

## 2

# Clinical Case Narratives

### 1 Introduction

For each of the clinical case narratives in this chapter, the following question prompts the application of the Incapacity and Legal Status Assessment Algorithm in practising the Mental Health Care Act (MHCA): What will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) the proposed intervention is legitimately declined or not applicable; or b) the proposed intervention should proceed by which suitable legal status? The proposed intervention is specified in this question for each case narrative including hospital admission or another mental health service.

The specification of the intervention in each narrative was chosen to serve the practising of the MHCA rather than capturing necessarily the best intervention or the details of the intervention. The reader is thus prompted to apply the MHCA as if the intervention specified in the narrative were indeed the proposed intervention. However, the one particular intervention foregrounded in the narrative does not preclude the reader, in practising the MHCA, to consider another (kind of) intervention too.

## 1.1 Ms BaSe

Ms BaSe presents as a 38-year-old single female without dependants. Her family have brought her to the hospital where you practise because of their concern for her safety and the state of her mental health. They report that she has experienced for the past month a low mood and they describe a disinterest that you recognise as anhedonia. They observed that her appetite was decreased during this time with a noticeable loss of weight. She often isolated herself from the family and reported that her prospects for a serious relationship, a rewarding career and a worthwhile life were all hopeless. They found her to be restless with insomnia and pacing during the night. She routinely struggles to fall asleep and wakes up multiple times during the night. Because of this she has experienced lassitude in the morning with little energy to do her chores at home, and not enough energy to meet deadlines at work.

When asked about her family being concerned about her, Ms BaSe comments that she is only mildly depressed and that 'things are not that bad'.

Ms BaSe has a history of two major depressive episodes in the past but no family history of mental illness. There is no personal or family history of a suicide or a known suicide attempt. She has a history of an ectopic pregnancy but no other significant medical history. She and her family deny the use of psychoactive substances.

On your examination you find that Ms BaSe is well-kempt but agitated with psychomotor restlessness during the interview. Her speech is soft and slow, and her responses are devoid of detail. She seems depressed with restricted affective flow. You also notice some impairment in her concentration and her memory functions. Despite these impairments, she nonetheless makes sense of the conversation and your efforts to assist her. You find no psychotic symptoms, nor indications of hypomanic or manic symptoms. She is worried about her relationship with her boyfriend that is 'yet again going to pieces'. You find no indication of another medical illness on physical examination nor any indication of substance use.

Although Ms BaSe disagrees with her family's assessment of the severity of her mood disorder, she concedes that something is wrong. She expresses her willingness to receive mental healthcare and treatment for her current recurrence of a mood disorder, including admission to the hospital. She says, 'perhaps that will help a bit'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.2 Mr QaBa

Mr QaBa presents to your clinic as a 28-year-old male. He was diagnosed four years ago with schizophrenia and has been following up regularly at his local clinic. He received treatment with antipsychotic medication which he took diligently. The day before the consultation Mr QaBa smoked a 'joint' of cannabis with friends. He is brought to your clinic by his parents who are concerned about him experiencing hallucinations. Mr QaBa reports to you that he experienced mild hallucinations after smoking cannabis. He is not concerned by these experiences and believes these will pass.

Mr QaBa is not known to have any other medical or mental illness. No family history of significance is reported. Except for his occasional use of cannabis, Mr QaBa avoids the use of psychoactive substances other than his prescribed psychotropic medication.

On clinical examination you find Mr QaBa awake and alert. You find no evidence of cognitive impairment as his attention, concentration, abstract reasoning, and executive function are all intact. You find no evidence of delusions. You find Mr QaBa's mood to be euthymic with no indication of either a major depressive or manic episode. Mr QaBa does not report significant anxiety.

Mr QaBa's parents urge you to admit him on account of the hallucinations. Mr QaBa however, does not believe that he needs admission. He is of the opinion that the hallucinations are transitory and a consequence of his use of cannabis. He understands his parents' concerns but chooses not to be admitted. Mr QaBa makes it clear to you and his parents that he does not agree with their request.

*His parents want to know from you whether you could admit him to hospital against his wishes at this time. To answer their question, apply the algorithm in answering: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.3 Ms BeHg

Ms BeHg presents to your practice with the complaint that she has lost interest in life, and can hardly imagine having a laugh, having joy and pleasure in her life again. This 'depressing state' has only gotten worse during the past three weeks. She further mentions that she has lost eight kilograms in weight over the past four weeks (amounting to ten percent of her baseline body weight) on account of her poor appetite. She also struggles to fall asleep and often wakes up during the night resulting in fragmented sleep. She reports that her energy levels are so low during the day that she can no longer complete all her tasks at work and her supervisor is complaining about her performance.

On enquiry she denies any suicidal thoughts. Her psychomotor activities are slowed but no one has commented on this yet. Her ability to think and concentrate is mildly impaired, but she is not really concerned about this. She suffers neither excessive feelings of guilt nor worthlessness. She considers her symptoms to be of mild to moderate intensity.

You do not elicit features of any other medical condition that may explain her mood nor any features of psychosis or mania (including hypomanic features). There are no indications from her history or your examination that Ms BeHg misuses any psychoactive substances. Neither of you are of the opinion that hospitalisation is required.

You diagnose her with a current major depressive episode. When you explain this to her, she understands and accepts your recommendation of initiating treatment with an antidepressant. She agrees to using the medication as prescribed and agrees to a follow-up appointment at your practice.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment with medication as an outpatient for her mood disorder is legitimately declined or not applicable; or b) treatment with medication for her mood disorder as an outpatient should proceed by which suitable legal status?*

### 1.4 Dr LuKo

Dr LuKo is a 32-year-old male physician and a friend of your family. His sister insisted that he professionally consulted with a colleague, and she has come along to

your office. Dr LuKo complains that he is feeling intensely 'shocked and shaken' for most of the time during the past four weeks since his wife left him. He married the 'love of my life' who was the 'most admired girl at school'. She recently left him for someone he feels is far less desirable than he is. This 'pains me' that she could make such a gross mistake. Since she left, he says, 'I have had no joy'. He has not gone for his twice-weekly golf games and stopped his daily jogging. He complains about 'pervasive fatigue and yet, my mind can't switch off during night'. He sleeps about three hours in total by the measurements reflected on his expensive sports watch. He has also noticed a decrease in his appetite with the loss of four kilograms of weight during the past three weeks. His sister also laments that they want 'our sparkling brother back'.

Dr LuKo tells you during the interview that he has always been a highflyer and has been very successful in his career. He goes for 'only the best of everything'. He says people are often drawn to him because of his success and brilliance, which his sister confirms. He also relates that he attends meticulously to his appearance and physical fitness, which contributes to being more attractive than most men of his age. People can see that he is 'somebody of note', he says, telling you about a recent incident at a local restaurant where the waiters made other patrons wait to serve him first. He is frequently consulted by colleagues at work for his wisdom and experience. He finds the mediocrity of some of his colleagues and other individuals frustrating. The reason for this, he adds, is that too many people are merely parasites in life. He adds he hates wasting his time on mere parasites and those who are weak.

He reports to you that he had tried an antidepressant six years ago that precipitated a 'hypomanic' episode for which he was hospitalised for a week. On questioning he responds evasively regarding his subsequent diagnosis and treatment. He is not currently taking any medication and is not prepared to take an antidepressant again owing to the previous response on it. On enquiring about suicidal thoughts, Dr LuKo says 'having those are normal when one's wife makes such a grave mistake'. He skirts all your attempts to tell you more about these thoughts. His sister tells you that their father committed suicide when Dr LuKo was seven years of age. The mother of their father also committed suicide in her early thirties. Dr LuKo is otherwise medically well with no history of any chronic or acute medical illness. He drinks 'only the finest whiskey'

and admits having drunken a lot on four or five evenings since his wife's departure.

On examination you find that Dr LuKo tries to keep up good appearances and that he often underplays the extent of his afflictions and symptoms. Similarly, he tries to suppress tears and emotional lability, but these attempts often fail. He then reflects 'this is too embarrassing'. His speech is pressured at times and his thought processes often show tangentiality and derailment. He admits his concentration is impaired, but you find no other cognitive impairment. His mood is severely depressed, and congruently, his thought contents are dominated by themes of failure and weakness, which are 'shameful' and 'despicable'. You find no psychotic features.

You want to admit Dr LuKo to the hospital on account of the severity of his mood episode and a significant suicide risk. Dr LuKo does not agree with your assessment of the severity of his current state. He thinks that he is not mentally ill at all, but that 'this is all my wife's fault'. He believes that all will be resolved when she realises her mistake and returns. He declines your firm recommendation of hospital admission and says, 'I am offended and you are making a massive professional error. To be hospitalised when one's wife is making a gross mistake, is humiliating, repulsive and morally wrong'. He is also annoyed with his sister when she expresses her concern for his safety and pleads with him to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.5 Ms SaKe

Ms SaKe presents as a 38-year-old single female without dependents. Her brother has brought her to the hospital where you work because he is worried about her safety and the state of her mental health. The brother reports that Ms SaKe has been negative and worried about more or less everything during past two months. He reports that she seems interested in nothing not even watching television. She snacks and has clearly gained weight. She has been keeping to herself, not answering his or his mother's phone calls or messages. At times, she has often said everybody is useless and everything is hopeless. When her brother stayed over at her place a few times, he found her not

sleeping but walking for much of the night from room to room for no apparent reason. The patient confirms that she routinely struggles to fall asleep and when she does fall asleep, she would awaken in the early morning hours before dawn. Because of this she has been listless and lacking in energy.

Her brother tells you in confidence that she mentioned 'ending it all' and that 'life is not worth it', implying suicidal thoughts. They found links to suicide discussion sites on her computer's internet browsing history.

Ms SaKe has no history of prior mental illness nor a family history of mental illness. She has never been treated for a mental illness before nor is there a personal or family history of a suicide attempt. She has a history of a termination of an unwanted pregnancy in the past but no other significant medical history. She and her brother deny the use of illicit psychoactive substances.

On your examination you find that Ms SaKe is well-kempt. She is agitated as seen in the wringing of her hands and her legs being restless during the consultation. Her speech is soft and slow, and she seems reluctant to participate in attempts to talk to her, saying the bare minimum. She seems depressed with restricted expression of affect. You also notice lapses in her concentration and poor memory of that which has just been discussed, but she contributes sensibly and relevantly in your conversation with her. You do not find any psychotic symptoms, nor indications of hypomanic or manic symptoms. Although she reveals little of her thoughts, these are most mostly about worries regarding her financial situation and stating a few times 'it's not worth it'. You find no indications of other significant medical problems on physical examination nor any indication of substance use.

Ms SaKe admits that she feels 'a bit low' but adds 'who wouldn't in my circumstances'. She also says, 'I am not as bad as my brother thinks' and 'your help or treatments will achieve nothing in my case – sorry!'. Enquiring about suicide thoughts and plans, she says 'don't you worry, it's not your life, it's mine'. She also says, 'if I seriously planned suicide, I would not have told you, would I?'. When you recommend that she be hospitalised, she responds dismissively 'whatever' and 'I don't actually care what you decide'. She nonetheless expresses her willingness to go along with arrangements for hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified*

*by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.6 Mr FeRu

You visit Mr FeRu, a 46-year-old overweight male in the internal medicine ward of the hospital for a consultation. He was admitted there a week ago owing to a bleeding peptic ulcer and poorly controlled diabetes mellitus. These conditions have responded well to treatment since.

Your colleague informs you that Mr FeRu has become progressively more restless over the past four days to the extent that they sedated him yesterday evening. He is not sleeping, has become 'hyperactive' (in their words), and is inappropriately flirting with the nursing personnel and even so with the very ill dyspnoeic young man in the bed next to him. Despite being reprimanded, he gets 'in-and-out' the bed all the time, goes to the bathroom several times each hour and talks continuously ('non-stop') irrespective of whether someone listens. He often does not make sense with loud rambling speech.

Mr FeRu was diagnosed with a major depressive disorder 18 months ago following a previous suicide attempt by medication overdose. He also has a family history of death by suicide. Except for his diabetes mellitus and recent bleeding peptic ulcer, Mr FeRu has no other chronic medical illness. Although not verified, it appears that the use of psychoactive substances is restricted to about six beers taken 'only' at parties – the last party was three weeks ago.

On mental state examination you find a dishevelled man looking old for his age. You struggle to establish rapport with him on account of his severely disorganised thoughts. His speech is rambling and at times incoherent. You notice pressured speech as well as psychomotor agitation despite the sedation he received prior to your visit. He is clearly disinhibited during the interview, being overly familiar and even brash towards you. He also speaks loudly without any concern about being over-heard by other people, stating 'I want some desperately...actually a lot of it...I am so horny...unbelievably...erect and ready, so very ready'. He promptly demonstrates his erect state to you inappropriately. You find no indications of hallucinations or delusions. The extent of his agitation and disorganised thoughts compromises cognitive testing at present considerably, but his consciousness is not clouded.

His is orientated for person. He knows in which hospital he is, but not the ward. He is orientated for time except for the day of the month.

You discuss with Mr FeRu the need for a transfer to the psychiatry ward owing to your grave concerns about his reputation and disorganised mental state. He does not follow your concerted explanation of a proposed transfer to the psychiatric ward, responding incoherently, with much tangentiality and loosening of associations. When told to pack his belongings in preparing for the transfer, he needs help to get this completed but goes along without reluctance.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment and care by a transfer to the psychiatric ward is legitimately declined or not applicable; or b) treatment and care by a transfer to the psychiatric ward should proceed by which suitable legal status?*

## 1.7 Ms BeSo

Ms BeSo presents as a 40-year-old female with a depressed mood at the hospital where you work. She is accompanied by her spouse. They have been married for 20 years and she is the mother of two children.

She reports that she has experienced a low mood for the past two months. She lacked appetite during this time and noticeably lost weight. She also reports that she has been feeling excessively worried, which is uncharacteristic of her, and to such an extent that 'I cannot find anything funny, or enjoyable. My husband often says that he has been joking, but I do not get it as a joke. To me his 'joke' is either not funny or rather something I worry about'. She often isolates herself from her spouse and children on account of feeling guilty about being 'moody' and making them gloomy too. She struggles to fall asleep and when she does manage to fall asleep, she would awaken during the early morning hours after only a few hours of rest. Her husband gets very upset with her when she gets out of bed long before dawn. Owing to a lack of energy and a lack of interest in doing or completing chores at home, her husband and children are 'filling in the gaps' and 'keep the wheels turning'. She is of the view that she is 'in bad state and not well at all'.

Ms Beso's spouse surprisingly does not share her view. He is of the view that she is not mentally ill and that they

all just have to 'try harder' by which she should 'pull herself together'. The spouse also says that their family 'doesn't believe in mental illness' and that he is sceptical of psychiatric treatments.

Ms BeSo has no history of prior mental illness nor a family history of mental illness. She denies any past suicide attempts or current suicidal thoughts or plans. She has a history of a hysterectomy for myomatous uterus in the past but no other significant medical history. She and her spouse deny any use of psychoactive substances as it is not compatible with their religion.

On your examination you find that Ms BeSo is in an unkempt state with little regard for personal grooming. She seems agitated with wringing of her hands and restless legs. She often gets up, walks about during the interview, and finds it hard to sit still. Her speech is soft and slow, and her verbal responses are impoverished and vague. She seems depressed and her affect is blunted. You also notice lapses in her concentration and memory during your interview. Her thoughts are nonetheless coherently structured. You do not find any psychotic symptoms, nor hypomanic or manic symptoms.

Ms BeSo is of the opinion that she requires mental healthcare and agrees with you that hospitalisation is needed at this time despite her husband's reluctance.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.8 Ms BaNe

Ms BaNe presents as a 39-year-old female with a history of a recurrent major depressive disorder as well as bulimia nervosa. Her family has brought her to the hospital because she complained of 'feeling down in the dumps' during the past three weeks. She mentions a lack of energy and drive with a change in her sleeping pattern. She cannot fall asleep at night. During the past month she has often been lying awake at night times. Consequently, she has been exhausted in the mornings. She further mentions that her appetite is poor but that, despite this, she started to binge eat again. Her weight remains unchanged. The binge eating makes her feel guilty and worthless 'because I've lost control again'.

She has a family history of mental illness as her sister was diagnosed with major depressive disorder and anorexia nervosa. She is not known with any other medical illness except for the history of bulimia nervosa. Your physical examination reveals no additional medical morbidity. You also find no indication of a substance use disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She denies any suicidal thoughts during your interview. You find that her thought processes are slow and belaboured. She nonetheless maintains her concentration during the interview and, albeit with difficulty, participates in the interview and planning of her treatment with you. She then discloses to you that one week ago she began to hear the voice of several unknown people 'calling me' and 'I can't figure out from where they are calling as they remain elusive'. She finds their calling bothersome and intrusive even if she tries to ignore it. She says moreover, 'if I only can get rid of them'. She suspects that their intentions may be evil, but you do not find that she holds any accompanying delusions, nor features of hypomania or mania.

Ms BaNe concurs with your assessment that her depressed mood is of a severe degree and that she needs to be hospitalised for it. She says, 'I know that I am not well at the moment' and that 'all is going off the rails fast for me'. She tells you that she'd be better off as an inpatient in the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.9 Mr JaLo

Mr JaLo presents as a 23-year-old male student. His friends who have brought him for the evaluation mention that his energy levels were 'amazing', being on the go all the time with apparently little if any need for sleep during the past ten days. Mr JaLo himself has no complaints, except that his friends are 'chicken' and 'boring'.

He was diagnosed with bipolar I disorder two years ago and was admitted to a public sector psychiatric hospital for two months. He had been placed on a combination of mood stabilisers at the time of discharge from this hospital, but defaulted his maintenance treatment as he felt he did

not need it. He has a family history of bipolar disorder as his sister was also diagnosed similarly.

Mr JaLo has no history of any other acute or chronic medical illness. He denies any use of psychoactive substances. This is confirmed by his friends.

On examination you find a flight of ideas, which Mr JaLo describes as being 'supercharged' with one brilliant idea being outdone by the next 'in seconds'. His friends report that he is very talkative, yet they cannot really have a conversation about anything in particular as he is easily distracted and quick to change topics. They describe his mood as 'high' and 'wanting to party all the time'. He is restless and pacing persistently during the consultation. His speech is pressured, and it is difficult to interrupt him. He speaks loudly and he seems at times hostile and potentially aggressive. His thoughts are replete with grandiose ideas pertaining to his power and importance, but his thoughts are expressed logically and systematically. His self-esteem seems inflated, obviating a suicide risk as stated in 'I am too important for the world to kill myself'. He considers himself an especially important person 'with so much to offer the world'. He excitedly tells you of all the celebrities who are his friends and who, he asserts, are preparing 'the world stage for me to come out'. He is adamant that this is so even when you challenge his assertions. His friends deny that he is acquainted with any of these celebrities. In making similar claims, his behaviour in class has been 'shocking' in that he is rude and making sexually crude remarks. His friends are concerned that he is ruining his friendships and relationships with his peers.

You find no evidence of any other acute or chronic medical pathology that can explain the manic symptoms. He tests negative for all psychoactive substances.

Mr JaLo resists your firm recommendation of hospital admission. He claims that 'someone as important as me can never be admitted here' and that no celebrity has ever been admitted in a 'mental hospital'. He remains unconvinced that he is mentally ill, saying: 'How can you be ill if you feel as well as I do'. He is not prepared to be admitted to the hospital and forcefully prepares to leave the consulting room. His friends are deeply concerned about his health.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately*

*declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.10 Prof LuCe

Prof LuCe is a single 75-year-old female and emeritus professor of music presenting with the complaint that she suffers from brain cancer that taps all joy and energy from her life. She consequently feels very despondent and extremely depressed. She sleeps poorly with initial and terminal insomnia. She lacks appetite and has lost much weight, stating 'eating serves no purpose for me anymore'.

Prof LuCe's family corroborates her complaints from their observations. However, they say that she visited several other physicians who examined her, but none could find the brain cancer, even when an MRI was performed. (The MRI neither revealed any other pathology). Prof LuCe confirms the same but claims that 'current technology is evidently not up to scratch' to detect the brain cancer. There is no other explanation for her 'dire state' at present, she says. Her family has also noticed some forgetfulness that has started recently. They find that she is unable to sustain her concentration and that she often misunderstands what they are telling her.

Prof LuCe has a family history of major neurocognitive disorder. Her medical history includes hypertension and diabetes mellitus, but these are well-controlled by medication and have been within acceptable parameters for years. She does not use alcohol and stopped smoking 20 years ago.

On your examination, you find that Prof LuCe is somewhat unkempt. Her affect is blunted with a 'wooden' quality. Her mood is depressed, and her thoughts are congruently preoccupied by her suffering from brain cancer and its overwhelming depressive effects. She attributes to the brain cancer all her anhedonia, insomnia, lack of energy, and 'brakes being put on my thinking clearly'. Her speech and thought processes are seemingly unaffected. Her concentration is mildly impaired but her other memory and other cognitive functions test intact. You appreciate nonetheless that her high intelligence may be masking some cognitive impairment, which should thus be tested more extensively. Other than the somatic delusion, you find no psychotic features and no hypomanic symptoms. You find no lateralising neurological signs, but she is clearly underweight.

You want to admit Prof LuCe to hospital with the view to treat her severe degree of a major depressive episode. Prof LuCe disagrees with you that she is mentally ill and needs hospital admission. She says her problem is brain cancer and treatment for anything else is inappropriate and mistaken. If your recommended hospitalisation were for brain cancer, she would have agreed, but 'your technology can't even locate my brain cancer, how would you operate on a cancer that you can't even locate!'. She refuses hospitalisation for whichever reason because, she claims, 'there is simply no treatment and no surgery possible, and thus there is no hope for me'. Her family supports your recommendation of hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.11 Ms BaCe

Ms BaCe presents as a 34-year-old female. She was so depressed that her family decided to bring her to the hospital where you work. She tells you that 'I just have too many problems in life'. She also mentions that she is often in conflict with her family.

On questioning, her main complaints are her depressed mood and a lack of interest and enjoyment of life during the past month. She also reports that she lacks drive and energy during the same time. Her sleep is severely affected with initial, middle, and terminal insomnia. Her appetite has decreased, and she has lost weight. She reports feelings of worthlessness and guilt about 'failing her family' being on her mind most of the time. She denies thoughts of suicide or recurrent thoughts of death. She has found that she struggles to remember that which she reads on account of her poor concentration and memory impairment.

Ms BaCe was previously diagnosed with major depressive disorder (recurrent), and she used to take maintenance treatment that she discontinued 'a while ago'. She is known to use alcohol and cannabis at regular intervals. She denies recent use of either of these substances, corroborated by recent special tests.

Ms BaCe reports no family history of mental or other medical illness. Her personal medical history is unremarkable.

Your examination confirms the features of a major depressive episode. She presents as an unkempt young person whose speech is soft and clearly slowed. Her affect is blunted. Her main concern is her cognitive difficulties. She tells you: 'Doctor, I just can't concentrate anymore. I hardly remember anything'. You find upon testing that her short and long term memory functions are clinically impaired, also affecting her orientation for time. She knows the current month but not the date nor the day of week. You also notice that her thoughts processes are slowed down considerably. She mentions that 'everything just feels harder'. She also says: 'I am worried about myself and I need your help'. You find no evidence of a current manic episode nor psychotic symptoms. Despite her mood and cognitive impairment, Ms BaCe's social judgement and insight seem to be intact.

Ms BaCe agrees with your assessment that she is currently severely depressed. She is of the opinion that psychiatric care and treatment will benefit her. She is desperate to get better, she says, and wants to be admitted to the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.12 Ms HuCe

Ms HuCe presents as a 19-year-old single female with no dependants. She is a student at a local university in her first year of study. She was brought to the hospital where you work presenting with noticeable symptoms of hypomania. Her roommate tells you that she struggles to sleep at night and is awake after three to four hours of rest. Her mood seems to be elevated. She is also irritable for no good reason. This is clearly different from her usual self. Her roommate says that she has become more talkative and that she talks much faster than usually.

Ms HuCe previously suffered a major depressive episode and took an antidepressant for six months on prescription of her general practitioner. She has no family

history of mental illness. She is not known to have a history of any other significant medical illness.

On examination you find features of mild grandiosity with her self-appraisal notably more favourable and her having much more confidence than usual according to her roommate. These features do not amount to delusions currently, and you find no psychotic features. Her thoughts objectively flow faster than expected in keeping with a flight of ideas and she is talkative with pressured speech. Despite this she is still able to organise and structure her thoughts and express them clearly. You also notice her restless behaviour during the interview.

Ms HuCe agrees with you that her symptoms (even the prominent cognitive symptoms) are mild but that it could potentially escalate. You plan to initiate treatment with an appropriate mood stabiliser. She is of the opinion that psychiatric medication and even hospital admission would be appropriate but only if her symptoms would worsen. She is of the opinion that she does not require treatment at present. She declines your prescription of medication, preferring to follow a 'spiritual route' in keeping with her culture.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based treatment with medication is legitimately declined or not applicable; or b) outpatient based treatment with medication should proceed by which suitable legal status?*

### 1.13 Mr HiSu

Mr HiSu presents as a 54-year-old divorced father of two adult children with whom he has no contact. He is currently unemployed and lives on the street sleeping rough. He is brought to the hospital by a district social worker who was concerned by Mr HiSu's behaviour. He is also accompanied by his estranged sister whom the social worker has brought along.

Mr HiSu was diagnosed with bipolar I disorder at the age of 18 years. His father was also diagnosed with bipolar disorder and his brother with an alcohol use disorder. Mr HiSu previously experienced a severe 'allergic reaction' to the mood stabiliser he was prescribed. He is not clear which medication this was, nor the details of the 'allergic reaction'.

His other medical history is unremarkable, and he denies the recent use of any psychoactive substances.

You find on your examination that Mr HiSu is talkative, and he hardly allows you to speak. Both his speech and thoughts are pressured. He is distractible during the consultation. He reports to you that he has been walking a lot and covered a vast distance by foot during the past week. As evidence, he shows you his feet that are clearly in a bad state. He also relates that he rather kept moving because people irritated and annoyed him wherever he paused during the past week. You find no features of a depressed episode and he does not seem suicidal during the current interview. He becomes irritated with you at times during the consultation, raises his voice, swears profusely, and gets out of his chair, especially when you seek further clarification or do not do immediately as he says you should. He also expresses his impatience with you trying to obtain his history, telling you 'you really are too slow for a !@#^\$&@ doctor'. Similarly, when you try to test his cognitive functions, he does not co-operate. He responds that he is exceptionally bright, and your testing would be too simple. On further questioning, he says, 'I am brighter than you or most doctors' and 'I will soon be famous for my brilliance'. He cannot qualify more details of his brilliance and imminent fame. You recognise that these thoughts constitute delusions of grandeur.

You find no other medical pathology on clinical examination that can explain his current symptoms. His toxicology screen is negative.

Mr HiSu says he knows that he is currently ill, 'the same #!\*&^!!@# problem my dad had!' He reckons he should be admitted to the hospital, for which he offers the evidence, 'just look at the #!\*&^!!@# state of my feet!' His sister however seems unconvinced and claims that he has exaggerated his problems since childhood. She does not think that he is ill at all, and she threatens with taking legal action against you if you proceed with admitting him to hospital. You want to admit him to hospital. The reasons are that you anticipate his condition getting worse living rough, and that it will be best to initiate his treatment under medical supervision. Mr HiSu agrees with the recommended plan.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.14 Ms BeCi

Ms BeCi presents as a 21-year-old whose family have brought her to the clinic with the view to get a 'tonic, so she can study better'. She says, 'life is getting too much' for her and she needs 'something to pick me up'.

On questioning she tells you that she feels 'very down' and that she no longer enjoys her life. She is tired all the time and feels that she does not have enough energy for all with which she is confronted. Her sleep is severely affected with initial, middle, and terminal insomnia. She has lost her appetite with subsequent noticeable loss of weight. Excessive feelings of worthlessness and guilt about 'failing her family' preoccupy her mind. Despite these feelings she denies thoughts of suicide or recurrent thoughts of death. She tells you, 'I struggle to concentrate and to remember things now, which makes studying hard, but I've been through this before and I've always survived'.

Ms BeCi was previously diagnosed with bipolar II disorder and used to take maintenance treatment that she discontinued six months ago. She is not known to use alcohol and cannabis or any illicit drugs. She drinks, however, a lot of coffee.

Ms BeCi reports a family history of bipolar disorder comprising two close family members who were diagnosed thus. Her personal medical history is unremarkable.

Your examination confirms the features of a major depressive episode of a severe degree. She presents as a poorly kempt young female with soft, slow speech. Her affect is blunted with little emotional flow. The tempo of her thoughts is slow, her thoughts lacked in detail, but she tells you: 'I know what I am doing'. She nonetheless expresses herself clearly and you understand what she means. You find no evidence of a current manic episode or psychotic symptoms. Despite her mood symptoms, Ms BeCi seems to have intact social judgement and insight, appreciating for example that 'my current state is no good for my family'.

In discussing the need for hospital admission, Ms BeCi agrees with your assessment that she is currently depressed and accepts that in-hospital treatment could benefit her. She however chooses not to be admitted to the hospital as her exams at the university are approaching. She believes that she will still be able to 'pull through' and successfully complete the exams if she 'just try harder'. She claims that she has been through 'tough times before and always pull through'. She is adamant in declining to be admitted to

the hospital at this stage, but is willing to receive treatment as outpatient.

*Concerning hospital admission specifically, apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.15 Ms QaBo

Ms QaBo presents as a thirty-six-year-old female at the emergency unit of the hospital where you work. Her partner has brought her there as he is concerned about her. The partner reports that they have recently started using cannabis recreationally and that Ms QaBo began to 'hear voices' about two weeks ago. This greatly upset them both as Ms QaBo was adamant that she was being 'bewitched' by unknown conspirators. Ms QaBo says these conspirators are plotting against her and that her life is in danger. Ms QaBo's partner reports that it became increasingly difficult to follow her conversations during the past week. She often speaks nonsensical and claims that the conspirators are 'out to get me'. She also claims that the conspirators are 'forcing ideas into my head'.

According to both her and her partner, Ms QaBo suffers from no serious chronic medical illness. Except for the cannabis she does not use any other licit or illicit psychoactive substances. Ms QaBo has no history of previous mental illness. She also has no family history of chronic medical illness, including any mental illness.

On mental state examination you find that Ms QaBo is orientated to time, place, and person. She sustains and shifts her attention and concentration appropriately, but you become aware of her severe thought process disorder. Her thoughts flow disjointedly with loosening of associations. She struggles to express her thoughts during the interview which often results in an incomplete train of thoughts. You find that her mood is euthymic. Her anxiety symptoms are related to her hallucinations and in fear of being 'bewitched' and persecuted. Both her short and long term memory seem unaffected.

You advise Ms QaBo to be admitted to the hospital as you are concerned about her safety on account of her acting out on her hallucinations and delusions. Her partner agrees with your recommendation, but Ms QaBo

is not convinced that this is the most appropriate course of action. She is unwilling to be admitted as she reckons that such an admission is part of the plan by the conspirators to have her killed. She is convinced of this, claiming as evidence that unwanted thoughts are being 'forced into' her mind.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.16 Ms Zala

Ms ZaLa, a 54-year-old female, is brought to your office by her spouse who is worried about her functioning at work and home. Ms ZaLa is a mid-level manager at a bank, holding a master's degree in accountancy. Three weeks ago, she stopped going to the branch where her office is located. There is no need to go into the office, since 'most of my tasks have been automated' and the rest, she says, is covered by 'my very competent team'. Her spouse says that her colleagues were rather relieved on her not coming to work as she had been acting strangely at work, not doing her assigned tasks properly, all posing risks to the bank and its clients. This contrasts with her usual standards of work quality, but her colleagues have been covering for her owing to their longstanding high regard for her. She was usually considered a highly motivated and efficient employee who outperformed her peers, evidenced by regular promotions of which the last was two years ago. Her spouse is concerned about her good reputation at work being tarnished at present. Also at home, she has progressively 'given up on chores' and if not reminded to take a shower or a bath, she would 'just neglect that too'.

Ms ZaLa has no personal or family history of any mental illness. Ms ZaLa confirms that she has been on treatment for hypertension for about 10 years, but no other chronic illnesses. Ms ZaLa is not known to use or abuse any active psychoactive substance.

You find that Ms ZaLa is awake and fully oriented in all spheres on mental state examination. You do not find any clear-cut psychotic symptoms. She also denies any depressive or (hypo)manic symptoms. You find her mood to be euthymic and no clinical features of a mood episode. Ms ZaLa also does not present with any significant features of anxiety. Her attitude towards you may be described

as somewhat indifferent, and her affect appears reserved. Her thoughts flow logically and are goal-directed. Her verbal responses are all to the point and very brief, often using a mere word, or a mere phrase rather than a complete sentence. She offers no details spontaneously and when prompted for these, not much is forthcoming. On testing her cognitive functions, she scores 30 out of 30 on Folstein's mini-mental state examination. She dismisses the concerns of her spouse and colleagues with a mere pulling her shoulders up slightly and saying 'whatever'.

You are concerned about a minor neurocognitive disorder and a potential cerebrovascular disease for which you recommend further investigations (even though you have found no current bodily signs other than moderate hypertension). Ms ZaLa is adamant that she is not willing to be admitted to hospital, but is receptive about doing further investigation as an outpatient as, she says, 'those would make sense...better to rule out bad stuff going on in your brain'. Her spouse pushes for a hospital admission as the expenses of further investigations would then be covered by their medical insurance.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.17 Ms QaBe

Ms QaBe presents as a twenty eight-year-old female at the emergency unit of the hospital where you work. She has been brought there by her partner who is concerned about her mental health. The partner reports that Ms QaBe has begun to hallucinate about three weeks ago. For example, she got annoyed with the neighbours for making derogatory comments when they were in fact not even at home. All has become worse since. Ms QaBe now also accuses him and the neighbours of using witchcraft against her. Ms QaBe's partner also reports that he finds it increasingly difficult to have any kind of conversation with her as she does not make sense.

According to both her and her partner, Ms QaBe suffers from no other medical problems. Her partner confirms she does not use illicit psychoactive substances. Ms QaBe has no history of previous mental illness. She also has no family history of chronic medical illness, including any mental illness.

On mental state examination you find that Ms QaBe is oriented to time, place, and person. She is rather incoherent and often responds with irrelevant content. Her thoughts flow disjointedly with loosening of associations. She struggles to express her thoughts during the interview and often leaves her sentences unfinished. You find her mood to be euthymic. Her memory and abstract cognitive abilities seem unaffected, but her concentration is impaired as observed in the 100 minus 7 test which she could not complete on her own.

You recommend that Ms QaBe be admitted to the hospital. Her partner agrees with your recommendation but, despite your concerted attempts, you find it rather impossible to uncover the view of Ms QaBe on admitting her. She has been going along with the consultation without resistance or expressing discontent, which also seems to be her stance towards the recommendation that she be admitted to hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.18 Mr QaBi

Mr QaBi is a twenty-five-year-old male who presents to your office worrying that he is 'losing my mind'. He reports that he started hearing voices of people he does not know without being able to see them. They speak about him in mysterious ways of which he says he is kept in the dark. He says, 'I do not know how they do it, but I know they are evil'. He reports they have become progressively more intrusive. Although they comment on almost everything he does, he says they do not tell him what to do and he would anyway resist and disobey such if they were telling him what he should do. He is desperate that they be stopped, as his own attempts at plugging his ears with cotton wool and even his fingers at times do not stop or even mute them a bit.

On further questioning Mr QaBi reports no mood symptoms. His anxiety is related to the experience of evil people that pose a mysterious threat to him. He has no additional features of any specific anxiety disorder. Mr QaBi reports no history or features of another medical condition. Mr QaBi also denies the use of any licit or illicit

psychoactive substance. You find no indication of such use on special investigation.

On your mental state examination of Mr QaBi you find that he experiences auditory verbal hallucination and poorly differentiated secondary delusions. His thought processes are logical and goal directed with no formal thought process disturbance. His mood is euthymic without significant anxiety symptoms. You also find no evidence of cognitive impairment.

You offer Mr QaBi a course of antipsychotic medication as per the local treatment protocol. Mr QaBi accepts your explanation of the rationale for the intervention and understands the treatment you've explained to him. He agrees to the treatment and arranges for a follow up visit.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment using antipsychotic medication is legitimately declined or not applicable; or b) treatment using antipsychotic medication should proceed by which suitable legal status?*

## 1.19 Ms HeRo

Ms HeRo presents as a 38-year-old mother of two children aged 8 and 5. She was referred to you from the oncology unit on account of her mood symptoms. The doctors at the oncology unit found that her breast cancer returned including evidence of liver metastases. They informed her of this six weeks ago.

She reports that she felt depressed for the past month. All joy 'has been sucked from my life', she says. She feels despondent about surviving the cancer, and overwhelmingly guilty of all the mistakes she has made in her life, and in particular for turning a blind eye to the wrongs her children have been doing. Her children will never overcome her mistaken ways of raising them, she says, 'they are doomed by the mistakes of their mother who now will fail in finishing the parenting job'. She also experiences a loss of appetite and disturbed pattern of sleep since the confirmation of the diagnosis, worrying about her children and her spouse getting on when so would not be there for them anymore. Her spouse mentioned to her that she had become short-tempered, impatient, and irritated about the slightest of unwanted events. She also tells you that some days she buries her sorrows under a deluge of energetic talking, trying to get

all together, but she ends up frustrated by her spouse and children not sharing her objectives. Her husband prefers sleeping instead of participating in crucial the discussions they should have regardless of it being night-time or not, she says.

She was previously diagnosed with bipolar I disorder and is still taking maintenance treatment. She has a family history of mental illness with a first-degree relative also diagnosed with a bipolar disorder as well as a history of death by suicide in the family. She was diagnosed with breast cancer two years ago for which she underwent the appropriate treatment and recovered.

On examination you find that her mood has been depressed for most of the time of most days during the last month interspersed with a few energetic but irritable days and nights. She presents currently with a depressed facial expression and rapid speech. She admits to multiple thoughts 'racing' through her mind, yet she remains logical and goal-directed in her thinking. You notice some restless behaviour during the interview. You find no psychotic features. Ms HeRo mentions in passing that she would be better off dead than subjecting herself, her husband, and her children to her current state. On enquiry, she admits that she has given it thought how she could end it all, but she is not willing to disclose which plans 'have crossed her mind'.

You are concerned about her suicide risk in view of the absence of mood stabilising treatment and her family history. You want to admit her to hospital to stabilise her mood with medication and to protect her against her suicide risk. Although she is less concerned about her suicide risk, she says 'I suppose someone with my family history poses a risk whether I want to know it or not'. Ms HeRo takes your point that hospitalisation and your proposed treatment plan are sensible courses of action at this point of time, agreeing to the proposed admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.20 Mr ZaLe

You have been requested to see 45-year-old Mr ZaLe, accompanied by his concerned neighbour. Mr ZaLe

had some training as a computer technician and is self-employed, usually helping people who get stuck with software problems on their computers. He has been complaining about his deteriorating state of health over the past few months. Mr ZaLe says his 'intestines are rotting'. He complains of indigestion, abdominal unease, noisy bowel sounds, excessive flatus, infrequent passing of stools and foul smelling stools. He consulted several gastroenterologists, but all their investigations were 'inconclusive'. Mr ZaLe was not assured by the findings at all. On the contrary, the 'inconclusive' findings have only re-affirmed that which 'I know has been developing for some time.... the worst'. He also expresses his frustration and anger with the doctors he has seen so far who are 'clearly negligent' or 'incompetent' in recognising his disease that is 'obviously running its fatal course'. His neighbour often brings him a meal, as Mr ZaLe claims that the poor state of his intestines makes it impossible to prepare a meal.

Mr ZaLe has no history of prior mental illness. He also raises no medical complaints other than the previously mentioned gastrointestinal symptoms. Mr ZaLe has no family history of serious medical or mental illness. Mr ZaLe denies the use of any psychoactive substances.

Mr ZaLe is non-revealing about his social functioning. It appears that he has very limited social interaction with other people except e-mail requests for help with software issues on their computers. He presents as a very skinny and unkempt male with long unwashed hair. Your mental state examination of Mr ZaLe finds him awake, alert and fully orientated. He has no signs of cognitive impairment, and he appears to be rather bright in keeping with the distinctions he obtained while at school. You find no evidence of any perceptual disturbance, nor of a formal thought disorder. You also find no evidence of a mood disorder. His thoughts are pre-occupied by his health worries most of the time during the interview and more or less all the time during the past few months.

Mr ZaLe rejects your explanation to him that various psychiatric disorders may explain his difficulties (including some caused by endocrine and cerebral diseases) and that hospitalisation on the psychiatric unit of the hospital is important for further investigations and finding potential treatment. He is adamant, however, saying 'my guts are rotting, not my head!'. Nonetheless, he is prepared to follow the advice of his accompanying neighbour who is strongly supportive of hospital admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.21 Ms HeVa

Ms HeVa presents as a 60-year-old divorced mother of three adult children with whom she has no contact. She is currently unemployed and homeless. She is brought to the hospital by a district social worker who has been concerned by Ms HeVa's behaviour in the community.

Ms HeVa was diagnosed with bipolar I disorder at the age of 18 years. Her father was also diagnosed with bipolar disorder and her sibling with an unspecified substance use disorder. Her medical history is unremarkable, and she denies the recent use of any psychoactive substances.

You find on your examination that Ms HeVa is very jovial, talkative, and difficult to interrupt. Both her speech and thoughts seem markedly pressured. She is distractible from time to time during the consultation with an intense interest in rapidly successive topics, her immediate surroundings, and everyone who is willing to listen. She reports to you that her levels of activity and energy have been 'fantastic' during the past week. Her mood was 'great' she says, but she was also irritated and angry at the 'clueless' people with whom she crossed paths during the past week. You find no features of a depressed episode and she does not seem suicidal during the current interview. She is both irritated and seductive towards you at times during the interview, exclaiming loudly, 'come on, have some fun, my cute sexy doctor!'.

You find no other medical pathology on clinical examination that can explain her current symptoms. Her toxicology screen is negative. You find no psychotic features, no cognitive impairment, and no suicidal risk of clinical significance.

Although Ms HeVa underestimates the extent of her affliction, she concedes that she is in a similar state when she was hospitalised in the past. However, she makes comparisons with those episodes from which you concur with her that she is not as ill as she was then. Ms HeVa and you concur furthermore that she can be treated as an outpatient re-introducing the medication that worked well in the past, and she says she know that it is important that

she should follow up next week. The social worker confirms that she has found her accommodation at a charity providing for homeless women.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based care is legitimately declined or not applicable; or b) outpatient based care should proceed by which suitable legal status?*

## 1.22 Mr WiGo

Mr WiGo, a 50-year-old male, presents at the emergency unit where you work. His friends have brought him, all coming from the same party. They inform you that Mr WiGo used 'tik' (methamphetamine) at the party a few hours ago.

Mr WiGo presents with a euphoric and excited mood. He is restless and paces incessantly in the unit. He seems suspicious of the bystanders in the unit, including the friends who accompanied him. They tell you that he is very different from usual. At the party, he was aggressive and shouting, and he smashed some furniture. They feared he would hurt someone.

According to his friends Mr WiGo has no history of mental illness. He also denies a prior mental illness or family history of mental illness. He has no history of chronic medical illness. He is known to take legal and illicit drugs on occasion.

On physical examination you find that Mr WiGo has a tachycardia with mydriasis. His blood pressure is raised, and he complains of chills.

On mental state examination you notice most strikingly Mr WiGo's elevated mood and psychomotor agitation. His speech is loud and rapid. His thoughts seem to jump from topic to topic, but he is still able to engage in conversation in an understandable and logical way. He reports having visual hallucinations of seductive half-naked people who wanted to undress him at the party. He says, 'I know those were not real, but I felt almost as if they were going to rape me'. You find no signs of a depressed mood or indications of a suicide risk.

After a few hours in the emergency unit and appropriate sedation, all his symptoms clear up and Mr WiGo wants to leave the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.23 Mr ZaLo

Mr ZaLo, who is a 45-year-old male, is brought to your practice for assessment and treatment by a representative of the employees' wellness program at the large company where he works, following complaints by the company's management. It is alleged that Mr ZaLo is 'making a nuisance of himself' by emailing and telephoning the chief executive officer of the company with 'unwanted and untoward advances of a sexual nature'. In response, the chief executive officer and her wife are contemplating legal and/or other disciplinary action against Mr ZaLo.

Mr ZaLo is surprised by the need for this consultation. He is of the view that his advances are welcomed by the chief executive officer as she is in love with him but that she is obliged to hide her true feelings in their working environment. He finds it offensive that anyone would think he would want to harm her reputation. Although she has never reciprocated his feelings directly or ever responded positively to his advances, he is resolutely convinced of her love. He sometimes feels disappointed that she does not respond in kind, but also understands her difficult position as CEO. He reports not harbouring any ill feelings towards the CEO or her wife. He has never threatened to harm either of them or himself. He denies feeling depressed or unduly anxious.

Mr ZaLo lives alone since his divorce 22 years ago. His marriage had lasted only 7 months when his wife left for another man. He has not had a serious relationship since. His parents are deceased, and his older sister emigrated more than 14 years ago. He goes to church every Sunday but is socially reclusive. He has worked for the same company that he joined shortly after graduating with a BCom-degree at the age of 24. His annual performance appraisals have always been satisfactory, but never exceptional. His financial circumstances are stable, but he has no reserves or savings, owing to the steep rent he pays for his semi-luxury apartment for many years.

You find no other psychiatric symptoms or signs on systematic enquiry. Mr ZaLo denies any chronic medical

illness. He also denies the use of any licit or illicit substances. Mr ZaLo has no family history of mental illness.

On mental state examination Mr ZaLo appears calm and fully oriented in all spheres. You find no features of delirium or dementia. All Mr ZaLo's cognitive functions seem fully intact. Mr ZaLo feels very embarrassed about being brought to you. He says his reputation is now 'shattered' at his workplace and feels humiliated such that he would have to resign. After resigning, the CEO would be free for them to have a relationship, and she would be supporting him financially when he is unemployed. Apart from some dysphoria about the current situation, Mr ZaLo does not display any features of a mood or anxiety disorder.

You advise Mr ZaLo of your intention to admit him to the hospital as you are concerned about his reputation and financial interest being at risk and that further investigations are needed, and potential treatment should be initiated. Mr ZaLo is not willing to be admitted to hospital at all, saying 'but there is nothing wrong with me, this is ludicrous' and 'this is all a misunderstanding, plainly because my love [that is, the CEO] is not allowed to go public'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.24 Ms HuBe

Ms HuBe presents as a 51-year-old married mother of two adolescent daughters. She reports a depressed mood for the past two weeks associated with sleep disturbance, a loss of pleasure in life as well as a loss of appetite. She experiences these mood symptoms with mild intensity. She also mentions noticeable weight loss but is not able to quantify this. She further mentions that she often feels 'confused', meaning that she struggles to concentrate. On questioning she denies any psychomotor abnormality and any suicidal thoughts and plans.

Ms HuBe's spouse informs you that she has an enduring need to be 'taken care of' over many years since her adolescence. She is unable to make even minor decisions without copious amounts of reassurance and advice from her spouse or children. She rarely disagrees with family members or friends, always wanting relationships to be 'smooth'. She is described as a 'people's pleaser' and will

often perform unpleasant tasks to feel wanted and liked. She is always concerned that her spouse or children will abandon her and requires frequent reassurance of their love and support. She usually defers to her spouse to make the 'important decisions in the house', which turns out to be most decisions.

Her past psychiatric history includes three previous depressive episodes without suicide attempts. Ms HuBe's medical and family histories are unremarkable. She avoids the use of any psychoactive substances as confirmed by her spouse.

You find that Ms HuBe displays features of a mild major depressive episode. She displays no features of a hypomanic or manic episode and no mixed mood features either. She displays no features of psychosis. Although she complains about her concentration her thought processes are clear, goal directed and logical. No cognitive impairment is found on objective testing. Her medical examination reveals no significant pathology. Although her social judgement is often poor, she understands that she requires treatment.

Ms HuBe agrees with your assessment of her mental state and wants you to help her. She is willing to do 'anything you say, Doctor'. She understands that you want to treat her mood disorder and is willing to follow up for psychotherapy with a registered clinical psychologist in your referral pathway.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based care is legitimately declined or not applicable; or b) outpatient based care should proceed by which suitable legal status?*

## 1.25 Ms SuKo

Ms SuKo presents as a 50-year-old female with a history of recurrent major depressive disorder as well as anorexia nervosa. Her family brought her to the hospital because she had complained of feeling depressed. They are very worried about her. They say she is severely depressed, and they are worried about her committing suicide. She has a history of one previous suicide attempt by overdose a few years ago.

Ms SuKo reports that she is feeling only 'moderately' depressed and does not 'enjoy life like I used to'. This has been so for the past month but has gradually worsened

during the past week. Her appetite has been poor for the past month, and she eats minimally. Consequently, she has lost significant weight with a re-emergence of features of anorexia nervosa. She further complains of not sleeping well. She tends to wake up after only two or three hours of sleep and then lay awake for most of the night. She feels 'dead tired' and listless during the day with little energy to attend to her daily tasks. Her lack of drive and impaired functioning have been noticed by both her employer and family. She says she is feeling worthless and guilty 'because I cannot cope'. She further says, 'I should not be alive if I am this useless'. She has been contemplating suicide by jumping off their high-rise building or from a bridge.

She also reveals that all is hopeless anyway, she is already dead 'inside' and all interventions would be futile. You try to convince her otherwise, as evidenced from her own history when she was depressed before, but she remains unreceptive and dismissive of such possibility in her case. She says furthermore that she noticed that both her family and employer are doing things behind her back, that they are against her, trying to work her out, and want her gone. She cannot substantiate this with events but that does not preclude it from being in fact the case as she knows it is.

Her family tells you in confidence that they are worried about her and especially her suicide risk. They confirm her lack of appetite and weight loss. They confirm that she became increasingly suspicious of them and have been avoiding and withdrawing from the family. According to them she is not able to work at present as she has little to no emotional drive and struggles significantly with her memory. They describe a clear deterioration in her functioning but that she, in their view, denies her symptoms and minimises her concerns.

She has a family history of mental illness with her mother diagnosed with major depressive disorder. Her mother subsequently died by suicide. The family does not 'want to lose her through suicide as well'.

She is not known with any medical complications as a result of her history of anorexia nervosa and a major depressive disorder. Your physical examination finds that she is currently clearly under-weight with muscle loss and weakness. She also displays neurological signs compatible with anorexia nervosa.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She

speaks softly and slow and displays a blunted affect. She is unkempt with little regard for her personal appearance. During the clinical interview she clearly struggles with her concentration and finds it hard to make decisions. She is unable to give a coherent history and description of her mental health difficulties. You find that her working memory and executive functioning are impaired on formal testing. Her abstract thinking and verbal reasoning are also distorted. You find no features of hypomania nor mania.

Ms SuKo disputes her family's assessment of her mental state. She does not comprehend their concern. She does not agree regarding being seriously ill but responds that 'I just need to pull myself together'. You want to admit her on account of her psychotic symptoms and suicide risk.

*Apply the algorithm for each of the following scenarios:*

- (a) *Although Ms SuKo does not agree with her family and you on the seriousness of her mental condition at this time, she says regarding the recommended hospitalisation 'do as you please, I won't resist' and 'whether admitted or not, it's futile anyway'. What will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*
- (b) *Ms SuKo is empathically against and unwilling to be hospitalised as it would be 'a waste of time and money' and 'futile'. What will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.26 Ms HeLa

Ms HeLa presents as a 50-year old single female. She is referred from her work's employee wellness program for an assessment. Ms HeLa is described as a shy person who has been employed at the same company for the past 20 years. She reached middle management level despite not being very popular with her peers and subordinates. She was offered a promotion to senior management level three months ago which she declined. Her supervisor noticed a concerning change in her behaviour ever since the promotion had been discussed with her. She is not productive as of late, postponing meetings and tasks almost as a 'rule of thumb'. Her supervisor also noticed a significant slowing of her thoughts and actions.

Ms HeLa tells you that she is very upset about the proposed promotion. She prefers things to 'remain stable and predictable'. She tells you that she generally distrusts people and that the promotion 'is too much for me' because it will 'place me under scrutiny'. She has always been sensitive to other people's criticism. She tends to shy away from relationships until she is absolutely sure that the person in question will like her. She counts only 'one or two people' as her friends. She has never had a romantic relationship as she finds this too daunting and anxiety-provoking. She fears being rejected or humiliated. She claims that she would 'rather be dead than be humiliated'. She tells you that life has become too much for her to bear and the pressure at work to perform 'at all costs' may just cost her life as life is not worth it. She also says that 'I am insignificant fish and rather limiting others at work'.

On her mental state examination, you find that she displays an irritable rather than depressed mood. She avoids eye contact most of the time and her speech is monotonous. Her thoughts are objectively slow, and she confirms a tardiness in her thinking. Despite this, she formulates her ideas coherently and succinctly. She is restless during the interview and struggles to sit still. She tells you that she has lost her interest in life and finds little enjoyment even in the things she used to enjoy. Her sleep is disturbed by both initial and terminal insomnia. Her appetite also decreased but her weight has remained the same. You find no other potential hypomanic or manic signs, nor any indication of psychosis. Ms HeLa's social judgement seems intact.

Based on her clinical presentation, you recommend that Ms HeLa be admitted to hospital on account of her suicide risk. She goes accord with your recommendation and is willing to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.27 Ms VeFa

Ms VeFa is a 30-year-old widow with no dependants. She came to consult you at your clinic for her routine chronic medication prescription and mentioned in passing that her partner passed away six months ago.

On your questioning she reports feeling depressed for most of the days since his death in a motor vehicle accident. She tells you that she lost interest in activities that she usually finds pleasurable. She considers these symptoms 'normal' following the loss of a loved one. She does not think that the symptoms are of severe intensity. On further questioning she also reports that she has no appetite, and she mentions insomnia. She lost around six percent of her body weight during the past six months. She finds this strange as she is also less active than usual. She reports, 'it is almost as if I cannot get going' and describes a loss of energy and drive. She thinks this is because she often wakes up during the night and is unable to sleep after four o'clock in the morning. She usually spends the time awake during the night thinking about her late partner. She also ruminates about her late partner during the day. Consequently, she struggles to think clearly at work and is unable to concentrate for longer than a few minutes at a time.

She previously developed a major depressive episode after her father demised, about ten years ago. She was treated with an antidepressant for a few months and remained well. Her medical history includes hypertension, dyslipidaemia and history of a peptic ulcer and polycystic ovarian syndrome. She has no family history of any medical illness.

On examination Ms VeFa presents with an objectively depressed mood and anhedonia. Her concentration and her memory testing are objectively impaired. You find that her speech is soft and slow, and her speech contents are devoid of detail. She presents with thought blocking at times. Her affect is blunted. You do not find features of psychosis. She denies any suicidal thoughts on direct questioning. Despite her cognitive symptoms and signs Ms VeFa is still able to reason and express her wishes clearly.

You find no indication of another acute medical illness that could explain her mood symptoms. Her chronic medical conditions are well-controlled on chronic treatment. You also find no indications of any substance use disorder.

Ms VeFa understands that you think she is ill, but she is of the opinion that her symptoms are to be expected following the death of a loved one and that she is not mentally ill. She thinks that 'people should not drink medicine for normal human experiences' and that 'to grieve is normal'. As Ms VeFa is not convinced, as you are, that she suffers from a major depressive disorder, she

does not agree to your recommendation of reinitiating her antidepressant medication.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based treatment with medication of her mood disorder is legitimately declined or not applicable; or b) outpatient based treatment with medication of her mood disorder should proceed by which suitable legal status?*

## 1.28 Ms ZaLi

Ms ZaLi visits your consulting room with the complaint that she is being pursued by unknown individuals. She noticed that cars unfamiliar to her were following her. She knows, she says, that random strangers and other people residing in the apartment block where she does, are being paid to keep track of her movements. Ms ZaLi cannot explain the reason for this as she is not an especially important person, and she has no enemies as far as she knows. She has become aware of these ongoing events during the past two months, and this is on her mind all the time, worrying her, 'what do they actually want with me?'. She is concerned that her family does not want to believe her, leaving her alone and exposed in this ominous situation. Her family encouraged her to consult with you as they think 'there is something wrong with me'.

Ms ZaLi denies any other psychiatric symptoms on systemic enquiry. She also denies the use of any licit or illicit substances. Ms ZaLi however complains of worsening headaches, dizzy spells as episodic numbness of her limbs. She has no family history of psychiatric nor other chronic medical conditions.

On clinical examination you find Ms ZaLi awake and alert. She displays no signs of impaired concentration or memory. Her executive functioning and abstract reasoning seem intact. Ms ZaLi's thought processes are logical and goal-directed. You can't find any indication of perceptual disturbances. Ms ZaLi's mood is euthymic. Ms ZaLi is anxious about the unknown intentions of the people who are watching her. She asks that you to please help her.

You advise her of your intention to hospitalise her for further investigations. She concurs with your recommendation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified*

by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?

### 1.29 Ms SeKa

Ms SeKa is a 25-year-old female who presents at your hospital office with the complaint that she 'is not feeling well'. She defaulted her usual treatment as she did not have money to visit her local clinic. She reports that she also 'anyway did not feel like following up there'.

Ms SeKa reports that she easily feels rejected and struggles to maintain long term relationships. Her mood rapidly alternates between feeling 'happy' and 'upset' even when she is well and using mood stabilising treatment. She often experiences episodes of intense anger which her family and clinical psychologist ascribed to her temperament. She has experienced feelings of chronic emptiness and boredom since adolescence. She mentions a pattern of self-injurious behaviour when she becomes upset or agitated during which she would cut or burn herself 'to cope with how I'm feeling'. Lately she started contemplating ending her life and wonders 'who will miss me if I do it?'. She denies a definite suicide plan and has never attempted suicide in the past. She does not reckon that she would be severely mentally ill. She wants you to re-prescribe her usual medication.

Ms SeKa's sister, who accompanies her to this visit, tells you in confidence that the family is quite worried about her well-being. In their view Ms SeKa is often not truthful with her treating clinician. They think that she minimises her symptoms and problems and further think that she should be hospitalised. The family beliefs that she has a firm suicide plan and that 'it is bound to happen sooner rather than later'.

Ms SeKa is known with bipolar I disorder according to DSM-5 criteria and was using maintenance treatment. Her sister also suffers from a mental illness, but her sister's diagnosis is unknown to Ms SeKa. Ms SeKa is otherwise medically well with no history of any chronic or acute illness known. She does not use any psychoactive substances.

On examination you find her mood severely depressed with features of anhedonia. She reports hypersomnia as well as an increase in her appetite. Her affect is labile during the interview. Her speech is soft and slow. She mentions that she is often indecisive and struggles to focus

her thoughts or sustain her concentration. She is however able to formulate and articulate her wishes and to plan for the immediate future. She verbalises a preoccupation with her being guilty of promiscuous behaviour in the past, which affirms her worthlessness, she says. You find no current hypomanic, manic, or psychotic features.

Her medical examination is unremarkable with no signs of an acute or chronic medical illness. You find no indication of psychoactive substance use or abuse.

Her sister wants you to admit Ms SeKa to the hospital. They think that she is 'going to kill herself'. Ms SeKa does not agree with her family's assessment of the severity of her mood episode and her suicide risk in particular. You think she could benefit from hospital admission, and you are aware that treating her as an outpatient is subject to a suicide risk. You would have preferred admitting her, but in your assessment, you do not consider hospital admission an imperative. She makes it clear to you that she should not be admitted to the hospital. She tells you: 'I know I sometimes do silly things when I feel like this. Sometimes I spend way too much money. Or I fight and push people away which I regret when I get better. I know I can hurt myself'. She is however of the opinion that 'outpatient treatment will be fine'. She promises not to act on her suicidal thoughts.

*Her sister wants to know from you whether you could admit Ms SeKa to hospital against her wishes at this time. To answer her question, apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.30 Ms HeCa

Ms HeCa presents as a 20-year-old single female with no dependants. She is a student at a local university in her second year of study. She came to consult you on account of worrisome mood symptoms. She reports that she feels 'different from usual' and that she feels overwhelmingly both excited and irritable for no apparent reason. She has been intensely aware of this during the past five days. Ms HeCa had to submit on a number of assignments and experienced much pressure to complete these. She took to drinking energy drinks to help her stay awake and work. To her relief, she progressively needed less and less sleep than usual. Her thoughts are pressured, 'as if they

are racing through my head'. Her roommate complained that she talked excessively and at times so fast that the roommate could not follow her.

She is not known with a history of any other significant medical illness. She has never been diagnosed with any mental illness. She has a family history of a brother who was admitted to a psychiatric hospital when he was her age eight years ago, but she does know the details or his diagnosis.

On examination you find features of mild grandiosity including her being boastful, over-evaluating her own importance and successes, all expressed with unwavering confidence. You do not find that this grandiosity is of delusional extent, nor other features of psychosis. Clinically her thoughts flow fast with pressured speech, but she is still able to organise and structure her thoughts and express them clearly. You also notice her restless behaviour during the consultation.

Ms HeCa agrees with you that her symptoms are mild but that it could potentially escalate. She concurs that psychiatric medication could benefit her, and she is prepared to take the medication that you prescribe. She is prepared to arrange for a follow up visit and undertakes to contact you, should her symptoms worsen.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based medical treatment for her mood disorder is legitimately declined or not applicable; or b) outpatient based medical treatment for her mood disorder should proceed by which suitable legal status?*

### 1.31 Mr SeFu

Mr SeFu is a 24-year-old male who is unemployed and lives with his parents. He visits you at your practice accompanied by his parents who are concerned about his erratic and irresponsible behaviour and the strange state in which he has been for the past eleven days. They report that he only sleeps a few hours per night and keeps them awake with his nocturnal activities. Mr SeFu has no psychiatric complaints and visits you to 'humour my parents'.

On history taking his parents inform you he is very talkative, seeking out conversations with everyone, even on the street with strangers, as if knows them all very well, even when they do not want to speak to him. He talks so fast that they often struggle to follow the train of his thoughts.

They are also taken by surprise when he casually reveals private details of his sexual activities. They have never seen him so confident but fear that he is taking too many risks. For example, he speeds off when departing from home with screeching tires, and 'heaven knows' about the risky sexual encounters he is talking about. He has spent all the money in his bank account and repetitively requests more money from his parents. He hardly works on any given task for more than a few minutes before being distracted both at the university where he studies and at home. He stopped going to class, saying the lecturers are too slow and boring. The parents report that he went out 'partying' almost every night, returning in the early morning hours. He then continues to play his music loudly without regard for them or the neighbours. He is sometimes intoxicated on his return.

Mr SeFu tells you that he is 'fine'. 'I have no problems', he says, '...and certainly not mentally ill'. He says his parents 'worry too much' and that they should 'live a little'.

Mr SeFu has a history of multiple failed relationships. His family reports that he becomes 'too clingy' which makes his partners feel uncomfortable. He is often afraid that his partners would abandon him. He often quickly falls deeply in love but would also become resentful and jealous of his partners, accusing them of infidelity. He would also become angry with his partners or parents for no good reason.

Mr SeFu has no history of other acute or chronic medical illnesses that would explain his mood symptoms. He admits to frequently drinking alcohol and smoking cannabis when at a party, but not when at home. This often (but not invariably) leads to intoxication.

On clinical examination you find that Mr SeFu is not intoxicated at present. He is fully orientated, euphoric, objectively agitated, hyperalert and hyper-aware of his surroundings. He struggles to remain seated during the interview, gets up every few minutes but responds to requests to return to his seat. Even when seated, he is on the move all the time. He has flight of ideas and his speech is rapid and loud. He struggles to focus on any one topic during the interview and continually seeks out yet another item of interest in and outside your office. He is very pleasant, even entertaining, and eager to please. You find no features of a depressed mood and he denies any current thoughts or plans of suicide. You can also not find any features of psychosis. His concentration is clearly

impaired, and he ridicules your attempts to get him to do the 100 minus 7 test.

Based on the severity of his mood episode and the risks it poses to his health and safety as well as his reputation, you recommend that Mr SeFu be admitted to the hospital. His parents concur and want him to be admitted. Mr SeFu at first says the admission could be fun, then he says he wants to go to a party too. He thinks hospitalisation is 'in principle OK, I suppose, at least it will give you some joy' as long as 'I can listen to music on my earphones'. He says further, 'I am easy, ...just go with the flow...hopefully it's not too slow...so I shall bow, tow and grow in delight without flight with your desire in sight'. He says 'my call is your call, or is it that your call is my call? Either way let's laugh about it – everyone is just too damn serious!'

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.32 Ms Sale

Ms SaLe is a 25-year-old female who presents to your office at the hospital where you work with the complaint that she is 'not feeling myself. I am not well'.

She defaulted her usual treatment as she 'felt like stopping it' and that she also 'did not feel like following up there. The people there annoy me'. Ms SaLe reports that she has suffered much rejection and struggles to maintain long term relationships. She says when she is happy, she is properly happy and when upset she is properly upset. There is no in-between for her, and it often changes instantaneously 'even before you see it coming'. Ms SaLe says she represents the rubbish of society and has been treated as such all her life. She often experiences episodes of intense anger which her family ascribed to her temperament. She was recently involved in a verbal altercation with her supervisor at work during which Ms SaLe threatened to attack her. The supervisor is contemplating legal action. Ms SaLe told her sister that she is going to 'to set that supervisor straight' when she returns to work.

Ms SaLe's sister, who has accompanied her to this visit, tells you in confidence that the family is quite worried about her well-being. In their view Ms SaLe is often not truthful with anyone including the doctors. They think that she puts up

a front, pretending as if her symptoms and problems are not that bad. They think that she should be hospitalised. Ms SaLe's sister does not think that she is currently suicidal.

Ms SaLe is known with bipolar II disorder according to DSM-5 criteria and was using maintenance treatment. Her aunt also suffers from a mental illness, but her aunt's diagnosis is unknown to Ms SaLe. Ms SaLe is otherwise medically well with no history of any chronic or acute medical illness. She does not regularly use any psychoactive substances.

On examination you find her mood has been depressed for most of the time during the last few weeks including features of anhedonia. She reports hypersomnia as well as an increase in her appetite. Her affect is labile during the interview. Her speech is soft and slow. She denies current thoughts of suicide, but she reveals that she often is rather impulsive. She often struggles to focus her thoughts and sustain her concentration, but she is still able to plan for her immediate future and act accordingly. She verbalises excessive feelings of guilt as well as worthlessness during the interview, but she says, 'I will deal with it as these are old issues'. The mood episode is of a moderate to a severe degree in your assessment. You find no current hypomanic or manic features and no psychotic features either.

Her medical examination is unremarkable with no other signs of an acute or chronic medical illness. You find no indication of psychoactive substance use or abuse.

You plan to admit Ms SaLe to the hospital to restart her treatment. Ms SaLe does not agree with your and her sister's assessment of the severity of her mood disorder. She makes it clear to you that she does not want to be admitted to the hospital. She is aware of the risks the current mood episode poses to her health, financial well-being, and reputation. She is of the opinion that 'outpatient treatment will be fine' and would like to arrange for a follow-up outpatient visit. Her sister insists that you admit Ms SaLe to the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.33 Mr FuKi

Mr FuKi is a 39-year-old widower with no dependants. He was brought to the hospital following a suicide attempt.

He reports feeling depressed since his wife's demise three months ago. This has become progressively worse, feeling low every day. He reports that he does more or less nothing because nothing interests at this time and has not been looking forward to anything. Quite the contrary, looking ahead and planning even for the same day has been too daunting to even attempt doing. He attempted suicide three times during the last three months since losing his wife. He reports his suicidal thoughts worsening over the past two weeks. He also reports that he has 'no appetite' and mentions that he suffers from severe insomnia. He lost seven percent of his baseline body weight during the past month on account of his poor appetite. He reports that he struggled to fall asleep most nights for the past three months. When he does manage to fall asleep, he is awake by 3 a.m., unable to sleep again. This leaves him exhausted and without energy the subsequent day during which he struggles to cope at work and his daily chores at home. He also mentions having a problem concentrating and his memory is impaired. He ruminates about the death of his spouse. He expresses significant feelings of guilt about not having been 'a good husband', and 'all the bad things I said to her'.

He previously developed a major depressive episode after his father demised, about fifteen years ago. He was treated with an antidepressant for twelve months and remained well. He discontinued his treatment after one year. His medical history includes hypertension, dyslipidaemia, and history of a peptic ulcer. He has no family history of medical or mental illness.

On examination Mr FuKi presents with an objectively depressed and irritable mood. His affect is blunted, and his speech is slow and halting. Mr FuKi displays significant impairment of cognitive functioning with slowing of his cognitive processes, indecisiveness, and ambivalence. You do not elicit any psychotic or mixed mood features. Mr FuKi's social judgement and insight into his current mental state however seem intact. You find no signs or symptoms indicating that his condition is the result of another medical condition or substance use disorder.

You want to admit Mr FuKi on account of the severe degree of his mood episode and a suicide risk. You have noticed that he struggles with some decision making during the clinical examination on account of his impaired processing speed and ambivalence that lead to significant indecisiveness. He does not see the link between his mood disorder and suicide ideation but assumed instead that the latter is an inevitable consequence of his current life

circumstance. He is however adamant that you must not admit him to hospital as he thinks this is not appropriate and necessary, because, he says, 'feeling guilty about your deceased wife is no reason for being admitted to hospital'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.34 Mr FeRh

Mr FeRh presents as a 40-year-old divorced male with one son. He reports feeling depressed after his most recent romantic relationship ended three weeks ago. He tells you that he has felt so bad that he again contemplates ending his life. He made a serious suicide attempt a year ago. The suicidal thoughts have remained since then, but he has not acted on them. Mr FeRh reports however that these suicidal thoughts have recently become more frequent, but he is not really that concerned about these.

His past psychiatric history includes features of a posttraumatic stress disorder related to a motor vehicle accident and an armed robbery that he experienced. He also has a history of the misuse of various substances. Mr FeRh's family psychiatric history comprises his father and brother suffering from an anxiety disorder.

He has no significant history of bodily problems. When exploring his substance use history, Mr FeRh reports that he binges alcohol on occasion and often smokes cannabis to help him 'relax and fall asleep'. He mentions using cocaine on occasion in an effort to improve his mood. He is of the opinion that the substances are not harmful to him and do not affect his mental functioning in any way.

On your clinical examination you find a severely depressed mood with anhedonia. Mr FeRh presents with a decrease of his appetite and weight loss. For the past three weeks he has slept even worse than before. He has noticed that he dislikes the company of others and is even more socially withdrawn than usual. He reports that 'nothing is worth anything and I don't know why I'm still carrying on'. You notice that he often returns to the thought of suicide as an escape from his feelings of loneliness and despair. From your interview with him, you realise that he frequently contemplates suicide, even if he is not fully aware of this.

You find no indications of a personality disorder or current psychosis. His thought processes are goal-directed, logical, and well-reasoned. He does not seem to have any form of cognitive impairment. You find no indication of another medical condition or the ill effects of any class of psychoactive substance.

You recommend hospitalisation on account of his mood disorder of a severe degree that includes a significant suicide risk. Although he disagrees with your assessment of the severity of the risk, Mr FeRh agrees with your opinion that he requires care and admission. He is willing to be admitted and does not oppose inpatient psychiatric care.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.35 Mr HeKa

Mr HeKa presents as a 20-year-old single male student in his first year of study at a local university. His friends have brought him to the hospital where you work. They report a persistently elevated mood, pressured speech with grandiose ideas for the past two weeks. He denies any mental health concerns. He also has no family history of mental illness. He is not known with any other chronic medical condition.

On examination you find features of grandiosity in his self-appraisal of his history and current activities, but these do not amount to delusions or any other signs of psychosis. The tempo of his thoughts is faster than usual, but he is still able to organise and structure his thoughts and express them clearly. You also notice his restless behaviour during the interview. His friends report a decreased need for sleep and an increase in his goal-directed activities and energy but with less productive output. They have lately experienced him as rather insensitive and even offensive, yet he generates a pleasant and cheerful atmosphere.

Mr HeKa confides in you that he has not been feeling 'himself' for the past week despite the 'thrill' and increased energy during the last few weeks. It is like not reaching the experience of joy when doing pleasurable ('fun') activities. He feels guilty that he 'was too frank with my friends about their oddities and shortcomings'. He is worried that he damaged his friendships for ever. It has crossed his mind

several times during the last few weeks that 'people might be better off without me'.

His friends also report that he was very different a few months ago when he avoided them and everyone, was socially withdrawn, and slept for most of the day. At that time, he was 'thinking too much', they say, and that he remarked being hopeless in his studies and his life being in 'deplorable state'. These symptoms gradually changed over time without a medical intervention.

Upon your explanation, Mr HeKa understands and accepts that his condition may get worse and that it is important that he gets help to prevent this from happening. To this end, he decides to follow your recommendation that psychiatric medication may help preventatively as well as remedy his current difficulties.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based medication treatment is legitimately declined or not applicable; or b) outpatient based medication treatment should proceed by which suitable legal status?*

### 1.36 Ms SaNe

Ms SaNe presents as a 53-year-old female with a history of recurrent major depressive disorder and a panic disorder. Her family brought her to the hospital because she had complained of feeling depressed and they were worried about her.

Ms SaNe reports that her mood has been 'moderately' low, and she can't recall the last time she enjoyed something. She admits that she has been sleeping poorly. She tends to wake up after only two or three hours of sleep and then she lays awake for most of the night. She feels 'dead tired' and listless during the day with little energy to attend to her daily tasks. Her lack of drive and impaired functioning were noticed by both her employer and family. She has been on sick leave for the past three weeks.

Ms SaNe has felt worthless and guilty 'because I cannot cope'. She has come to the conclusion that 'I am hopeless' and 'it takes too much effort to live'. She says she is worthless and not worthy of any help. Any effort spent on her would be a waste as it is bound to fail, she says. There is no other possibility of failure in her case since she is destined to fail, she maintains. Attempts to help her, medical or otherwise, are also so destined. She says that her ancestors have irrevocably determined her failure,

which is now 'finishing me off'. She says, furthermore, that she understands why her family and her employer turned against her, since 'no one wants a failure like I am'. Regarding recent panic attacks, she says, 'there is nothing to panic about anymore, all is done and dusted, ...history'. She dismisses thoughts of suicide, saying she does not have the 'guts' for that, and that would require effort that she is 'dismally lacking too'.

She has eaten almost nothing during the past month and lost a lot of weight. Her family is very worried about this. They confirm that she has been hostile towards them, pushing them away emotionally and withdrawing from them. She does not do any chores at home and is washing herself and brushing her teeth only when they supervise her. They also relate that Ms SaNe dismissed any suggestion that she was ill and needed help. In fact, they had to force her to come and see you today.

She has a family history of mental illness with her mother who had problems with depression. She is not known with any other medical illness. Your physical examination reveals that she is mildly dehydrated, under-weight with a BMI of 16.5, and having an unpleasant body odour.

On mental state examination you find her mood to be severely depressed with prominent anhedonia and mood-congruent delusions. She speaks softly and slow and displays a blunted affect. She is poorly groomed with apparently no regard for her personal appearance and hygiene. During the clinical interview she struggles to concentrate and finds it hard to express herself. She presents her history in an inchoate and chronologically confused way. On testing, her short-term memory, executive functioning, concentration, and abstract thinking are impaired.

Ms SaNe says your proposed hospitalisation is suitable for someone who is ill, and she is not. She will not 'just go along' with hospitalisation and she insists 'being left alone' instead.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.37 Mr HaSe

Mr HaSe presents as a 23-year-old single male who is experiencing a relapse of his mood symptoms after

defaulting treatment. He is known with bipolar II disorder according to DSM-5 criteria. He stopped taking his medication for the past month owing to experiencing erectile dysfunction that he attributed to his medication. His family noticed that his mood was elevated with a significant increase in his energy for the past four days.

Mr HaSe denies any other significant medical history or the use of psychoactive substances. You find no indications of either on physical examination. He was diagnosed with bipolar II disorder a year ago for which he was hospitalised at the time.

On mental state examination you find that he is distractible during the interview, but he nonetheless contributes constructively. He reports an excited mood with a decreased need for sleep for the past five days. His speech is somewhat pressured, and he says his thoughts are highly charged with energy and creativity. You do not find any formal thought disorder, psychotic symptoms, or significant impairment in cognitive functioning.

Mr HaSe recognises that he is in a different state from the usual and he is concerned that he may develop the same problems and turmoil he experienced a year ago. He does not want a recurrence of these and does not want to end up in hospital again. His parents reckon it best that he be hospitalised, but he declines hospitalisation. Instead, he proposes that you prescribe him medication (as long as it is not the same as his previous prescription). He is prepared to follow up as an outpatient at your office.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment with medication as an outpatient is legitimately declined or not applicable; or b) treatment with medication as an outpatient should proceed by which suitable legal status?*

### 1.38 Mr MaFe

Mr MaFe is a 40-year-old male who is admitted to the neurology ward of the hospital where you work. Owing to your interest in psychiatry, your colleague consults you to assess Mr MaFe's mental state and to assist in treating him. Your colleague is particularly concerned about his suicide thoughts. Mr MaFe was admitted a week ago with what looked like an epileptic seizure even though he is not known to suffer from epilepsy. During his stay in the ward the medical team noticed that his sleeping pattern

was fragmented and that he required less sleep. He had been restless and agitated but this state changed three days ago when he became mute and immobile. Initially the tempo of his thoughts had been fast evidenced by pressured and rambling speech. Before turning mute, he had been emotionally labile with strong emotional responses to rather ordinary events in the ward, oscillating between tears of joy and sorrow. The colleague reports to you that Mr MaFe mentioned thoughts of suicide when he was still talking.

The family who regularly visits him informed the team that he was diagnosed with a 'bipolar disorder of sorts' in his twenties. They do not think this is relevant to his current condition as he 'has been doing well' for many years 'because they prayed for him'. They had noticed a change in his behaviour, crying for apparently for no reason, four days before he was admitted to the hospital.

Mr MaFe has indeed been well for many years according to his medical history. He is not known with any chronic illness except the (unspecified) bipolar disorder. He has had no major surgery. Mr MaFe is known to frequently drink alcohol. He sometimes drinks to the point of intoxication. His family reports that his alcohol intake steadily increased over the past year. They are not aware of any other drug use. You find no indication of a substance use disorder on special investigation other than elevated liver enzymes. Neurological investigations revealed no lateralising pathology and no lesions on a brain CT-scan.

On mental state examination you find Mr MaFe lies still and speechless in his bed. He is nonetheless awake and alert, without clouding of his consciousness apparent. He speaks minimally to you but when he does speak, it is in no more than single words expressed with a low and soft voice. He often does not respond verbally at all, nor does he use any hand or other gestures. He seems reluctant to communicate or engage with anyone. He presents with a blunted affect and does not display any emotion. He rarely makes eye contact with you during the interview and lies with his eyes staring at nothing. You notice that he lies in an unusual and uncomfortable position that he maintains throughout the interview. On prompting him about his mood, he responds, 'down'. During the interview the tempo of his speech is very slow, and his thoughts are impoverished in content. He tells you that he wishes he were dead and that he would end his life if he could. He has a history of four previous suicide attempts in his early twenties, all of which were nearly fatal. His family does not believe that his suicide attempts were related to a mental

illness but attribute those to his faltering in his faith at the time. He has been resolute in his faith during the past years and for this reason, his family are not concerned about suicide at the moment.

You plan to transfer him to the psychiatric ward with the view to initiate psychiatric treatment there. While you are discussing this with Mr MaFe, he stares elsewhere as if you are not talking to him. Despite your best attempts, you remain in the dark about Mr MaFe's take on the recommended medication as his communication remains scant. His family reckons that psychiatric medication is not required. You and your colleague who consulted you are of the opinion that Mr MaFe requires psychiatric treatment and care urgently.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) transfer to the psychiatry ward is legitimately declined or not applicable; or b) transfer to the psychiatry ward should proceed by which suitable legal status?*

### 1.39 Ms HaMe

Ms HaMe presents as a 26-year-old single female student whose mood disorder relapsed after she had defaulted her treatment. She was previously diagnosed with bipolar I disorder according to DSM-5 criteria. She says that she discontinued the use of her medication a month ago as she saw no further need for it. Her mother says that she has become annoyed and dissatisfied with them and her friends. Unlike usual, during the last couple of weeks she has been very 'moody', 'disgruntled', 'scolding' 'argumentative', and 'even hurtful with little regard for the view and feelings of others'. Her mother also reports that she has become highly strung and on everyone's case for not performing in the ways that Ms HaMe expects them to perform. Ms HaMe is very unreasonable in these expectations but fails to see this. During the last week or so, she is always on her way somewhere, making multiple visits at several places every day, and incurring much transport expenses. Her mother wants her to be admitted to the hospital.

Ms HaMe confides in you that she got angry and almost drove into a wall, wanting to damage something and 'perhaps ending it all'. Her family remains unaware of this event. She denies any subsequent thoughts of suicide or death.

Ms HaMe was admitted to a psychiatric hospital twice before. She was diagnosed with and treated for bipolar II disorder. She reveals that she was suicidal when admitted the first time. Ms HaMe also has the family history of a death by suicide as an additional suicide risk factor. She denies any other significant medical history. She denies the use of any psychoactive substances. Your physical examination yields no indication of another serious medical condition or a substance use disorder.

On mental state examination you find that she is mildly distractible during the interview but that she is still able to participate in the interview. She reports a decreased need for sleep for the past four days and feels rested after only three hours of rest. Her speech is pressured, and she tells you that she 'needs to keep talking'. You do not find any psychotic symptoms or significant impairment in cognitive functioning despite these symptoms. Despite her experience that her thoughts are 'racing in my mind' they remain logical and goal-directed. She is angry at her mother as she thinks she is 'holding me back' by wanting her to be hospitalised.

Ms HaMe recognises that she is not well at present. She is concerned that she is beginning to relapse into a manic episode. Her mother is of the opinion that she is in need of hospitalisation, saying 'we should not take any chances'. Ms HaMe, however, declines hospitalisation as she is preparing for her university examinations. However, she is prepared to use the medication that you prescribe and to follow up as an outpatient at your office. You are prepared to treat her as an outpatient.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment with medication as an outpatient is legitimately declined or not applicable; or b) treatment with medication as an outpatient should proceed by which suitable legal status?*

### 1.40 Ms NePu

Ms NePu is a 45-year-old female who presents to you at a clinic, accompanied by her father. He wants your opinion regarding her treatment. Her father says initially to you, but it seems rather directed at Ms NePu, that he is concerned about her medication regimen owing to an allergic drug reaction she previously experienced on carbamazepine. Carbamazepine was prescribed as treatment for a diagnosis of bipolar I disorder. It transpires that her father

thinks she may have relapsed again. Her mood symptoms had been well-controlled until a month ago.

Ms NePu has a long history of alcohol abuse, often in the company of her now ex-husband. Ms NePu used to drink alcohol multiple times per week to the point of intoxication but since her divorce eight months ago, her alcohol intake has decreased, and she is now completely abstinent of alcohol. You notice no evidence of excessive alcohol use on physical examination.

Ms NePu tells you in confidence that she is cursed by hearing people talking to her at all 'ungodly hours', some who are unknown to her and others who are deceased relatives. These people are 'calling me to come to them'. She explains that their talking to her is made possible by a 'force' that entered her head and that is controlling her. She reveals to you that she is considering suicide as 'I can't cope with this all anymore'. They began harassing her about a month ago for the first time, she says.

You find on clinical examination that Ms NePu seems markedly depressed. Although rather vague, she seems mostly despondent regarding her employment and finding a partner again. Her affective flow is restricted. She reports a loss of enjoyment of most things for the past month and often feels listless. She stopped watching her favourite 'soapy' on television as of late. She lacks drive and energy to do most things to the point that she sometimes spends the day in bed, not turning up for work. Her employer threatened her with dismissal if she did not improve her attendance. You notice that her self-esteem is inflated and not in keeping with her current mood state. Her ability to concentrate as well as her short term memory are poor. Her sleeping pattern is severely disrupted with initial and terminal insomnia. For the past week she also experienced a decreased need for sleep. Owing to these factors her thoughts are slow and belaboured. Striking during the interview, thought blocking permeates all her thinking, meaning most of her sentences are incomplete, making it rather impossible for you to gain clarity on what her thought contents are really about. She reports a significant loss of weight over the past four weeks although she is not intentionally dieting.

You believe that Ms NePu suffers from a mood disorder of severe degree and requires hospital admission to mitigate against her suicide risk. She seemingly rejects your suggestion that she is seriously mentally ill and needs treatment. Instead, when you recommend hospitalisation, she responds with talk about where the 'force' would

be resident and on your more insistent prompting, she proclaims 'hospitals and schools are irrelevant to me and the force'. When you try to discuss medication, she laments that she 'can't think things through' because her thoughts are being controlled by the 'force'. She often responds, 'ask my father, he knows better'. Her father supports your recommendation of hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.41 Ms GaTo

Ms GaTo presents as a 76-year-old female. Her family is concerned about her and wants you to intervene. Ms GaTo tells you that her spouse suddenly passed away last week and that she has been overwhelmed by sadness since. She thinks about her husband all the time and dreams of him every night since his passing. They were married for fifty two years. She tells you that suddenly there is a huge gap in her life, so much so that it feels as if very little remains. She cannot imagine her life henceforth, she says, 'all of a sudden the tallest of walls has appeared between me and tomorrow' and 'I am very scared of whatever goes on, if anything, on the other side of that wall'. She reports of uncontrollable 'waves of crying'. It helps when she is not alone, she says, especially when her adult children and grandchildren visit.

On questioning Ms GaTo tells you that she gets up several times during the night, but this is her usual pattern she shared with her husband, having a cup of tea together. Although her appetite is somewhat diminished, she has been eating as she routinely does. Although she wishes she could be with her deceased husband, she denies any thoughts of suicide.

Ms GaTo has no medical history other than 'high cholesterol' and her physical examination is unremarkable. She is not known to misuse any psychoactive substance. She has no personal or family history of mental illness.

On the mental state examination, you find her a pleasant, well-dressed elderly lady who engages in conversation with ease. She maintains appropriate eye contact and speaks spontaneously in a clear voice. She is clearly tearful when speaking about her husband. Her

thought processes are not impaired. You elicit no signs of hypomania, mania, nor psychosis. Her cognitive functions are all intact and she denies typical anxiety symptoms other than feeling apprehensive about the future without her husband.

Ms GaTo is of the opinion that she does not require any treatment. She came to consult you to satisfy her children. She says she will need time but supposes that she will improve without medical intervention and that 'things will be okay'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) a medical intervention is legitimately declined or not applicable; or b) a medical intervention should proceed by which suitable legal status?*

## 1.42 Mr SaKu

Mr SaKu presents as a 38-year-old single male without dependants. His family brought him to the hospital where you work. They report that he experienced much sadness, excessive worrying, and a lack of interest during the past two months. He withdrew from them and expressed feelings of hopelessness and despair. They found him to be restless at times.

He reports being very worried and not sleeping well at all. He struggles to fall asleep and when he managed to fall asleep, he would awaken in the early morning hours. Unable to sleep during the night, he would walk around aimlessly and worry about everything. He also says he lacks energy during and procrastinates endlessly. He says, 'I don't feel like doing anything'. His appetite has increased, and he has gained weight. Mr SaKu confides in you that he has recently begun to contemplate suicide, saying 'I wish I could end it all and just rest'. He expresses the view that his family will be better off without him. Despite these symptoms, Mr SaKu comments that 'things are not as bad as they think' and does not accept that he may be mentally ill.

Mr SaKu has never been treated for a mental illness before nor is there a personal or family history of a suicide attempt. There is no family history of mental illness. His family is aware of his suicidal thoughts, having found a letter to this effect he recently wrote. They are consequently extremely worried as they have read in the popular press that this is a 'danger sign'.

Mr SaKu has no other significant medical history. He and his family deny his excessive use of psychoactive substances.

On your examination you find that Mr SaKu is well-groomed. His speech is monotonous and slow, lacking in spontaneity and substantive content. Mr SaKu struggles to formulate his ideas coherently and frequently abandons sentences halfway. He displays impaired concentration that affects the testing of his short-term memory. He seems objectively depressed with restricted affective flow. He rejects any discussion of the way forward, saying 'tomorrow is impossible'. You find no indication of hypomanic or manic symptoms. His thoughts are filled with anxiety and worry, mostly regarding imminent hardship and bad events happening to him, his family, and the country. He thinks all time 'what if this or that happens'. Although some of these anticipated events are extremely unlikely, Mr SaKu considers them differently, stating 'not so unlikely at all...I would not be surprised' and 'one should be prepared for all events'. His thoughts, however, do not amount to delusions. You find no indication of significant medical illness on physical examination nor any indication of excessive substance use.

Although Mr SaKu disagrees with his family's assessment of his suicide risk being high, he concedes that 'I have felt better before'. He is very doubtful about your suggested hospitalisation. He cites many worries about being hospitalised including the costs even if he or his family does not have to bear these; the efforts so incurred for his family, personnel at the hospital and for you; the watering of his plants at home; the feeding of his cats; etc. He is also very worried about making the 'right' decision at this time, and that he is 'likely to get it wrong once again'. He remains non-committal about hospitalisation, but it appears that he would not go against his family's wish that he be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.43 Ms HaLo

Ms HaLo presents as a 50-year-old single female. She consults you following the death of her partner six weeks ago. They were in a relationship for 20 years.

She reports to you that she is unusually irritable with racing thoughts. It feels to her as if her thoughts are 'shooting through my mind' and that she 'cannot keep up'. Her supervisor at work complained that she did not focus, got too easily distracted, and did not complete her tasks. Ms HaLo finds that she is more active but less productive than usual.

Ms HaLo tells you that she is very upset by the death of her partner. She says she generally distrusts people and that this was the only romantic relationship she ever had. She is aware that she is overly sensitive to criticism and tends to shy away from people unless she is absolutely sure that someone will like her. She counts only 'one or two people' as her friends. She says she lacks in self-esteem.

Ms HaLo was diagnosed with bipolar II disorder in the past. She used to take maintenance treatment but discontinued it six months ago because she 'felt well'.

On her mental state examination, you find that her mood is a bit elevated but markedly irritable. Although flight of ideas is apparent, no tangentiality is evident and she formulates her ideas coherently and succinctly. She is talkative during the interview with pressured speech but expresses her ideas clearly. She is restless during the interview and struggles to sit still. You find no other hypomanic or manic signs. You do not find any indication of psychosis. Ms HaLo's social judgement seems intact.

Based on the symptoms she described and signs you have found, you recommend that Ms HaLo start with a course of mood stabilising medication. She goes accord with you recommendation. The two of you agree on a follow up visit and that she will contact you if her symptoms should take a turn for the worse.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment in the form of mood stabilising medication is legitimately declined or not applicable; or b) treatment in the form of mood stabilising medication should proceed by which suitable legal status?*

#### **1.44 Ms SaFo**

Ms SaFo presents as a 23-year-old female student. Her father has brought her to the clinic where you work. Very worried about Ms SaFo, her father tells you that she was 'high' and 'behaving as if in paradise' for the past week or so. He also says Ms SaFo is short-tempered towards

everyone, 'terribly busy all the time', and hardly sleeps at all.

Ms SaFo tells you that she is busy with a 'very, very important secret project' and that she does not need to sleep until she has accomplished these successes in the waiting. She is hesitant to tell you 'too much details' as to maintain confidentiality and she is concerned about 'people who are trying to stop me'. She is prepared to attack and get those people out of the way of her higher calling. She intimates to you that she is 'a key player in South Africa' where she will 'solve all the big problems of the country and put it on an incredible trajectory'. She began to 'invest' a large part of her savings in the project but is unable to specify on what she spent the money. She says some people might not believe it, but she is 'the anointed One – spelt with a capital!'. Her father tells you that her self-worth is greatly inflated and out-of-character. He denies that she is politically active or in any position of authority. He also denies that anyone has been working against her.

Ms SaFo was diagnosed with bipolar I disorder two years prior to this visit during an admission to a public sector psychiatric hospital for two months. After discharge, she had used a combination of mood stabilisers, but she stopped taking these three months ago.

There is no family history of mental illness. Ms SaFo has no history of any other acute or chronic medical illness. She denies using psychoactive substances. This is confirmed by her father.

On examination, you observe most strikingly Ms SaFo's cheerfulness, her psychomotor agitation, hyperactivity, and continuous pacing. Her speech is highly pressured, and she dominates the interview in all respects, making it almost impossible for you to conduct it systematically. She interrupts you all the time, and most of your sentences remain incomplete. She speaks loudly, is excessively animated in her expressions and she uses superlatives and other adjectives in abundance. Her thoughts are replete with ideas grandiose in nature pertaining to her power and importance. She displays no signs of a depressed or anxious mood. Her judgment and insight are markedly impaired.

You find no evidence of acute or chronic medical pathology that can explain her current mood symptoms on physical examination. She tests negative for all psychoactive substances on special investigations.

Ms SaFo is very surprised by you recommending her admission to the hospital. She says you might have recommended surgery just as well, which would have been 'no less a surprise' and 'no less inappropriate'. She ridicules your expertise and judgment, asking 'can a professional get it so grossly wrong?' She accuses you of colluding with a strategy to 'silence me and to stop me from achieving extra-ordinary successes'. She views your recommendation as politically motivated. She is adamant that she will not be admitted to the hospital. Her father, in contrast, is gravely concern about her and is clearly anxious that she be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.45 Mr FuSo

Mr FuSo presents as a 28-year-old male with a history of feeling depressed persisting throughout each day of the past month. This is his first episode of a mood disorder. Mr FuSo complains of concentration and memory impairment and features indicative of anhedonia. He furthermore reports that he struggles to make decisions in his daily life. Because of his indecisiveness he is struggling to complete projects at work and his small business is struggling with a loss of income and at risk of closing down at this time owing to the lack of his input.

He tries to hide these symptoms from his family and friends, and he tries to avoid them as far as possible. He says there is no prospect of improvement, everything is in a downward spiral. He feels 'useless and incompetent in failing so spectacularly'. He denies any suicidal thoughts or plans. Mr FuSo reports that he has little appetite and lost 10kg during the past month weighing 72 kg now. He struggles to sleep every night and feels and exhausted and drained all the time. He reflects on his situation saying that he cannot deny that he is responsible for his dire situation. He knows, he says, that attributing this to a mental illness is simply a kind, but not quite truthful attempt to exonerate him for his actual failures.

Mr FuSo's sister who has come along to the consultation is not convinced that his situation would be so dire. She says, 'it cannot be that bad'. His behaviour is unacceptable in

her view and not fitting with their family values by which one should 'work hard and shine at all times'.

He has no history of any other mental illness, nor a family history of mental illness. Mr FuSo's medical history is unremarkable. He denies the use of any psychoactive substances, which is confirmed by his sister.

On examination you find that he is suffering from a severe degree of a depressive episode featuring marked psychomotor agitation and restlessness. The tempo of his thoughts is fast by his own admission as 'opposing thoughts are in perpetual battle all the time', meaning ambivalence in being 'indecisiveness about everything'. Mr FuSo presents with a restricted affect, but his speech is pressured and seemingly continues endlessly. His thought processes are circumstantial and over-inclusive, adding details of doubtful relevance continuously. His excessive talking is however void of emotional expression and expressed in a monotonous low pitched voice. Other than the agitation and pressured speech, you do not find other features indicative of a hypomanic or manic episode. You neither find psychotic symptoms.

On the strength of the severity of his symptoms and to protect his health and financial interests, you urge Mr FuSo to be admitted to the hospital. He is in two minds about the recommendation, and he cannot decide what the best course of action is. His sister is not convinced that he requires admission, but she is willing to do 'whatever is necessary to help him'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.46 Ms FuRa

Ms FuRa presents as a 50-year-old lawyer with a history of recurrent major depressive disorder as well as bulimia nervosa. Her family brings her to the hospital because she has been in 'bad state'. She has the history of one previous suicide attempt by overdose a few years ago. Her weight is currently stable, and she reveals no signs of bulimia nervosa at present. Ms FuRa describes her mood as sad and empty. For the past two months there is 'nothing' that she enjoys. She is awake for most of the night during the same time frame and often gets up at four o'clock

in the morning as she then 'gives up' on trying to sleep. She also mentions a lack of energy and drive. Her appetite is 'non-existent' she says, but her weight has remained unchanged. She also mentions that she struggles with her concentration and finds it hard to make decisions. Lately she has not gone to work, but even before, she avoided doing tasks, which is out of character for her, and which led to several complaints from her colleagues.

She has a family history of mental illness with her mother and maternal aunt diagnosed with major depressive disorder. A risk factor is her aunt who committed suicide about six months ago. She is not known with any other medical illness despite the history of bulimia nervosa. Your physical examination reveals no indication of bulimic behaviour nor other medical morbidities.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She verbalises suicidal thoughts during your interview. Her affective flow is blunted and her speech soft and slow. Her thought processes are congruently slow and belaboured. Her concentration difficulties and indecision are clearly apparent. You find no features of hypomania or mania.

Regarding her thought contents, she says, all the bad she did is on her mind most of the time, about which she feels very guilty. She says, 'I am a very, very bad person'. She is rather vague about what was so bad and what she did, but she discloses that she should be punished for this. 'In fact...', she says, '...the Universe is already punishing me, but it has difficulty finding punishment severe enough in accordance with the bad I did'. She reveals moreover that death would be too kind a punishment for her. On further prompting on whether she did something criminal or illegal, she replies, 'it is worse than that. I have ruined the prospects of good jurisprudence in all future court judgments in South Africa'. She is however not prepared to explain this to you, saying 'it's technical and I am too ashamed any way.'

Owing to the severity of her depressive episode as marked by her delusions of guilt among other symptoms, you are concerned about her being in this ill state, not only for the hardship that she is enduring, but also for the damaging effects on her occupational, reputational, and financial interests. Your recommendation that she should be admitted to hospital, however, is met with fierce objection. She says, 'you do not get it, do you!' and she dismisses hospitalisation and any treatment as inappropriate and useless for her problems.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### **1.47 Mr PoTa**

Mr PoTa, a 45-year-old male, has been brought to the emergency department by the South African Police Service. They apprehended him in a traffic road-block on suspicion of driving under the influence of alcohol. On inspection he reeks of alcohol.

Mr PoTa reports to you that he is feeling depressed and considers ending his life. He cannot face being arrested.

Mr PoTa has no history of any mental illness including any substance use disorder. He spent the evening with friends at a birthday party and admits to taking alcohol. He denies any chronic medical conditions. You find no evidence of a medical illness or substance use disorder on clinical examination.

On mental state examination you find that Mr PoTa is partially disorientated to time but orientated for place and person. He speaks with a slurred speech and the tempo of his thoughts is slow and unsteady. He displays no other signs of major depressive episode except those already mentioned. You find no indications of a hypomanic or manic episode, nor features of psychosis.

Mr PoTa insists on being admitted to the hospital as a mental health care user. He is of the opinion that it is not safe to discharge him in the care of the authorities. He points to his suicide risk.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### **1.48 Ms PeNi**

Ms PeNi is a 24-year-old female who presents to the clinic where you work for an opinion regarding her future treatment. She developed a skin rash owing to the use of carbamazepine for a diagnosis of bipolar I disorder. Ms

PeNi consulted a dermatologist who treated her condition with corticosteroid medication.

Ms PeNi has an eight year history of cannabis abuse. Ms PeNi smokes cannabis almost every evening, which she claims helps her fall asleep. She reports that she is not able to sleep without it. Lately she noticed that it does not help as much as it did before.

On clinical examination Ms PeNi presents with an expansive mood, racing thoughts and pressured speech. For the past week she has experienced a decreased need for sleep and rather 'goes out and party'. She tells you that she has had 'the best sex of my life' on multiple occasions during the past two weeks with different fellow students. This behaviour is out-of-character for her. She is not in a romantic relationship with any of these men. She does not consider this behaviour unsafe because she 'trusts them all'.

She also believes that she is 'the best student in class' even though she failed all her tests during the past month. You notice that her self-esteem seems grossly inflated. Her ability to concentrate is poor as is her short term memory on account of her distractible thoughts. Her thoughts are racing so much that she cannot order her thoughts coherently. You struggle to follow Ms PeNi's reasoning or to understand what she tries to convey to you.

Ms PeNi tells you in confidence that she, for the past week, had 'the most intense religious experience'. Although she has been religious since childhood, she has never experienced her faith in this way. Her experience is particularly 'wonderful' at this time, owing to spirits that have given her instructions and provided commending comments on her behaviour since last week. The spirits have assured her that she is 'a very special person'. At times she feels quite threatened by these spirits, as she cannot see them, and does not know their origins and hidden intentions.

You believe that Ms PeNi suffers from a mood disorder of severe degree. In your opinion she requires hospital admission and treatment to protect her against the danger her behaviour poses. She is aware that 'something is not right' (with her mind) but she is unsure whether this of importance at this time or whether she should rather follow the instructions of the spirits as 'they may be angels after-all'. If important to do something about 'something not being right' with her, she says she understands and accepts that hospitalisation would be a sensible way to

obtain help. However, she would rather that the spirits indicate whether hospitalisation is the course of action. She remains unclear on the decision of hospitalisation, seemingly awaiting guidance from the spirits, but does not resist when you tell her that you are proceeding with arrangements for admission. Her friend who had accompanied her, is supportive of hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.49 Mr FoVu

Mr FoVu is a 57-year-old widower with no dependants. He consults you at your clinic on the insistence of his brother who noticed the onset of mood symptoms since the demise of his partner six months ago. He is accompanied by this brother.

He reports feeling depressed for more days than not ever since his partner died. He tells you that he lost interest in activities that he usually finds pleasurable. He considers these symptoms normal following the loss of a loved one. He does not think that the symptoms are severe. On further questioning he also reports that he has no appetite, and he mentions insomnia. You calculate, based on his description, that he has lost around six percent of his body weight during the past six months as he does not eat as much as he used to. He finds this strange as he is also less active than usual. He says, 'it is almost as if I cannot get going', and he describes a loss of energy and drive. He thinks this is because he often wakes up during the night and is unable to sleep after four o'clock in the morning. He usually spends the time thinking about his late partner. He also ruminates about the loss of his late partner during the day. Subsequently he struggles to think clearly at work and is unable to concentrate for longer than a few minutes at a time.

Mr FoVu then reports that he does not really believe that his partner passed away although he attended the funeral with the family and friends. He tells you that he has been hearing his partner's voice talking to him for the past two months, giving him encouraging messages as well as commenting on his behaviour. He finds it strange that he also hears several other voices of unknown people in conversation about him with his partner's voice.

He previously developed a major depressive episode after his father demised, about eleven years ago. He was treated with an antidepressant for a few months and remained well till the death of his partner. His medical history includes hypertension, dyslipidaemia and a history of a peptic ulcer. He has no family history of psychiatric or any other medical illness.

On examination Mr FoVu presents with an objectively depressed mood and anhedonia. His concentration and his memory are impaired on bedside testing. You find that his speech is soft and slow, and that it is difficult to sustain conversation with him. He presents with significant thought blocking. His affect is blunted. You do not find mixed mood features. Mr FoVu denies any current suicidal thoughts. Mr FoVu is fearful of 'losing contact' with his late partner.

You find no indication of another acute medical illness that could explain his mood symptoms. His chronic medical conditions are well-controlled on treatment. You also find no indications of any substance use disorder.

You recommend hospitalisation owing to the severity of Mr FoVu's symptoms and the disruption his condition causes. In your assessment, he is severely ill. You propose treatment in the hospital. Mr FoVu considers hospital admission as unsuitable as he is not ill at all. He maintains his experiences are normal for someone who lost a loved one. He is fearful that treatment might make his late partner's voice 'going away and we will lose contact again'. He however defers to your and his brother's judgement regarding hospitalisation and treatment because he 'does not want to do anything wrong'. His brother supports the recommendation of admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.50 Mr FoSe

Mr FoSe presents as a 34-year-old male with a history of feeling severely depressed for the past month. This is his first episode of a mood disorder. A social worker has brought him to the hospital where you consult. She is concerned about his welfare and mentions that he has been in verbal altercations in the community, usually when in an intoxicated state. They are accompanied by his uncle.

Mr FoSe reports he is struggling to complete projects at work and his business is subsequently failing leading to financial strain. He reports feeling hopeless and worthless and began to withdraw from his friends and family. Mr FoSe reports that he has little appetite due to abdominal pain and nausea. He lost five percent of his baseline body weight during the past month. He struggles to sleep every night and feels chronically tired. He reports to you in confidence that he started drinking alcohol heavily during the past six months. Initially he used it to cope with his work related stress but recently he has found that it helps him to fall asleep. He denies any suicidal thoughts or plans. He furthermore complains that he struggles to make decisions in his daily life because of these symptoms. He tries to hide these symptoms from his family and friends because he does not want them to worry.

Mr FoSe's uncle reports to you in confidence that the family is against the social worker bringing Mr FoSe to you. They 'don't believe in mental illness' on religious and cultural grounds but the uncle says, FoSe only had a bit too much to drink on a few occasions. The family is of the view that he requires a spiritual intervention and not hospitalisation. The social worker became involved with him on insistence of his business partners who were concerned about his mental health and use of alcohol, which they felt jeopardise the business.

Mr FoSe has no history of illness and no family history of mental illness. He denies the use of any other psychoactive substances.

On examination you find that seems his mood to be severely depressed with psychomotor agitation. He presents with disorganised thoughts. This disorganisation adds to his indecision. Mr FoSe presents with a restricted affect, but his speech is rapid. He avoids any seriousness in the interview and shifts the topic by often posing rather frivolous dichotomous questions. Despite these symptoms, you don't find enough features in keeping with a full syndromic hypomanic or manic episode. You do not find any psychotic symptoms.

On physical examination you find signs indicative of alcoholic hepatitis with right upper quadrant pain, tachycardia, and a tender enlarged liver. A blood test reveals hyperbilirubinemia with deranged liver enzymes.

Based on the severity of his physical and psychiatric symptoms and signs, you and the social worker urge Mr FoSe to be admitted to the hospital where you consult. His

response to your explanation about the serious nature and risks of his current state, is replete with tangential thought processes that end at the general negative state of social affairs among people. When pressured on whether he considers his state of health as being serious currently such that it requires hospitalisation, he responds: 'well, it is, and it isn't' and 'maybe it is, maybe it isn't'. Whether he agrees or declines hospitalisation, he remains non-committal, saying for example, 'I may agree now and refuse later, or perhaps it would be better that I refuse now and agree later'. He agrees that he is not sure what the best course of action would be. His uncle is adamant that he does not require admission and wants him to visit a spiritual healer instead.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.51 Ms ReBh

Ms ReBh presents as a 37-year-old divorced female with no dependants. She complains of a depressed mood and expresses suicidal thoughts following the loss of a romantic partner. She made a suicide attempt a year ago and has had suicidal thoughts (especially during emotionally taxing times) since then but did not act on these. Neither will she do so now, and hence she is not concerned in this regard.

Her past psychiatric history includes a panic disorder as well as a history of the use of multiple substances. Ms ReBh's family psychiatric history reveals that her mother has always 'been anxious' and her sister died by suicide 11 years ago.

She has no other significant medical history. When exploring her substance use history, Ms ReBh reports that she drinks alcohol irregularly but becomes intoxicated when she drinks. She usually smokes cannabis at night to help her 'relax and fall asleep, especially when I feel anxious'. She also uses a benzodiazepine. She is of the opinion that the substances are not harmful to her and do not affect her mental functioning adversely.

On your clinical examination you find features indicative of a mildly depressed mood with some anhedonia. She reports a decrease in appetite and weight loss of three percent of her baseline body weight. She also mentions

a change in her sleeping pattern in which her sleep is fragmented. She relates that she is more socially withdrawn than usual. She mentions that she has felt worthless ever since her partner left her. You notice that she often reverts to the thought of suicide as an escape from her feelings of loneliness and despair. You find no indications of a personality disorder or current psychosis. Her thought processes are goal-directed, logical and coherent. No cognitive impairment is evident, nor any other significant medical condition.

You recommend hospitalisation on account of severity of Ms ReBh's suicide risk, and with the view to introduce treatment in a more therapeutic environment. Although she disagrees with your assessment of the severity of her suicide risk, she is grateful that you recommend thus, and welcomes being cared for in this way at this difficult time in her life.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.52 Ms FoRe

Mrs. FoRe is a 71 female presenting with her first major depressive episode. For the past month, she reports an absence of any enjoyment in her life, and she tells you that it would be better 'for everyone if I was no longer here on earth' as she, in her estimation, 'is a waste of space' and 'in everyone's way'. Her sleep is disturbed by early morning awaking that leaves her tired and without energy during the day. Her appetite is also disturbed with a significant loss of weight. When you ask her opinion about how she makes sense of her current state, she says, 'Well, I have reached the end of my life. I have consumed it all. There is nothing left for me'. Then later she says, '...plainly, there is no sense by which to make of sense my current state'.

Mrs. FoRe's family corroborates her complaints from their observations. They brought her for consultation as they are concerned about her. They also mention that she is becoming increasingly forgetful. They find that she is unable to focus her concentration and that she struggles to make sense of new information. They further report that she often complains that she is worthless and 'no longer wish to be here'. They show you a letter she wrote

indicating her wish to die as well as thoughts of suicide. She currently denies such thoughts.

Mrs. FoRe has a family history of major neurocognitive disorder. Her medical history includes (currently uncontrolled) hypertension, dyslipidaemia, and a mitral valve replacement with atrial fibrillation several years ago. She underwent a hysterectomy 'many years ago'. She stopped using alcohol years ago but still smokes cigarettes on occasion.

On clinical examination you find that Ms FoRe displays features of a major depressive episode of a severe degree. She exhibits a significantly depressed mood with blunted affect and impoverished speech content. On questioning about her activities of the past month you find no activities in which she has taken an interest or enjoyed. You notice that her thought processes are extremely slow, devoid of detail, not always making sense, and somewhat incoherent. As reported by her family, she is unable to process new information or to evaluate the importance and value of such information but rely on a few, well-worn ideas about herself and about the world around her. Her ability to think coherently is impaired and she is also indecisive to the point of indecision. She displays marked psychomotor retardation. You do not find mixed or psychotic features on her mental state examination.

Your physical examination confirms the diagnoses mentioned during history taking. You find no evidence of substance related pathology.

You are of the opinion that Ms FoRe requires hospital admission to stabilise both her life-threatening mental and other medical conditions. Her family is very concerned about her suicidal thoughts despite Ms FoRe brushing these off. As there is 'nothing worthwhile to be concerned about', Ms FoRe thinks admission is unnecessary and would be 'a total waste' but she is prepared to go along with her family's wishes. Her family shares your opinion and wants you to admit Ms FoRe to the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.53 Ms PaNu

Ms PaNu is a 38-year-old female who presents to the clinic where you work for an opinion regarding her future treatment, wanting confirmation that she actually does not need to take medication anymore. Earlier this year she was placed on lamotrigine for a diagnosis of bipolar I disorder, but that promptly elicited an exfoliative skin reaction. Except for her dermatological concerns, Ms PaNu has no other bodily problems and no history of any other medical conditions. PaNu has no history of any substance use disorder.

On clinical examination Ms PaNu presents with an expansive mood, racing thoughts and pressured speech. She considers herself as the best worker at her place of employment despite two letters of warning in the past month. She presents with an inflated self-esteem, boasting keenly regarding her achievements. She tells you that she's had the 'most thrilling sex one can imagine' as of late of which 'I just can't get enough' and 'why not?' she asks rhetorically. She has found many willing men during the past two weeks at the local shebeen. She does not consider this behaviour unsafe because 'they are too good looking'. Her ability to concentrate during the interview is poor as is her short term memory. on account of her distractible thoughts. For the past week she has experienced a diminished need for sleep.

Ms PaNu tells you in confidence that she is blessed, as she has this new-found ability to hear people that other people cannot hear. Unlike other people, she can hear people who she cannot see and who communicate with her using 'mysterious or perhaps even magical means'. Some of those who communicate in this way are unknown to her whilst others are some of her deceased relatives. She considers herself to be 'a special vehicle' through whom 'the dead communicate with the world'.

In your assessment, Ms PaNu suffers from a mood disorder of severe degree that requires hospital admission and treatment by which to protect her wellbeing and reputation against the adverse consequences of her behaviour. She, however, does not agree with your assessment, and declines your proposed hospitalisation as 'I don't need it'. She is perplexed and offended that you even suggest it, for she says, 'I am blessed, not ill'. She decides not to stay for the hospital admission and prepares to leave your office. Her family is of the view that she requires admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.54 Mr PaGo

Mr PaGo, a 47-year-old male, was admitted three days ago to the nephrology unit of the hospital where you work. Your colleague, the medical officer working in the ward, consults you for a second opinion on the further course of action in terms of the MHCA.

Mr PaGo was informed of his diagnosis of stage four kidney failure two months ago. He has been in and out of the hospital since dialysis was introduced. Since his admission three days ago, his renal difficulties have stabilised. On your further enquiry, he tells you that he is feeling despondent and lost 'the joy in life' after learning of the diagnosis. His sleep is affected with a pattern of fragmented sleep during the night. He tells you that he is feeling so bad that he is unable to function at home or at work. He however denies any suicidal thoughts or plans.

Mr PaGo is known with hypertension and diabetes mellitus for which he receives the appropriate treatment. He avoids alcohol and other psychoactive substances owing to his impaired kidney function. Your physical examination and the results of special investigations confirm his medical conditions. He has no history of a previous mental illness.

On mental state examination you find that Mr PaGo appears sad. He engages well with you and converses with ease. His thought processes are clear, goal-directed, and logical. He seems to have enough energy during the day. His appetite is undisturbed. You don't find any evidence of cognitive impairment nor psychotic features. You cannot categorically rule out episodes of delirium at this time, although you find no clouding of his consciousness or disorientation during the last week.

You propose transferring Mr PaGo to the psychiatric ward for further assessment. Mr PaGo tells you that he does not want to be transferred to the psychiatry unit of the hospital. He claims that 'it is my right to decide whether I want to be admitted to the psychiatry ward or not'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the*

*information provided: a) transfer to the psychiatry ward is legitimately declined or not applicable; or b) transfer to the psychiatry ward should proceed by which suitable legal status?*

### **1.55 Ms FoKu**

Ms FoKu presents as a 47-year-old female brought to you by her family. Her family says that she is feeling lonely and unloved after her husband of 20 years has instituted divorce proceedings. Her family reports that she tried to end her life twice during the past three years and that they are concerned about her posing a suicide risk.

She admits to you that she harbours suicidal thoughts including a plan to overdose on her medication. She also reports that she is feeling depressed and that there is 'nothing worth living for'. She has experienced depressive symptoms for the past two years, but these have worsened during the last six months since her husband insisted on their divorce. In addition, she finds that she is more irritable than usual – unlike her usual interactions, she has had regular disagreements with her children and family. She was involved in altercation with a colleague that ended up by her pulling her colleague's hair. When asked regarding her expectations for the coming days and weeks, she says that thinking about this is too daunting and there is no way out. She is stuck and 'pathetically drowning in my own vomit'. She has no appetite and has lost eight kilograms during the past month amounting to ten percent of her baseline weight. She suffers from early morning awakening and is 'overwhelmingly' fatigued during the day.

Ms FoKu has no family history of mental illness. She is physically healthy and does not consume psychoactive substances at all. You find no indication of physical illness during your examination.

On mental state examination you find that Ms FoKu is clinically severely depressed with a blunted affect and depressed facial expression. She is tearful during your consultation. You have no reason to doubt her description of her subjective mood experience. She seems unreasonably irritable at times during the interview, does not initiate any communication spontaneously during the interview, communicates in very brief sentences, and is disinterested in communicating with you. You do not elicit psychotic symptoms or signs.

You strongly recommend that Ms FoKu be admitted to the hospital on account of the severity of her mood

episode and her suicide plan. On this recommendation, Ms FoKu is not convinced that hospital admission is really necessary, and she responds, 'I don't care, whatever... whatever happens, happens'. After you discussed the matter with her family (with her permission), they support her being admitted to hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.56 Ms NuRa

Ms NuRa presents as a 34-year-old female with a history of recurrent major depressive disorder as well as anorexia nervosa. She was brought to the hospital by her family because of their concern for her mental health. Ms NuRa reports a lack of energy and drive with poor sleep. She struggles to fall asleep and has been often awake during the night for the past month or so. She further mentions that her appetite is poor and that she eats less than usual, but her weight is currently stable with no signs of anorexia nervosa. Despite this she feels guilty and worthless, saying: 'I should not be alive'. She confides in you about her suicide plan that she devised during the past three weeks.

Ms NuRa works at one of the mobile telecommunication networks in the country as a personal assistant to a senior manager in the company. She explains that she has access to commercially sensitive information and that she works under high pressure to perform at her best at all times. Her boss sent her home about three weeks ago and instructed her to take some ordinary vacation leave.

She shares a history of mental illness with her mother who is also diagnosed with major depressive disorder. She has personal history of two serious suicide attempts during past depressive episodes.

She is not known with any medical illness despite the history of anorexia nervosa. Your physical examination yields no indication of any medical comorbidity. You also find no indication of any substance use disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She discloses to you that she hears several known voices of customers as well as employees of a competitor company have been bothering her since last week. They are intrusive

particularly at night when she tries to sleep. Ms NuRa is vague in explaining how these people can communicate with her in this way, except for saying that one of the competitor companies is 'messing with my thoughts' by way of 'cell phone technology'. She says that 'they are sending waves into my head' during the past three weeks. She is unwaveringly convinced of a conspiracy to attack her and the company she works for. She came to the realisation that these waves are so powerful that it even influences people with whom she is in contact. She tells you that she intends to end her life before 'they get me'. You find that her thought processes to be coherent and relevant without signs of disorganisation of her thoughts. Her concentration is poor on testing, but no other cognitive impairments are apparent. You find no features of hypomania or mania with your examination.

You want to admit Ms NuRa to the hospital on account of the severity of her symptoms as well as her declining food intake. She opposes your recommendation of an admission as she thinks that you are also influenced by the waves and that your recommendation is part of the conspiracy to 'have me removed'. She clearly does not want to be admitted to the hospital. She complains that the waves interfere so much with her thoughts that she simply cannot think what to do but she does not believe that she is suffering from any illness. She forbids you to discuss the matter with her family and does not want them involved as 'they are also influenced'. Her family wants her to be admitted to hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.57 Mr FiKu

Mr FiKu is a 37-year-old divorcee with no dependants. He was brought to the hospital by his brother following a suicide attempt. He reports feeling very depressed for more days than not since his wife left him six months ago. He attempted suicide five times during the last six months, and he reports his suicidal thoughts worsening over the past month. He also reports that he does not bother much about food, never feels like preparing it, and would just 'grab a can' from time to time. He has lost a significant amount of body weight during the past month. He suffers

from early morning awakening. This leaves him drained and without energy to cope with his tasks during the day. He also mentions having a problem concentrating. He ruminates a lot about his ex-wife and all the hurtful comments he made to her about which he feels very guilty.

He previously developed a major depressive episode after his mother demised, about ten years ago. He was treated with an antidepressant for twelve months and remained well since. He discontinued his treatment after one year. His medical history includes hypertension, dyslipidaemia, and history of a peptic ulcer. He has no family history of any medical illness.

On examination Mr FiKu presents with an objectively depressed and irritable mood. Although his affect is responsive, he takes a long time to respond, and his speech is monotonous. Mr FiKu displays significant impairment of cognitive functioning with slowing of his cognitive processing tempo, indecisiveness, and ambivalence. You do not elicit any psychotic or mixed mood features. Mr FiKu's social judgement and insight into his current mental state seems intact. You find no signs or symptoms indicating that his condition is the result of another medical condition or substance use disorder.

You want to admit Mr FiKu on account of his suicidal thoughts and the risk his past attempts pose. Mr FiKu hesitates in response to your recommendation of hospitalisation, saying 'I can't make up my mind' and 'I think too much'. He expresses much ambivalence as 'I see your point and I don't see your point – it changes all the time, I am hopeless. You ask too much'. About posing a suicide risk, his view (and vague planning) seems to vary from minute to minute. He also says he does not have the energy and desire to think about any next steps, as 'my head has been emptied'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.58 Mr NuKa

Mr NuKa presents as a 32-year-old computer soft-ware programmer. His family brought him to the hospital on account of his depressed mood and suicidal attempts. He

mentioned that he 'can no longer cope with the pressure of life'. He also mentioned that he often is in conflict with his mother and two siblings.

On questioning he mentions that he feels intensely depressed with loss of all pleasure or interest in life for the past month. His sleep is severely affected with initial, middle, and terminal insomnia. He subsequently has little energy and lost his drive to succeed at work. He also lost his appetite with subsequent noticeable loss of weight. He reports excessive feelings of worthlessness and guilt about 'failing his family and his employer' and 'all the bad things I've done'. He is afraid that he 'will be punished and made to suffer' and made two poorly planned and executed suicide attempts during the past week. In the first attempt he drank 'a handful' of 'all the pills I could find in the house'. He suffered no ill effects other than that the ingestion made him sleep for a few hours. In the second, he made superficial cuts across his right wrist.

He reports on further questioning that he finds that he struggles to remember what he reads or talks about on account of his poor concentration as well as significant memory impairment. He also struggles to make decisions for the past month. He describes how he struggles to grasp the information required to make decisions at work. For the past month he has been concerned that he would 'make a mistake because I can't think things through'. This had a significant impact on his performance at work.

Mr NuKa used to take an antidepressant that had been prescribed by his general practitioner, but he discontinued it six months ago. He is known to use alcohol and cannabis at regular intervals. He denies recent use of either of these substances and tests negative on special investigations.

Mr NuKa reports a family history of unspecified psychiatric problems on his mother's side of the family. His personal medical history is unremarkable.

Your examination confirms the features of a major depressive episode as reported. He presents as poorly kempt with soft, slow speech. His affect is restricted with little emotional flow. His thoughts were coherently organised but slow in tempo. You find no evidence of mixed mood features currently. When asked, Mr NuKa comments that a 'supernatural creature took over my thoughts'. He claims that this 'evil beast' is controlling his thoughts and actions, causing him to do 'bad things'. When asked about these bad things, he mentions 'evil and aggressive intentions, wishing my family and employer would die'.

He would rather end his own life than to harm them, he says. Mr NuKa's social judgement and insight seem to be significantly impaired in your judgement.

Mr NuKa feels so negative that he thinks inpatient care and treatment would not make 'much of a difference' despite you extensively explaining the benefits and the risks of in- versus outpatient care including protecting him from further suicide attempts and the risk to financial interest and reputation at work. He does not believe that either is indicated as his main problem is not a mental illness but the 'evil beast' controlling him. He comments that: 'It does not make sense that you admit me'. He says that dying is inevitable, and his end has come.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.59 Mr NiKu

Mr NiKu presents as a 55-year-old male. His family brought him to the hospital on account of his depressed mood and recent suicide gestures. He mentions that he 'can no longer cope with all the nasty people he has to deal with' and that 'life is not worthwhile, it's too much of a battle going nowhere'.

On questioning, he mentions that he feels intensely depressed with loss of all interest in life for the past month. He just remains in his bed for most of the day and keeps his cell phone switched off and put away in the drawer. He does nothing then and can't find the courage to do anything. He sleeps haphazardly 'for an hour here and 10 minutes there'. He can't say how much he sleeps in 24 hours, but says, 'I wish I could just sleep without waking up at all'. He lost more than 20kg of weight during the last three months. He reports feeling worthless, saying 'all has come to naught' and 'I made shitty choices as adolescent'. These choices he made then 'haunt' him several hours each day, and he feels guilty about these, saying 'horribly wrong decisions they were, that's for sure'. On enquiry about his concentration and memory, he says, 'no need for that no more'. His family informs you that he has neglected bathing, and all is in disarray and very dirty at home. The family says he mentioned a few times that he resolved to starving himself to death as he was 'too much of a coward to commit suicide properly'.

Mr NiKu is evasive about his history and his family responds, 'let the past stay in the past'. He denies recent use of psychoactive substances and you find no indication of the contrary.

Your examination confirms the features of a major depressive episode as reported. He presents as poorly kempt, with a smelly body odour. He comes across rather abrasively and seems disgusted about you and everyone. His affect is restricted to a disgruntled expression. He remains vague on the contents of his thoughts. Despite that you make much of an effort in eliciting his responses, he remains aloof and disinterested in the interview. You find no evidence of current mixed mood features.

Mr NiKu feels so negative that he thinks inpatient care and treatment would be of no help, saying it would be '@!#@% useless'. You recommend that he be hospitalised owing to the severity of the mood episode that requires urgent medical care and his self-neglected state. When urged to make a call on this, he says dismissively 'I am too f%# useless to agree or disagree – what the f%&\$@ ever'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.60 Ms FeMu

Ms FeMu is a 37-year-old female whom your colleagues are about to discharge from the oncology ward where she has been receiving treatment for stage IIIB mamma carcinoma. During the past week the staff noticed that her sleeping pattern has changed and that she needs less sleep. She also became restless and had more energy than before. Her mood became irritable, which was unusual for her. They noticed that she became more talkative, her thoughts proceeded rapidly from topic to topic, and they were perplexed by the absent or 'weird' connections between these topics.

Ms FeMu tells you that she feels depressed and despondent. She feels worthless on account of her medical condition and the chronic treatment she requires. She believes she failed her family because she is ill so often and cannot take care of her family as she would like to do. She longs to be back at home. She reveals to you that she seriously considers ending her life, and 'take a short-

cut' in the course of her cancer. In her mind, this would release her and her family of the 'terrible burden everyone is suffering' and it would 'free up the oncology bed for someone better than me'. She says, 'there is no alternative really'. The nursing staff informs you that the family is very concerned about her suicidal ideas, compounded by their experiences of a death by suicide in their family in similar circumstances.

Ms FeMu developed liver pathology on account of her chemotherapy. She often experiences pain and often requires opioid medication as treatment for the pain. She does not use any other psychoactive substances.

You find the signs described above on your mental state examination. Ms FeMu is a sickly looking female with mild jaundice. She presents with a blunted affect but rapid speech. Flight of ideas is evident. She appears agitated and struggles to keep track of the conversation. Her thoughts are coherent and logical at the time of your assessment. During the interview she tells you about the 'visitations' that she has been receiving. These are in the form of visual and auditory experiences of 'supernatural beings like ghosts or angels coming to me'. She hears these 'beings' calling her, sometimes giving her instructions. She says these 'beings' tell her that she is not 'worthy of being here and that I must die'. They are sure that 'my end should come now' and they are 'very convincing'. On prompting, she says that it is not 'as if' she receives these visitations. On the contrary, these beings insist that they be taken seriously.

You are concerned about Ms FeMu's suicide risk, but she does not agree that this would warrant concern. She is of the opinion that her imminent death by cancer, and not her mental health or suicide risk, is the 'undeniable reality' at this point. She is however unsure of the best course of action. On the one hand the 'beings' urge her to end her life but on the other hand she wants to be back at home and return to her family. The 'beings' tell her 'convincingly' that treatment won't work. She remains non-committal about your recommended hospitalisation but concedes that she will not resist the wishes of her family and your recommended course of action.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission for treatment and care is legitimately declined or not applicable; or b) hospital admission for treatment and care should proceed by which suitable legal status?*

## 1.61 Ms NeLu

Ms NeLu is a 69-year-old female presenting with her first episode of a severely depressed mood. She reports a loss of interest and enjoyment in life. She sleeps poorly, is awake several times during the night and is unable to fall asleep until the early hours of the morning. She eats less than usual and lost a significant amount of weight. Ms NeLu's family says she is becoming increasingly forgetful. Conversations are limited to brief interactions, and they cannot engage her in discussion or future planning. They describe her thinking as 'muddled and confused'. She has been communicating coarsely and her vocabulary has shrunk to a limited number of well-worn words. She used to be a dignified and decorous person. She was known in the community as a well-kempt person but lately she has not been taking care of herself, neglecting her personal hygiene and grooming.

Ms NeLu is accompanied by her husband of the past 35 years. Over the years, she has become dependent on him and would not 'cope on her own' or without his help. She always needs his advice and reassurance before she could make any decision. She never disagrees with his opinions. Her family recounts how she would allow people to take advantage of her. She would usually prioritise the needs of people at the expense of her own, even at times to her detriment.

Ms NeLu has a family history of major neurocognitive disorder. Her medical history includes hypertension, dyslipidaemia, diabetes mellitus, and a stroke three years ago from which she recovered fully. She avoids all psychoactive substances.

Ms NeLu presents as a dishevelled elderly woman. She seems agitated and restless during the interview. Her speech is soft and slow, and her responses are devoid of detail. She seems unhappy and withdrawn, with restricted affective flow. Her concentration is poor and short-term memory impairment is clearly evident. Her thoughts seem disjointed and do not always follow logically. At times you cannot decipher what she is communicating. There are no signs of dysarthria, aphasia, apraxia, nor agnosia.

Dominant in the thoughts of Ms NeLu is her concern about her brain that is 'rotten'. Most of her brain has died and is 'shrivelled', she says. She offers this an explanation for her poor memory and concentration. She has noticed an odious odour, but other people deny smelling it merely as an act of kindness and courtesy towards her. She knows,

she says, that the odour is irrefutable proof of her 'rotten brain'. You find no indications of hypomanic or manic symptoms.

You recommend that Ms NeLu be admitted to the hospital for medical assessment and treatment of her psychiatric symptoms for the sake of her health and dignity. Ms NeLu does not comprehend how hospital admission could be of benefit to her as her brain is already 'rotten and dead'. She is unable to tell you what she thinks the most appropriate course of action should be as she struggles to structure and verbalise her thoughts. She is however adamant that she will not be hospitalised as she only wants to be home with her husband. Being so adamant is out-of-character for her but she is unrelenting in this regard. Her husband tells both of you that he wants her to be admitted as, in his opinion, 'this is the care she needs right now'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.62 Mr NaRe

Mr NaRe presents as a 25-year-old male with a history of recurrent major depressive disorder with the background history of bulimia nervosa. He was brought to the hospital by his family because he complained of 'feeling depressed' for the past month. He mentions a disturbed sleeping pattern with a lack of energy and drive for most activities. He finds it hard to fall asleep and for the past month he often wakes up during the night. He also mentions that his appetite has changed and that he started to binge eat again a couple of weeks ago. He also began to exercise excessively as he had done before 'as a way to cope'. His weight remains stable for the moment. He feels guilty about the 'relapse' and worthless as he is unable to 'control myself'. He despairs that he will 'never get better and should just end it all'. He reports suicidal thoughts to you and his family.

He has a history of mental illness with his mother diagnosed with major depressive disorder. There is no family history of completed suicide.

He is not known with any other medical illness despite the history of bulimia nervosa. Your physical examination

also reveals no indication of any medical comorbidity. You find no indication of any substance use disorder.

His severely depressed mood, prominent anhedonia and mood-congruent psychotic features are most striking. He discloses to you that he began hearing several unknown people speaking to him one week ago. These people 'speak from nowhere' as he cannot see them. They reprimand him on his binge eating, and his body shape and size. He tries to counteract their comments by exercising excessively. Their comments are very upsetting even if he tries to ignore them. He has come to the recent realisation that he is the most unattractive male in the history of mankind. The unknown people criticising him 'day and night' insisted that he should stop denying this fact.

He verbalises vague suicidal thoughts but no specific plan during your interview. You find that his thought processes are slow and belaboured. He is still able to maintain his concentration during the interview and is able, albeit with difficulty, to participate in the conversation and planning of his treatment. You find no features of hypomania or mania.

Ms NaRe concurs with your assessment of the severity of his depressed mood and the need for hospitalisation. He thinks that he would be better off as an inpatient in the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.63 Ms FeCo

Ms FeCo is a 25-year-old female. She was referred to you for an assessment after an altercation with a colleague at work. Her aggressive outburst is out-of-character for her. During the interview she tells you that her mind is racing and that for the past ten days she feels restless. Her friends and colleagues also noticed that she is more active than usual, but she gets less done. She has excessive energy and does not need to sleep much. She mentions that during the past week she went on a buying spree for jewellery and other luxury items that she could not afford.

Ms FeCo was diagnosed with bipolar I disorder two years ago when she had a severe manic episode. This

required hospital admission. Although she improved, she explains that it was a 'terrible experience' and she vowed that she would never be admitted again. She used maintenance treatment for a few months after her discharge but discontinued it as she felt that she did not need preventative treatment. She also experienced one depressive episode at the onset of her mood disorder during her teenage years. The depressive symptoms gradually improved without medical treatment. Ms FeCo's sister was also diagnosed with bipolar I disorder.

Ms FeCo has no history of any other acute or chronic medical condition that could explain her manic symptoms. She is not known to use any psychoactive substances. You also find no other medical pathology on physical examination. She tests negative for all psychoactive substances.

On examination you find that Ms FeCo is energetic and restless. She hardly sits still during the interview. Her speech is loud and rambling, often not making sense. She displays flight of ideas expressed in rapid and pressured speech. Her mood is best described as expansive and euphoric. She feels 'on top of the world' and does not consider that she needs treatment. She cannot understand her employer's concern as she considers herself 'probably the best employee there'. She adds, 'perhaps he needs a proper 'klap' (that is, a slap) to recognise the job I do'. The latter evaluation does not amount to a delusion, however, and you find no psychotic features.

You strongly urge Ms FeCo to be admitted to the hospital on account of her being ill at this time and the consequences of her behaviour. Ms FeCo is not accepting that anything is amiss and that she requires treatment. She is dead set against hospital admission because she claims, 'the previous time was the worst experience of my life' and that she does not require admission because 'I am exceptionally well, and not ill at this time'. She is not willing to consider admission at all.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.64 Mr FaVo

You are asked to assess Mr FaVo, a respected elder in the community who is admitted to the hospital for treatment of his hypertension but who is due to be discharged after your consultation. Mr FaVo is known with bipolar I disorder. He tells you that he discontinued his treatment a few weeks ago but that he feels 'great'. He has no problems, he maintains.

The nursing staff however noticed over the course of the five days in hospital that he rarely slept for more than two hours per night. They report that he was talking excessively and so fast that they had much difficulty in following what he was actually saying. They struggled to keep him in the ward as he was forever wandering around in the hospital. Lately they found him flirting with fellow patients. One nurse relayed an incident of him indecently exposing himself to her.

Mr FaVo tells you that it is in his nature 'to be so friendly' and that he meant no harm. He does not consider his behaviour inappropriate. He claims he is well-loved and respected in his community and that 'people know how I am'.

Mr FaVo has no other chronic medical illness. He is not known to use any psychoactive substances. Your physical examination reveals that he is currently normotensive with no other medical pathology. You find no evidence of substance use disorders of any kind.

On mental state examination you find a slightly dishevelled elderly gentleman. He struggles to engage with you on account of his distractible thoughts, flight of ideas and rapid speech. His thought processes are not so impaired that he often fails to make himself understood. You notice how he acted impulsively and socially inappropriately on several occasions during the consultation. You find no depressive features and he is not a suicide risk. You similarly find no psychotic symptoms or symptoms of a major neurocognitive disorder.

You are concerned about the severity of Mr FaVo's current mental state. You try in vain to convince Mr FaVo that he requires admission to the psychiatry unit of the hospital, but he does not accept your arguments. He simply does not believe that he is currently mentally ill. He understands that you may think he is ill but insists that you 'just don't know me well enough' and that this is 'all just a

big misunderstanding'. He further insists on going home 'as the other doctor promised'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.65 Mr BhCe

Mr BhCe is a 30-year-old male, currently single with no children. He ended a long-term relationship three weeks ago after his partner had terminated her pregnancy. This led to him feeling low and 'hurting' a lot of the time. He says, all fun has been sucked out of his life and 'how can one enjoy anything when killing a baby is on your mind'. He pleads for help to make 'my pain bearable'.

On further enquiry Mr BhCe reports that his sleeping and eating patterns have changed. He now often wakes up during the night, thinking about the abortion. The lack of sleep and ruminations are 'ever-so exhausting'. He is still able to complete his tasks at work and no one complains about his functioning there. He complains that he lacks energy and motivation, stating that 'I do not feel like going to work' and 'I just wish I could take a break and rest'. He wants you to admit him to hospital for this 'rest'. Despite his lack of appetite his weight is unchanged. He denies any suicidal thoughts and plans on direct questioning. He admits to feeling guilty about the abortion as he is of the opinion that he 'did not do enough' to prevent it.

Mr BhCe has no other psychiatric history. He also has no family history of mental or medical illness. His own medical history is unremarkable.

During the interview with Mr BhCe, you find features sufficient to diagnose a major depressive episode. You find no mixed mood features nor psychotic symptoms. Notwithstanding that he experiences his depressed mood as extremely intense, you assess his disorder as being of mild severity. You do not find any indications of suicide risk during the clinical interview and assessment. No signs of substance use or abuse were present.

Although Mr BhCe insists on admission you do not consider this to be indicated and warranted. You offer Mr BhCe the option of outpatient counselling with or without antidepressant medication, but he declines this and says, 'It is either admission to hospital or nothing'. He moreover

threatens you, saying that you must admit him because the MHCA compels you to do so.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.66 Ms NaPo

Ms NaPo is a 53-year-old female who presents to the clinic where you work for an opinion regarding her future treatment on account of an allergic drug reaction to the use of carbamazepine for a diagnosis of bipolar I disorder. Her previous treating psychiatrist in private practice diagnosed her with 'manic depressive illness' in the 1990s and treated her with a combination of fluoxetine and amitriptyline for several years with good effect. In 2011 a doctor in the public sector added valproate as a mood stabiliser to her treatment following a manic episode. This led to an exfoliative skin reaction. Ms NaPo consulted a dermatologist who treated her condition with corticosteroid medication. Earlier this year she was placed on lamotrigine that promptly elicited an exfoliative skin reaction again.

Ms NaPo has a long history of alcohol abuse, often in the company of her now ex-husband. Ms NaPo used to drink alcohol in excess multiple times per week. Since her divorce eight months ago, she has decreased her alcohol intake. She now drinks alcohol mainly over weekends but denies that her intake is excessive or any alcohol related problems. She is still not completely abstinent of alcohol and her family remains concerned about its effect on her mental health. You notice evidence of excessive alcohol use on physical examination.

On clinical examination Ms NaPo is markedly depressed with a tearful affect and an unhappy mood. Her facial expression is restricted. She reports a loss of interest and enjoyment in most things for the past month. She lacks drive and energy to do most things to the point that she sometimes spends the day in bed, not turning up for work. Her employer threatened her with dismissal if she did not improve her attendance. She is not concerned about the threat as she believes that her employer knows her worth. You notice that her self-esteem is inflated and not in keeping with her current mood state. Her ability to concentrate is poor as is her short-term memory. She often

struggles to sleep and regularly wakes up during the night if she does fall asleep. For the past week she has experienced a decreased need for sleep. You notice thought blocking during the interview. The thought blocking prevents Ms NaPo to complete her train of thoughts leading to incomplete ideas and decisions. She noticed a significant loss of weight over the past four weeks although she was not dieting intentionally.

Ms NaPo tells you in confidence that she is bewitched. She has been hearing various 'spirits' of deceased relatives during the past week who are 'calling me to them'. She blames her neighbours for this interference by the spirits in her life, who bewitched her 'for no reason at all'. The spirits make it unbearable for her and she reveals to you that she is considering suicide as 'everything is getting too much'.

By your assessment, Ms NaPo suffers from a mood disorder of severe degree for which she requires hospital admission in containing her suicide risk and the risk her current behaviour holds for her health, safety, and reputation. She understands your explanation but is skeptical about being seriously mentally ill and requiring hospitalisation. She is perplexed by your recommendation as she believes the root of her problems is the neighbours' bewitching her. She says that she is not prepared to be hospitalised as she fears a re-emergence of adverse effects of the medication. She comes to this conclusion despite her struggling to consider the various treatment options owing to her thought blocking.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.67 Ms BhJe

Ms BhJe is a 24-year-old female who is single. She developed depressive symptoms after her family had 'forced' her to terminate her pregnancy. She is the mother of a two-year-old child from a previous relationship. Ms BeHj lives with her parents.

Ms BeHj reports to you that she often feels low but that she still enjoys her life most of the time. She feels sad and upset when she is with her parents because of the strained relationship between them. The pregnancy was not planned but she wanted to have another child. However,

her parents put her under emotional pressure to terminate the pregnancy. She reports that her appetite is somewhat less than before but that her weight is unchanged. She still dreams about being pregnant and since the termination, she struggles to sleep as well as she has done before. She often feels emotionally drained and without energy. She finds that her ability to concentrate and think is also mildly impaired. She however denies any feelings of worthlessness or guilt.

Ms BhJe has no history of prior mental illness. She has a family history of completed suicide with a much older cousin of her who passed away five years ago. Ms BhJe denies any suicidal thoughts and plans.

She presents with clear sensorium and is fully orientated in all spheres. She maintains appropriate eye contact and is mostly engaging. Her speech is normal in all respects. She seems sad with an appropriate affect. The relationship with her parents is clearly uncomfortable prior, during and after the consultation. She reports mild anhedonia since the termination of pregnancy a month ago. You find no evidence of hypomanic, manic, or psychotic symptoms. You find no indication of suicide risk during your assessment. Her cognitive functioning is intact on formal testing. You find no indication of other medical illnesses or substance abuse on your physical and mental state examinations.

Her family is concerned about her and says she is 'hiding her problems'. They are of the view that her problems are very serious, and they want you to admit her to the hospital for 'tests and treatment'. Ms BhJe understands her family's concern, but she disagrees that her problems would be 'so serious'. She is not willing to be admitted to the hospital but agrees to see a suitable clinician for psychotherapy as an outpatient. She is not willing to take an antidepressant. You are of the opinion that hospital admission is not crucial in the management of her condition.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA if hospitalisation is to be considered, that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.68 Ms BeNo

Ms BeNo presents as a 48-year-old female with a history of recurrent major depressive disorder. She was brought to the hospital by her family because she complained

of 'feeling extremely sad' for the past three weeks. She describes her depressed mood as 'being dead is better than feeling like this'. On questioning, she mentions a lack of energy and drive with poor sleep. She struggles to fall asleep and is for the past month often awake during the night. She further mentions that her appetite is poor and that she has lost about three to four kilograms. She admits to feeling guilty about what she did when she was in her early twenties, but she is not willing to disclose more.

She has a family history of mental illness. Her sister is also diagnosed with major depressive disorder. She and her family confirm to you that her mood disorder was treated successfully as an outpatient in the past. She is not known with any other medical illness. Your physical examination yields no indication of any medical morbidity. You also find no indication of any substance use disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She does not report any suicidal thoughts during your interview. She is still able to maintain her concentration during the interview and is able to participate, albeit with difficulty, in the conversation to plan of her treatment. She discloses to you that one week ago she began hearing several unknown voices 'calling my name'. She cannot explain the origin of these 'voices', but she finds these upsetting. You do not find any accompanying delusions. You also find no features of hypomania or mania.

You want to admit Ms BeNo to the hospital as that would allow for an optimal therapeutic environment in which to re-introduce anti-depressant medication. Ms BeNo concurs with your assessment of the severity of her condition but not on the need for hospitalisation. She thinks that she'd be better off as an outpatient than in the hospital and she reckons her condition will improve over time as it did before. She claims that 'this is not my first time. It will get better like before'. Although she understands that it is a risk, she is not concerned about her current poor appetite and losing weight as 'this often happens when I get stressed'. She is clearly determined not to be admitted and states this without hesitation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.69 Mr FeVi

You have been asked to assess Mr FeVi, a respected ward counsellor of the town council. He was admitted to the hospital for treatment of his hypertension, but he is now due to be discharged. Mr FeVi is also known with bipolar I disorder. He tells you that he discontinued his treatment a few weeks ago but that he feels 'tremendously well considering all the municipal problems currently brewing'. He denies having any illness at present and minimises his high blood pressure values of 190/110 mmHg measured last week as 'it's no big deal, only my blood pressure that got enthusiastic a bit, but now it is only me who is enthusiastic'.

The nursing staff however noticed over the course of the five days of his admission that he rarely slept for more than two hours per night. The nurse found that he was talking excessively and that he was sharing his plans for the municipality insistently with everyone, demanding their attention as if entitled to it. It is as if he is delivering political speeches, claiming that 'major breakthroughs are forthcoming', and that 'it is high time that I set the record straight and fix the municipality for once and for all'. They struggled to keep him in the ward as he was forever reiterating that his constituency was not confined to the hospital ward but extended to a much larger 'ward'. He would then tirelessly highlight, 'do you get my wonderful pun on 'ward'? Great, isn't it?'

They also found him gambling online at all hours of the day and night. He claims that this relaxes him and that he enjoys it. He does not consider it a risk. His spouse previously confided in the nurse that the family is concerned about their financial wellbeing as this is badly compromised by his gambling. According to his spouse he gambles on occasion but significantly more 'when he gets like this'. It tends to escalate until he receives adequate treatment. The family decided to avoid visiting him in the hospital because of his demands on them. The nursing staff and the family are of the opinion that he is currently not 'his usual self at all'.

Mr FeVi has no other chronic medical illness. He is not known to use any psychoactive substances. Your physical examination reveals that he is blood pressure is well-controlled at about 140/85, with no other signs of pathology. You find no evidence of substance use disorder.

On mental state examination you find a slightly dishevelled elderly gentleman. He is very pleasant to interview even though he makes it impossible for you to

investigate his history and mental state in a systematic sequence. He insistently steers the interview in a new direction and keeps changing the topic tangentially or with no connection apparent. He seems to be on his own mission and does not really engage with you owing to his distractible thoughts, flight of ideas, and rapid speech. His thought processes are not so impaired, however, that he is unable to make himself understood. You find no depressive features and he is not a suicide risk. You similarly find no psychotic symptoms or symptoms of a major neurocognitive disorder.

You inform Mr FeVi of the findings of your clinical assessment and recommend that he be admitted to the psychiatry unit of the hospital. You are concerned about the risks that his manic state and behaviour pose to his financial interests, health, and his reputation. Mr FeVi laughs at your recommendation, as he is not convinced that he is currently mentally ill. He thought you were pulling his leg, and then continues with stories on how well he has been 'pulling legs' in his work as councillor. He reckons the best course of action would for him to return to work and 'succeed in implementing the major successes I have in the making'. He is not keen to be transferred to the psychiatry ward but says he harbours the tremendous virtue of heeding the determinations of experts like yourself. Although he says unequivocally that he does not want to be hospitalised, he is prepared to 'go along' with your suggested hospitalisation as 'my destined detour to newly inspired success'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.70 Mr FaSo

Mr FaSo is brought to the emergency unit where you work following a motor vehicle accident in which he was the driver of one of the vehicles. He suffered soft tissue injuries but was not seriously injured. His father follows shortly. While examining Mr FaSo you notice that he is restless and agitated in the absence of a head injury. He is talking loudly and so fast that you follow his train of thought only partially and with difficulty.

Mr FaSo mentions that he, and his colleagues, are under much pressure at work where they have an urgent

project to complete. Because of the strain, Mr FaSo has barely slept the past two weeks. His father noticed that he is more active than usual and that he is 'constantly busy'. His father also noticed that he is thinking excessively and that he talks both faster and much more than usual. His father does not think this is strange given the circumstances. His father is of the opinion that 'a man should be working hard' and that there is nothing (mentally) wrong with his son. Mr FaSo tells you in confidence that he started to gamble online and that he is about to win millions. Rather than sleep, he gambles to 'relax and get away from it all'. He tells you that he thinks he is 'not okay and has taken too much hammering at work' but he is unsure of what is wrong with him.

Mr FaSo was previously diagnosed with bipolar I disorder, and he is still taking maintenance treatment. He and his father deny a family history of psychiatric disorder. His father remains unconvinced of his psychiatric diagnosis. Mr FaSo is otherwise in good health and he and his father both deny that he abuses any substances.

On your physical examination of Mr FaSo, you find no indication of neurological signs or another medical condition that could explain his current symptoms. On his mental state examination, you find that Mr FaSo's mood is euphoric, that his thinking is rapid and that he changes the topic of conversation every few seconds. He says his thoughts are 'competing to be the fastest ever'. He is distractible and seems to respond very impulsively during the interview. His concentration is poor on testing, and you suspect that his current state may be the reason for the motor vehicle accident. He is visibly agitated and struggles to remain still during the interview. He often paces around while talking. You find no indication of other cognitive impairments nor psychotic signs and symptoms.

You are of the professional opinion that he should be admitted to the hospital on account of the severity of his mood episode as well as the risk his behaviour poses to his (and other people's) safety and health and further, to his reputation. You notice that he is ambivalent about your proposed treatment. There is the need to get his work done and all is neither 'okey' and being highly distractible, he cannot focus on your recommendation and make up his mind. He can neither tell you what the best course of action is, but he does want your help and is not refusing hospitalisation. His father, however, is of the opinion that he does not require admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.71 Mr FoVe

Mr FoVe presents as a 28-year-old male with a history of feeling severely depressed for the past month. This is his first episode of a mood disorder. His sister has brought him to the hospital where you consult.

Mr FoVe reports to you in confidence some degree of anhedonia with loss of concentration as well as memory impairment. He furthermore reports that he struggles to make decisions in his daily life. Because of his indecisiveness he is struggling to complete projects at work and his business is subsequently struggling leading to a loss of personal income. He tries to hide these symptoms from his family and friends. He reports feeling hopeless and worthless and began to withdraw from his friends and family. He however denies any suicidal thoughts or plans. Mr FoVe reports that he has little appetite due to abdominal pain and nausea. He lost seven percent of his baseline body weight during the past month. He struggles to sleep every night and feels chronically tired. He reports to you in confidence that he started drinking alcohol heavily during the past six months. Initially he used it to cope with his work related stress but recently he found that it helps him to sleep. Despite experiencing these symptoms Mr FoVe does not think he is seriously ill. He rates his symptoms overall as 'mild to moderate' in degree.

Mr FoVe's sister reports to you in confidence that the family is concerned about the state of his health. She urges you to 'do your best for my brother'.

Mr FoVe has no history of any other mental illness. No family history of mental illness is known. Mr FoVe's medical history to date is unremarkable. He denies the use of any other psychoactive substances.

On examination you find that he seems objectively severely depressed with psychomotor agitation. He presents with racing thoughts and impulsiveness which adds to his indecision. Mr FoVe presents with a restricted affect, but his speech is rapid and difficult to interrupt. He engages only superficially with you. Despite these symptoms mentioned you don't find enough

features in keeping with a full syndromic hypomanic or manic episode. You do not find any psychotic symptoms.

On physical examination you find signs indicative of alcoholic hepatitis with right upper quadrant pain, low grade fever, tachycardia, and a tender enlarged liver. A blood test reveals hyperbilirubinemia with deranged liver enzymes.

You are extremely concerned about Mr FoVe's health and safety. Based on the severity of the psychiatric and other symptoms and signs you observe, you urge Mr FoVe to be admitted to the hospital where you consult. He refuses to be admitted to the hospital and downplays the severity of his symptoms. He does not believe that admission is necessary as he thinks 'things are not that bad'. You notice that he struggles to express what will be best for him. He is indecisive about his immediate future, but he is adamant not to be admitted. His sister accepts your recommendation and agrees with the recommendation of hospital admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.72 Ms HaVi

Ms HaVi presents as a 60-year-old divorced mother of three adult children with whom she has no contact. She is currently unemployed and homeless. She is brought to the hospital by a district social worker who was concerned by Ms HaVi's behaviour in the community.

Ms HaVi was diagnosed with bipolar I disorder at the age of 18 years. Her father was also diagnosed with bipolar disorder and her sibling with an unspecified substance use disorder. The rest of her medical history is unremarkable, and she denies the recent use of any psychoactive substances.

You find on your examination that Ms HaVi is talkative with an excited mood. Both her speech and thoughts seem mildly pressured. She is distractible from time to time during the interview especially when one of the fellow patients was admitted or received food. She reports to you that her levels of activity and energy increased during the past week. Her mood was subjectively more irritable over the past week. You find no features of a depressed

episode and she does not seem suicidal during the current interview. She becomes aggressive at times during the interview, especially when you contradict her or do not want to fall in with her plans.

You find no other medical pathology on clinical examination that can explain her current symptoms. Her toxicology screen is negative.

Ms HaVi is of the opinion that she is currently seriously mentally ill, and she wants to be admitted to the hospital especially now that the winter is approaching. All of Ms HaVi's symptoms are mild in your opinion and do not justify hospitalisation. You advise Ms HaVi that you plan to treat her as an outpatient with the required medication and refer her to the district social services. She rejects this plan and insists that you admit her to hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.73 Mr FaVe

Mr FaVe is a 45-year-old widower with no dependants. He came to consult you at your clinic on account of his mood symptoms since the demise of his partner six months ago.

He reports feeling depressed since then for more days than not. He tells you that he lost interest in activities that he usually finds pleasurable. He considers these symptoms 'normal' following the loss of a loved one. He does not think that the symptoms are severe. On further questioning he also reports that he has no appetite and mentions insomnia. He lost around six percent of his body weight during the past six months as he does not eat as much as he used to. He finds this strange as he is also less active than usual. He says: 'It is almost as if I cannot get going' and describes a loss of energy and drive. He thinks this is because he often wakes up during the night and is unable to sleep from four o'clock in the morning. He usually spends the time that he lies awake thinking about his late partner. He also ruminates about his late partner during the day. Subsequently he struggles to think clearly at work and is unable to concentrate longer than a few minutes at a time.

He previously developed a major depressive episode after his father had demised, about eight years ago. He

was treated with an antidepressant for a few months and remained well since. His medical history includes hypertension, dyslipidaemia, and diabetes mellitus. He has no family history of any medical illness.

On examination Mr FaVe presents with an objectively depressed mood and anhedonia. With bedside testing his concentration is objectively impaired. You find that his speech is soft and monotonous, and he maintains an excessively submissive attitude towards you. His affect is restricted. His thought contents are dominated by the events that caused his wife's death and their history together. You do not find mixed mood features or features of psychosis. Despite his concentration impairment, Mr FaVe is able to reason well and express his will clearly.

You find no indication of an acute medical illness that could explain his mood symptoms. His other chronic medical conditions are well-controlled on treatment. You also find no indications of any substance use disorder.

Mr FaVe attributes his difficulties to the loss of his wife rather than suffering from a major depressive disorder. He is nevertheless willing to reinstate antidepressant medication on your prescription. He will commit to regular outpatient contact and will sign a written suicide prevention plan.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based treatment with medication for his major depressive disorder is legitimately declined or not applicable; or b) outpatient based treatment with medication for his major depressive disorder should proceed by which suitable legal status?*

### 1.74 Ms HiLu

Ms HiLu presents as a 46-year old single female. She is referred from her work's employee wellness program for an assessment. Ms HiLu is described as a shy person who has been employed at the same company for the past 20 years. Despite not being very popular she has gradually made her way up the corporate level to middle management. She was offered a promotion which she declined. Her employer is pressuring her to accept the promotion but ever since the promotion was discussed with her, her colleagues noticed a marked change in her demeanour.

The referral letter states that Ms HiLu became depressed and anxious. Her supervisor also noticed a decrease in her

activity with significant slowing of her thoughts and actions. Her supervisor noticed that she has become much more distractible.

Ms HiLu tells you that she is truly upset by the proposed promotion and pressure from the employer. She prefers to 'keep things as they are'. She tells you that she generally distrusts people and that the promotion 'is too much for me' because it will 'put me in the limelight'. She is aware that she is sensitive to criticism and tends to shy away from relationships until she is absolutely sure that the person will like her. She counts only 'one or two people' as her friends. She has never had a romantic relationship for fear of being ridiculed or rejected. She feels that she has a low self-esteem and that she would 'rather be dead than be humiliated'. She tells you that she has a plan to end her life if the planned promotion goes ahead.

Ms HiLu reveals to you that she was previously diagnosed with bipolar II disorder. She did not use maintenance treatment because she was not sure that she could trust the prescribing clinician.

On her mental state examination, you find that she displays an irritable rather than depressed mood. She is talkative with pressured speech, but she is still able to express her ideas clearly as she is able to formulate her ideas succinctly. She is restless during the interview and struggles to sit still. You find no other hypomanic or manic signs. You don't find any indication of psychosis. Ms HiLu's social judgement seems intact.

Based on the symptoms she described and signs you have identified, you recommend that Ms HiLu be admitted to hospital on account of her current suicide risk. She understands that she is at high risk of suicide. She agrees to follow up weekly as an outpatient. She is at odds with your recommendation although she comprehends your concern. She agrees that some else who is in a similar condition that she is in, should be admitted to the hospital. She however refuses hospital admission on account of her fear that it might stigmatise her at work.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.75 Ms NaLu

Ms NaLu is a 66-year-old female presenting with her index episode of a severely depressed mood. She reports a loss of enjoyment in life and that 'my life is not worth living anymore'. She struggles to sleep during the night and is often awake. Her weight has decreased noticeably because of a lack of appetite. Ms NaLu's family is concerned by her poor memory. They notice that she cannot participate in conversations as she used to do. She seems to lose the thread of a conversation and cannot remember what she was talking about a few minutes ago. She also cannot recall events of the recent past.

Ms NaLu is accompanied by her husband of the past 30 years. He mentions that she has always been submissive and dependent on him to take care of all her needs. She always turns to him for advice and reassurance. She needs his say-so before she could make any decision. She avoids conflicts by sharing her own view. Over the years Ms NaLu's husband noticed how other people exploit her because she would 'always put other people first' even at her expense. She has never been employed.

Ms NaLu has a family history of major neurocognitive disorder. Her medical history is unremarkable, and she avoids all psychoactive substances. She went to her general practitioner two months ago as she had been worried about cancer, but she cannot specify any symptoms or signs that caused her to be worried. The general practitioner did several blood tests and x-rays but found no reason for concern. Your physical examination at this time neither reveals any bodily signs of cancer.

You find that is Ms NaLu unkempt and poorly groomed. She seems agitated and restless during the interview. She says she is worried but cannot say what her worries are about. Her speech is soft. She talks very little, and her responses remain brief despite prompting. Her mood is objectively depressed, and her affect is restricted and unresponsive to your emotional prompts. Her poor memory and concentration deficits are obvious. Her thoughts are disconnected and illogical at times.

Ms NaLu explains her difficulties as resulting from 'terminal cancer that has spread throughout my body'. She concedes that the general practitioner and you have found no evidence of this, but she maintains, 'I just know that is the case. It must be'. She maintains that her 'sad state' and poor memory attest to 'the fact' of having cancer. She also says that nothing can be done to treat

this, the cancer is too far advanced, and she is in a terminal state on the evitable brink of dying. You recognise this as a somatic delusion. You find no indications of hypomanic or manic symptoms.

You recommend that Ms NaLu be admitted to the hospital for medical assessment and treatment of her psychiatric condition. Ms NaLu says she does not understand how hospital admission would be of benefit to her as she is 'untreatable'. The most appropriate course of action, she says, is to just let her die peacefully at home. However, she enquires from her husband, 'what do you say? Should I be admitted?'. On his affirmative answer, she says, 'you know better than I do' and 'so be it then'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.76 Mr MoHa

Mr MoHa presents as a 25-year-old single male who is brought to the emergency department of the hospital by the district social worker. Mr MoHa has no fixed abode and lives on the street as he is unemployed and without family support. The social worker managed to track down Mr MoHa's sister who reluctantly agrees to talk to you.

Mr MoHa was diagnosed with bipolar I disorder at the age of 20 years following a serious suicide attempt. His father also received treatment for unspecified psychiatric problems during his compulsory psychiatric admission of five years duration as a state patient after being found not criminally accountable on the charge of assault with the intent to do grievous bodily harm. The family has always been following traditional cultural practices and their father did not take treatment after discharge from hospital because 'he did not believe in it'. The family has always expected Mr MoHa to 'make a success of his life' but has been disappointed in him.

His medical history is unremarkable, and he denies the recent use of any psychoactive substances. Special investigations and toxicology screen yield negative results.

You find on your examination that Mr MoHa is talkative. He does not let you talk much during the interview. Both his speech and thoughts seem mildly pressured. He is distractible from time to time during the interview.

He reports to you that his levels of activity and energy increased during the past week. His mood was subjectively more irritable over the past week. He seems objectively mildly agitated. He displays no other signs of a hypomanic or manic episode. He reports to you that he also feels low and irritated with everyone most of the time. He feels guilty for 'failing my family and bringing shame on them'. You do not consider these thoughts of a delusional quality, nor do you find any other signs of psychosis. He confides in you his persistent suicidal thoughts and wish that he 'is no longer there'.

Mr MoHa is well-aware and affirms that he is currently mentally ill and needs medical care. He says he feels out of control regarding the suicidal thoughts, and you are concerned about these. His sister, however, is not convinced at all. She maintains like the rest of their family that he needs help instead from their church. She is convinced that he will not die by suicide as 'he knows how sinful this is'. She points out that their father 'did fine without medication'.

Mr MoHa's disorder is, in your opinion, currently of mild severity. Nonetheless, you want to admit him to hospital as you are concerned about his suicide risk. Mr MoHa takes issue with your recommendation of admission. He understands your concern and is willing to take the medication that you prescribe. He agrees to follow up as an outpatient but not to be admitted. He is afraid that his family will completely reject him if he agrees to admission. He tells you that he 'does not want to bring further shame on them'. He refuses to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### **1.77 Mr FaRi**

You visit Mr FaRi, a 49 year-old male in the nephrology ward of the hospital for a consultation. The referring clinician reports that his mood changed noticeably over the past five days. He has become increasingly agitated and irritable, which is unusual for him. He is also restless, incessantly pacing in the ward even at night. He rarely sleeps but disturbs other patients with his agitated behaviour and loud talking. He began to talk a lot more than he used to. He, however, does not make sense and

is 'all over the place' when trying to have a conversation with him.

On his own report Mr FaRi tells you that he feels 'dreadful'. His life has become meaningless and 'awfully unhappy'. Tomorrow, as is the rest of his life, is 'unthinkable'. He says, 'I go from hour to hour' and 'I might as well be dead'. He feels useless and a drain on society, forced into this by his chronic and severe kidney disease. He confides in you that he has already made a suicide plan to steal and then take an overdose of the medication in the ward. He denies that this is part of a mental illness. In his case, it is not so but rather the 'only logical thing for me to do'.

Mr FaRi was diagnosed with a major depressive episode 18 months ago following a previous suicide attempt by medication overdose. He has a family history of death by suicide.

Except for his chronic kidney disease and hypertension, Mr FaRi has no other chronic medical illness. He is abstinent from all psychoactive substances. You find no evidence of any other medical illness other than that described. His kidney problems are currently optimally treated, and he is due for being discharged from the nephrology ward.

On mental state examination you find a dishevelled man looking old for his age. You struggle to establish rapport with him and he remains emotionally distant during the interview. His speech is rambling, pressured and at times incoherent. You also notice psychomotor agitation. You find no indications of psychosis.

You try to convince Mr FaRi to transfer to the psychiatry ward so you can treat his psychiatric condition and prevent a potential suicide attempt. The only matter that he is clear on is that he does not want to be transferred. He emphatically rejects your recommendation. He underplays the risk of suicide, about which he says, '... wouldn't matter any way'. He appreciates your concern about his mental health, but he is of the opinion that he is not mentally ill at all.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment by a transfer to the psychiatric ward hospital is legitimately declined or not applicable; or b) treatment by a transfer to the psychiatric ward hospital should proceed by which suitable legal status?*

## 1.78 Ms FaMo

Ms FaMo is a 35-year-old female currently admitted to the oncology ward. She is treated for stage IV ovarian carcinoma. Over the past week the staff noticed that she sleeps much less than she previously did. She is restless during the night, pacing up and down in the ward and disturbing the sleep of other patients. It seems to them that she has more energy than before. They know her as a generally pleasant and friendly person, not as aggressive and irritable as she is now. Now they struggle to follow a conversation with her as she talks 'too fast' as her thoughts jump rapidly from topic to topic. The nursing staff can often not make sense of the connection between her thoughts.

The family tells you that they are gravely concerned about her suicide risk. The family has a history of a suicide death during cancer treatment. They report that she had previous bouts of depression with at least one suicide attempt. They think she urgently requires psychiatric treatment to prevent her death by suicide.

Ms FaMo's experiences are that of a low and hopeless mood. There is hardly anything that she enjoys anymore. She earnestly believes that her family is ashamed of her condition and that she somehow failed them by being ill and requiring chronic treatment. She is often away from home for hospital based treatment. She reveals to you that she seriously considers ending her life. In her mind this will release her and her family of their current burden, and it would also 'free up the bed for someone better than me'.

Ms FaMo developed liver pathology on account of her chemotherapy and metastasis of the cancer. She often experiences pain and often requires opioid medication as treatment for the pain. She does not use any other psychoactive substances. Your physical examination confirms the clinical features of these medical concerns.

You find the signs described above on your mental state examination. Ms FaMo is a sickly looking female with jaundice. She hardly expresses any emotion on account of a blunted affect. Her speech is rapid with a clear flight of ideas. She seems agitated and struggles to keep track of the conversation but is still able to express her ideas, preferences, and decisions.

During the interview she also tells you about the ghosts that have entered her life as of late. She sees these and they call her. Sometimes they give her instructions and other times they discuss her fate. The ghosts tell her that

she is not 'worthy of being here and that I must die'. She is afraid that these ghosts will kill her, and she would rather end her own life than 'wait for them to do it'. She cannot explain from where these ghosts come and that other people could not verify their talking to her.

You share the family's concern about Ms FaMo's suicide risk, but she does not think it warrants concern. She is of the opinion that her cancer, and not her mental health or suicide risk, is of concern. She firmly rejects your recommendation that she receives psychiatric treatment and tells you emphatically that she will not drink the medication because the ghosts have forewarned her that she should not agree to any instructions but from them. She feels powerless against them, and it seems to her unintelligible how psychotropic medication could possibly help.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment using medication is legitimately declined or not applicable; or b) treatment using medication should proceed by which suitable legal status?*

### 1.79 Ms FaKo

Ms FaKo presents as a 35-year old female brought in by her family. She reports that she is feeling lonely and unloved after her husband of 15 years instituted divorce proceedings. Her family reports that she tried to end her life twice during the past three years.

She mentions that suicide thoughts 'crossed my mind' during the past six months but she denies current thoughts of suicide or a suicide plan. She confirms that she is feeling intensely depressed with a loss of interest and pleasure in life. She experienced depressive symptoms for the past year, but it worsened noticeably during the last six months since her husband insisted on their divorce. In addition, she finds that she is more irritable than usual. She reported a sense of hopelessness for the future and believes herself to be worthless as 'proven' to her by the divorce. She lost her appetite but her weight remained stable. Her sleep is affected by insomnia, and she is often tired during the day.

Despite this, she has episodes of excited energy lasting a few days during which she acts uncharacteristically reckless. During such episodes she buys clothes and luxury items on credit which she now struggles to repay. She admits that this was impulsive behaviour. She also feels as if

her thoughts are racing through her head and her speech becomes rapid and pressured.

Ms FaKo was diagnosed with bipolar I disorder four years ago. She took maintenance treatment for one year before she discontinued treatment. She has a family history of an unspecified mood disorder as well as a death by suicide of a family member. She is otherwise healthy and does not consume psychoactive substances at all. You find no indication of any other physical illness during your examination.

On mental state examination you find that Ms FaKo is clinically severely depressed with a blunted affect and facial expression in keeping with depression. She is tearful during your consultation. You have no reason to doubt her description of her subjective mood experience. Despite this her thoughts flow rapidly from topic to topic with pressured speech. She seems unreasonably irritable at times during the interview. She struggles to maintain the conversation on account of the distractibility of her attention. You do not find psychotic symptoms or signs.

You strongly urge Ms FaKo be admitted to the hospital on account of the severity of her mood episode and her potential suicide risk. Ms FaKo acknowledges that she is currently unwell and that she could benefit from hospital admission. She concurs with your opinion and tells you that she is prepared to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.80 Mr DeKo

Mr DeKo presents as a 51-year-old married father of two children. He consults you on the insistence of his spouse who complains that he has become 'gross and vulgar'. She is worried about a recurrence of two years ago when he was extremely irritable, harsh, and offensive towards everyone. He denies that she has reason for concern.

Mr DeKo was diagnosed with a major depressive episode two years ago. He was suicidal at the time and used maintenance treatment in the form of an SSRI for a few months before he discontinued the treatment. In his opinion his mood disorder is 'a thing of the past'. His father was also diagnosed with an unknown mood disorder and

remains on treatment. Mr DeKo reports a family history of a completed suicide as part of mental illness.

The rest of Mr DeKo's medical history is unremarkable with no history of any other chronic disease. He denies using any use of psychoactive substances, which his spouse confirms. All remains as usual at his place of work, and no one has complained about him, he says. Different from his spouse, he says, 'there they take me as I am – rough and ready'.

On examination Mr DeKo displays a somewhat expansive and irritable mood. You notice mild pressure of speech and he confirms that his thinking is faster and of more content than usual. Although he speaks fast, you find no tangentiality or difficulty in following the train of his thoughts. His affect is congruent with his thought contents, and it is appropriate albeit somewhat superficial. He concedes that his current sleeping of five hours per night is less than usual, but he reckons he does not need more sleep. His concentration is not impaired on testing it. You find no indications of psychotic symptoms. You find no features of a depressive episode currently. He denies having suicidal thoughts recently. His spouse tells you in confidence that he often refers to suicide 'as a way out' when he is under strain and that he made three impulsive suicides in the past, even when he was not depressed.

He reckons that he does not currently require medication, but he understands and accepts that medication may become necessary if his condition worsens. Mr DeKo firmly declines your recommended prescription of medication, but he appreciates that you and his spouse are concerned, and he commits to visiting you again next week.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) the prescription of medication proposed is legitimately declined or not applicable; or b) the prescription of medication should proceed by which suitable legal status?*

### 1.81 Ms DaKe

Ms DaKe is a 25-year-old female. She is involved in a heterosexual relationship and has no dependants. She lives alone. She presents with an irritable mood as well as an increase in energy and activities for the past six days. She reports a decreased need for sleep during this time, sometimes sleeping only an hour or two at night. Her family

has brought her to the hospital as they are concerned about her increasingly erratic behaviour. They report that her irritability is out-of-character and that they are worried about her.

She was diagnosed with bipolar I disorder four years ago. After recovery from a manic episode, she used maintenance treatment for about two years before discontinuing it.

Ms DaKe was diagnosed with an HIV-associated urinary tract infection one month ago. This was quite a shock to her as she had not been tested for HIV before. Her family reports that they noticed a change in her mood and behaviour since the diagnosis. She has become uncharacteristically negative about her life and future and 'just wants to give up'. She seems sad and upset. She no longer goes out with friends as she has done before. She was initiated on antiretroviral treatment following the diagnosis but has adhered only partially to the prescription.

On examination you find features of a mixed mood episode comprising marked dysphoria, irritability, and mild restlessness in that she wriggles much in her chair during the interview but without getting up. Her thoughts are 'rather busy' lately, she says. Her speech is fast, and she frequently changes the topic. On testing, her concentration is mildly impaired. She is nonetheless able to formulate her ideas and express her thoughts understandably.

She is also tearful at times. She describes her mood as 'up and down'. You notice evidence of anhedonia for the past month. She confides in you that she considers ending her life as 'my future looks bleak'. You do not elicit any psychotic features.

Ms DaKe recognises that 'something is not right with me'. She considers her current condition as less severe than when she was admitted in the past. She agrees to your recommendation that hospital admission and treatment is sensible to reintroduce psychiatric treatment, proper anti-retroviral treatment, and to prevent her from acting on her suicidal thoughts and impulses.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.82 Ms BhMo

Ms BhMo is a 21-year-old female student who had overdosed on diet pills and subsequently ended up at the hospital where you work. She reports symptoms of a depressive episode for the past few weeks. She reports a depressed mood of 'profound' intensity during the last few weeks. As of late, she says she is living a rather worthless life one day at a time, just 'going through the motions'. The only highlights remaining, she says, are visiting her friends and when they go out together. Her appetite is less than usual, and she mentions that she has little energy during the day. She deliberately suppresses any feelings of guilt that sometimes emerge and 'then they disappear quickly'. Ms BhMo seems unconcerned by the overdosing. In her view she did not 'really want to die' but 'just did it'. Her family is however very concerned about what they assume to be a suicide attempt and wants her to be admitted to hospital.

Regarding her past psychiatric history, Ms BhMo reports that she had five previous suicide attempts. All these attempts involved taking an overdose of medication. These attempts were also associated with depressive feelings. She denies any features of hypomanic, manic, or mixed mood episodes.

Ms BhMo has an unremarkable medical history with no chronic illness. She has no family history of bodily or mental illness. Although she drinks alcohol on occasion, she denies any substance related concerns. She denies the use of any illicit substances.

On your examination Ms BhMo presents with features of a major depressive episode of a mild degree notwithstanding her intense feelings of depression. Her speech is normal in rate, rhythm and volume and she displays a full range of appropriate affect. Her mood seems to be low, but she still fully engages in the interview with no indication of cognitive impairment. You do not find any indications of psychotic symptoms or mixed mood features. Her social judgement seems intact.

Ms BhMo disagrees with her family regarding her suicide risk and makes it clear that she does not want to be admitted to hospital. She understands that her mood episode requires treatment and is willing to receive treatment as an outpatient, but her family insists that she should be admitted. She resolutely declines hospitalisation, saying she has to complete a couple of university assignments and she cannot afford to be admitted. Her

family insists that she should be admitted on account of her suicide risk.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.83 Ms BuCa

Ms BuCa presents as a 32-year-old female receptionist who works at a legal practice. Her family has brought her to the hospital because she is 'so depressed'. She mentions that she 'can no longer cope with life'.

On questioning she mentions that for the past month she has felt intensely depressed with loss of all interest in life. She reports that she has little energy and cannot get her work done. Her sleep is severely affected with initial, middle, and terminal insomnia. She lost her appetite with subsequent noticeable loss of weight. She reports excessive feelings of guilt about the work that she failed to do and that she was hiding this from her employer. This is on her mind all the time. She denies any thoughts of suicide or recurrent thoughts of death. She finds that she often struggles to remember that which she has been on the brink of doing, and staying on track with a particular task is very difficult owing to poor concentration. She has also noticed that she procrastinates endlessly and avoided making decisions during the past month 'as I just can't make up my mind this way or that way'. For the past month she has been worried that she would make mistakes and consequently lose her job because she 'can't think things through properly'. Her employer is rather ruthless, she says, and she fears returning there.

Ms BuCa was previously diagnosed with major depressive disorder and used to take maintenance treatment. She discontinued it six months ago. She uses alcohol only 'special occasions'. Ms BuCa reports a family history of bipolar disorder among two of her aunts on her mother's side of the family. Her personal medical history is unremarkable.

Your examination confirms the features of a major depressive episode of severe degree. She presents as poorly kempt with soft, slow speech. Her affect is restricted in expressive range and her attitude suggests defeat. She seldom makes eye contact, and her eyes are mostly staring

at nothing specifically. Although rapport is reasonable and she is responsive to your prompts, all her responses are cast in misery and gloom. She lacks in spontaneity and her responses remain laconic and impoverished in content. Her thought contents reveal no delusions. You find no perceptual disturbances, except for multiple nightmares in which her employer assaults her physically for not doing her work properly. You find no evidence of a current manic episode.

Her psychomotor functions are clearly retarded. She walks like an elderly person, using small and slow steps with a stooped posture. Her arms remain at her sides when walking and she hardly moves while seated. Concentration impairment is apparent not only upon testing but clearly so during the interview. She displays clear difficulty in following you when you explain treatment options, the need for these and potential benefits and risks thereof. She muddles the treatment options and their potential consequences. For example, she understands mistakenly from your explanation of hospitalisation that it would serve well as a place where she may hide evidence of the work that she failed to do. Her retention of information about the purposes of hospitalisation is clearly poor.

You consider it crucial to admit Ms BuCa for the sake of her health and wellbeing. Ms BuCa is very pessimistic, such that she reckons 'whatever you do, it's hopeless'. She insists on going home.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.84 Ms BoSe

Ms BoSe presents as a 50-year-old married mother of two adolescent daughters. During a routine medical visit for her anti-hypertensive medication, she reports on questioning that she is not feeling well and 'down in the dumps' for the past three weeks. She also suffers sleep initiation problems, a loss of pleasure and interest in activities. She experiences the intensity of these feelings as 'terrible'. She also mentions loss of appetite but no weight loss. She denies any restlessness, tardiness, or suicidal thoughts. She does her usual chores and activities as always, except for preparing meals. She says her husband can prepare his meals for himself, and she will not do it. She denies feeling

guilty, and says her husband is the one who should feel guilty.

This strikes you as odd as her accompanying husband seems uncomfortable about her complaints. He does not seem to think there is anything wrong with her. He claims that she is angry at him. Neither of them is willing to say what their quarrels have been about. He says he has not done anything wrong. He adds that she feels uncomfortable when she is not the centre of attention, that she always exaggerates and inflates much commotion, claiming major calamity when everyone else is amazed that she reacts so fiercely. When he relates this to you, she clearly becomes annoyed.

Ms BoSe was treated two years ago by the general practitioner who prescribed an antidepressant, but she discontinued it after a few weeks. Ms BoSe's medical and family history is unremarkable. The anti-hypertensive treatment has been effective, and no other signs of vascular disease have emerged. Although she uses alcohol on occasion, she and her spouse deny any alcohol related concerns. She uses no other psychoactive substances as confirmed by her spouse.

You find no indication of any substance use disorder related features on examination. She displays no features of a hypomanic or manic episode and no mixed mood features either. She displays no features of psychosis. Although she complains about her concentration, the testing of her concentration shows no impairment and her thought processes during the consultation are clear, goal directed and logical. You do not find cognitive impairment. You find no indication of a suicide risk.

Ms BoSe proclaims that 'my husband makes me suffer from depression' and she shows clear hostility towards him. Despite the intensity of her depressive feelings, her condition does not seem to meet the diagnostic criteria of a major depressive disorders. She may suffer from an adjustment disorder, but the clinical picture is not conclusive at this time.

You all agreed that hospitalisation is not required. She declines outpatient based treatment and says she will not agree to any therapy or marriage counselling. She insists that her husband will have to suffer her being miserable for the foreseeable future.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based medical care is*

*legitimately declined or not applicable; or b) outpatient based medical care should proceed by which suitable legal status?*

### 1.85 Mr GeWi

Mr GeWi is 39 years old and presents to your practice with the complaint 'all is going to pieces in his life' after his boyfriend of six months 'dumped me'. Mr GeWi says he misses him a lot and all the fun they had together. He ruminates a lot about their fun times together and their conversations. This keeps him from falling asleep for an hour or so, but he sleeps well for the remainder of nights. He has neither lost appetite nor weight, but he is not eating healthy food since the departure of his boyfriend. On questioning, he says he has enough energy to complete his daily tasks and that he manages to do his work and other social activities as usual. He denies suicidal thoughts. He regrets some of things he said to his boyfriend, but he denies feeling guilty. Although preoccupied by thoughts of his boyfriend, his concentration is not affected subjectively nor on your testing of it.

You also find no indication of a substance use disorder nor any medical co-morbidity. Mr GeWi does not believe that he requires hospital admission but requests instead that you prescribe antidepressant medication. On your professional assessment, Mr GeWi does not require either intervention.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) medication is legitimately declined or not applicable; or b) medication should proceed by which suitable legal status?*

### 1.86 Mr KaNu

Mr KaNu presents as a 51-year-old male with a history of recurrent major depressive disorder. He was brought to the hospital by his son because he had complained of 'feeling depressed and unwell'. Mr KaNu was divorced 22 years ago after being married for only six months. He has one son from his brief marriage, who maintains regular contact with him. Mr KaNu now suspects that he has been poisoned. He made a suicide attempt four days ago by drinking an overdose of over-the-counter medication.

His son, who is the only person of his family with whom he still has contact, tells you that Mr KaNu has always been

quite suspicious of the motives of other people including that of his own family. He easily feels exploited or deceived and tends to read 'hidden meanings' into even the most innocuous remarks. His son describes him as 'someone who can hold a grudge for years'. He finds it hard to trust most people including his family and friends. He does not really have any friends.

He is not known to have any other medical illness. Your physical examination also reveals no indication of co-morbidity. He reports that he seldom drinks alcohol because he 'does not want to compromise himself'. His son confirms his sober habits.

On mental state examination you find his mood to be severely depressed with prominent anhedonia. He is not forthcoming during the interview, and his son mentions to you that he is afraid that you 'may use what he says against him'. His thoughts are well-connected, flow logically, and are goal-directed. He sustains his attention and concentration during the interview and expresses himself well. He reports a lack of energy and drive with poor sleep. He struggles to fall asleep every night for the past month and is awake for many hours during the night. He further mentions that his appetite is poor but that he has not lost weight. Mr KaNu reports that he feels very guilty, and that God is currently punishing him suitably for his sins. He is not willing to tell you which wrongs he did other than saying his 'offensive' actions go back to his school days. He says moreover that he is not worthy of living and will be punished by death. He says, 'there is no alternative to death anymore, no redemption is possible, I am irrevocably condemned'. Contrastingly, he denies any suicidal thoughts during your interview. You find no features of hypomania or mania.

You are of the professional opinion that Mr KaNu is severely depressed and requires hospital admission for his health and safety. Mr KaNu, however, questions your motives and integrity. He is concerned that you may also be 'plotting against me'. He views your recommendation with suspicion and as a way to 'control me like the others want to do'. He is not convinced that your recommendation is founded on his mental state but rather your malicious intentions towards him. He further remarks that hospital admission would be a ridiculous attempt to go against God's condemnation of him. His son pleads with him that he nonetheless follows your recommendation, upon which he renounces resistance to hospitalisation. He responds to

his son's concern about his well-being and agrees to his son making the call on this.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.87 Mr HuKu

Mr HuKu presents as a 21-year-old single male with no dependants. He is a medical student at a local university in his third year of study. His accompanying girlfriend, a 6th year medical student, insisted that Mr HuKu gets some help and he reluctantly agreed that he would consult you.

His girlfriend says Mr Huku has recently changed and behaves very differently from before. He is not sleeping and is very demanding day and night, insisting on her attention all the time as well as making multiple quick visits to their friends. His girlfriend also says that he is elated, overly energetic, and preoccupied with his previous academic achievements.

Mr Huku confides in you that he has not been feeling well for the past 10 days and he has been fighting off the mounting pressures of his studies. He describes a dysphoric mood and that it takes extra effort and energy to enjoy activities. Even sex tends to be disappointing lately, he admits. The only remedy that has come to his mind so far, has been 'try harder'. He says despite his efforts, he knows he is less productive than usual, and it worries him that he failed to submit an assignment last week. He fears that he may become 'a failure in the making'. He feels also guilty in failing to enjoy his girlfriend properly. He denies current suicide thoughts.

His girlfriend reports that a few months ago he became socially withdrawn with a loss of energy. He slept for most of the day and was 'overthinking' everything. Mr HuKu admits feeling depressed then, but this gradually improved over time without medical intervention. His uncle had psychiatric problems, but he does not know the details. He denies other significant medical illnesses or the regular use of psychoactive substances.

On examination you find features indicative of hypomania including mild pressure of speech, some boasting, and mild social disinhibition. An example of the latter is his talking about private sexual activities with

which his girlfriend is clearly uncomfortable. You find no delusions or other signs of psychosis. His thought processes are coherent, and cognitive functions are not impaired except for three mistakes in the 100 minus 7 concentration test.

Although you consider Mr HuKu's disorder of mild severity at this time, you are concerned about the consequences of his impaired social and occupational functioning. You recommend the initiation of medication treatment with an appropriate mood stabiliser with regular follow up at the outpatient clinic. Mr Huku agrees with you that his symptoms are of concern particularly so in that they may worsen. He is of the view that psychiatric medication and even hospital admission would be appropriate if his symptoms would get worse, but medication is not crucial at this time in his view. He recognises that he is at risk of becoming manic, as his girlfriend also told him. He clearly declines your recommendation of prescribing a mood stabiliser. He says he will instead take a proper break during the upcoming recess next week, deliberately take the tempo of his activities down, pursue peace and quiet, and keep a watchful eye together with his girlfriend so that his condition does not get worse.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient based treatment with medication is legitimately declined or not applicable; or b) outpatient based treatment with medication should proceed by which suitable legal status?*

### 1.88 Ms KoFi

Ms KoFi presents as a 40-year-old female brought to you by her brother. She reports that she is feeling lonely and unloved after her husband of 20 years instituted divorce proceedings. Her brother reports that she tried to end her life twice during the past three years. They are concerned that she might become suicidal again and wants you to admit her to the hospital to prevent this from happening.

She reports that she is feeling intensely sad about losing her husband and that she is interested in nothing in his absence. She has experienced this for the past two years, but all has worsened during the last six months since her husband insisted on their divorce. In addition, she finds that she is more irritable than usual – she had several rows with her children and family, which does not normally happen, and she was involved in an altercation with a colleague

that ended up in much shouting and her throwing a stapler at her colleague. She is now grateful that she missed her aim. She reported a sense of hopelessness for the future without her husband and believes herself to be worthless. She lost her appetite and lost 'many' kilograms of weight. She admits that her sleep is disturbed but cannot provide more details as 'it varies', and she feels tired during the day.

Ms KoFi was prescribed antidepressants in the past but discontinued these about eight months ago. She has a family history of mental illness with her mother having an unspecified mood disorder as well as a death by suicide of her grandmother, presumably due to a mood disorder. She is physically healthy and does not consume psychoactive substances at all. You find no indication of physical illness during your examination.

On mental state examination you find that Ms KoFi is clinically severely depressed with a blunted affect and marked psychomotor retardation. She is tearful during your interview with her. She finds it difficult to talk and gets irritable when she fails to formulate a response to your question. Her speech is slow and monotonous. She presents as distant and disconnected interpersonally, and rapport remains elusive despite your empathetic responses. The tempo of her thoughts is slow, and her thought contents are impoverished. Her account of her history is chronologically inchoate. Cognitive testing reveals impaired concentration, some disorientation for the date and day of the week, and concretisation in her abstract thinking. You do not find psychotic symptoms or signs.

In contrast with her brother's concern, she denies current thoughts of suicide or a suicide plan. You sense from your interactions with her is that she may be hiding her suicidal ideation from you, but you have little to support this intuition. You are however also aware of several risk factors pertaining in this regard.

You strongly recommend that Ms KoFi be admitted to the hospital on account of the severity of her mood episode and a potential suicide risk. Ms KoFi acknowledges that she is currently unwell and that she could benefit from hospital admission, but she clearly underestimates the severity of her condition and the need for hospitalisation. She decides not to be admitted because she should prepare for the pending divorce. She is also afraid that 'it would count against me if I were admitted' during the divorce proceedings. When challenged on whether she is

currently in a mental state to prepare for this, she reckons that she is 'perfectly able'. She cannot say what these preparations would entail and in which way hospitalisation would 'count against her', saying 'it just would'. Her brother is concerned about her welfare and believes that she should be admitted. She refuses.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.89 Ms KoSe

Ms KoSe presents as a 50-year-old married mother of two adolescent daughters. During a routine medical visit for her chronic hormone replacement therapy prescription she reports on questioning, a depressed mood for the past two weeks. This is associated with sleep disturbance, a loss of pleasure and a loss of interest in activities as well as a loss of appetite. She also reports 'scary' thoughts of suicide. She experiences the intensity of her depressive feelings as 'the worst possible experience in the world ever' which she believes originates from the conflict between her and her spouse, but she 'cannot live without him'. She believes all would be well if they could reconcile. She also mentions noticeable weight loss but is not able to quantify the loss. She further mentions that she often feels 'confused', which turns out to mean that she tends to forget what she has done earlier that day, or what she was about to do, or where she left her keys and other belongings. On further questioning she denies any psychomotor abnormality since the onset of the depressive symptoms which follows accusations of infidelity. She claims to feel 'horribly guilty' about what she had done and that she 'does not deserve such a good partner (as her spouse is)'.

Her spouse believes that she is exaggerating her symptoms (including her suicide risk) as a way to 'get away with what she has done'. Ms KoSe's spouse informs you that she experiences everything in 'top gear' and she is most able to exaggerate and generate 'drama'. She likes being the centre of attention and he has endured many years of her provocative and seductive behaviours towards other men. This tends to lead to conflict with her female friends as she frequently misinterprets relationships as more intimate than they are and transgresses social boundaries.

Her past psychiatric history includes depressive symptoms without suicide behaviour or self-injury. Ms KoSe's other medical and family history is unremarkable. The hormone replacement therapy is the only treatment she takes. Although she uses alcohol on occasion, she and her spouse deny any alcohol related concerns. She uses no other psychoactive substances as confirmed by her spouse.

You find no indication of any substance use disorder related features on examination. She displays features of a DSM-5 defined major depressive episode with a depressed mood most of the time, significant and pervasive anhedonia, and associated vegetative symptoms affecting her eating and sleeping patterns. She displays no features of a hypomanic or manic episode and no mixed mood features either. She displays no features of psychosis. Although she complains about her concentration her thought process during the interview is clear, goal directed and logical. She does not display significant cognitive impairment on your testing of these functions. Her physical examination similarly reveals no significant pathology. By your professional evaluation, Ms KoSe's depressive episode is of a moderate to severe degree as evident in her daily functioning. She hardly does anything other than her basic self-care (which she does meticulously as always). She stopped doing chores at home, goes nowhere, and sits or lies on the sofa all day long. Her husband says, she does not bother about food supplies, or anything, or anybody, 'she just sits there all day browsing social media on her phone'. Despite her history of three prior suicide attempts, her current presentation does not indicate that she would be a high suicide risk at present. Ms KoSe says attempting suicide is 'way too scary a thought' for her, compounded by the 'horrific' events that followed from her previous attempts.

Ms KoSe understands that you are concerned about her mental state and even agrees that she is 'depressed to some extent'. She is however unwilling to receive psychotherapy as an outpatient, or alternatively, the medication you want to prescribe as she is concerned about the cost associated with treatment and the time and effort required for therapy. She believes that 'time heals all wounds' and that 'things will come right eventually' when she reconciles with her spouse. Her husband remains unimpressed by her mood symptoms and believes she is 'putting it on'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) treatment as an outpatient is legitimately declined or not applicable; or b) treatment as an outpatient should proceed by which suitable legal status?*

### 1.90 Ms MoFi

Ms MoFi, a 26-year-old female, is brought to the emergency department by her family after she has drunk a handful of unknown pills. Her family is clearly upset with her. They accuse her of 'playing up' and 'wasting our time'. They want you to 'pump her stomach and send her home'.

Ms MoFi discloses to you that she has been feeling 'hyper' for the past week (referring to an elevated mood). She began to drink more alcohol than usual, buying luxury goods she could neither afford nor need. She had unprotected sex with various men whom she did not really know well. She hastens from one activity to the next, because 'I ooze loads of energy'. She joined three new clubs during the past week because of her heightened interest in joyful activities.

Her family tells you that Ms MoFi is usually a 'hyperactive' person who struggles to control her emotions and 'who does before she thinks'. She is often angry or upset for no apparent reason. When she is upset, she would 'lose it' and start to throw items around. She does not care if she destroys expensive glassware and ornaments. At times, she becomes unreasonably suspicious of family members or friends, saying they are against her and undermining her, especially in days following a disagreement. She is always afraid that she would 'end up alone with no one who loves me'. She describes her relationships as invariably of short duration, beginning 'in the sky' and ending 'in the sewer'. She usually terminates the relationship before 'they dare to reject me'. Her family says she often describes herself as 'a nobody' and feeling 'empty', but to their surprise, she is currently very self-confident in contrast with her usual low self-esteem that has been self-defeating since adolescence. They are not concerned about this overdose she took. In their experience she often threatens suicide and has a habit of cutting herself when she is upset. The family thinks this 'upheaval will pass like all the others'.

When asked about this overdose, Ms MoFi intimate to you that this was an impulsive act in anger towards her most recent partner. Her most recent female partner became fed-up with her sexual indiscretions. They had a

fight after Ms MoFi told her how much fun she had had at the club. She denies that she ever made suicide plans, and says, 'neither do I have such now'.

Ms MoFi is not known to suffer from any acute or chronic medical illness, and she has not been diagnosed with a psychiatric disorder before. Her sister however died by suicide two years ago, after multiple instances of self-harm behaviour. Ms MoFi frequently drinks alcohol and is often under the influence of alcohol. She smokes cannabis on occasion 'to get high' and tried on several occasions a variety of illicit substances such as cocaine and methamphetamine. On physical examination, she shows no physical signs of intoxication, but some old scarring of linear cuts on her upper thighs.

On the mental state examination, you find that Ms MoFi is a neatly dressed young woman. She engages well during the interview and comes across very friendly and pleasant. She says she is 'happier than ever' at this point, and you should mistake her overdose as indicating the opposite. She says, 'just because I am happy does not mean I cannot get angry too'. She is fully orientated, and there is no impairment in consciousness. She is unequivocally talkative. Her thought processes are over-inclusive, and she uses inflated descriptions (with superlative adjectives and adverbs) in almost every sentence. She describes the tempo of her thoughts as 'fast and furious'. Her thought contents are dominated by themes of joy, excitement, and jokes. You find no psychotic features. She concedes that she needs much less sleep lately. She denies any concentration or other cognitive difficulties, but you find impairment of her concentration on testing it. She formulates her ideas and communicate these clearly.

You are concerned about the adverse consequences of her current manic episode compromising her reputation and interests. Hence, you strongly advise hospital admission. Her family brushes aside the concerns and says she is 'just playing up'. Despite her concern Ms MoFi is in two minds as to the best course of action. She wants help but does not 'feel like being in hospital'. She is also not convinced that hospitalisation would make a difference to her 'actual problem' that she says, is 'relationship difficulties'. She therefore declines your recommendation of hospital admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately*

*declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.91 Ms RoHu

Ms RoHu presents as a 36-year-old divorced mother of two children. She was referred to you from the oncology unit on account of her mood symptoms. She reports that she felt fatigued, very weak, and pessimistic during the past month. She is just too tired, and everything has turned out to be hopeless, she says. The doctors at the oncology unit found that her breast cancer had returned with evidence of liver metastases. They informed her of this six weeks ago. Since then, her sleep is disturbed, she has lost her appetite and has little to no interest in doing the usual chores. Her family mentioned to her that they find her irritability and being unreasonable to them, very difficult.

She has no previous psychiatric problems and no family history of mental illness. She was diagnosed with breast cancer two years ago, which went into remission on the appropriate treatments. Her metabolic, thyroid, and other serum parameters are currently within normal ranges. She is booked for further chemo-treatment that will begin in two weeks.

On examination you find a depressed facial expression and features of a major depressive episode. Although she presents with slowing of her thoughts, these remain logical and goal-directed. She can express her ideas with clarity. You notice some restless behaviour during the interview. You find no psychotic features. Ms RoHu mentions in passing that the battle against the cancer in trying to stay alive is at times too much for her to bear, and at such times she wishes that she would just die 'without further ado'. She says, 'I would trip off the switch if there were such to end my life suddenly and painlessly, but I do not have the courage nor the means'. She denies suicidal planning.

In your estimation Ms RoHu's mood episode is of mild severity. You are of the professional opinion that she would benefit from hospital admission for psychiatric treatment. Ms RoHu does not concur with this recommendation. She wants to 'spend as much time as I can with my children' and mentions that she is 'tired of being in the hospital'. She explicitly declines the hospital admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately*

*declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.92 Mr FaKe

Mr FaKe is a 35-year-old father of three children ages 12, 10 and 7. He was brought to the hospital following a suicide attempt. He reports feeling very depressed for more days than not after his wife left the family two months ago. He attempted suicide twice during the past two weeks and he reports his suicidal thoughts worsening over the past week. He also reports that he has 'little appetite' and mentions that he suffers from severe insomnia. Despite his anorexia his weight remained the same. He reports that for the past six months he struggled to fall asleep for most nights. He will sleep on-and-off until he is fully awake in the early morning hours. This disrupted sleeping pattern causes him to be drained of energy the following day and he struggles to cope with his duties including the care of his children. He also mentions having a problem concentrating. He denies any activity during the past month causing him any joy or pleasure.

Mr FaKe has a history of a previous major depressive episode following his mother's passing nine years ago. He also had one suicide attempt during this episode. His own medical history includes diabetes mellitus and hypertension with dyslipidaemia. He has no family history of psychiatric or other medical illness.

On examination Mr FaKe presents with an objectively depressed mood. His affect is flat, and his speech is slow and stuttering. Mr FaKe displays significant impairment of cognitive functioning with slowing of his cognitive processing speed and poor concentration testing. You do not find any psychotic or mixed mood features. Mr FaKe's insight into his current mental state seems intact. You find no signs or symptoms indicating that his condition would be the result of another medical condition or substance use disorder.

Despite the severity of Mr FaKe's condition, he understands that he needs psychiatric care and treatment. He accepts your recommendation of admission to hospital on account of his severely depressed mood and current suicide risk. He will make the necessary arrangements to be admitted and for his children to be taken care of during the time of the admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.93 Mr RoBh

Mr RoBh presents as a 40-year-old divorced male with no dependants. He complains of a feeling low every day following the breakup of a romantic relationship two weeks ago. He says at times this is very bad and he gets severely depressed to the extent that he feels like 'ending it all would be better' as he 'cannot bear being dumped like this'. He made a suicide attempt four years ago and suicidal thoughts have crossed his mind many times since then, but he has not made plans or acted on these. Mr RoBh does not think that these suicidal thoughts currently pose a risk, saying 'I think about it, but I know I won't do it'.

His past psychiatric history includes features of panic disorder and sub-syndromal features of a posttraumatic stress disorder following a life-threatening motor vehicle accident. He has a history of using alcohol irregularly but usually to the point of intoxication. Mr RoBh's family psychiatric history comprises his mother having an anxiety disorder and his brother making a near-fatal suicide attempt three years ago. He has no other significant medical history.

On your clinical examination you find a major depressive episode of mild severity. Features of this include anhedonia on some days, a raised appetite, weight gain, initial stage insomnia, and social withdrawal on some days. He mentions that he feels hopeless and worthless. You notice that he often returns to the thought of suicide as an escape from his feelings of loneliness and despair. This may be an expression of his personality, but you find no indications of a personality disorder or current psychosis. His thought processes are goal-directed, logical and well-reasoned. He does not seem to have any form of cognitive impairment. His social judgement and insight are seemingly not impaired. You find no indication of another medical condition or bodily effects of alcohol on your clinical assessment.

You recommend hospitalisation to initiate treatment in a therapeutic environment and because you are concerned about Mr RoBh's suicide risk. He does not agree that his suicide risk is such that he needs admission. He is

unwilling to be admitted to the hospital as he does not want to compromise his situation at work. He makes it clear that he is not willing to be admitted. Mr RoBh understands that his suicidal thoughts may pose a risk, but he believes that he is emotionally 'strong enough' to resist acting on these as he has been doing for some time now. He will go to his family and draw on their support if he feels that he can't resist any longer. Although he accepts that he requires help, he does not accept your recommendation of admission. He is willing to accept outpatient treatment.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.94 Ms FaCe

Ms FaCe is a 25-year-old female. She was referred to you for an assessment after a physically aggressive altercation with a colleague at work. This aggressive outburst is unusual for her. During the consultation she tells you that her mind is racing and that she has been feeling restless for the past ten days. Her friends and colleagues also noticed that she was (in their words) 'more busy than usual' but that she got less done. She confirms having 'loads of' energy and needing less sleep lately. She mentions that a few days ago, she went on a buying spree for jewellery and luxury clothes that she could not afford.

Ms FaCe was diagnosed with bipolar I disorder 18 months ago. She used maintenance treatment for a few months but discontinued it as she felt she did not need it. She had one depressive episode at the onset of her mood disorder four years ago. The depressive symptoms gradually improved without medical treatment. She had a manic episode of severe degree 18 months ago. This episode had required admission and medical treatment before her condition improved. She explained that it was a 'very bad' experience and she vowed that she'd never be admitted again. Ms FaCe's sister was also diagnosed with bipolar disorder.

Ms FaCe has no history of acute or chronic medical pathology that could explain her manic symptoms. She is not known to use any psychoactive substances. You also find no other medical pathology on physical examination. She tests negative for all psychoactive substances.

On examination you struggle to engage with Ms FaCe, and rapport remains superficial at best. She seems unable to engage in a conversation as her mind is jumping from topic to topic. You struggle to follow her train of thoughts that often seems illogical. You also notice how restless and excitable Ms FaCe is. You find that she often laughs inappropriately. Her speech is loud and seems pressured. She does not allow you to speak much and dominates the consultation. Her thought processes show perseveration and verbigeration, and her thought contents are dominated with optimistic expectations and joyful activities that she 'can't wait to take up'. Her mood is best described as expansive and euphoric. She feels 'on top of the world' and does not think that she needs treatment. She cannot understand her employer's concern as she considers herself to be an 'exceptional employee'. Although this thought is grandiose in nature you don't consider it to be of delusional quality. You find no signs of psychotic features.

You strongly urge Ms FaCe to be admitted to the hospital on account of her mood. She says she does not understand why you think that she requires admission because she is 'feeling so well'. In her view, it does not make sense and it would be a waste of time. She however realises that the recurrence of an aggressive outburst could have legal and other consequences. As she does not want to risk this, she chants, 'then you and my family decide, for I am easy, very easy...in many ways, for I shall have fun anyway, fun this way, fun that way, this way, that way, easy, easy, easy in so many, many, many ways'. Her family is also concerned about her and is of the opinion that she should be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.95 Ms LiKa

Ms LiKa is a 30-year-old female who presents to your office with the complaint that she 'is not feeling well'. Ms LiKa tells you during the interview that she has always been a sensitive person who easily feels hurt. Since adolescence she has felt that she is 'just not good enough'. She tends to shy away from relationships because she is afraid that people would hurt her. Although she often fantasised

about having an intimate romantic relationship, she could never find a partner for whom she felt 'good enough'. She considers herself a 'shy ugly duckling'. She usually avoids relationships unless she is sure that people would like her. She also avoids participating in any group activities for fear of being embarrassed.

She reports to you that she has been feeling intensely depressed for the past three weeks. There is 'nothing that I enjoy any longer'. She verbalises feelings of guilt and worthlessness that 'take my whole head hostage'. She complains about poor concentration and being fatigued all the time. She ruminates about past events and potential consequences of any decision to such an extent that she procrastinates and 'just can't get to decide anything'. Ms LiKa reports that these symptoms have intensified during the past three weeks and that these have 'captured' her day and night. Her family commented on her symptoms and said that she was not herself lately. She also confides in you about intrusive suicide thoughts that she tries to suppress. These thoughts are about jumping from a tall building, but she has not tried to identify a suitable building so far.

Ms LiKa is otherwise medically well with no history of any chronic or acute illness known. She does not use any psychoactive substances. She used to take benzodiazepines regularly for two years but successfully came off these three years ago.

On examination you find her mood severely depressed with lability and features of anhedonia. She reports hypersomnia as well as an increase in her appetite. Her affect is congruent with her mood. Her speech is soft and monotonous, and she avoids eye contact most of the time. She structures and formulates her thoughts clearly. The thoughts of suicide recur frequently during the interview. Her concentration is mildly impaired, but other cognitive functions are intact. You find no current hypomanic, manic, or psychotic features.

Ms LiKa agrees with your assessment of the severity of her current mood episode and her suicide risk. It is clear to her that she requires care, but she is not sure 'what will be the best plan of action'. She is afraid that she will 'make a mistake' and be 'laughed at' and that 'people will see I am not good enough'. She changes her mind several times after you have recommended hospitalisation. Compounding her ambivalence is that she is fearful of going against your recommendation on the one hand, yet also dreads facing other patients at a hospital who, she

says, will be scrutinising and evaluating her every move. She adds, 'I just cannot even decide if I should leave the decision up to you'. Her family is of the view that she requires hospital admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.96 Mr LuJe

Mr LuJe presents as a 24-year-old male who has recently started working at his first job responsible for preparing and reconciling invoices at a medium-sized company. His colleague and another friend who accompanies him, mention that his energy is excessive and that he has slept very little during the past ten days. They both mention that he is unusually irritable and acts aggressively. According to his colleague, Mr LuJe was exceptionally productive during the first two weeks of his employment, but he hardly completed any tasks during the last week. His supervisor has now second thoughts about his appointment and considers dismissal. Mr LuJe says forcefully, 'I am fine!', and adds, 'If they do not appreciate my real worth at this company, they will certainly do so elsewhere'.

Mr LuJe denies any history of any serious illness or previous surgery, except for a tonsillectomy at the age of six. He denies a family history of psychiatric problems. He regularly uses alcohol and often goes to parties. He also uses marijuana from time to time. He does not believe that this has ever affected him negatively.

On examination you find that Mr LuJe's is conscious and his sensorium clear. You observe no signs of intoxication. He is somewhat irritated about seeing you. He complains that you are too slow, saying that you should 'really shape-up professionally and not come across so stupid' because he would have thought that 'you were much more intelligent being a doctor'. He is also clearly irritable towards his accompanying colleague and his friend. He describes his mood as 'I am extravagantly happy, unless someone pisses on my batteries, like you are doing now'.

On questioning, he describes the tempo of his thoughts as 'just right and up to speed where it should be'. The problem, he says, is with the tempo of your thoughts and that of most other people, which is 'moving at a snail's

pace'. His speech is very fast and pressured. He speaks loudly and seems at times aggressive towards you during the interview. He is distractible and remains in his seat for no more than 20 seconds at a time before getting up repetitively, despite being asked to remain seated. He is not cooperative in your attempts to test his cognitive functions, responding that you are grossly underestimating his abilities. When you enquire about his abilities, he says these are emerging progressively and he already sees exceptional beauty being generated in the world by his remarkable doing that will only be fully appreciated in the future. He suspects, but is not certain 'as yet', that people are already jealous of him and are trying to undermine him.

Mr LuJe decisively refuses to be admitted to the hospital. He is not receptive to any possibility that he is mentally ill. It simply does not make sense to him that you want to admit him to hospital or provide him with treatment. He gets up and walks out of the consultation room. His friend is deeply concerned about him and wants him to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.97 Ms CuRa

Ms CuRa presents as a 31-year-old female working as administrator at the local municipality. Her family has brought her to the hospital on account of her depressed mood even though she resisted. She complains that she 'can no longer cope' and that 'this life is no longer worth living'. She returned to tertiary education six months ago to advance in her career but has experienced working and studying simultaneously as 'much too much'. She has not gone to work during the past week, and before while at work she 'failed big time'. She also mentions that she is often in conflict with her mother and two siblings.

On questioning she mentions that she feels intensely depressed with loss of all interest in her usual activities for the past month. She reports that she has little energy and lost her drive to succeed at university. Her sleep is severely affected with initial, middle, and terminal insomnia. She lost her appetite with subsequent noticeable loss of weight. She reports feelings of worthlessness and feeling guilty about 'failing my family and at my studies'. She

acknowledges thoughts of suicide and admits to a recent suicide attempt with an overdose of medication of which her family remains unaware. She concedes that since this attempt, she has given thought to 'another way of ending my misery', specifically to jump into the way of a large truck, perhaps from a bridge. She finds that she struggles to remember what she has read on account of her poor concentration and says, 'by the end of a paragraph, I can't remember its beginning'. She further describes how she struggles to get going with plain tasks especially in the mornings. Later in the day, she quickly gives up and completes hardly any chores. All is in a mess at her home with dirt and garbage all-over, she says, which 'is fitting because I am garbage'.

Ms CuRa used to take maintenance treatment for bipolar II disorder, which she discontinued six months ago. She is not known to use any psychoactive substances. Ms CuRa reports that her sister was diagnosed with borderline personality disorder. Her personal medical history is unremarkable.

Your examination confirms the features of a major depressive episode of severe degree. She presents submissively and with a stooped posture. Her affect is blunted with little emotional flow. Her speech is at a persistently high pitch, and it sounds as if she is on the brink of crying all the time. The tempo of her speech seems slow, and her speech contents are sparse. Rapport is superficial, and her speech is devoid of emotional expression, and she discloses everything in a matter-of-fact way. This contrasts starkly with the persistently imminent crying. She is rather reluctant to reveal the contents of her thoughts. You find no evidence of a current manic episode.

You propose hospital admission to Ms CuRa on account of the severity of her mood episode as well as her current suicide risk. Ms CuRa's mental state is dominated by hopelessness to such an extent that she dismisses treatment as irrelevant to her as 'it cannot make any difference'. Despite your explanations, she is not receptive to it even be possibility that her depressed state and hopelessness are affecting her expectations of no response to treatment. She remains steadfast in her view that she is precluded from any treatment benefits, as she is 'not worthy' of a positive response. She firmly declines your recommendation, and she forbids you to inform her family of her suicide attempt. Her family is so concerned about her health that they want her to be admitted to

the hospital, even though they are unaware of her suicide attempt and current plan.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.98 Ms LeKi

Ms LeKi is a 25-year-old female who presents to your office with the complaint that she 'is not feeling well'. She defaulted her usual treatment as she did not have sufficient money to visit her local clinic. She reports that she also 'don't like to follow up there anymore. I don't like the people there'. Ms LeKi reports that she easily feels rejected and struggles to maintain long term relationships. Her mood rapidly alternates between feeling happy and upset, even when she is well and using mood stabilizing treatment. She often experiences episodes of intense anger, which her family ascribed to 'who she is'. She has experienced enduring feelings of emptiness and worthlessness since adolescence.

She reports to you that she is feeling intensely depressed for the past three weeks. She denies any pleasurable activities. She verbalises feelings of guilt about insulting her mother and sister that have been on her mind much of each day. She complains about poor concentration and persistent fatigue. She finds herself making decision rather impulsively and erratically, much more so than usually. Ms LeKi reports that these symptoms have been present for most days over the past three weeks. Her family commented on her behaviour and said that she was 'worse than ever before'. She adds that 'I know they are right although I hate it that they are'. She also says, 'I have never liked myself nor anyone in the family, but now hate myself and them flat-out'. She also tells you in confidence about her suicidal thoughts and a tentative suicide plan.

She is known with bipolar II disorder and was using maintenance treatment. Her sister also suffers from an unspecified psychiatric problem. Ms LeKi has no other history of any chronic or acute medical problems. She does not use any psychoactive substances at the moment. Self-defeating behaviour features often in her history often in relation to relationships. She denies any self-harm behaviour or previous suicide attempts. She admits

that often fantasied about the responses of other people if she were found dead.

On examination you find her mood to be depressed with lability and features of anhedonia. She reports hypersomnia, an increase in her appetite and 8kg weight gain during the past 4 weeks. Her affect is congruent with her mood. Ms LeKi comes across assertively and coarse. Her speech is loud. She feels somewhat threatened and vulnerable at this time but denies that anyone specific is giving her a hard time at present. She expresses this vulnerability as an intolerance towards anyone who would dare to disagree or challenge her, in her words, 'I take no shit from nobody.' She claims that she has never felt her 'reserves being depleted so much' and that she would end her life 'if things don't get better'. You find no current hypomanic, manic, or psychotic features.

You want to admit Ms LeKi to treat her severe mood episode and reduce the risk of suicide. Ms LeKi agrees with your assessment of the severity of her current mood episode as she mentions that 'I'm not feeling well' and 'something is seriously wrong'. She wants to restart her treatment. She actively engages in the interview regarding the most appropriate medication for her current mood episode and planning of her treatment.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.99 Mr CuNa

Mr CuNa presents as a 32-year-old male. His family has brought him to the hospital on account of his depressed mood. He mentions that he 'can no longer cope with the pressures of life'.

On questioning he mentions that he feels intensely tired and has been 'robbed' from being interested in anything during the past month. He reports that he has little energy and lost his drive to carry on doing business. (He is self-employed.) He is unable to manage his business as he has done before. His sleep is severely affected with initial, middle, and terminal insomnia. He lost his appetite with subsequent noticeable loss of weight. He reports feelings of worthlessness and guilt about 'failing his family and his employees' and 'all the bad things I've done'. Despite these feelings he denies thoughts of suicide or recurrent

thoughts of death. He finds that he struggles to remember what he read on account of his poor concentration as well as significant memory impairment. He also noticed that, for the past month, he struggles to make decisions. For the past month he was always concerned that he would 'make a mistake because I can't think things through'. This had a significant impact on his performance in his business.

Mr CuNa was previously diagnosed with bipolar disorder and used to take maintenance treatment that he discontinued six months ago. He is known to use alcohol and cannabis at regular intervals. He denies recent use of either of these substances and tests negative for any signs associated with the use of these substances on special investigation.

Mr CuNa reports a family history with his brother diagnosed with bipolar disorder. His personal medical history is unremarkable in other respects.

Your examination confirms the features of a major depressive episode. He presents as poorly groomed, impatient and somewhat evasive. His speech is restricted to short, mostly mono-syllabic responses. His affect is blunted with little emotional flow. The flow of his thoughts seems retarded. When asked about his concentration, Mr CuNa relates that 'a beast took hold of my thoughts', which makes it difficult to concentrate. He claims that this 'evil beast' is controlling his thoughts and actions, causing him to do 'bad things'. When asked about these 'bad things' he mentions 'evil and aggressive thoughts, wishing my family would die'. You find no evidence of a manic or current mixed feature. Mr CuNa's social judgement and insight seem to be significantly impaired.

You plan to admit Mr CuNa to hospital owing to the risk that his psychiatric disorder poses to his financial interests and reputation. Mr CuNa is currently so pessimistic that he thinks inpatient care and treatment would not make 'much of a difference' despite you extensively explaining the benefits and the risks of in- versus outpatient care. He does not believe that admission is indicated as his main problem is not a mental illness but the 'evil beast' controlling him. He comments, 'It just does not make sense that you admit me. The beast is everywhere'. He believes that a (unspecified) 'spiritual intervention' is the only reasonable course of action. He gets up to leave your office.

His family does not share his explanation of his experience and wants him to be admitted to hospital for psychiatric care and treatment.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.100 Ms LiCa

Ms LiCa is a 71-year-old female presenting with her index episode of a severely depressed mood. She reports a loss of interest in life and is of the view that her 'life is just not worth the effort anymore'. Her sleep is disturbed with initial, middle, and terminal insomnia. Her appetite is also disturbed with a significant loss of weight.

Ms LiCa's family corroborates her complaints from their observations. They also mention that she is becoming more and more forgetful. They find that she cannot focus her attention or sustain her concentration. They noticed how she often struggles to make sense of new information. She told them that she often feels worthless.

Ms LiCa is accompanied by her husband of the past 49 years. He describes he always 'needed to take care of her' as she was reliant on him. She always needed and heeded his advice in the past. She requires his reassurance before she makes any decision. She finds it hard to be on her own or away from him. Ms LiCa tells you that she 'wouldn't know how to take care of myself without him'. They say they have never had major disagreements in their marriage. He describes her as a 'do-gooder' who would 'do herself in' as to assist others.

Ms LiCa has a family history of major neurocognitive disorder. Her medical history is unremarkable in other respects, and she does not use any psychoactive substances.

On your examination you find that Ms LiCa is unkempt and dishevelled. She seems agitated and fidgets with her hands all the time during your interview. Her attitude is submissive, and her speech is soft. Her verbal responses are subject to a long latency before she responds in brief phrases. She seems objectively depressed with a blunted affect. You also notice the marked impairment of her concentration and poor short-term memory. You do not elicit any psychotic symptoms and no indication of hypomanic or manic symptoms.

You want to admit Ms LiCa to hospital for the sake of her health and safety. Ms LiCa agrees with your and

her husband's assessment of her current dire mental health state. She can however not contribute much to the discussion of her further management. She remains disengaged despite your concerted efforts to involve her in this discussion and further planning. It appears that she loses track of the discussion very quickly even when it comes to the practical arrangements for hospital admission. Her responses are often not relevant in this discussion, also when you ask her about hospitalisation. She often does not recall pertinent information you have discussed a few minutes earlier. Her husband accepts your recommendation that she should be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.101 Ms LeNi

Ms LeNi presents as a 50-year-old female with a history of recurrent major depressive disorder. Her spouse has brought her to the hospital. He tells you that she complained of the effects of poison, but they could not corroborate that she would have been exposed to any poison. He tells furthermore that Ms LeNi has always had problems trusting people, doubting their 'true' intentions. She easily feels exploited and deceived and tends to read 'hidden meanings' into even the most innocuous remarks. The spouse describes her as 'someone who can hold a grudge for years'. She also finds it hard to trust him and often accuses him of wrongdoing. She has alienated most people including her family and the neighbours. She does not really have any friends.

Ms LeNi says that her husband is poisoning her and has been doing so for years. She does not know which poison he is using as she has never seen it, but she feels the effects of it. These effects that she experiences are extreme exhaustion and pain all over her body. She suspects her husband has recently intensified the poisoning as the pain is worse than ever and it prevents her from sleeping and eating properly. She has lost a lot of weight, but cannot quantify this as she has no scale. On questioning her state of mood, she says that she feels 'at the bottom of overwhelming sadness and disappointment', and that 'she is on the brink of dying with no energy left to fight back'. She also says that all is hopeless as nobody

including yourself would believe her that her husband is poisoning her, as he is doing it in a very clever way that is not detectable by anyone, including you.

She has a family history of her sister suffering from mental illness, but she and her husband know little details of this. The husband also mentions an aunt of Ms LeNi who had suffered psychiatric problems before she died some years ago.

Ms LeNi is not known with any other illness. Your physical examination reveals no indications of co-morbidity or effects of toxins. She is touch-sensitive all over her body, responding 'that hurts' even when your touch is soft. She does not use any psychoactive substances as corroborated by her spouse.

On mental state examination you find her to be severely depressed with prominent anhedonia. She is not forthcoming during the interview worrying that you 'might use my words against me'. She denies any suicidal thoughts. Her thoughts are coherent and goal-directed. She can sustain her concentration during the interview and expresses herself unambiguously. You find no features of hypomania or mania.

You are of the professional opinion that Ms LeNi is severely depressed and requires hospital admission and treatment for the sake of her health. Ms LeNi however questions your motives for this proposed admission. She is concerned that you 'also want to get me'. She views your recommendation with suspicion, saying it is a way 'to exert power over me'. She is not convinced that your recommendation is founded on her mental state but rather your malicious intentions towards her. Despite her spouse's concern about her wellbeing, Ms LeNi is not willing to be admitted and wants to go home and 'die in familiar surroundings'. She says you would also not be able to do anything about the poisoning in the hospital because nobody, except her husband, knows which poison is affecting her. Ms LeNi's spouse wants her to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.102 Mr MiHu

Mr MiHu presents as a 20-year-old single male who has been brought to the hospital by the community social worker. Mr MiHu is unemployed and lives alone in a small shack in an informal settlement. The social worker has brought him to the hospital because Mr MiHu behaved sexually inappropriately by exposing his genitals in public. The community knows of his mental illness history and for this reason they contacted the social worker rather than the police. The social worker managed to track down Mr MiHu's brother who agrees to talk to you about his brother's care.

Mr MiHu was diagnosed with bipolar I disorder at the age of 18 years following a serious suicide attempt. His father was also diagnosed with bipolar disorder and admitted as an involuntary mental health care user following an incident of physical violence. Mr MiHu and his brother tell you that they grew up in a strict home where their parents had high expectations of them. The family was conservative in their culture and religion. Their father never adhered to treatment because he did not believe in it. The family is now disappointed in Mr MiHu for not having a job.

His medical history is otherwise unremarkable, and he denies the recent use of any psychoactive substances.

You find on your examination that Mr MiHu is talkative but difficult to engage. He hardly allows you any opportunity to talk. Both his speech and thoughts are mildly pressured. He is distractible from time to time during the interview. He reports to you that his levels of activity and energy have been high during the past week. He describes his mood as irritable during the past week. He is mildly but visibly agitated during the interview. He displays no other signs of a hypomanic or manic episode. You do not find signs of psychosis or suicide ideation. You find no other medical pathology on physical examination that can explain his current symptoms. His toxicology screen is negative.

Mr MiHu's mood episode is, in your professional opinion, of mild severity. However, you want to admit him to hospital as you are concerned about his reputation and his sexually inappropriate behaviour. Mr MiHu agrees that hospital treatment may help him again as it did the previous time. He thinks this is the most sensible course of action at this time. His brother however is not happy about your recommendation. He wants to take his brother to a traditional healer instead, as their family is against medical

treatment for 'his kind of problem'. He points out that their father also refused medication.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.103 Ms CiRu

Ms CiRu presents as a 32-year-old female who is accompanied by her mother. She describes typical symptoms of flu that she contracted six weeks ago, corroborated by her mother. These symptoms have all disappeared except that 'the flu entered my brain' about three weeks ago where it is 'eating it away'. She suffers now because much of her brain is gone, she says. She knows this is the case because she is very tired, wants to sleep all the time, has no energy to do any tasks, and the dead parts of her brain have rotten and 'stink too much'. She apologises that you should endure this nauseating stench. She does not believe you when you tell her that you cannot smell it.

She was promoted to supervisor at her work three months ago and experienced a lot of pressure and expectations from her employer. She has not been back at work since contracting the flu six weeks ago. She has no history of receiving psychiatric treatment, and no history of major illness. She had an ulna fracture that required brief hospitalisation 6 years ago, but no other medical problems of note. She denies the use of psychoactive substances. Her physical examination and basic blood tests reveal nothing of medical concern at this time.

Your examination confirms the features of a major depressive episode of a severe degree with a somatic delusion, olfactory hallucinations, anhedonia, lack of energy and drive, hypersomnia, and a loss of appetite and weight. She also reports feeling guilty about 'failing' to be at work and do her job. Her concentration is significantly impaired on the serial-sevens subtraction test, but you find no other cognitive impairments.

When you recommend hospitalisation, Ms CiRu says that too little of her brain remains to concentrate and make decisions. She says she 'can't think things through properly at the moment' and that 'I do not know what

we should do'. She leaves the decision regarding hospital admission to her mother and you.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.104 Ms CuGi

Ms CuGi is a 25-year-old female, employed as a bank clerk. She was brought to you in lieu of arrest by the SA Police Service after she had been aggressive in public. She claims that her aggressive outburst was out-of-character and that she 'lost my mind in the heat of the moment'. During the consultation she mentions another impulsive act: she almost bought an expensive luxury car during the previous week despite the fact that she was over-drafted on her bank account. She confirms having excessive energy and that she does not need to sleep much. With so much energy, she says, one cannot really sit still and do nothing, conceding to being restless. Her family and friends also 'moaned' that she was 'busier' than usual. She mentions that she has a bit of difficulty keeping up with her very fast thinking, as her mind is racing 'to come first and win'. But a fast mind, she says, is fitting for 'someone like me'. She cannot elaborate on 'someone like me' and you take it as an expression of some grandiosity but not a delusion.

Ms CuGi developed a depressive episode after the birth of her child 18 months ago. The depressed mood lasted for eight months during which she was hardly talking to anyone and isolated herself. She felt 'stressed' about her baby and her financial circumstances. She made a suicide attempt during this time by drinking an unknown mixture of medicine but 'nothing happened'. She slept off the effects of the medication but did not consult a doctor or visited a hospital. The depressive symptoms gradually improved without medical treatment.

Ms CuGi has no history of any other acute or chronic medical pathology which could explain her manic symptoms. She is not known to use any psychoactive substances. You also find no medical pathology on physical examination. She tests negative for all psychoactive substances. She is not aware of anyone in her family having psychiatric problems.

On examination you find that Ms CuGi is energetic and restless. She hardly sits still during the consultation. She displays flight of ideas with rapid, pressured speech. Her speech is loud and rambling, often not making sense. Her experiences both euphoria and dysphoria during the consultation. She says, 'I am so happy about everything and anything. I am very unhappy about the involvement of the SAPS and possible legal proceedings'. She regrets the aggressive outburst and feels guilty about her behaviour. Her concentration is impaired on testing, but you find no other cognitive impairments. You find no psychotic features.

You strongly urge Ms CuGi to be admitted to the hospital on account of her mood and your concern about her financial interests and reputation. Ms CuGi concedes that 'all is not well with me' but 'it is not that serious at all'. She is dead set against hospital admission because she claims, 'that would be like prison, just because I lost my cool for a bit. I have too much to do and I won't let my current joy be dampened. I don't fit in hospital'. She denies that she may act impulsively or aggressively again, or that she may harm her financial interests or reputation. Her family is concerned about her state of mind. They are of the opinion that she needs to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### **1.105 Mr CiNu**

Mr CiNu presents as a 35-year-old male, employed as a driver at a retail outlet. His family brought him to the hospital on account of his depressed mood that worsened during the past month. He complains that he 'can no longer cope with all the demands placed upon me'.

On enquiry about his mood, he says, for the past month he has felt numb and emotionally dead with a loss of all interest to carry on living. Moreover, whatever happens, he says, when there is reason for happiness or sadness, 'I can't feel it'. He reports that he has little energy and lost his drive to succeed at work. His sleep is severely affected with initial, middle, and terminal insomnia. He lost his appetite with subsequent noticeable loss of weight. He reports feelings of worthlessness and guilt about 'farting in the face of having a steady job'. Despite these feelings he

denies thoughts of suicide or recurrent thoughts of death. He finds that he struggles to remember what he read on account of his poor concentration. He also noticed that he struggled to make decisions, 'I can't keep all in my head, and then goes back and forth in changing my mind endlessly'. For the past month, he has been persistently worried that he would make a mistake because 'I can't think clearly'. This had a significant impact on his output at work. He stopped going to work two weeks ago, placing his employment in jeopardy. His family noted that he began to give his possessions away.

Mr CiNu denies any previous psychiatric problems, but his family mentions that there were periods when he was very unhappy in the past. These always abated after a couple of weeks without treatment. This time it is much worse, however, they say. He is known to use alcohol and cannabis during some weekends. He denies recent use of either of these substances and tests negative on special investigation. Mr CiNu reports no family history of psychiatric disorder. His personal medical history is unremarkable in other respects.

Your examination confirms the features of a major depressive episode of severe degree. He presents as poorly kempt with soft and slow speech. His affect is blunted with little emotional flow. The flow of his thoughts is slow. Poverty of thought makes it difficult to follow what he says in that connections between thoughts are often not expressed, which then suggests incoherence. You find no evidence of current mixed mood features. Mr CiNu reports that he has been hearing voices of unknown individuals for the past week. The voices comment on his behaviour and sometimes give him instructions, which he tends to follow. The voices tell him to get rid of all his 'excessive stuff'. He cannot explain the origin of these voices, which are at times comforting and other time upsetting. Mr CiNu's social judgement and insight seem to be impaired on account of the auditory hallucinations that he experiences.

You intend to admit Mr CiNu and treat him with the expectation that he would probably become apsychotic and well enough to return to his employment. Mr CiNu feels so negative and despondent that he thinks inpatient care and treatment would not make a difference despite you extensively explaining the need for treatment. He responds that he is not in a position to make a decision as he 'can't think at the moment' and 'cannot say what we should do'. He does not think the voices are resulting from mental illness and he does not understand how treatment 'would

make me better'. He tells you, 'the voices say I should not be admitted'. He is however not sure if he should trust the voices. He says you and his family should decide.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.106 Ms CeKu

Ms CeKu is a 73-year-old female presenting with her index episode of a severely depressed mood episode. She reports a loss of enjoyment in life and that 'life is not worth living'. She confides in you about her suicide thoughts and desire to 'end it all'. Her sleep is disturbed by early morning awakening. Her appetite is also disturbed with a significant loss of weight. Ms CeKu's family corroborates her complaints from their observations. They also mention that she is becoming increasingly forgetful. They find that she is unable to focus her concentration and that she often struggles to make sense of new information. They further report that she often complains that she has become worthless.

Ms CeKu's husband of the past 50 years describes that she always 'needed taking care of'. She always needs his advice and reassurance before she makes any decision. They have a wonderful marriage as she never disagrees with him. He describes her as someone who 'always goes the extra mile for everyone else' even if that is at a significant cost to herself. She finds it hard to be alone or away from him. Ms CeKu tells you that she 'wouldn't know how to take care of myself without having him at my side'.

Ms CeKu has a family history of major neurocognitive disorder. Her medical history includes hypertension, dyslipidaemia, and a mitral valve replacement. She underwent a hysterectomy 'many years ago'. She stopped using alcohol years ago but still smokes cigarettes on occasion.

On your examination you find that Ms CeKu is a well-groomed female. She seems agitated with wringing of her hands and restless legs during the interview. She struggles to sit still during your interview. Her speech is soft and slow, and her responses are devoid of detail. She seems objectively depressed with restricted affective flow. Her thoughts seem to be preoccupied with worry and anxiety.

You also notice her lapse in concentration and her poor memory function. She is unable to structure her thoughts during the interview. You do not find any psychotic symptoms. You find no indication of hypomanic or manic symptoms either.

You want to admit Ms CeKu to hospital to mitigate against her suicide risk. Ms Ceku disagrees with your and her husband's assessment of her current dire mental state and does not accept that she requires care. It is uncharacteristic for her to disagree so vehemently with her husband. Unlike you, she is unconcerned about her recurring suicidal thoughts and is not afraid that she may act on this. She tells you and her husband: 'I want to go home now'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.107 Ms CaRe

Ms CaRe presents as a 33-year-old female. She is accompanied by her mother who has brought her to the hospital on account of her depressed mood. She mentions that she 'can no longer cope' and that 'I have become completely useless'. She adds that she is currently not on speaking terms with her husband and daughter, as they make her very angry.

On questioning she mentioned that she feels intensely angry with everyone including herself. She has not resorted to physical violence 'yet', she says, but over and above the regular shouting, the situation is very tense and hostile at home. In such a situation, she says, there cannot be any activities of enjoyment. For the past month, she has little energy and lost her drive to do her work properly, and she neglects the chores at home. Many of the fights at home often concern who should have done which chores.

Her sleep is severely affected with initial, middle, and terminal insomnia. She lost her appetite with subsequent noticeable loss of weight. She reports that she feels useless and guilty about not performing at work and home as she should. She also feels very guilty and ruminates a lot about 'each and every bloody altercation', regretting it each time, but she does not feel like attempting reconciliation because as 'I remain furious although I realise that I am

unreasonable'. She adds, 'I hate myself endlessly'. She concedes to having thoughts of suicide and recurrent thoughts of death. She finds that she struggles to remember what she read on account of her poor concentration as well as memory impairment. She is employed as a bookkeeper and has noticed that she is regularly making mistakes in capturing the information she is supposed to. This leads to conflict with her clients and supervisor at work.

Ms CaRe used to take an antidepressant for a previous depressive episode that was 'not as bad as this one', she says. She discontinued it four months ago because she wanted to fall pregnant. She is not known to use any psychoactive substances. She tests negative for any substance on special investigation. Her personal medical and family history is unremarkable, except that her mother reports that 'everyone in the family is highly strung'.

Your examination confirms the features of a major depressive episode including anhedonia and dysphoria. She presents somewhat dishevelled with an irritated and somewhat hostile attitude. Her speech is belaboured, loud and its articulation is overly strong. It is as if she must keep herself from shouting all the time instead of speaking plainly. Her affect is restricted to a frustrated and hostile expression. The flow of her thoughts is measured, logical and goal-directed. You find only minimal cognitive impairment, mostly related to difficulty with concentration. You find no evidence of a current manic episode or psychotic symptoms. Despite her mood symptoms, Ms CaRe's social judgement and insight seem to be intact.

Ms CaRe agrees with your assessment that she is currently severely depressed. She wants to be admitted to the hospital because 'I desperately need to get out of this' and is willing to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.108 Mr LeJi

Mr LeJi presents as a 28-year-old male who recently started working at his first job. His colleague and housemate who accompanied him to the evaluation mentions that his energy level has markedly increased with a decreased need for sleep during the past ten days. They both mention

that he is unusually irritable and acts aggressively. Mr LeJi tells you that he is feeling 'bad'.

He is known with bipolar I disorder for the past four years. He was placed on a combination of mood stabilisers but defaulted his maintenance treatment. He has a family history of bipolar disorder with a brother also diagnosed with the condition. They have a family history of relative who died by suicide.

Mr LeJi has no history of any other acute or chronic medical illness. He regularly uses alcohol and marijuana mainly to help him sleep. He does not believe that this habit affects him in any way.

On examination you find that Mr LeJi's mind is objectively racing with a flight of ideas. His colleague reports that he is distractible and more talkative than usual. The colleague noticed in the recent past that he was unable to sit still for long which hampered him in completing his tasks. Mr LeJi is objectively restless and finds it hard to remain seated during the interview. His speech is pressured and it is difficult to engage him. He does not allow you to speak much. He speaks loudly and seems at time aggressive towards you during the interview.

His mood for the past week is best describes as depressed. Although driven, he claims that he no longer enjoys the things he used to enjoy. He tells you that the reason he is feeling 'bad' is the presence of 'voices in my head'. He cannot explain the 'voices' other than 'my brain is broken'. The people whose voices he hears, are threatening, telling him that he should die or that they are going to kill him. He confides in you that he is 'tired of struggling like this' and that he plans to end his life. He is of the opinion that 'there is nothing that you can do for me'. He does not believe that any medical intervention will be of benefit.

You find no evidence of acute or chronic medical pathology that can explain the manic symptoms. He tests positive for cannabis and has raised liver enzymes on special investigation.

Mr LeJi is not at all convinced by your recommendation that he needs to be admitted to the hospital. He fails to understand how this would prevent the people of the 'voices' from killing him. He tells you that he feels 'a bit lost and afraid' and would like his housemate to help him to decide. His housemate (who is also a friend) is deeply concerned about his health and agrees that Mr LeJi should be admitted to the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.109 Ms LaKe

Ms LaKe is a 25-year-old female who presents to your office with the complaint that she 'is not feeling well'. She defaulted her usual treatment as she did not have enough money to visit her local clinic. She reports that she also 'did not feel like following up there anymore'. She reports to you that she has been feeling intensely depressed for the past three weeks. She says that there is 'nothing that I enjoy anymore'. She verbalises during the interview unyielding feelings of guilt as well as worthlessness. She complains about her lack of concentration as well as relentless fatigue. She finds it difficult to make decisions owing to these symptoms. Ms LaKe reports that these symptoms have been present for most days during the past three weeks. Her family commented on her symptoms and said that this was 'not how we know you'. She denies any thoughts of suicide or a suicide plan on your direct questioning.

She is known with bipolar I disorder and was using maintenance treatment. Her sister also suffers from a mental illness, but her sister's diagnosis is unknown to her. Ms LaKe is otherwise medically well with no history of any chronic or acute illness. She does not use any psychoactive substances.

On examination you find her mood severely depressed with mood lability and features of anhedonia. She reports hypersomnia as well as an increase in her appetite. She displays an affect in keeping with her mood. Her speech is soft and slow, and you notice some cognitive slowing. The slowing is however not so severe as to impair her cognitive functioning. Ms LaKe is engaged in the interview and expresses her thoughts lucidly. You find no current hypomanic, manic, or psychotic features. Her daily functioning is significantly impaired.

You recommend to Ms LaKe that she resumes her medication. Ms LaKe agrees with your assessment of the severity of her current mood symptoms as she herself mentions that 'I'm not feeling well'. She wishes to resume her medical treatment and actively takes part in a

discussion regarding the most appropriate medication for her current mood episode.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) medical treatment as an outpatient is legitimately declined or not applicable; or b) medical treatment as an outpatient should proceed by which suitable legal status?*

### 1.110 Ms CiKe

Ms CiKe is a 71-year-old female presenting with her index episode of a severely depressed mood. She reports a loss of enjoyment in life and that 'life is not worth living anymore'. She confides in you about her suicidal thoughts and her desire to 'end it all'. Her sleep is disturbed with early morning awakening. Her appetite is also disturbed with a significant loss of weight. Ms CiKe's family corroborates her complaints from their observations. They mention that she is becoming increasingly forgetful. They find that she is unable to focus her concentration and that she often struggles to make sense of new information. They further report that she often complains that she has become (in her words) 'worthless'.

Ms CiKe has a family history of major neurocognitive disorder. Her medical history includes hypertension and dyslipidaemia. She had no surgery before. She stopped using alcohol years ago but still smokes cigarettes on occasion.

On your examination you find that Ms CiKe is well-groomed. She is agitated and keeps pacing during the consultation. Her speech is soft and slow, and her responses are devoid of detail. During the interview she is unable to structure her thoughts during the interview or to indicate what her choice is. She seems objectively depressed with restricted affective flow. Her concentration and short-term memory testing are impaired. You do not find psychotic symptoms. You find no indication of hypomanic or manic symptoms either. Anxiety and worry feature prominently in her thoughts.

Ms CiKe has been married to her husband for the past 42 years. Her husband is extremely concerned about her mental health and wants you to admit her to hospital. You share her husband's view and want to admit Ms CiKe for the sake of her health and safety. Ms CiKe agrees with your and her husband's assessment that her current state is dire, but she cannot tell you what the best course of action

would be. She is unable to convey her wishes because her current state, on your professional assessment, precludes her from structuring her thoughts or give voice to her decision. Ms CiKe is content to allow you and her husband to decide on the need for hospital admission and treatment.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.111 Mr LaNu

Mr LaNu presents as a 40-year-old male with a history of recurrent major depressive disorder. He was brought to the hospital by his spouse because he had complained of 'being doomed to death' and she had been concerned by his 'failing to go to work and just doing nothing at home'.

He is not known with any medical illness and his family history is unremarkable. Your physical examination also yields no indication of any medical morbidity. He reports that he seldom drinks alcohol because he 'does not want to compromise himself'. His spouse confirms his sober habits.

On mental state examination you find his mood to be severely depressed with prominent anhedonia. He is not forthcoming during the interview and his spouse mentions to you that when in a state like this, he hardly trusts her and certainly nobody else. He denies any suicidal thoughts. Suicide would not make sense, he says, as 'I will soon be dying any way'. On the reasons for this claim, he says, 'I just know this is so'. His thoughts are well-connected and goal-directed, but he often contradicts himself. He is able to sustain his attention and concentration during the interview and expresses himself intelligibly. He reports a lack of energy and drive with poor sleep. He struggles to fall asleep for the past month and is often awake during the night. He further mentions that his appetite is poor but that he maintained his weight. Mr LaNu reports that he feels very guilty, saying: 'God is punishing me for my sins and that is the reason for my suffering'. He is not willing to provide details about these sins. You find no features of hypomania or mania.

You are of the opinion that Mr LaNu is severely depressed and requires hospital admission and treatment for his health and safety. Mr LaNu questions your motives and integrity, claiming that your recommended hospitalisation is 'nothing but a prison to punish me further'. He also acknowledges his spouse's concern about his well-being and defer the decision about the appropriate course of action to her. Mr LaNu's spouse is of the opinion that 'it would be better' that he be hospitalised.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.112 Ms LaCu

Ms LaCu is a 69-year-old female presenting with her index episode of a severely depressed mood. She is accompanied by her second husband. They married three years ago after divorcing her first husband 12 years ago. She reports that she has had enough and can't face anything or anyone any longer. She wishes her life to end at this point, because 'I am done'. On questioning, she denies participation in any joyful activities during the last month or so. She does not sleep as before and struggles with early morning awakening. She also does not eat as well as before with a lack of appetite leading to a significant loss of weight. These symptoms have developed insidiously over the past few months.

Ms LaCu's husband corroborates her complaints from his observations. He also mentions that she is becoming increasingly forgetful. He says that she is unable to focus her concentration and that she sometimes struggles to make sense of new information. He further reports that she often complains that she is 'useless'. He reckons that she is overly critical of herself, even if something falls only slightly short of being done perfectly.

Ms LaCu has a family history of major neurocognitive disorder. Her medical history includes hypertension, dyslipidaemia, and a mitral valve replacement. She has not taken any alcohol for the last few years and never smoked.

On your examination you find that Ms LaCu is well-kempt and impeccably dressed. She seems agitated with restless movements during the interview. Her speech is

monotonous, and her attitude is defeatist. She is objectively depressed with restricted affective flow. You also notice the slips in her concentration and her poor memory. You do not find any psychotic symptoms. You find no indication of hypomanic or manic symptoms either. Anxiety and worry are the main themes of her thoughts, as well as much self-reproach and discontent about herself and others failing to meet her high expectations.

You want to admit Ms LaCu to hospital to improve her health and ensure her safety. Ms LaCu agrees with your and her husband's assessment of the current dire state of her mental health. Despite her slow thought processes and poor memory, she concurs that she needs treatment. She says, 'I cannot go on like this'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.113 Mr KuSo

Mr KuSo presents as a 28-year-old male with a history of feeling severely depressed for the past month. This is his first episode of a mood disorder. He has been brought to the hospital where you are consulted by a community social worker who is concerned about his welfare. They are accompanied by his sister.

Mr KuSo reports significant anhedonia (a loss of interest in life) accompanied by a loss of concentration as well as memory impairment. He furthermore reports that he struggles to make decisions in his daily life because of the two latter symptoms. He also mentions that he is contemplating suicide by shooting himself. His severe indecision has thus far prevented him from acting on his suicidal thoughts, but he is worried that 'things might get worse, and I end up doing it'. Because of his indecisiveness and cognitive impairment, he is struggling to complete projects at work. His business is subsequently floundering leading to a decline in income. He tries to hide these problems from his family and friends because he feels ashamed. He reports feeling hopeless and worthless and has begun to withdraw from his friends and family in the recent past. Mr KuSo reports that he has little appetite owing to abdominal pain and nausea. He lost seven percent of his baseline body weight during the past month. He struggles to sleep every night and feels tired all

the time. He tells you confidentially that he secretly started to drink alcohol heavily during the past six months. Initially he used it to cope with his work-related stress but recently it has helped him to fall asleep.

Mr KuSo grew up in a family that is conservative and religious. He tells you that he, out of the blue and for the past week, started to hear (what he describes as) 'God's voice' who speaks to him and gives him instructions and even commands. He has never experienced something like this. As part of his suicidal thoughts, he says he will 'be with God when I am dead'. He claims to have an unusually close relationship with God who also sends him covert messages through random TV and radio programs. He claims that no one else can understand or even recognise these messages as they are meant only for him.

Mr KuSo's sister reports to you in confidence that the family is not concerned about his physical or mental health. She and other members of the family believe that his current state reflects a 'higher calling', signalling a future of much fortitude and prosperity. The family does not think he poses any suicide risk at all. The family is of the view that he requires spiritual support and counselling and not hospitalisation. The social worker became involved with him on the insistence of his business partners who were concerned about his mental health and use of alcohol, as he was jeopardising their business.

Mr KuSo has no history of previous mental illness and his medical history to date is unremarkable. No family history of mental illness is known. He denies the use of any psychoactive substances other than alcohol.

On examination you find that Mr KuSo is objectively depressed with psychomotor retardation. He presents with a restricted affect. He engages rather superficially during the interview. His thought processes are coherent. His cognitive functions are significantly impaired by severe indecision due to impaired memory and concentration as reported above. You recognise Mr KuSo's auditory hallucinations and delusions.

On physical examination you find signs indicative of alcoholic hepatitis with a tender enlarged liver and right upper quadrant pain. Blood tests reveal mild hyperbilirubinemia and deranged liver enzymes.

Based on the severity of his physical and psychiatric symptoms and signs you urge Mr KuSo to be admitted to the general hospital where you consult. He is unwilling to be admitted to the hospital (despite his concern about

his suicide risk) 'because I have to do God's work'. He insists that for him to be admitted would 'go against what God tells me to do'. He consequently refuses admission. His sister is convinced that he does not require admission, and she urges him to visit a spiritual counsellor instead. The social worker is concerned about his well-being and is of the opinion that he should be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.114 Mr BoMh

Mr BoMh is a 21-year-old male who overdosed on medication that he had been prescribed for a migraine. He reports symptoms of a depressive episode for the past few months. He experiences a depressed mood of mild to moderate intensity with a lack of appetite. He also mentions low levels of energy and feelings of helplessness and worthlessness in his current life circumstances. He does not report excessive feelings of guilt or any insomnia. Mr BoMh seems very concerned by what he describes as a suicide attempt. His family however describes this as attention-seeking and are not concerned about his behaviour at all.

Regarding his past psychiatric history, Mr BoMh reports that he had five previous suicide attempts. He had two attempts four years ago where he first tried to drown and then tried to hang himself. Two years later he twice tried to poison himself. These attempts were also associated with depressive symptoms. He denies any features of hypomanic, manic, or mixed mood episodes.

In other respects, Mr BoMh has an unremarkable medical history with no chronic illness known. He has no family history of mental or other illnesses. Although he drinks alcohol on occasion, he denies any substance related concerns. He denies the use of any illicit substances.

On your examination Mr BoMh presents with features of a mild depressive episode. His speech is normal in terms of rate, rhythm and volume and he displays a full, appropriate affect. His mood seems to be low, but he still fully engages in the interview with no indication of cognitive impairment. You find no indications of psychotic symptoms or mixed

mood features. His judgement and insight seem to be intact.

Mr BoMh disagrees with his family regarding his suicide risk and wants to be admitted to hospital. You are also concerned about the severity of his suicide risk and want to use hospital admission as a suicide risk management strategy. He understands that he requires psychiatric treatment. He accepts your recommendation of admission.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.115 Ms KuFi

Ms KuFi presents as a 45-year old female brought by her family. She reports that she feels rejected and lonely after her husband of the past 15 years instituted divorce proceedings. Her family reports that she tried to end her life by taking an overdose a month ago.

She tells you that she seriously considers suicide with a plan to overdose on her medication. She further reports that she is feeling depressed and experiences a loss of interest and pleasure in life. These depressive symptoms have been present for the past two years but have worsened since her husband insisted on their divorce six months ago. She finds that she is more irritable than usual as she fights with her children and family, which does not normally happen. She reports a sense of hopelessness and feels worthless. She lost her appetite and shed ten kilograms during the past two months amounting to ten percent of her baseline body weight. Her sleep is affected by early morning awakening, and she is often tired during the day.

Her general practitioner prescribed an antidepressant two years ago, but this 'no longer helps me', she says. She has no family history of mental or other illnesses. She is physically healthy and does not consume psychoactive substances at all. You find no indication of physical illness during your examination.

On mental state examination you find that Ms KuFi's mood is depressed with a blunted affect and an unhappy facial expression. She is tearful during your consultation. You have no reason to doubt her description of her subjective mood experience. She seems irritable at times

during the interview. You find neither cognitive impairment, nor psychotic symptoms.

You urge Ms KuFi to be admitted to the hospital on account of the suicide risk she poses as part of her mood episode. Ms KuFi cannot decide what to do. She also thinks that 'something is wrong with me' and that 'something must be done' but she is not convinced that hospital admission is the most suitable intervention. She cannot choose between your proposed psychiatric intervention and counselling from her religious counsellor. After extensive discussion involving her and her family in which you strongly recommend hospitalisation, she refuses this because she feels that she is not worth your time and effort as she states, 'I am not worth it that you should bother. You should rather spend time and energy on someone who deserves it'. Her family is however extremely concerned about her welfare and her current mental state.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.116 Ms BoNi

Ms BoNi presents as a 40-year-old female with a history of recurrent major depressive disorder. She has been brought to the hospital by her family because she complained of unbearable headaches and fatigue for the past three weeks. She hates herself for being 'so useless' and she wishes she were dead. She struggles to fall asleep and is often awake during the night for the past month. She further mentions that her appetite is poor and that she started to eat less than usual but her weight is currently stable.

Ms BoNi lives in a high rise block of flats. Lately, she fights often with her neighbours who 'watch my every move' and 'cause my headaches'. She tells you that she cannot bear their onslaught any longer in which they try to get rid of her. She claims that some of the neighbours mock her by implying that she is mentally ill. She shouted at them 'many times in desperation', threatened them, and almost assaulted them a few times, she says.

She is not known with any other medical problems. Your physical examination also yields no indication of any comorbidity. You also find no indication of any substance

use disorder. She has a family history of mental illness with her father diagnosed with major depressive disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She does not acknowledge during your interview suicidal thoughts. Ms BoNi tells you that her neighbours planted secret devices in her apartment. She has not seen these because they are too small, but she knows of these because they transmit inaudible waves that damage her brain and cause her headaches and unbearable fatigue. She dismisses the possibility that these would be suspicions and insists this is in fact so.

Her concentration is poor, and she is unable to make sense of new information or to use it in making decisions. She is struggling at work and in danger of losing her employment. You find no features of hypomania or mania with your examination.

You want to admit Ms BoNi to the hospital as she needs treatment and to prevent her from acting further on her delusions to the detriment of her reputation and financial interests. Her family is relieved that she is agreeable to being admitted. However, Ms BoNi says she does not require admission for treatment at all. She says no treatment can fix the damage that has already been done to her brain as it is permanent. She is agreeable to hospitalisation only because it is a way to escape and hide from the onslaught from her neighbours.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.117 Ms KuBh

Ms KuBh presents as a 51-year-old married mother of two adolescent daughters, who took an overdose of 20 paracetamol tablets three days ago. She has been observed for liver complications in the internal medicine ward and will be discharged this afternoon. This was the first time she had taken an overdose. She has never harmed herself in a similar way or attempted suicide before. She explains that she took the overdose because she was extremely angry at her oldest daughter who, she says, does not treat her with the necessary respect. She will never do something like this again, and this was 'scary',

also because she had discovered that paracetamol may be lethal even if available from the supermarket.

On your enquiry about her mood, she says that she is 'severely depressed' and that she is mainly depressed about her daughter who 'does whatever she pleases with no regard for my wishes'. She denies feeling depressed about anything else except for the consequences of her daughter's 'disobedience'. These depressive feelings persist for most of the time every day. She struggles to fall asleep every evening with 'her daughter on my mind and all', but the rest of her sleeping is not disturbed. She denies anhedonia except that 'my daughter steals my joy all too often'. She reports a loss of appetite and weight. She admits to feeling guilty every day for hours on end about 'failing to raise my daughter better'. Her daughter's bad behaviour is the punishment that she receives for her failures, she says. She reports that her despondency about her daughter drains her energy, and she consequently neglects some of the chores at home. She denies any current suicidal plans, saying 'I have learned my lesson, thank you very much!'

She denies a psychiatric history. She suffered from many bodily problems in the past, she says, but was hospitalised for none. Ms KuBh's family history is unremarkable. Although she uses alcohol on occasion, she denies any alcohol related concerns. She uses no other psychoactive substances.

You find no indication of any substance use disorder related features on examination. She displays no features of psychosis, a hypomanic, manic, or mixed mood episode. Although she complains about her concentration, the testing of it reveals no impairment. Her thought processes are clear, goal directed and logical. Her physical examination reveals no significant pathology.

You diagnose a major depressive episode of a mild degree (notwithstanding the intensity of her depressed feelings), and you consider her risk of suicide to be low at this time. You recommend that Ms KuBh be treated as an outpatient using an antidepressant or psychotherapy. Ms KuBh however is not receptive to your recommendations at all, saying that she has always been sceptical of psychiatric medication as well as psychological help, 'neither sits well with my constitution, sorry. I hope you are not offended'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the*

*information provided: a) treatment as an outpatient is legitimately declined or not applicable; or b) treatment as an outpatient should proceed by which suitable legal status?*

### 1.118 Ms BiNu

Ms BiNu presents as a 40-year-old female with a history of recurrent major depressive disorder as well as epilepsy. She was brought to the hospital by her family because of their concern for her mental health. Ms BiNu reports a low mood and a lack of enjoyment in life. She tells you that she feels more guilty than usual as well as worthless, saying: 'I should not be alive'. She struggles to sleep for the past month and is often awake during the night. This leads to a lack of energy and drive during the day. She also complains that her appetite is poor and that she started to eat less than usual.

In other respects, she is medically well except for the epilepsy. Her epilepsy is poorly controlled, and she suffered at least two seizures during the past week. You find no indication of any substance use disorder. She does not seem to adhere to her prescribed treatment. She has a family history of mental illness with her mother diagnosed with major depressive disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. She denies any recent suicidal thoughts. When you enquire about unusual perceptual experiences, she discloses that she for the first time began hearing music that is playing and a choir singing about one week ago, but this is not only new, it is also unusual, she says, for the source of this is not apparent, for the radio and TV are switched off. She came to the conclusion that this 'must come directly from God' and that she was receiving messages of encouragement to 'protect me'. She does not find this music or the choir's singing threatening but this is soothing and comforting her. She rejects the suggestion that this may be mere experiences or a product of her own mind. She says she hears this no differently from hearing you speaking, except that the singing and messages are 'heavenly'. The protection that she receives in this way is 'a saving grace', she says, because spirits have intensified their attack on her. She is not prepared to reveal more about the spirits or the attacks at this time.

Her thought processes and cognitive functions are seemingly not impaired. You find no features of hypomania or mania with your examination. You come

to the conclusion that she lacks insight into her current mental state.

You want to admit Ms BiNu to the hospital for the sake of her health and well-being. She resists your recommendation of an admission to hospital and responds that you are 'colluding with' those who want to harm her. She tells you: 'I'm not staying here at the hospital, Doctor, because it is not safe'. She forbids you to discuss the matter with her family and does not want them involved as 'they are also influenced'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.119 Ms KiLa

Ms KiLa is a 66-year-old female who presents at your office with her index episode of a severely depressed mood, accompanied by her husband. She retired as a primary school teacher about nine months ago. She reports a loss of enjoyment in life and states that 'life is not worth living'. Her sleep is disturbed by early morning awakening. Her appetite is also disturbed with a significant loss of weight. Ms KiLa's family corroborates her complaints from their observations. They also mention that she is becoming increasingly forgetful. They find that she is unable to focus her concentration and that she sometimes struggles to make sense of new information because of her disordered thoughts. They further report that she often complains that she has become worthless. She tells you in confidence that she intends on ending her life. She says: 'It would not matter if my body were dead too, because my brain is already dead'.

Ms KiLa has a family history of major neurocognitive disorder. She also has a family history of completed suicide in that a family member ended her own life upon receiving the diagnosis of Alzheimer's disease. Ms KiLa's medical history includes hypertension, dyslipidaemia, and a mild stroke from which she recovered. She underwent a hysterectomy 'many years ago'. She still uses alcohol on occasion and smokes cigarettes.

On your examination you find that Ms KiLa is poorly kempt. She seems agitated and restless during the interview. Her speech is soft and slow, and her speech is devoid of detail.

She seems objectively depressed with restricted affective flow. You also notice her lapse in concentration and poor memory. Her thoughts seem disjointed and do not always follow logically. At times she is incomprehensible owing to loosening of associations. She is unable to express her thoughts clearly. Ms KiLa tells you that her brain is 'melting'. She says most of her brain has shrivelled and does not work anymore, hence her she is struggling to think clearly and can feel how she is dying. She also reveals that she can hear her brain making cracking sounds as parts of it are 'breaking and adjusting' to the 'melting'. She is surprised that you cannot hear this too. You find no indication of hypomanic or manic symptoms.

You recommend that Ms KiLa be admitted to the hospital for medical assessment and treatment of her psychiatric disorder and to prevent a potential suicide. Ms KiLa cannot comprehend how hospital admission could be of benefit to her, for a hospitalisation is 'redundant if one's brain is irreversibly gone'. She is unable to tell you what she thinks the most appropriate course of action should be as she struggles to verbalise her thoughts. She seems indifferent about this and goes along without resistance when you address her husband about practical arrangements for her to get to the hospital. Her husband supports your recommendation and does not try to engage in a discussion with her about hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.120 Ms KeSo

Ms KeSo presents as a 40-year-old female with a depressed mood. Her spouse accompanies her. They have been married for 20 years and she is the mother of two children. She lost her job two months ago when her employer had closed the business. Her spouse is unemployed.

She reports that she has felt overwhelmingly despondent since she lost her job. Although she has much time now, nothing is interesting enough for her to make the effort. She says, 'I am interested in nothing and do very little'. She says that even eating does not interest her. She had lost a lot of weight. She also reports that she worries all the time, which is uncharacteristic for her. She tries to avoid her spouse and children as they remind her of their

predicament of having no income and mounting debts. She blames herself for this and sees no possible way of escaping or solving their problems. She can't imagine that they would get out of this mess. All will only go downhill further, she says.

She struggles to fall asleep every night and she gets up tired in the morning. Her husband tells her that she is very restless during the night. She says she is tired of thinking about potential solutions, and not only that but 'of everything'. She says she has given up on chores at home. Her husband and children are doing these. She concedes regarding suicide ideation that if she had not been worried about her husband and children, she would have committed suicide already. Finding a way to do it is easy enough, she says. The irony is, she says, that she is now useless to them anyway, being in her current state.

Ms KeSo's spouse says she is fussing unnecessarily and that 'all is not that bad'. He admits that they have serious financial problems, hardly enough to eat, and that they are likely to be evicted from their current residence. Her spouse denies that their situation is causing her to be ill, and he maintains that she 'should try harder and pull herself together'.

Ms KeSo has no prior history of mental illness nor a family history of mental illness. She denies any past suicide attempts but has a history of suicide in her family of origin with an aunt who died by suicide when Ms KeSo was a teenager.

Ms KeSo has a history of an ectopic pregnancy in the past but no other significant medical history. Congruent with their religion, she and her spouse deny any use of psychoactive substances.

On your examination you find that Ms KeSo is unkempt with little regard for personal grooming. She seems agitated with wringing of her hands and restless legs. She often walks about during the interview and finds it hard to sit still. Her facial expressions and thought contents are replete with themes of distress, dejection, and despondence. She describes her mood as 'I am surrendering to the onslaught' and 'I am defeated'. She shows mild impairment in concentration upon testing it, but she is still able to structure her thoughts in a systematic and reasoned manner. You do not find any psychotic, hypomanic or manic symptoms.

Ms KeSo says she knows that she needs help and mental healthcare. She agrees with your recommendation

that she be admitted to hospital despite her husband's objections, as she says, 'the wheels are coming off' and 'I am losing it'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.121 Mr BiCu

Mr BiCu presents as a 32-year-old male who lives alone, after a divorce six years ago. His family has brought him to the hospital on account of his depressed mood. He mentions that he is 'not able to cope anymore'. He also mentions that he is often in conflict with his mother and sister.

He tells you how intensely depressed he feels with loss of pleasure in all things he used to enjoy. This has been so for the past month. Because of his disturbed sleep (with initial, middle, and terminal insomnia), he has little energy and lost his drive and is not performing well at work. He eats much less than he used to, with subsequent noticeable loss of weight. He reports feelings of worthlessness and 'failing at everything'. He denies thoughts of suicide or recurrent thoughts of death. Mr BiCu finds his work hard because of concentration difficulties. He describes how he struggles to focus and persevere in trying to complete his tasks, often taking no more than first few steps before 'giving up at it'. Particularly, when decisions are required in answering e-mails of example, he procrastinates and 'simply cannot make a call this way or that way'.

Mr BiCu was previously diagnosed with bipolar II disorder and used to take maintenance treatment that he discontinued three months ago. He is known to use alcohol and cannabis at regular intervals. He tests positive for cannabis on special investigation.

Mr BiCu reports no family history of any mental illness. His personal medical history is unremarkable in other respects.

Your examination confirms the features of a major depressive episode. Mr BiCu strikes you as poorly kempt. His speech is monotonous and slow. He shows little emotional expression. The tempo of his thoughts is slow and the contents of his thoughts lack in detail. His thought processes are coherent. You find no evidence of a current manic episode or psychotic symptoms. Mr BiCu's social

judgement and insight seem to be somewhat impaired in your judgement.

You want to admit Mr BiCu to protect him from self-neglect and harm. He feels so negative and pessimistic that he says inpatient care and treatment would not make 'much of a difference'. You spend considerable time discussing various treatment options but strongly recommend hospital admission. In response, he says he 'can't think straight and properly at the moment' and 'cannot say what we should do'. He leaves the decision regarding hospital admission up to his family and you, saying 'you decide'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.122 Mr BhMe

Mr BhMe is a 25-year-old male who took an overdose of antibiotics and analgesics a week ago. He reports symptoms of a depressive episode during the past few weeks. He experiences a depressed mood of mild to moderate intensity with a lack of appetite. He also mentions low energy levels. He reports feelings of helplessness and worthlessness for the past week after failing an exam at college. He denies feeling guilty or any insomnia. Mr BhMe seems unconcerned by the suicide gesture. In his view he did not really want to die and that it was merely 'a cry for help'. His family is however quite concerned about what they believe to be a suicide attempt. They want him to be admitted to hospital.

Mr BhMe has no past psychiatric history. He denies any features of hypomanic, manic, or mixed mood episodes in the past. Also in other respects, Mr BhMe has an unremarkable medical history with no chronic illness. He has no family history of medical or mental illness. Although he drinks alcohol on occasion, he denies any substance related concerns. He denies the use of any illicit substances.

On your examination Mr BhMe presents with features of a mild depressive episode. His speech is normal in rate, rhythm and volume and he displays a full, appropriate affect. His mood seems low, but he still fully engages in the interview with no indication of significant cognitive

impairment. You do not find any indications of psychotic symptoms or mixed mood features. His judgement and insight seem intact.

Although Mr BhMe disagrees with his family regarding his suicide risk, he admits that he is currently mentally ill and that he requires treatment. The family insists that he is admitted to the hospital. You do not consider admitting him to the hospital as crucial but want to schedule outpatient visits to initiate treatment. The family insists that outpatient based treatment would be inadequate. He is prepared to follow your recommendation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) the outpatient treatment proposed is legitimately declined or not applicable; or b) the outpatient treatment proposed should proceed by which suitable legal status?*

### 1.123 Mr JiLa

Mr JiLa presents as a 22-year-old male student. His friend who has brought him for the evaluation, is concerned that he is having a relapse. His friend mentions that he is not sleeping much, behaving strangely, and 'moving all the time'. All this is getting more intense during the past ten days. Mr JiLa in contrast has no complaints and tells you, 'in fact, I feel very well'.

Mr JiLa had used a combination of mood stabilisers for a bipolar I disorder but defaulted his maintenance treatment about a year ago, as he felt he did not need it any longer. He has a positive family history of bipolar disorder. Mr JiLa has no history of any other acute or chronic medical illness. He denies any use of psychoactive substances. This is confirmed by his accompanying friend.

In your professional opinion Mr JiLa is currently having a manic episode. His mind is racing, and he has a flight of ideas. His friend confirms that he is distractible and 'very' talkative. Mr JiLa described his mood as 'ready for action', and you recognise it as elated. You notice that he is restless with psychomotor agitation throughout the interview. His speech is pressured in keeping with his racing thoughts. He speaks in a loud and animated voice, congruent with a lively and energetic affect. You are struck by his grandiose ideas about his influence and importance. His thought processes flow logically and coherently, and he expresses himself with clarity. He is very self-assured and ridicules your enquiry about suicidal ideation, claiming 'that society

cannot afford losing him at this time'. He remains vague about reasons for and the extent of being important and influential. It appears that these thoughts are not delusional at this point in time.

You find no evidence of any other acute or chronic medical pathology that can explain the manic symptoms. He tests negative for all psychoactive substances.

You are concerned about Mr JiLa's health and reputation. Mr JiLa is perplexed by your firm recommendation of hospital admission. He claims that he cannot be mentally ill, replying, 'how can you be ill if you feel this well!'. He concedes however that all is not the same but very different from usual. Granted accordingly, he commits to 'just go with the flow' and abide by 'whatever you and my friend decide'. His friend is deeply concerned and worried that he is ill again like he was about two years ago.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.124 Ms BhKu

Ms BhKu presents as a 45-year-old married woman with no children. She reports a depressed mood for the past two weeks associated with sleep disturbance, a loss of pleasure in life as well as a loss of appetite. She experiences all these mood symptoms of mild intensity. She also mentions noticeable weight loss but was not able to quantify the loss. She mentions that she struggles with her concentration and finds it hard to 'keep my mind on things'. On questioning she reveals that she developed some suicidal thoughts since the onset of the depressive symptoms which followed from a dreadful argument with her spouse. She wants your help 'to feel better'.

Ms BhKu's spouse informs you that she always flourishes on getting attention, since they've been at school together. She dresses flamboyantly and would use her physical appearance through make-up and jewellery to draw attention to herself. She often acts provocatively and seductively to gain attention. This leads to conflict in their relationship. She frequently flirts with people she does not know well and tend to misinterpret relationships as more intimate than they are in reality.

Her past psychiatric history includes three previous depressive episodes with suicide attempts. Ms BhKu's medical and family history is unremarkable. Although she uses alcohol on occasion, she and her spouse deny any alcohol related concerns. She uses no other psychoactive substances.

You find no indication of any substance use disorder related features on examination. She displays no features of a hypomanic or manic episode and no mixed mood features either. She displays no features of psychosis. Although she complains about her concentration, the testing of it using the serial subtraction of sevens shows no impairment. Her thought processes are clear, goal directed and logical. Her bodily examination similarly reveals no significant pathology. In your estimation Ms BhKu's depressive symptoms are of mild severity. Although her social judgement is often poor, she now understands that she requires care and treatment.

Ms BhKu agrees with your assessment of her mental state, the severity of her mood episode and the need for treatment. She is willing to receive treatment as an outpatient.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) outpatient treatment is legitimately declined or not applicable; or b) outpatient treatment should proceed by which suitable legal status?*

### 1.125 Ms BeHj

Ms BeHj is a 26-year-old female who is single and lives with her parents. She developed a depressed mood after her family had 'forced' her to terminate her pregnancy a month ago. She is the mother of a young child from a previous relationship. The father of her child lives with Ms BeHj's parents.

Ms BeHj reports to you that she feels intensely depressed some days but that she still participates in her usual sport and social activities as these 'lift her from the dumps'. When at home, she feels sad and upset with her parents. She had wanted to proceed through the pregnancy, wanting to have her second child but that her parents put her under emotional pressure to terminate the pregnancy. She reports that her appetite is somewhat less than before but that her weight is unchanged. She still dreams at night about being pregnant and has struggled to sleep during

the past month. She often feels emotionally drained and without energy. She finds that her ability to concentrate is somewhat impaired, but her work as administrative clerk has not been affected. She denies any feelings of worthlessness but feels guilty about the termination.

Ms BeHj has been brought to the clinic because of her family's concerns about her mental health and hostility towards them. She has no history of prior mental illness. They have a family history of suicide in that her cousin took her own life one year ago. Ms BeHj denies any suicidal thoughts and plans of her own. Her family is of the opinion that she is hiding her symptoms. They are of the view that she is seriously mentally ill and wants you to admit her to the hospital for tests and treatment.

She presents with a clear sensorium and is fully orientated in all spheres. She maintains appropriate eye contact and is mostly engaging. Her speech is normal in all respects. She seems sad with an appropriate affect. The relationship with her parents is clearly uncomfortable prior, during and after the consultation. You find no evidence of hypomanic, manic, or psychotic symptoms. Her cognitive functions are intact on testing. You find no indication of suicide risk during your assessment. Other than the depressive symptoms, you find no indication of suspected medical illness or substance abuse on your physical and mental state examination.

Ms BeHj understands her family's concern but disagrees with their assessment that she would be seriously mentally ill. She tells you that she is not willing to be admitted to the hospital or to treatment as an outpatient. She is of the opinion that her emotional state will improve with time and that she requires neither medication nor therapy.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) medical intervention is legitimately declined or not applicable; or b) medical intervention should proceed by which suitable legal status?*

### **1.126 Mr BhGe**

Mr BhGe presents at your clinic as a 30-year-old single male with no dependants, who lives in a commune. He is accompanied by his aged parents. He complains of a severely depressed mood, poor sleep, and a lack of appetite. He also mentions that he feels listless and without energy. According to him these complaints have been

present for the past month and he reports that it is steadily getting worse. Mr BhGE reports no suicidal plan but five weeks ago he realised that he 'was not himself' and 'felt like damaging anything and everybody including myself'. He tells you that he isolated himself socially and 'could not face people'. He has lost interest in his favourite activities including his regular physical exercises and jogging, and has to 'force myself' to do these. He suffers early morning awakenings, lacks energy more so in the mornings, and his mood is at its worst in the mornings. This is so most days and nights, but not every night and day. Although he usually feels not good enough, does not like himself, and feels 'like a failure', these feelings have become unbearable.

Mr BhGE's parents report that they did not see a change in his mood or behaviour during the past month. They know him to be somewhat pessimistic and 'sulking' at times.

Mr BhGE underwent an appendectomy at age 15, but his medical history is otherwise unremarkable. He has no history of any manic or mixed mood episode symptoms. He has no family history of any mental or other medical illness. He does not use any licit or illicit psychoactive substances as confirmed by his parents.

You find Mr BhGE suffers a depressive episode of a mild degree of severity, notwithstanding his intense feelings. On your mental state examination, his speech is mostly normal in rate, rhythm, and volume. His affect is reactive and appropriate. Despite his complaints of feeling tired and listless, his speech and tempo of thoughts are not reflecting these features. He participates fully in the mental state examination and his thought processes are coherent. You don't find indications of cognitive impairment or features of psychosis during the clinical interview. He does not display any features of a manic or hypomanic episode. You find no current suggestions of suicide risk. You also do not find clinical indications of a significant medical or mental illness or the use of psychoactive substances.

Mr BhGE insists on treatment for his mood symptoms. You both agree that hospitalisation is not indicated in his case. He is amenable to your recommendation that counselling or psychotherapy be taken up as an outpatient.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) counselling or psychotherapy is legitimately declined or not applicable; or b) counselling or psychotherapy should proceed by which suitable legal status?*

### **1.127 Mr KeNi**

Mr KeNi presents as a 55-year-old male with a history of recurrent major depressive disorder. He has been brought to the hospital by his spouse because he complained of 'feeling unhappy and unwell', which Mr KeNi suspects is the result of poisoning. He reports a lack of energy and drive, and that he has been sleeping poorly. For the past month, he has been struggling to fall asleep and is often awake during the night. He further mentions that his appetite is poor as 'one never really knows what is in the food'. He lost much weight, which his wife confirms.

Mr KeNi made a serious suicide attempt a week ago by drinking an overdose of his wife's benzodiazepine. Mr KeNi explains this attempt as that he could not stand the onslaught and harassment that he had been suffering any longer. He remains vague about this onslaught and harassment, saying 'I dare not reveal anything of it'.

His brother received treatment for a mental illness but he or his wife does not provide more details. He is not known to have any other medical illness. Your physical examination also yields no indication of co-morbidity. He reports that he seldom drinks alcohol because he 'does not want to compromise myself'. His spouse confirms his sober habits.

On mental state examination you find prominent anhedonia and a depressed mood. He denies any current suicidal thoughts during your interview. However, he is not really forthcoming, and his spouse mentions to you that he always maintains that it is best to say as little as possible as 'people always twist one's words' and that 'one should trust nobody'. His thoughts are coherent, goal-directed and flows logically during the interview. He sustains his attention and concentration during the interview and expresses himself clearly. You find no features of hypomania, mania, or cognitive impairment.

You are of the professional opinion that Mr KeNi is mentally ill with a depressive episode of a severe degree, and that he requires hospital admission for the sake of his health as well as protection against a further suicide attempt. Mr KeNi, however, questions your motives and integrity. He disagrees that your recommendation is founded on his current mental state. He says your recommendation of hospitalisation is 'unequivocal proof' that you are 'also in on the action against me'. He views your recommendation as a way 'to control me in playing into their devious schemes'. Despite his spouse's concern

about his well-being, Mr KeNi is insistent on going home immediately, adding that he has now discovered that his wife is also unreliable.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.128 Mr KeBh

Mr KeBh is a 36-year-old male. He is divorced and a father of a two-year old child. He is known with a depressive disorder and defaulted his treatment on an SSRI. He reports feeling depressed and 'unable to feel my emotions'. He also complains that he struggles to wake up in the morning and often feels tired during the day. These symptoms have been present for the past month and he has recently developed suicidal thoughts. He began using alcohol in the form of beer in an attempt to 'feel and sleep better'.

Mr KeBh was diagnosed two years ago with a depressive disorder. He took medication and followed up regularly as an outpatient. He defaulted this treatment three months ago. He has no family history of psychiatric problems. His personal and family medical history is unremarkable.

On examination you find that Mr KeBh presents with a depressed mood and anhedonia. He is easily fatigued and struggles to maintain his concentration. His speech is soft and slow in keeping with a depressed mood. He displays a restricted affect. His thoughts are logical and goal-directed without features of psychosis or mixed mood features, but reflect his feelings of hopelessness and despondency. You find no clinical indications of another medical condition that explains his mood symptoms. His use of alcohol seems to be infrequent and does not explain his mood symptoms.

Mr KeBh understands your concern about his mood symptoms in general and his suicidal thoughts in particular. He agrees with your recommendation to reinstate his antidepressant medication and he is willing to arrange for a follow-up appointment in two weeks' time. He is also prepared to discuss and formulate a suicide prevention plan with you.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) his outpatient based treatment is*

*legitimately declined or not applicable; or b) his outpatient based treatment should proceed by which suitable legal status?*

### 1.129 Ms GeCi

Ms GeCi is a 21-year-old female accompanied by her sister. Her sister agreed with the police that she would bring Ms GeCi to you instead of the police arresting her. The police arrived while Ms GeCi was aggressive in public. She shouted and swore at people close to the apartment building where she and her family reside. Ms GeCi admits that she pointed a finger in one person's face but says that it could have been worse as 'I almost shoved my full fist up their arrogant noses, as I lost my mind at that point'. The precipitants of her aggressive behaviour remain unclear except that Ms GeCi says that they annoyed her in being so 'slow and stupid'. During the interview, she tells you that people are frustrating her 'too much' and that she cannot bear it that they are 'so boring'. They should have her amounts of energy, she says, then one will get things happening fast. She says her mind is working in top gear and she has many plans evolving continuously as she speaks. These plans will fix the mess left by arrogant people, she says, but on probing she denies having any specific mess or arrogant person in mind. She adds, 'but that does not of course preclude you from being that person causing the mess'. Her family and friends also noticed that she is in their words 'much busier' than usual. She has excessive energy and does not need to sleep much. She mentions that she almost bought a designer handbag of R30 000 on her credit card, but she 'unfortunately' already reached its limit of R70 000. She is working as a receptionist earning about R9 000 per month. She is quite concerned about the involvement of the police and would 'simply threaten them with suicide rather than going to jail'.

Ms GeCi was diagnosed with bipolar I disorder three years ago. She had used maintenance treatment for a few weeks but discontinued it because she believed that she did not need it. She tells you about one depressive episode in the past during which she made a suicide attempt by trying to cut her wrists. She shows you the scars from this attempt. The depressive symptoms gradually improved without treatment. Ms GeCi's mother was also diagnosed with bipolar disorder.

Ms GeCi has no history of other medical pathology that could explain her manic symptoms. She is not known to use any psychoactive substances. You also find no medical

pathology on physical examination. She tests negative for psychoactive substances.

On examination you notice Ms GeCi's restless energy. She can hardly sit still during the interview. You notice the flight of her ideas with rapid and pressured speech. The tempo of her thoughts is so fast that the connections become illogical, and her speech often does not make sense. Her thought process disorder makes it hardly possible for her to express her ideas clearly. Her mood seems upset and dysphoric. She is concerned by the police's involvement. She tells you that she cannot face going to jail and would rather kill herself. She also feels guilty about her behaviour, but this does not seem to be excessive or delusional. Nor do you find other psychotic features. Her concentration is clearly impaired.

You strongly urge Ms GeCi to be admitted to the hospital on account of her current mental illness, the risk of suicide, and the risks to her reputation and financial interest. Ms GeCi is willing to concede that 'something is wrong' and that she requires treatment. Although she tries to gather her thoughts, she is unable to tell you what she thinks the best course of action should be. In your view she does not pay adequate attention to her suicide risk, and she seems oblivious that her reputation and financial interest remain at risk. She says her family should rather decide on her behalf and she will abide accordingly. Her sister is concerned about her state of mind and reckons that Ms GeCi should be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.130 Ms ToPa

Ms ToPa, an 80-year-old female, has been brought to the hospital by her two daughters because she was 'acting strange for the past few hours'. She is usually a dignified lady but acted out-of-character during this period to the detriment of her reputation. She started to talk incomprehensibly and became disorientated to time and place.

Ms ToPa's daughters inform you that she is not known with any mental illness. They are not aware of any family history of mental illness including a minor or major

neurocognitive disorder. She is known to suffer from hypertension and diabetes mellitus that are usually both well controlled. She is not known to use any psychoactive substances.

On physical examination you find a tachycardia as well as a fever and diaphoresis. You clinically find an area of consolidation in her right lung, which is confirmed on X-ray examination. Her infective markers are raised double the upper limit of normal on special investigation. Her blood sugar level is also raised above the normal limit.

On mental state examination Ms ToPa responds poorly to your attempt to converse with her. She is not able to sustain her attention during the interview and you often have to repeat your questions. She is disorientated for the date of the month and day of the week, but her orientation in other respects is intact. You notice her memory impairment, but you do not find any specific mood symptoms or signs of psychosis.

Ms ToPa is not able to express her wish regarding treatment. Her daughters are concerned about her wellbeing and wants you to admit her to the hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission for a mental health service is legitimately declined or not applicable; or b) hospital admission for a mental health service should proceed by which suitable legal status?*

### 1.131 Ms NoRi

Ms NoRi presents as a 45-year-old female with a history of both recurrent major depressive disorder and anorexia nervosa. Her family brought her to the hospital because she complained of feeling depressed for the past three weeks. She mentions a lack of energy and drive with a disturbed sleep pattern. For the past month she struggles both to fall asleep and stay asleep throughout the night. Although her appetite is poor and she eats less than usual, her weight remained stable with no current signs of anorexia nervosa. She also feels so guilty and worthless that she firmly believes she ought not be alive. She tells you in confidence about the suicidal thoughts she had during the past week.

Ms NoRi works at one of the mobile telecommunication networks in the country as a procurement officer. She explains that she has access to commercially sensitive

information and that she works under high pressure to always perform at her best.

She has a family history of mental illness with her mother diagnosed with major depressive disorder.

The history of anorexia nervosa is her only known medical history. Your physical examination yields no indication of any medical morbidity. You also find no indication of any substance use disorder.

On mental state examination her severely depressed mood and prominent anhedonia are clearly evident. She discloses to you that she began hearing several unknown voices calling her name one week ago, even though she cannot see them. She does not know where they come from and whose voices these are. She finds them upsetting as they are intrusive even if she tries to ignore these. She has come to the conclusion that these are the result of brain damage that she sustained from working at the mobile network company where 'digital radiation' is unavoidable. This radiation, she is sure, 'burnt my brain'. She considers herself the first victim of this and expects that her colleagues will soon show similar effects. She plans to sue her employer for the brain damage that she suffered. You find that her thought processes are slow and belaboured. She struggles to formulate her ideas, which are often disjointed and illogical with a loosening of associations. Her concentration is so poor that she is unable to make sense of new information and use it in making decisions. She confides in you that she thought it would be better if she ended her own life preventing the 'indignity' that will come with the brain damage. Thus far, she has struggled to formulate a suicide plan and has not yet made preparations to this end. You find no features of hypomania or mania.

You want to admit Ms NoRi to the hospital on account of the severity of her mood episode as well as her suicide risk. She does not believe that she requires admission. She thinks that 'hospitalisation will not make that better, the damage is done'. Ms NoRi cannot tell you what she thinks the best course of action would be. She complains that the brain damage is so severe that she simply cannot think what to do. Despite her scepticism, she leaves the decision regarding hospital admission to you and her accompanying family. The family thinks she should be admitted to hospital.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified*

*by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.132 Ms NeRo

Ms NeRo presents as a 40-year-old female with a history of recurrent major depressive disorder as well as anorexia nervosa. She was brought to the hospital by her family because she complained of feeling depressed for the past three weeks. She mentions a lack of energy and drive with poor sleep. She struggles to fall asleep and is often awake during the night for the past three weeks. She further mentions that her appetite is poor and that she started to eat less than usual but her weight is currently stable with no signs of anorexia nervosa at present. Despite this she feels guilty and worthless, saying: 'I should not be alive'. She tells you in confidence about the suicidal thoughts she has had lately.

She has a history of mental illness with her mother diagnosed with major depressive disorder.

She is not known with any other medical illness despite the history of anorexia nervosa. Your physical examination also yields no indication of any medical morbidity. You also find no indication of any substance use disorder.

On mental state examination you find her mood to be severely depressed with prominent anhedonia. During your interview she tells you that she has been thinking about ending her life on three separate occasions during the past week. She did not formulate a specific plan, make any preparations, nor attempted suicide in any way. You find that her thought process is slow and belaboured. She is still able to maintain her concentration during the interview and is able to participate albeit with difficulty. This is also so in the planning of her treatment. She discloses to you that she began hearing several unknown voices 'calling her dirty names' one week ago. She cannot explain the origin of these voices but finds them intolerable. You do not find delusions secondary to these experiences, nor features of hypomania or mania.

You want to admit Ms NeRo to the hospital on account of the severity of her mood episode as well as her declining food intake and high suicide risk. Ms NeRo concurs with your assessment of the severity of her mood episode but not the need for hospitalisation. She thinks that she would be better off as an outpatient than in the

hospital. She thinks that her condition will improve over time. She claims that 'I've been through this before and it always gets better'. Although she understands that it is a risk, she is not concerned about her current food restriction as 'this often happens when I get stressed'. She accepts that you are concerned about her health and safety but do not consider her condition serious enough as to warrant hospitalisation. She is clearly determined not to be admitted and states this without hesitation and in no uncertain terms.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.133 Ms FaCi

Ms FaCi is a 27-year-old female. She was referred to you for an assessment after a violent altercation with a colleague at work. This is not something she has ever done before. During the interview she tells you that her mind is racing and that she feels restless for the past ten days. Her friends and colleagues also noticed that she is more active than usual, but she is less productive. She has excessive energy and does not need to sleep much. She mentions that during the past week she has gone on a shopping spree for luxury items that she could not afford. She is concerned that she was unable to 'stop myself from doing this'.

Ms FaCi was diagnosed with bipolar I disorder a year ago. She had used maintenance treatment for a few months but discontinued it as she felt that she did not need it. She has been without medication for the past six months. Ms FaCi has no history of any other acute or chronic medical pathology that could explain her manic symptoms. She is not known to use any psychoactive substances. You also find no other medical conditions on physical examination. She tests negative for all psychoactive substances.

On examination you find that Ms FaCi is energetic and restless. She hardly sits still during the interview. Her speech is loud and rambling, but it is still coherent, and she expresses herself understandably. She displays a flight of ideas with rapid, pressured thoughts and speech. Her mood is best described as expansive. She subjectively feels 'on top of the world'. She is concerned about her behaviour and its consequences, especially the aggressive outburst at work.

She recognises that she is 'not myself at the moment'. You find no psychotic features.

You strongly urge Ms FaCi to be admitted to the hospital on account of her mood episode. Ms FaCi tells you that 'something is wrong in my mind' and that she accepts that she requires treatment. She further accepts that her current condition requires hospitalisation in order to be treated effectively. She tells you, 'I will stay in the hospital until I'm better'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.134 Ms CeRi

Ms CeRi presents as a 22-year-old female whose family has brought her to the hospital on account of her depressed mood. She mentions that she 'can no longer cope with all the pressure that she has to endure'. She also mentions that everyone is picking a fight with her lately.

On questioning she says she feels intensely depressed with no interest in anything during the past month. She reports that she has little energy and lost her drive to succeed at the university where she studies. Her sleep is severely affected with initial, middle, and terminal insomnia. She has lost her appetite with subsequent noticeable loss of weight. She reports feeling 'useless' and very guilty about wasting her parent's money by not achieving as she should in her exams. She reports in confidence that thoughts of suicide crossed her mind, as she thinks 'life is not worth living any more'. She denies making a specific suicide plan or any preparations for a suicide attempt. She finds that she struggles to remember what she reads owing to difficulty to concentration, and she cannot remember that which 'I have just read'.

Ms CeRi was previously diagnosed with bipolar disorder (the type is unknown to her) and used to take maintenance treatment that she discontinued six months ago. She is known to use alcohol and cannabis at regular intervals. She denies recent use of either of these substances. Her personal medical history in other respects is unremarkable. Ms CeRi reports a family history of mood disorder, as one of her two brothers suffers from depressive illness, and her aunt died by, they suspected, suicide.

Your examination confirms the features of a major depressive episode. She presents as poorly kempt with soft, slow speech. Her affect is restricted with little emotional responsiveness. The tempo of her thoughts is slow, but her thoughts remain logical and understandable. You find no evidence of a current manic episode or psychotic symptoms. Despite her mood disorder, Ms CeRi's social judgement and insight seem to be intact.

You want to admit Ms CeRi on account of the severity of her disorder and to prevent a potential suicide attempt even though there is no current indication of a suicide plan. Ms CeRi agrees with your assessment that she is currently severely depressed and understands that hospital treatment will be better and probably benefit her. She however chooses not to be admitted to the hospital as her exams at the university are approaching. She clearly declines your recommendation of hospital admission. She believes that she will still be able to 'survive' and successfully complete the exams if she 'just try harder'. She claims that she has been through 'tough times before and always pulls through'. She promises to contact you at once 'if things become worse and I can't cope any longer' and is willing to commit to an outpatient appointment with you next week.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.135 Ms CaKu

Ms CaKu is a 71-year-old female presenting with her index episode of a severely depressed mood, precipitated by her daughter dying from mamma carcinoma two months ago. She reports a loss of interest and enjoyment, and proclaims 'life is not worth living'. She confides in you about her suicide thoughts and desire to 'end it all'. Her sleep is disturbed with early morning awakening. Her appetite is also disturbed with a significant loss of weight. Ms CaKu's husband corroborates her complaints from their observations.

Ms CaKu has a family history of major neurocognitive disorder. Her medical history includes hypertension, dyslipidaemia, and a mitral valve replacement. She underwent a hysterectomy 'many years ago'. She

stopped using alcohol years ago but still smokes cigarettes on occasion.

On your examination you find that Ms CaKu is well-kempt. She seems agitated as she often wrings her hands and paces around during the interview. Her speech is monotonous, and she seems disinterested in participating in the interview. She initiates no contents to the interview spontaneously, responding only to prompting and then her responses are all brief. She is objectively depressed with a restricted affective expression and flow. You also notice lapses in her concentration during the interview, but despite this she is still able to formulate and express her responses. You do not find any psychotic, hypomanic or manic symptoms. Anxiety and worry are the main themes of her thoughts.

You conclude as her husband did, that Ms CaKu's depressed episode is of a severe degree. Ms CaKu agrees with your and her husband's assessment of her current dire mental state and accepts your recommendation of admission in aid of her health. She is concerned about her recurring suicidal thoughts and is afraid that she may act on these. She acknowledges the need for admission and treatment. She is keen to 'get better soon' and 'will do what it takes'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.136 Mr KeFa

Mr KeFa is a 37-year-old married male with no dependants. He was brought to the hospital after mentioning his suicidal thoughts to his spouse. He reports feeling very depressed for more days than not after his brother's murder a month ago. He also reports severe anhedonia. He made one serious attempt at suicide since his brother's demise, and he reports that his suicidal thoughts worsened over the past week. He also reports that he has no appetite and mentions that he suffers from severe insomnia. He lost a significant amount of his baseline body weight during the past month on account of his poor appetite. Regarding his insomnia, he has struggled to fall asleep most nights. When he falls asleep eventually, he is awake by 3 a.m., unable to sleep again. This leaves him drained of energy the following day and he struggles to cope at work as human

resources manager. He also mentions having a problem concentrating and his memory is subjectively impaired. He ruminates about the death of his brother. He expresses significant feelings of guilt about not being able to save his brother's life. He is usually a diligent employee, but his work has fallen far behind and he anticipates serious consequences and even disciplinary action against him.

He previously developed a major depressive episode after his parents had died in a motor vehicle accident about ten years ago. He had been treated with an antidepressant for a few months before discontinuing it, but he remained well until his brother's death. His medical history furthermore includes hypertension, dyslipidaemia, and diabetes mellitus. He has no family history of mental or other illnesses.

On examination Mr KeFa presents with an objectively depressed expression with much despondency pervading his thoughts all the time. His affect is blunted and his speech slow and halting. Although Mr KeFa displays significant slowing of cognitive processing, he is able to reason and express his wishes unambiguously. His thought contents are dominated by themes of hopelessness and despair. Moreover, he tells you that he is destined to failure, as evidenced in 'a persistent pattern of failure all through my life'. He adds that he has been nothing but a disappointment. You find no signs or symptoms indicating that his condition is the result of another medical condition or substance use disorder.

Despite the severity of Mr KeFa's disorder, he understands your recommendation of admission on account of a major depressive episode of a severe degree and a suicide risk. He however does not want to be admitted because of the demands at work which he considers the main priority. He clearly states that he will not be staying in the hospital and prepares to leave the consultation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.137 Ms MuFa

The family of Ms MuFa, a 30-year-old female, brings her to the emergency department where you work after she has drunken an unidentified liquid (which may have been

a poison) in a suicide attempt. Her family is clearly upset with her. They accuse her of 'playing up' and 'wasting our time'. They want you to 'pump her stomach and send her home'.

Ms MuFa discloses to you that she feels 'emotionally overcharged' for the past week. She says, it is as if 'my emotions are on steroids'. She elaborates that she has never experienced so much profound and even conflicting emotions 'all at once and all mixed up'. She feels 'energetic' and is more active than usual. She has recently been to several parties where she 'got wasted', 'went on an orgasmic rave', and had sexual interactions with men and women. She tells you somewhat seductively that she has turned out to be 'a girl of pleasure' in that 'I have got the energy, the moves, and the hots'.

Her family tells you that Ms MuFa is usually a 'hyper' person who 'acts before she thinks'. She is often angry or upset for no apparent reason. She becomes unreasonably suspicious of family members or friends for a few hours, especially when there is disagreement between them. She is always afraid that she would 'end up alone with no one who loves me'. She often describes herself as feeling 'empty'. Her relationships however tend to be intense but of short duration. She has struggled with her self-esteem since adolescence, but currently they are surprised by her self-confidence. They are not concerned about her taking an unidentified liquid as an authentic attempt at suicide. In their experience she often threatens suicide and has a habit of cutting herself when she is upset. The family thinks this 'incident will be like all the others we've been through all the years'.

When asked about this ingestion Ms MuFa informs you that this was the result of her being angry and 'I just had to do something'. Like before, she never plans to harm herself as 'it just happens'. She admits nonetheless that her 'emotional turmoil' at present involves suicidal ideation although 'this does not make sense to me'.

Ms MuFa seems otherwise medically well with no history of acute or chronic illness. It is not clear from your examination if she indeed took a poison. She has no previous psychiatric diagnosis, but the family has a history of the suicide death of her sister. Ms MuFa frequently drinks alcohol and often becomes intoxicated. She smokes cannabis on occasion 'to get high' and tried a variety of illicit substances such as cocaine and methamphetamine. She tests positive for these substances on special

investigation. You find no signs of illness on physical examination.

On the mental state examination you find that Ms MuFa is a neatly dressed young woman. She engages well and is talkative. You recognise her flight of ideas and pressured speech. She also seems agitated with some restlessness. Despite her racing thoughts she is still able to formulate her ideas and communicate clearly. She also expresses her emotions clearly. You find no signs of psychotic features. Other than her concentration being mildly impaired on testing, you find no cognitive impairment.

You are concerned about her mood episode affecting her social judgment and this risks that her mood-driven behaviour holds to her health and reputation. You advise hospital admission. Ms MuFa is receptive to your advice and is willing to be admitted, which she substantiates with 'I am out of control currently' and saying that she needs help. However, her family brushes aside the concerns and says she is seeking attention.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.138 Mr HeSo

Mr HeSo presents as a 23-year-old single unemployed male who lives with his parents. He usually takes medication for a bipolar I disorder, but he has not used it during the past week as the medication makes it difficult for him to ejaculate when he masturbates. He denies sexual interaction with anyone during the past year. His family is worried that he is relapsing. They say his mood has become elevated and he has become more talkative than usual during the preceding four days.

Mr HeSo was admitted to a psychiatric hospital three times for a bipolar I disorder. He presented with both depressive and manic episodes on separate occasions, following his index episode at the age of 17. He and his parents deny any other significant medical history or the use of any psychoactive substances. You don't find indications of either on your physical examination.

On mental state examination you find that he is distractible during the interview but that he is still able to participate in and contribute to the interview. He reports

an elated mood and a decreased need for sleep for the past four days. His speech seems pressured, and he tells you that 'I need to keep talking'. You do not find any psychotic symptoms or significant impairment in cognitive functioning. Despite his experience that his thoughts are racing, he remains logical, coherent, and goal-directed without any formal thought disorder. He is angry at his parents as he thinks they are 'over-reacting'.

Mr HeSo recognises that all is not well, and he is concerned that he is beginning to relapse into a manic episode, as he 'learned my lessons from previous times'. He says, 'I better take my medication again' and he is willing to receive outpatient treatment to this end. His parents are of the view that he is currently mentally ill to such extent that he requires hospitalisation. Despite their pressure to this end, he clearly refuses hospitalisation.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### 1.139 Ms KuLe

Ms KuLe is a 68-year-old female presenting with her index episode of a severely depressed mood. She complains that her brain has gone dead. It transpires on enquiry that she means this to be the case literally and not metaphorically. Consequently, she says, she feels 'flat' and can no longer experience excitement or laughter. She adds that 'a life with a dead brain is not worth living', and that she will end it if she finds the means to do so. Her sleep is disturbed by early morning awakenings. Her appetite is also disturbed, and she has lost much weight.

Ms KuLe's family corroborates her complaints from their observations. They also mention that she is becoming increasingly forgetful. They find that she is unable to focus and sustain her concentration during conversations. They also notice that she often struggles to make sense of new information because of her disordered thoughts. They further report that she often complains that she has become 'worthless without a brain'.

Ms KuLe has a family history of major neurocognitive disorder. She also has a family history of suicide when a family member ended her own life upon receiving a diagnosis of dementia. Her medical history includes

hypertension, dyslipidaemia, and a stroke from which she recovered. She denies smoking or using alcohol.

On your examination you find Ms KuLe is poorly kempt. She struggles to sit still during the interview and is moving continuously. You struggle to hear her soft speech. She speaks slowly and you find her thought contents devoid of detail. In your opinion Ms KuLe is severely depressed with a blunted affect. You also notice her wavering concentration and poor memory. Her thoughts seem disjointed, often derails, and are difficult to understand at times. You find no indication of hypomanic or manic symptoms.

You recommend that Ms KuLe be admitted to the hospital for medical assessment and treatment of her psychiatric symptoms, and to prevent her suicide. Ms KuLe cannot comprehend how hospital admission could be of benefit to her as she is convinced that her brain is dead and 'beyond repair'. She is unable to tell you what she thinks the most appropriate course of action should be as she struggles to verbalise her thoughts. Her husband tells both of you that he wants her to be admitted as, in his opinion, 'this is the care she needs right now'. She is however adamant that she will not be hospitalised.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

## 1.140 Mr FoRh

Mr FoRh presents as a 50-year-old divorced male with no dependants. He works as a labourer on a construction site. He complains of a depressed mood and expresses suicidal thoughts following the ending of a romantic relationship. He made a suicide attempt four years ago and often experiences suicidal thoughts, on which he has not acted since then. Mr FoRh reports that these thoughts are increasing in frequency and intensity, but he is not concerned that he would be acting on these.

His past psychiatric history includes features of an anxiety disorder with sub-syndromal posttraumatic stress disorder as well as the misuse of multiple substances. He has no significant medical history in other respects. Mr FoRh's family psychiatric history includes his mother suffering from an anxiety disorder.

When exploring his substance use history, Mr FoRh reports that he binge-drinks alcohol on occasion and often smokes cannabis to help him relax and fall asleep. He also used cocaine on occasion in an effort to improve his mood. He is of the opinion that the substances are not harmful to him and do not affect his mental functioning in an adverse way.

On your clinical examination you find a significantly depressed mood with anhedonia. Mr FoRh presents with an increase of appetite and weight gain. He also mentions a change in his sleeping pattern. He is more socially withdrawn than usual. He mentions that he feels hopeless and worthless. You notice that he often returns to the thought of suicide as an escape from his feelings of loneliness and despair. You find no indications of a personality disorder or current psychosis. His thought processes are goal-directed, logical and well-reasoned. He does not seem to have any form of cognitive impairment. His social judgement and insight seem intact. You find no indication of another medical condition or the ill effects of any class of psychoactive substance.

You recommend hospitalisation on account of the potential progressive nature of Mr FoRh's suicide thoughts. He disagrees with your assessment for the need of hospitalisation and is unwilling to be admitted to the hospital as he does not want to risk losing his job. Mr FoRh understands that his suicidal thoughts may pose a risk, but he believes that he is emotionally 'strong enough' to resist acting on these thoughts as he did in the past. You consider his suicide risk as relatively low. Although he accepts that he requires help, he does not accept your recommendation of admission. He is willing to accept outpatient treatment. He repeatedly makes it clear in his verbal communication that he does not want to be admitted.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*

### **1.141 Mr SaCe**

Mr SaCe presents as a 67-year-old pensioner who has been brought to you for an assessment by his male partner. His partner is a well-known professor in international law who tells you that Mr SaCe is depressed ever since he had a

brief fling with one of his students three months ago. Mr SaCe denies feeling depressed and says 'it is quite the opposite – I feel nothing. If only I could feel something like being depressed but all my emotions are dead. I cannot feel low nor excited about anything'. He relates moreover that his 'emotional death is rather contagious' and affects everyone who crosses his path, including his partner. For this reason, he has avoided people and prefers that everyone 'should just leave me alone' as he does not have the energy to fight against this 'inevitable contagion'. Despite doing very little nowadays 'being retired', he reports being tired all the time. When probed on what he anticipates happening going forward, he responds that he has given up on prospects for improvement, as he feels stuck in the 'world of nothingness where a future does not exist'. He has lost much weight and awakens early hours of the morning during which 'I have to suffer the boredom of thinking nothing, a mind that has seized up'. During the day, he says, he does not feel like doing anything. The mornings are the worst and 'I can hardly find the energy to get out of the bed, go to the toilet and empty my bladder'.

Mr SaCe has no personal nor family history of mental illness. He has suffered no major medical illnesses, and the only surgery he had was a tonsillectomy as a child. He has no chronic comorbid diseases. He and his partner deny the excessive use of alcohol and ever using illicit substances.

On your examination you find that Mr SaCe is dishevelled, wearing slippers, a pair of old shorts, and a dirty T-shirt. His attitude towards you is apathetic, making no eye contact and staring at the floor for most of the time. His psychomotor functions are few and limited. His speech is slow and scant in content. His affect is flat without any emotional expression or responsiveness at any point during the interview. He is orientated for place, person, year, month but not the day of the week nor the date. His slow responses make cognitive testing difficult to do, but his concentration and working memory are clearly impaired. His long-term memory and abstract abilities seem to be unaffected. The tempo of his thoughts is very slow. He suffers no formal thought disorder and responds relevantly and coherently. The contents of his thoughts are clearly impoverished. He denies suicidal thoughts. You find no indication of hypomanic, manic, or psychotic symptoms.

His physical examination reveals features of cachexia and dehydration, but no other indications of illness or excessive substance use.

You are of the professional opinion that Mr SaCe suffers from a major depressive episode of a severe degree, and that hospitalisation and an antidepressant are crucial. Mr SaCe disagrees with your recommendation, saying that an antidepressant would not be appropriate as he is not depressed but emotionally dead. He reasons that antidepressants cannot make alive that which is dead. However, he says, he is 'not a difficult person' and will go along with 'whatever you (the family and clinician) think is best'.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission and antidepressant treatment are legitimately declined or not applicable; or b) hospital admission and antidepressant treatment should proceed by which suitable legal status?*

### 1.142 Ms WoPe

Ms WoPe is 41 years of age, mother of two teenagers, and employed as a personal assistant to one of the deputy directors of a commercial company. She has come to your office on the insistence of her spouse who reports to you that she is 'difficult' and not doing the chores at home as she should, which is out-of-character for her. She confirms that she is not doing all the chores she used to do but explains that she made a firm decision that she would do no more than her 'fair share' and that her husband should 'step-up' his contribution to their household.

On questioning Ms WoPe reveals that she feels more confident and assertive as of late, inspired by a feminist book she has read recently. Since reading this book, she thinks more positively about herself, and she has discovered new abilities to assert herself. She has now joined the local gym, which she attends daily and enjoys 'in no small measure'. Although she exercises hard at the gym, she feels more energetic, and requires less need for sleep than usual. She attributes all this to having more leisure time at home and a relaxed approach to the daily chores and needs of her teenage children. She denies being more talkative than usual, which her husband confirms. She also denies having concentration problems or distractibility at work. Her libido is higher than before, but her husband seems less interested, being 'sour about me having discovered my new self'. She denies engaging in sexual activities with anyone else and remains 'rather stingy' when spending

money. From your enquiries, her social and occupational functioning seems better than before.

She visits her general practitioner routinely every year since a hysterectomy five years ago for a myomatous uterus. She has no history of psychiatric problems, but her mother suffered from two major depressive episodes for which her mother was hospitalised. She does not use alcohol regularly or excessively, nor any illicit psychoactive substances.

Your mental state examination yields a well-kempt woman who is courteous in her attitude towards you, but who is a bit irritated with her husband. Her mood is euthymic, and her affect is responsive and appropriate. You notice no pressure of speech, and she denies her thoughts would be racing. On testing, her concentration is not impaired, nor other cognitive functions. Her thought processes are coherent. Her thought contents reveal no pre-occupations. You find no psychotic features. She is meticulous and 'perfectionist' in performing her usual tasks, but this does not amount to features of an anxiety or another disorder.

Ms WoPe reckons that 'I doubt that anything is wrong with me'. She qualifies this, 'however, I may be mistaken as I am not a doctor'. For this reason, she says, 'I am willing to do whatever you recommend I should do'. Her husband is insistent that she should receive treatment.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) current outpatient based treatment is legitimately declined or not applicable; or b) current outpatient based treatment should proceed by which suitable legal status?*

### 1.143 Mr KaSo

Mr KaSo presents as a 30-year-old male, who runs a small business in association with a business partner, selling goods at a temporary pavement stand. A social worker who is concerned about his welfare has brought him to the hospital where you consult. The social worker became involved with him at the insistence of his business partner who was concerned about his talks about ancestors and a decline in his work performance. They are accompanied by his older brother.

Mr KaSo reports that he does not know the reasons for the social worker insisting that he comes to the hospital as he is not ill. He does not mind coming to the hospital

because his (deceased) ancestors will in any event determine the course of his life, he says. He then reveals that his ancestors have decided that he will join them soon because they need him. This means he must obey and join his ancestors, as his time has come to an end. He has already bought a rope by which to hang himself, as this would 'finish me off quickly' and will stop his 'unbearable suffering'.

He says he knows that his ancestors are making him suffer. They urge him to end it all. His suffering is all the time, he says, making it impossible to work, or think about anything else, or even doing anything because 'it is hopeless anyway'. He finds it extremely depressing that he will be leaving his loved ones behind, and this expectation is on his mind every night keeping him from sleeping most of the night. He says he tries to hide all this from his family and friends as they should not suffer and be sad. It is enough that he is suffering and sad. They need not experience this too, as 'it destroys one'. He has been avoiding them consequently. Mr KaSo reports that he has no appetite as eating 'really does not make sense' and brings him no joy anymore. He has lost much weight during the past month. He says he is very tired all the time and that 'my destiny is exhausting me, eating away at my bones'.

Mr KaSo has no history of mental or other major illnesses. No family history of mental illness is known. He denies the use of any psychoactive substances.

On examination you find that he is clearly underweight and unkempt. His clothes of good quality are dirty, and he seems in need of a bath or shower. His affect is unresponsive and restricted to an expression of suffering. His mood is depressed and indifferent to the emotional demands of events. His speech, psychomotor and cognitive functions are seemingly unaffected. The tempo of his thoughts is normal, and his thought processes are coherent and well-connected. His thought contents are preoccupied with his destiny as determined by his ancestors. He denies any verbal communication from his ancestors, but 'reads' their messages 'all over' by which 'I will have to go'. By his further descriptions, you recognise that these are delusions of reference. You find no evidence of hallucinations.

Based on the combination of a high risk of suicide and the severity of his mental illness, you consider it crucial that Mr KaSo be admitted to hospital. He is indifferent to your insistence on hospitalisation, maintaining that he will stay anywhere, wherever you decide, it does not matter to him, as he has no say anyway as he will be joining his

ancestors soon regardless. His brother is surprised by your recommendation. He is also worried about his brother committing suicide, after learning just now about his brother's intentions. However, the brother of Mr KaSo is adamant that he does not require hospital admission and wants him to visit a spiritual counsellor instead. The social worker shares your professional opinion that he should be hospitalised.

*Apply the algorithm in answering the question at this time: what will be the most suitable decision in terms of the MHCA that is justified by the information provided: a) hospital admission is legitimately declined or not applicable; or b) hospital admission should proceed by which suitable legal status?*