Less Restrictive Way (section 13 *Mental Health Act 2016*)
Decision Making for Adults – Mental Health Treatment and Care

When a person has capacity to consent

Capacity is presumed for people over 18 years of age.

Are there any triggers for capacity assessment present?

These may include (but are not limited to):

- Signs of problems with cognitive function (memory, attention, concentration, alertness, orientation) or severe mental health symptoms (psychosis, mood disturbance)
- Current or recent issues with decision making
- Concerns raised by family or carers
- The nature of the treatment has changed, or risk has increased, so that current consent may not be adequate
- The nature of the treatment has changed, or risk has lowered, so that current decision making may not be the less restrictive option.

Yes

Complete assessment of capacity. Clearly document the assessment and reasons.

Does the person demonstrate capacity to consent to mental health treatment?

No

Follow decision pathway for a person lacking capacity (overleaf)

Yes

No

Provide treatment and care as a voluntary patient.
Encourage supported decision making as appropriate*

Ensure that plans are reviewed and updated to capture goals and actions to enhance protective factors, strengths and support, including:

- Safety plan
- Recovery plan
- Care plan
- Any communication plans, e.g. PAIP

Planning to occur collaboratively with the person, carers and support people.

If an AHD has not been developed, consider development or review as part of recovery planning.

WHAT IF THERE IS A RISK TO SELF OR OTHERS?

Undertake thorough risk assessment to inform planning*

Follow local protocols and pathways, e.g. suicide prevention pathway.

Discuss all options with the person, including inpatient care, to come to an agreed approach.

Increased risk may be a prompt to formally assess and document capacity, if current consent is not adequate for reasonably necessary care for safety.

Consider seeking a second opinion if capacity assessment is not clear.

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Look at all options for support and care in the less restrictive way. How can these be enhanced? e.g. collaborative care planning; carer support and education; referral to financial support services

When a person is lacking capacity to consent

Complete capacity assessment
Clearly document assessment and reasons that capacity is lacking

Does the person have an Advance Health Directive?
Recorded on CIMHA, provided in person, or other means, e.g. My Health Record

No

Yes

Does the AHD provide consent for clinically appropriate care for the current situation?

No

Yes

Continue to respect and adhere to as much of the AHD as possible, and seek substitute decision maker

Provide treatment and care under the AHD, and in consultation with attorneys appointed* (consent by an attorney can occur when not inconsistent with a direction given in AHD)

Ensure capacity assessment is undertaken regularly, and the person is able to make their own decisions once stability of capacity is returned.

For inpatient admission, review is required by Clinical Director at or around 14 days

Does the person have a **guardian** appointed to make decisions about health care?

Yes

No

Provide treatment and care with the consent of the appointed substitute decision maker
(Guardian, EPOA, SHA) to provide substitute decision making and consent*

Ensure capacity assessment is undertaken regularly, and the person is able to make their own decisions once capacity is returned, e.g. substitute decision maker not making the decisions.

For inpatient admission, review is required by Clinical Director at or around 14 days.
(SHA cannot consent to inpatient admission)

Does the person have an **Enduring Power of Attorney** appointed for personal matters?

Yes

No

Is there a **Statutory Health Attorney** who can make decisions?

Yes

No

Is admission to an inpatient unit the treatment option being considered?

Yes

No

If the substitute decision maker is not able to provide support for reasonably necessary care AND there is no less restrictive way of providing treatment to meet the person's needs.
Always consider the treatment plan in its totality e.g. LCT

OPTIONS:

- *Application for Mental Health Treatment and Care Consent* form (Office of Public Guardian)
- If the treatment criteria apply, use treatment authority to treat under MHA2016*

Considerations:

- Timeframes for applications and decision versus level of risk
- Use a less restrictive way to consent to treatment when it becomes available or applicable
- Regularly reviewing capacity assessment
- Respect decisions that can be upheld, e.g. views, wishes and preferences

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Look at all options for support and care in the less restrictive way. How can these be enhanced?
e.g. collaborative care planning; carer support and education; referral to financial support services

If there is a dispute between decision makers, the person, or the person's best interests, refer to the general principles and the health care principles under the *Powers of Attorney Act 1998* and use local resolution strategies. Include the IPRA to consider and uphold the person's rights. Seek legal advice for unresolved disputes.

Ensure that care plans are reviewed and updated to capture goals and actions to enhance protective factors, strengths and support.

- Planning to occur collaboratively with the person, carers and support people.
- Document the decision maker and information provided, e.g. AHD, statutory health attorney.
- Review capacity at each contact where possible.
- If an AHD has not been developed, or has not been adequate, consider development or review as part of recovery planning.