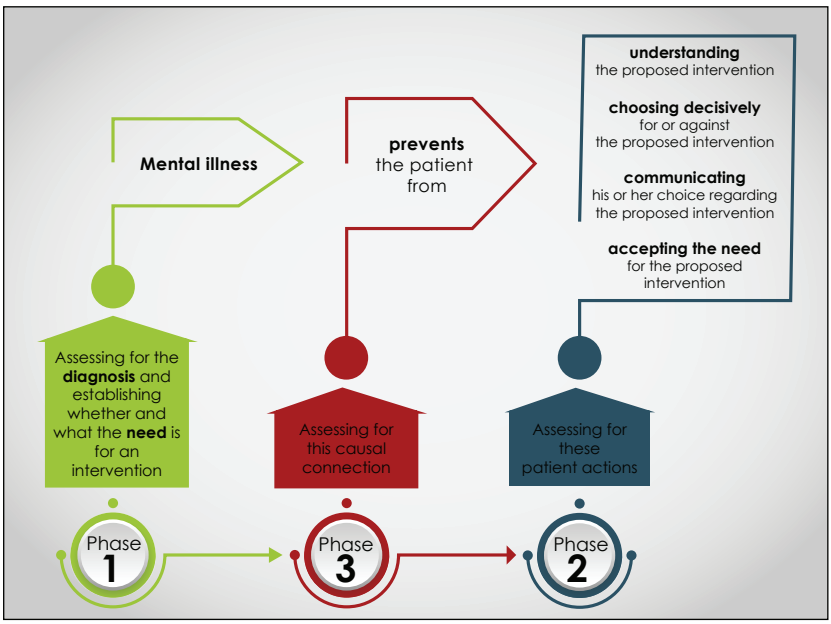
(iii) assessing for a causal connection by which the mental illness *prevents* the patient's understanding, choosing, communicating, and accepting the need.

The word 'prevent' in all four above criteria captures the latter causal connection. This causal connection should not be confused with the cause(s) of the mental illness. Instead, this causal connection is about the effects of the mental illness on the mind of a specific individual.

Assessing for this causal connection is crucial because a lack of understanding, or not exercising a choice, or not communicating, or not accepting the need for the intervention, should not be assumed to be caused by the mental illness merely because a mental illness is present. There may be other reasons for these. For example, a patient may choose not to understand, choose, or communicate, or may not accept the need for an intervention not owing to mental illness but for reasons that are not related to his or her mental illness. The mere co-occurrence of a mental illness and lacking in one of the four patient actions is not sufficient evidence to claim this causal connection pertains.

To assess for this causal connection, the individual or collective aspects of the patient's current mental state that prevent the patient's action (these are, understanding, choosing, communicating, or accepting the need) should be identified. These may for example be cognitive impairment (of various kinds), a delusion(s), disordered thoughts, marked ambivalence, the indecisiveness of a manic episode, and a lack of insight into suffering from a mental illness. All these aspects of the patient's mental state may present in numerous permutations, with varying degrees of severity and intensity.

Figure 1: Three Phases of Assessing Incapacity to Give Informed Consent



Good process in this assessment requires that the clinician makes a deliberate effort to optimise the patient's capacities including his or her understanding, exercising a choice, communicating, and accepting the need for the proposed intervention. Optimising the patient's capacity to give informed consent also applies to the other requirements of informed consent, such that undue influence (whether so perceived by the patient or that applies in fact) is averted. The information needs of the particular patient should also be tailored in both attempting to mitigate the patient's impairments and meet the preferences of the patient. Merely disclosing information to the extent that a reasonable practitioner and/or a reasonable patient standard is met, is not sufficiently person-centred.[1]

This means that the necessary conditions to both informed consent and incapacity to give informed consent should not be taken as fixed

1 J Katz *The silent world of doctor and patient* (2002); Van Staden (n 12); R Sommers CW van Staden & F Steffens 'Views of clinical trial participants on the readability and their understanding of informed consent documents' (2017) 8 *AJOB Empirical Bioethics* 277-284.

but are dynamic. Informed consent can be influenced by good process. In this way, understanding can be fostered, communication can be improved, undue influences can be managed, more certainty about the appropriate choices can be cultivated, and acceptance can be developed and co-produced. Rather than expecting ready-made universal answers, good process accounts for what and how much is required for co-producing informed consent to the specific CTR in a specific context: how much information is sufficient; what influences are pertaining and what should be done about them; how much understanding of the proposed intervention(s) is sufficient; how decisive and lasting a choice for or against an intervention may be; the need for an intervention from the respective point of view of the practitioner, the MHCU and other role players as relevant; and whatever the specific context would suggest or even demand. This may indeed be challenging, requiring much skill. Clinical examples of how these challenges may be processed practically and ethically, especially when values are conflicting, are described elsewhere.[2]

Good process accounts furthermore for the specific intervention to which informed consent is given. This means that giving informed consent to intervention X is not necessarily the same as giving informed consent to intervention Y. Moreover, incapacity to give informed consent to X is not necessarily the same as incapacity to give informed consent to Y. For example, a person may be incapable of consenting to hospitalisation yet simultaneously capable of consenting to taking medication (or vice versa).

5 Using the algorithm to aid good process

The Incapacity and Legal Status Assessment Algorithm is intended as an instrumental aid in good process when applying the MHCA. The algorithm captures the key decisions stipulated by the MHCA for

2 KWM Fulford E Peile & H Carroll '*Essential values-based practice: linking science with people*' (2012); KWM Fulford S Dewey & M King 'Values-based involuntary seclusion and treatment: value pluralism and the UK's Mental Health Act') in JZ Sadler CW van Staden & KWM Fulford (eds) *Oxford handbook of psychiatric ethics* (2015) 839-860; CW van Staden '"Thinking too much": a clash of legitimate values in clinical practice calls for an indaba guided by African values-based practice' in D Stoyanov and others (eds) *International perspectives in values-based mental health practice* (2021) 179-188.

deciding on the most suitable legal status including those decisions pertaining to incapacity to give informed consent. The algorithm may serve this purpose when applying it in a clinical instance, but also indirectly when it is used in the training and development of medical and other mental health professionals. It addresses one of several difficulties in applying the MHCA in South Africa that have been highlighted before.[3] This is that medical and other mental health practitioners should have the required understanding and knowledge of the MHCA.

The algorithm is designed for use by professionals so designated by the MHCA, supporting their decision-making rather than ensuring that all the administrative and procedural requirements of MHCA are met. The latter requirements may include for example a family member applying for hospital admission of a patient as an MHCU in terms of the MHCA on the prescribed form (Form MHCA 04), a second mental examination (with or without a physical examination) should be conducted by another mental health care practitioner as specified by the MHCA (that is, another registered medical practitioner, a nursing staff member, an occupational therapist, a psychologist, or a social worker with appropriate training to render CTR services), the approvals by the respective heads of establishments, the time frames for re-assessments, etc.

A decision on the suitable legal status of a patient should be valid and reliable, consistently so from patient to patient and practitioner to practitioner. To gather quantitative research evidence of this in South Africa is practically challenging. As a first step to remedy this, the algorithm affords both the clinical validity and reliability intended by the MHCA as well as quantified data in this regard. To this end, the next section summarises quantitative results on the validity and the reliability of the algorithm.

3 JK Burns 'Implementation of the mental health care act at district hospitals in South Africa: translating principles into practice' (2008) 98 *South Africa Medical Journal* 46-49.

6 The Incapacity and Legal Status Assessment Algorithm and its validity and reliability

The Incapacity and Legal Status Assessment Algorithm (ILSAA) (See Annexure B) addresses an assessment of incapacity to give consent to the proposed care, treatment and/or rehabilitation (CTR), the MHCU's willingness to receive CTR and the risk posed to his or her health or safety, the risks of serious harm to self or others or the financial interests or reputation of the patient. Through various decision paths, the ILSAA yields one of four possible legal statuses as being suitable: voluntary, assisted, involuntary or that TCR is declined.

The ILSAA begins with the decision whether there is a mental illness for which a mental health service (CTR) is the priority. By the stipulations of the MHCA, a mental illness is defined as a positive diagnosis of a mental health-related illness in terms of accepted diagnostic criteria by a mental health care practitioner authorised to make such a diagnosis. In South Africa, either the ICD-11 of the World Health Organization or the DSM-5 of the American Psychiatric Association is used to establish whether a mental disorder is present.[4]

The ILSAA derived its content validity from the stipulations of the MHCA and the literature on incapacity assessment.[5] Details of its predictive validity and its reliability were reported in Diagnostics (see Annexure A).[6] To test these qualities of the ILSAA, it was applied 4 052 times to 135 clinical case narratives by 294 research participants. It was accurate in yielding the correct legal status for the voluntary, assisted, involuntary and decline categories in 94%, 92%, 88% and 86% of clinical case narratives, respectively. Its specificity ranged from 89% to 96%, and its sensitivity ranged between 82% to 89% except for a 59% sensitivity in predicting the decline category.

For internal reliability, a correspondence model yielded a Cronbach's alpha coefficient of 0.998 and it accounted for 99.8% of the variance by

4 American Psychiatric Association *Diagnostic and statistical manual of mental disorders* 5th edition (2013); World Health Organisation *International classification of diseases for mortality and morbidity statistics* 11th Edition (2018) Ch 6.

5 Van Staden (n 8) (n 12); Van Staden & Krüger (n 9).

6 G Grobler & CW van Staden 'Algorithmic assessments in deciding on voluntary, assisted or involuntary psychiatric treatment' (2022) 12 *Diagnostics*, 1806.

which the decision paths clustered together fittingly with each of the legal statuses. Inter-rater reliability testing showed a moderate degree of agreement among research participants on the suitable legal status (Krippendorff's alpha = 0.66).

7 Derivation of the Clinical Case Narratives

One main purpose of developing the clinical case narratives was that these serve as an educational resource for medical and other mental health practitioners who are in formal training or as part of their continued professional development. The narratives represent a variety of clinical presentations and the challenges and complexities of these presentations in assessing the suitable legal status of MHCUs.

The clinical case narratives were derived through a rigorous process with pre-set requirements for the set as well for each of the case narratives. The set narrates clinical cases to which four potential legal statuses apply. These are voluntary, assisted, or involuntary TCR, as well as cases in which TCR was not clinically indicated or it was not the priority even when clinically indicated. For some of the latter cases, sufficient diagnostic criteria were not met for diagnosing a mental disorder.

Another requirement for the set was achieved by a systematic process to ensure that the set presented a variety of clinical presentations. This emphasis on clinical variety and authenticity meant that the algorithm did not prescribe the contents of the narratives. That is, the narratives were not primarily constructed as to provide contrived indications for each of the decision points on the algorithm. This meant furthermore that some decision paths pertained to the case narratives more frequently than others.

This variety represents permutations of mood, cognitive, and psychotic symptoms, the duration of these symptoms, the intensity and qualities of afflicted emotions, and that the content of experiences should be narrated (that is, for example, what the emotions or thoughts were about) rather than merely their form (for example, being depressed or delusional). Some narratives relate cases of incongruence between the patient's account of the intensity of experiences and the severity by the assessment of the physician, compounded by different points of view of family members on the seriousness of the presentation and the suicide risk. The narratives contain moreover details on a family history of completed suicide, past or recent suicide attempts, past or

current suicidal thoughts, suicide planning and current non-suicidal self-injurious behaviour. Much of the narrative contents originates from that which our patients have told us during many years of clinical experience.

Each clinical case narrative provides the information that is necessary for assessing the suitable legal status as applicable to proposed CTR. After each case had initially been drafted, its clinical authenticity and credibility were independently verified, and changes were made where improvements were recommended. Once confirmed as clinically authentic and credible, the most suitable of the four legal statuses to each of the clinical case narratives was assigned individually by a panel of three of us (PJ, GL, and CK) who had no knowledge or exposure to the algorithm at the time. Following assigning the suitable legal statuses individually, we then sought consensus through a process of discussion. To achieve 100% agreement among all of us, ambiguous narratives were discarded, and narratives were refined to ensure that the gold standard legal status was as unequivocal as was possible for each case narrative. A similar process was followed in adding a further eight case narratives after publishing the validity and reliability results on the algorithm.