

# The Mental Capacity Act Deprivation of Liberty Safeguards

## Guidance to the Forms

---

This guidance is not statutory. Rather it is meant to simply provide some helpful pointers on the use of the revised DoLS standard forms. Nothing in this guidance should be taken to replace anything in the statutory Codes of Practice for the MCA and DoLS

Lorraine Currie on behalf of the DoLS Project Team

The Deprivation of Liberty (DoLS) Forms were reviewed between September and December 2014.

The project group consisted of:

Lorraine Currie	ADASS MCA and DoLS Lead
Neil Allen	Barrister and Lecturer
Niall Fry	Department of Health Policy Lead MCA
Sheila Williams	Admin Support (previous DoLS Administrator)
Laura Rushton	Admin Support, BIA and AMHP Support Stoke
Justin Griffiths	MCA and MHA Lead Stoke
Rashpal Pahal	DoLS Lead Sandwell
Darren Carr	Consultant Psychiatrist Staffordshire, s12 Representative
Liana Kotze	London Borough of Enfield DoLS Lead
Pauline O'Hare	Royal Greenwich DoLS Lead
Betsey Lau-Robinson	University College London Hospital

The time to complete the work was short and therefore the consultation periods were short. However the team received many comments which were reviewed and where possible incorporated into the forms. Some comments were useful in other ways and as such will appear in this guidance.

New Form	Previous Form/s	Form Name
1	1,2,3,4	Standard Request, Urgent Authorisation and Extension to Urgent
2	NEW	Further Request for a Further Standard Authorisation (Current DoLS coming to an end)
3	5,7,8,10 & 24	Age, Mental Capacity, No Refusals and Best Interests Assessments
3A	NEW	No Deprivation Assessment
4	6,7,9	Mental Health, Mental Capacity and Eligibility Assessments
5	11,12,25	Standard Authorisation Granted (including detail of equivalent assessments if used)
6	13	Standard Authorisation Not Granted
7	14,15	Suspension of Authorisation
8	26,27	Termination of Relevant Person's Representative Appointment
9	23	Notification that an Authorisation has Ceased
10	19,20,21,22	Review of Current Authorisation
11	30	IMCA Referral
12	NEW FORM	Notification to Coroner of a Death Whilst Under an Authorisation

The forms shaded above namely 1, 2, 7, and 12 are to be used by the Managing Authority. The remainder are Supervisory Body forms. Form 10 is shared by both Managing Authority and Supervisory Body.

A decision was made by the project team to remove all notes from the forms as this made them lengthier than was needed. Those notes will be explained in this guidance and where appropriate links will be made to other useful legislation, guidance and Codes of Practice.

**Important note:** This guidance relates to completion of the forms and will not cover issues of substance such as the meaning of 'deprivation of liberty'. There will however be links to other sources of information and advice.

Table of Contents - Guidance

<b>FORM 1: STANDARD REQUEST, URGENT AUTHORISATION AND EXTENSION TO URGENT</b> .....	<b>4</b>
<b>FORM 2: REQUEST FOR A FURTHER STANDARD AUTHORISATION</b> .....	<b>7</b>
<b>FORM 3: ASSESSMENTS</b> .....	<b>8</b>
<b>FORM 3a: NO DEPRIVATION</b> .....	<b>14</b>
<b>FORM 4 ASSESSMENTS</b> .....	<b>15</b>
<b>FORM 5: STANDARD AUTHORISATION GRANTED</b> .....	<b>20</b>
<b>FORM 6: STANDARD AUTHORISATION NOT GRANTED</b> .....	<b>24</b>
<b>FORM 7: SUSPENSION OF AUTHORISATION</b> .....	<b>25</b>
<b>FORM 8: TERMINATION OF REPRESENTATIVE</b> .....	<b>26</b>
<b>FORM 9: STANDARD AUTHORISATION CEASED</b> .....	<b>27</b>
<b>FORM 10: REVIEW OF CURRENT AUTHORISATION (THIS FORM IS NOW SHARED WITH THE SUPERVISORY BODY)</b> .....	<b>29</b>
<b>FORM 11: IMCA REFERRAL</b> .....	<b>32</b>
<b>FORM 12: NOTIFICATION OF DEATH WHILST DEPRIVED OF LIBERTY</b> .....	<b>33</b>

**FORM 1: STANDARD REQUEST, URGENT AUTHORISATION AND EXTENSION TO URGENT**

**PLEASE NOTE THAT THIS FORM NOW BEGINS WITH A STANDARD REQUEST AND ONLY IN EXCEPTIONAL CASES SHOULD AN URGENT AUTHORISATION ALSO BE COMPLETED.**

**Remember in the vast majority of cases it should be possible to make the necessary arrangements to apply for a Standard Authorisation in advance before the need for the deprivation of liberty begins.**

**Page 1: This page will take you through the person's basic details.**

It is helpful to assessors if you can summarise relevant medical history, give details of any sensory loss and in particular describe the person's communication needs as this will help the assessor prepare and enable them to consider whether any aids are needed or in fact whether an interpreter may be needed.

However, the presence of sensory loss or communication needs is not necessarily indicative of a lack of capacity.

**Page 2: Purpose of the Authorisation - this provides two essential pieces of information.**

A description of the care and treatment - in other words: *Why do you need to accommodate the person in the care home or hospital?*

It asks you to describe in detail the care and/or treatment the person is receiving. It is helpful to assessors if this is as detailed as possible rather than a vague statement such as "24 hour care".

Secondly you are asked to explain why the person meets the acid test for a deprivation of liberty. The following information may be helpful:

[http://www.39essex.com/docs/newsletters/deprivation\\_of\\_liberty\\_after\\_cheshire\\_west\\_-\\_a\\_guide\\_for\\_front-line\\_staff.pdf](http://www.39essex.com/docs/newsletters/deprivation_of_liberty_after_cheshire_west_-_a_guide_for_front-line_staff.pdf)

[http://www.cqc.org.uk/sites/default/files/20140416\\_supreme\\_court\\_judgment\\_on\\_deprivation\\_of\\_liberty\\_briefing\\_v2.pdf](http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf)

[http://www.39essex.com/content/wp-content/uploads/2014/02/deprivation\\_of\\_liberty\\_in\\_the\\_hospital\\_settingv3.pdf](http://www.39essex.com/content/wp-content/uploads/2014/02/deprivation_of_liberty_in_the_hospital_settingv3.pdf)

In this section you need to describe all the measures you are taking which have led you to make a request for an Authorisation:

- describe the environment the person is in
- who has determined where they live
- whether it is a temporary or permanent arrangement
- how are they monitored by staff leading you to conclude they are under continuous or complete supervision and control and are not free to leave.

When describing all the restrictions it is helpful to say how frequently they are taking place.

For example it is better to say: *"Mrs X has to be reassured and redirected by staff at least 4-5 times a day as she is distressed and wants to leave."*

rather than: *“Mrs X says she wants to leave.”*

It is better to say: *“1:1 support is in place at all times of day, when John is in his room or moving around the building, when he has meals or takes part in social events. However at night there is less support as there is a sleeping night and no checks are made beyond the routine checks.”*

rather than: *“John has 1:1 support.”*

**Page 3: What is an Interested Person?**

An interested person is any of the following:

- The relevant person’s spouse or civil partner;
- Where the relevant person and another person of the opposite sex are not married to each other but are living together as husband and wife - the other person;
- Where the relevant person and another person of the same sex are not civil partners of each other but are living together as if they were civil partners - the other person;
- The relevant person’s children and step children;
- The relevant person’s parents and step parents;
- The relevant person’s brothers, sisters, half-brothers, half-sisters, step brothers and step sisters;
- The relevant person’s grandparents or grandchildren.

The form also asks for other people such as anyone caring for the person or interested in their welfare. This could include social workers or care staff.

**Page 4: IMCA – Advance Decision – Mental Health Act**

*IMCA:*

It is necessary for the Managing Authority to inform the DoLS team if the person will need an IMCA to support them.

The DoLS team at the Supervisory Body will make the referral but you need to state whether the person has anyone appropriate to consult with.

*Advance Decisions:*

There is also a question about any Advance Decisions to refuse treatment the person may have made that you are aware of.

*Mental Health Act 1983:*

If you are aware of any aspect of the Mental Health Act that applies to the person, for example they may be subject to a Guardianship Order, then this is where you need to include that information, with as much detail as you are able to provide.

Once you sign and date the form you will also be asked to confirm that you have advised any interested persons of the request for a DoLS Authorisation. Communication with close family members is very important from the beginning.

**Page 5: Important Data Collection**

This information is required for the quarterly DoLS returns to the Health and Social Care Information Centre. Please note this information is based on the Adult Social Care collection and the disability here does not refer to mental incapacity but to any other disability that may apply to the person.

**Page 6: Urgent Authorisation – complete only where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application is being considered.**

Although the original intention was that an Urgent Authorisation would be for “sudden unforeseen needs” in practice this has not been the case and Managing Authorities often use Urgent Authorisations. There is an expectation that in the vast majority of cases it should be possible to plan ahead and make sure that a Standard Authorisation is requested ahead of the need for the deprivation of liberty to begin.

An Urgent Authorisation should only be given where the need for the deprivation of liberty is so urgent that it is in the best interests of the person for it to begin while the application for a Standard Authorisation, which is expected to be necessary, is being considered. There are some situations where an Urgent Authorisation is generally not needed, such as:

- Someone has developed a mental disorder as a result of a physical illness which can be treated and treating it will rapidly resolve the mental disorder. An example of this would be someone currently confused due to a urinary tract infection, but when treated with antibiotics the confusion usually resolves within a negligible period of time.
- Where a person is in accident and emergency or a care home and it is anticipated that in a matter of hours the person will no longer be there.

The tick boxes are straightforward as all of the details will have been provided earlier in the form.

The Urgent Authorisation can be given for a period of up to seven calendar days and comes into force at the time it is signed.

**Page 7: Request for an Extension of the Urgent Authorisation**

The intention of adding the request for an extension of an Urgent Authorisation to the initial form is to identify this at the beginning due to the unprecedented numbers of applications following the Supreme Court Judgement:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/300106/DH\\_Note\\_re\\_Supreme\\_Court\\_DoLS\\_Judgment.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300106/DH_Note_re_Supreme_Court_DoLS_Judgment.pdf)

The DoLS Code of Practice describes that an Urgent Authorisation can be extended if there are “exceptional reasons” why the Standard Authorisation cannot be dealt with within the seven days.

The Code of Practice gives an example of when an extension may be justified as an assessor not being able make contact with someone who it is essential to speak to. The Supervisory Body must decide what it considers to be “exceptional reasons”. The Code is very clear about the following:

- A decision about exceptional reasons must be soundly based and defensible;
- It would not usually be justified due to staff shortages;
- An Urgent Authorisation can only be extended once.

## **FORM 2: REQUEST FOR A FURTHER STANDARD AUTHORISATION**

A Further Standard Authorisation is a new request for the same person.

When an existing DoLS Authorisation is coming to an end the Managing Authority must review whether it is still necessary. It is possible, at any stage, that things have changed and the person no longer needs such a restrictive environment. In this case the Managing Authority needs to request a Review to cease the DoLS Authorisation (Form 9 – Standard Authorisation Ceased).

If however, having reviewed the person's current situation, the Managing Authority concludes that the Authorisation needs to continue then a Further Authorisation should be requested. This can be done up to 28 days in advance and should not be left to the last moment.

The amount of information needed when a Further Request for Authorisation is being made, is much less than the initial requirement as the Supervisory Body will have already received a great deal of personal details and comprehensive information and will have carried out the necessary assessments to grant an initial Authorisation.

This form is short and should assist Managing Authorities to request further authorisations in a timely way.

The main focus of this form is on two essential pieces of information:

- 1) The purpose of the deprivation of liberty, in other words why the person is still a resident or a patient and a description of the current care or treatment arrangements
- 2) An opportunity to update any changes to the care or treatment plan and the restrictions in place, update information and record changes since the previous Authorisation was given.

## **FORM 3: ASSESSMENTS**

This form covers 4 separate assessments and the appointment of representative.

Should any individual assessment be required for another purpose, the appropriate pages can be removed and used as a stand-alone assessment.

During consultation it was clear that Supervisory Bodies vary as to whom they commission for the Mental Capacity assessment. For this reason this assessment has been included in both Form 3 and Form 4 and it is up to the Supervisory Body to make it clear to their assessors which assessments they are required to complete.

**Page 1: *Routine questions in relation to the person and the setting***

**Page 2: *Requests details of those who have, or have not been consulted***

You need to complete details of those who have been consulted, and if relevant, the name of anyone it has not been possible to consult and why.

This section was added during consultation, as in some cases, the assessment has to proceed without anyone being consulted due to shortage of time, or if the interested person is on holiday, sick or unavailable for another reason.

It is only necessary to enter details here of anyone the assessor has consulted with.

Documents Seen: This is a more detailed way of describing documents seen and their dates.

In practice BIAs often add this throughout the assessment so this change is to enable the assessor to consolidate this information and make it clearer for Authorisers.

**Page 3: *Mental Capacity Assessment***

After consultation this was placed as a first consideration as there seems to be a view that many people are failing this assessment. By completing this consideration first this means the assessment process can stop if the person is found to have capacity.

There is a box to detail how the BIA has complied with the second guiding principle of the MCA – supported decision-making.

The BIA should add here how they supported the person, such as using communication aids, interpreters, pictures etc. It is also useful to say if more than one visit took place in order to see the person at the best time.

The assessment then continues with the four elements of the functional test.

The assessment ends with a clear conclusion, taking note of the causal nexus by ensuring the assessor clearly records why the person's inability to make the decision is because of the impairment or disturbance in the functioning of their mind or brain.

<http://www.bailii.org/ew/cases/EWCA/Civ/2013/478.html> - emphasises the causal nexus

<http://www.39essex.com/content/wp-content/uploads/2015/01/capacityassessmentsguide31mar14.pdf> - guide to assessing capacity



**Page 4: No Refusals Assessment**

This assessment is short and to the point and does not need explanation. Note, however, that it is the view of any welfare LPA or welfare Deputy that counts. So if a property and affairs LPA/Deputy objects, that does not necessarily prevent the use of DoLS.

**Page 5: Best Interests Assessment**

Many Supervisory Bodies will have their own good practice guidance in relation to the completion of best interests assessments. This is general guidance in relation to the form.

*Background Information:*

This confirms the matters the BIA has taken into account.

*Views of the Relevant Person:*

During the first few years of DoLS many assessors found that the person was easily overlooked in the process and yet should be central to it; *“there should be no decision about me, without me”*.

Putting the person’s views first and expressing them clearly helps meet the requirements of a best interests decision. It shows the persons wishes, feelings, beliefs and values and if appropriate or possible, demonstrates the outcomes the person would like.

*Views of Others:*

Previously assessors would often note that they had consulted but not recorded the consultation. This form now offers a clearer way to do that. Each person can be named, their role described and their views noted.

*Is a Deprivation of Liberty Actually Occurring?*

The assessor will record their view as ‘Yes’ or ‘No’ (however it should be noted that the answer will certainly be ‘Yes’ if filling in this form otherwise the assessor should complete Form 3a).

Within the next box the assessor first needs to address the acid test and whether it is met.

The concrete situation of the person should be described. Although the components of the acid test must be described it is essential that everything else is not overlooked.

It is helpful to imagine a non-disabled person subject to the arrangements and then identify all of the measures which bear upon the person’s liberty, for example:

- locked/lockable doors/windows
- wheelchair/lap-strap
- degree of staff support inside and outside
- sedative medication
- restrictions on direct/indirect contact with family/friends
- nature and degree of physical or verbal intervention/restraint
- personal care arrangements
- level of observation etc.

All restrictive measures should be described along with the manner in which they are implemented, their duration, and the effect they have on the person.

Each aspect of the acid test must be described, not a simple statement that all elements are present but with clear evidence demonstrating analysis of the complex issues.

It is likely that this section will now be much shorter following the Supreme Court judgement than it was in the past; however it should still demonstrate the complex skills needed by a BIA. Identifying the measures affecting the person's liberty is also necessary before considering the other aspects of this form.

Reference can still be made to the descriptors in the DoLS Code of Practice to assist with demonstrating why the objective element is met.

The subjective element will be evidenced mainly from the Mental Capacity Assessment.

There should be a short statement as to why the placement is imputable to the state, for example, Local Authority/CCG commission the care package/arrange the provision of care. For self-funders, state the date when the Local Authority became aware that a deprivation of liberty might be occurring.

**Page 6:** *Following consultation the order of the next sections was swapped around. It will be helpful to continue to have feedback from assessors in relation to this.*

The assessor is now asked to consider why the deprivation of liberty is necessary to prevent harm to the person. Some notes are added for clarity. This box should detail the actual or likely harm that would be avoided by the authorisation.

Include particulars of the harm (including physical, psychological, financial) that will be avoided by depriving the person of liberty. Consider matters such as the type, severity and frequency of harm the person would otherwise suffer were it not for the measures.

Any actual incidents or details are helpful, even if they have already been mentioned in the form or in comments; this is the place where they should be consolidated in order to justify depriving a person of liberty.

The following box is about proportionality.

Many assessors repeat the same information in these two boxes and the notes have been added in an attempt to make this clearer. Having already described the harm and the risks to the person the assessor should now say why depriving liberty is a proportionate response.

It is necessary to state here:

- what else has been tried
- are there any less restrictive options
- if not why not
- what has been explored already
- what could be explored.

**Page 7:** *This is in the person's best interests*

The assessor needs to determine, in the light of all the foregoing, whether the deprivation of liberty is in the person's best interests.

This should have a clear connection with the statutory checklist for best interests decision making in the MCA: <http://www.legislation.gov.uk/ukpga/2005/9/section/4>

However the checklist is not exhaustive, issues of culture should be addressed here and the best interests decision should have regard to the person's emotional, social and psychological wellbeing as well as their physical wellbeing.

Many aspects of an assessment, which were previously noted in the consideration of a deprivation of liberty, are now recorded in the consideration of best interests.

A person who strongly objects to their placement may cause the assessor to consider whether they are really in the right environment. For example, if the person genuinely perceives themselves to be a prisoner, are they receiving care in the least restrictive way possible?

A burden and benefits analysis of all available options should then be inserted. Please note this is not a consideration of every possible option in existence but only of the actual and reasonably foreseeable options on the table.

*Example:* This case involved an 80 year old female with a diagnosis of dementia, physically well, very active and mobile but without mental capacity to make care, treatment, risk or financial decisions. She was constantly asking to go home and had tried to leave respite care. The analysis of the options was as follows (note that different fonts can be used to reflect the different weight of considerations – eg neutral; heavy; light; **VERY WEIGHTY**):

Benefits of own home (A)	Benefits of Care Home (B)
1. <u>Continues to remain in a familiar place</u> 2. <i>She does not feel unsafe</i> 3. She wants to be independent 4. She wonders why she is in a hotel and not at home 5. <u>More family contact and maintaining community contacts</u> 6. Increased care package 7. <b><u>THIS IS WHERE SHE IS HAPPIEST</u></b>	1. Regular meals/hydration 2. Prompting with medication 3. Prompting with personal care/hygiene 4. Pressure/skin area support/treatment 5. Physical safety improved 6. Staff available 24/7 to deal with crisis 7. Ongoing reassurance for her anxieties 8. <u>Improved dignity</u> 9. Release strain on family members 10. Anti-depressants and anti-psychotics can be administered 11. <u>She enjoys the company of others</u> 12. Care and treatment may slow her decline 13. Less need for her to contact emergency services 14. Reduced possibility of exploitation/cold callers
<u>PLUS Burdens of Care Home (B)</u>	<u>PLUS Burdens of own home (A)</u>
8. Likely to be affected by not being in own home 9. <b><u>LOSS OF INDEPENDENCE</u></b> 10. Inevitable short term anger/distress 11. Stronger possibility of depression 12. She may just give up 13. Problems with contact and community activities	15. <u>Not eating or drinking enough</u> 16. Insufficient/irregular medication 17. <i>Deteriorating personal hygiene</i> 18. Deteriorating pressure areas 19. Risks of wandering/falls 20. <i>Increased psychological distress</i> 21. Community/family support has failed

**Page 8:** *This page begins with the option to note the possibility of an unauthorised deprivation of liberty.*

It also recommends raising an Adult Safeguarding concern if an unauthorised deprivation of liberty is likely to be continuing. The assessor may well be able to discuss the options with the Managing Authority to immediately reduce restrictions to avoid the unauthorised deprivation.

**Page 9: BIA's Recommendations about Conditions**

This enables the BIA to make recommendations about conditions and any variation in conditions if the assessment is following a review.

Individual Supervisory Bodies may have guidance on the use of conditions. This guidance remains useful: [https://www.merton.gov.uk/conditions\\_guidance\\_v1.pdf](https://www.merton.gov.uk/conditions_guidance_v1.pdf)

Any other relevant information should be included on this page. There is an added box where the BIA can identify issues that would not fit the criteria as a condition of the Authorisation but which may need addressing. Most commonly here an assessor will note decisions that need formalising under the MCA.

**Page 10: Selection and Recommendation of Representative**

The final page of the assessment is now the selection and recommendation of representative. This will enable the BIA to complete all aspects of their work within the one assessment document.

The person may have capacity to select the representative (and may or may not wish to do so).

If not then someone else may have the power to make the selection by virtue of a health and welfare LPA or deputyship appointment.

If neither of these options is possible then the BIA recommends a RPR to the Supervisory Body.

The BIA is charged with confirming that the person proposed as representative is eligible for the role, no matter who has selected them.

In practice this means the BIA must confirm that the proposed representative is —

- 18 years of age or over;
- able to keep in contact with the relevant person;
- willing to be the relevant person's representative;
- not financially interested in the relevant person's managing authority;
- not a relative of a person who is financially interested in the managing authority;
- not employed by, or providing services to, the relevant person's managing authority, where the relevant person's managing authority is a care home;
- not employed to work in the relevant person's managing authority in a role that is, or could be, related to the relevant person's case, where the relevant person's managing authority is a hospital;
- not employed to work in the supervisory body that is appointing the representative in a role that is, or could be, related to the relevant person's case.

In addition, the BIA must confirm that the proposed representative would, if appointed —

- maintain contact with the relevant person,
- represent and support the relevant person in matters relating to or connected with the deprivation of liberty.

In *AJ v A Local Authority* [2015] EWCOP 5, it was decided that "it is likely to be difficult for a close relative or friend who believes that it is in P's best interests to move into residential care, and has

been actively involved in arranging such a move, into a placement that involves a deprivation of liberty, to fulfil the functions of RPR, which involve making a challenge to any authorisation of that deprivation. BIAs and local authorities should therefore scrutinise very carefully the selection and appointment of RPRs in circumstances which are likely to give rise to this potential conflict of interest.”

The person acting as RPR must, in particular, ensure that the relevant person is supported to bring a speedy challenge to their authorisation before the Court of Protection if the person shows (whether expressly or by their actions) that they wish to do so, and whether or not the RPR thinks such a challenge is in their best interests. If you are unsure that the RPR would act in this way you should not select them for the role.

## **FORM 3a: NO DEPRIVATION**

This form did not previously exist and removes a great deal of unnecessary detail should the assessor determine that the person in question is not being deprived of their liberty.

Although consultation is not a requirement if there is no deprivation of liberty, in practice consultation may be a key element in the decision making process. Therefore the form allows for consultation to be recorded if it has taken place.

### *Background information*

This is equally as relevant as it is on the Form 3 as it may add evidence to support the decision-making. For example, the person may actually be due to go home almost immediately as the placement was only for short respite.

### *Views of the relevant person*

Even though the Supreme Court judgement clarified that a lack of objection is not relevant to whether someone is deprived, the person's expressed views are key to providing person centred assessments. It is still vital that they are heard even if no deprivation of liberty is occurring.

### *Views of others*

It is sometimes necessary to obtain the views of interested persons in order to confirm the facts being expressed. This is because the views of others may sometimes be at odds with the views of care staff or professionals and this may influence your view as to whether a deprivation of liberty is in fact occurring.

A family, for example, may be best placed to explain that actually they take their mother out every day; she goes home at holiday times and frequently attends family events, which may have a bearing on whether she is deprived of liberty or not.

### *Best Interests Assessment –*

If the referral is for a 39C or 39D IMCA, then the duration for which the IMCA will be required needs to be stated. Any documentation provided can also be noted here.

## FORM 4      ASSESSMENTS

This form covers 3 separate assessments. Should any individual assessment be required for another purpose, the appropriate pages can be removed and used as a stand-alone assessment.

**Page 1:**            Routine questions in relation to the person and the care setting

**Page 2:**            Mental Capacity Assessment

The first box ensures compliance with the second statutory principle: – the need to support decision-making. The assessor should add here how they sought to support the person to make the relevant decision. For example:

- Did you use communication aids, interpreters, pictures, ensure someone familiar was there to support the person etc?
- Say if more than one visit took place in order to see the person at the best time.
- Was there a specific reason why the efforts taken did not succeed?

Stage one of the test requires the identification of the relevant impairment or disturbance (eg dementia, learning disability, acquired brain injury etc). Note that no formal diagnosis is required for this ‘diagnostic’ test. The second stage addresses the four elements of the ‘functional’ test. Provide as much narrative as possible for each element, bearing in mind that the burden is on you to prove (if this is your opinion) that the person lacks capacity to make the relevant decision on the balance of probabilities: the person need not prove anything. So if the assumption of capacity cannot be disproven, the person has capacity.

The assessment ends with a clear conclusion, taking note of the causal nexus by ensuring the assessor clearly records why the person’s inability to make the decision is **because of** the impairment or disturbance in the functioning of their mind or brain. For a more detailed discussion of the importance of the causal link see:

- [http://www.39essex.com/cop\\_cases/pc-and-nc-v-city-of-york-council/](http://www.39essex.com/cop_cases/pc-and-nc-v-city-of-york-council/)
- <http://www.bailii.org/ew/cases/EWCA/Civ/2013/478.html>

**Page 3:**            Mental Health Assessment

The following guidance is taken from the Code of Practice to the Mental Health Act 1983 (2015) as to the meaning of ‘mental disorder’:

- 2.4      Mental disorder is defined for the purposes of the Act as ‘any disorder or disability of the mind’. Relevant professionals should determine whether a patient has a disorder or disability of the mind in accordance with good clinical practice and accepted standards of what constitutes such a disorder or disability.
  
- 2.5      Examples of clinically recognised conditions which could fall within this definition are .....
  

  - Affective disorders, such as depression and bipolar disorder
  - Schizophrenia and delusional disorders
  - Neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
  - Organic mental disorders such as dementia and delirium (however caused)
  - Personality and behavioural changes caused by brain injury or damage (however acquired)
  - Personality disorders

- Mental and behavioural disorders caused by psychoactive substance use
  - Eating disorders, non-organic sleep disorders and non-organic sexual disorders
  - Learning disabilities
  - Autistic spectrum disorders (including Asperger’s syndrome)
  - Behavioural and emotional disorders of children and young people
- (Note: this list is not exhaustive)*

Having identified the mental disorder, providing a rationale and details of the person’s symptoms, diagnosis and behaviour, the assessor must detail whether, and if so the extent to which, the person’s mental health and wellbeing is likely to be affected by being deprived of their liberty. This information must be relayed to the best interests assessor to inform their assessment.

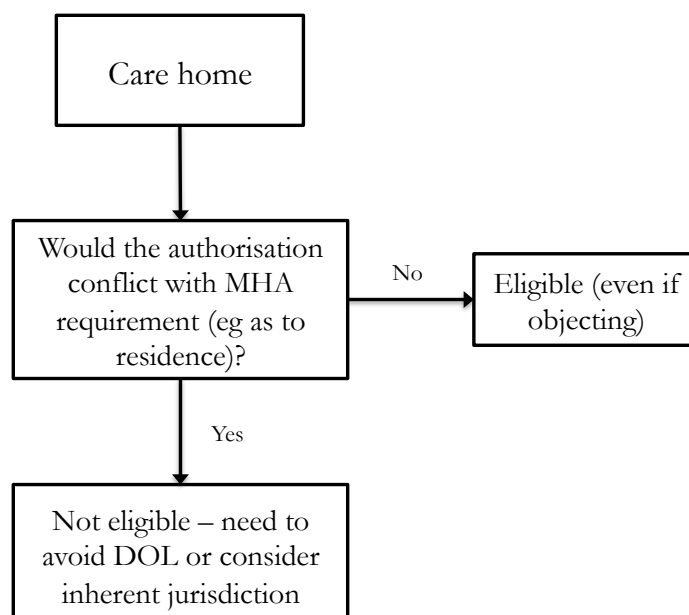
**Page 4: Eligibility Assessment**

**Case A:**

If the person is currently detained under one of the stated sections of the MHA, they are not eligible for either a DoLS authorisation or a Court of Protection authorisation. Their Article 5 rights are protected by the MHA and MHA Part 4 governs their psychiatric treatment. Their physical treatment is governed by the common law (if they have capacity) or the MCA (if they do not). In the unusual situation where physical treatment itself amounts to a deprivation of liberty (eg enforced caesarean section, forced feeding), an application to the High Court to invoke the inherent jurisdiction will be necessary to authorise it.

**Cases B-C:**

A person can be subject to both a DoLS authorisation and one of these provisions of the MHA provided there is no conflict between the MHA requirements and the proposed plan. For example, where someone lacks the relevant capacity, and is to be accommodated in a care home on section 17 leave, conditional discharge, or CTO, any deprivation of liberty will need to be authorised separately under DoLS. If they do not satisfy the six assessments, legal advice may be required.





If the person is subject to section 17 leave, conditional discharge, or CTO, and needs to be deprived of liberty in hospital to receive care and treatment consisting in whole or in part of treatment for mental disorder, they will be ineligible for DoLS. So the MHA recall process will be required instead. If, however, the hospital treatment is solely for physical ill health, the person is eligible for DoLS.

**Case D:**

A person can be subject to both a DoLS authorisation and guardianship provided there is no conflict between the MHA requirements and the proposed plan. Note that the use of guardianship itself does not amount to a deprivation of liberty; but the intensity of the accompanying care plan has the potential to do so. Where someone subject to guardianship requires hospital treatment in circumstances amounting to a deprivation of liberty, they are eligible for DoLS if the primary purpose is to give treatment for physical ill health (even if the person objects). If the primary purpose is to give treatment for mental disorder, they object (or would object if able) to being there or to some or all of the mental health treatment, and there is no welfare LPA or deputy consenting on their behalf, they are not eligible for DoLS. Consideration would therefore have to be given to providing the necessary safeguards under the MHA.

**Case E:**

This relates solely to hospitals, not care homes. It is sometimes difficult to determine which regime of safeguards should be used but here are some rules of thumb:

1. A person with the relevant capacity who agrees to hospital admission is a voluntary patient.
2. A person with the relevant capacity who refuses hospital admission cannot be detained unless the MHA is applicable.
3. A person lacking the relevant capacity to consent or refuse hospital admission can be subject to DoLS if:
  - (a) They are detained for physical treatment (whether they object or not); or
  - (b) They are detained for psychiatric treatment and could not be detained under MHA ss2 or 3 (whether they object or not); or
  - (c) They are detained for psychiatric treatment and “could” be detained under MHA ss 2 or 3 but are non-objecting (or, if they do object, a welfare LPA or deputy consents to what they object to).

Therefore, a person lacking capacity to consent or refuse hospital admission cannot be subject to DoLS if they are detained for psychiatric treatment, could be detained under MHA ss 2 or 3, and are ‘objecting’.

A common eligibility difficulty relates to those, typically with dementia or learning disability, who are not actively trying to leave a ward that is registered to take MHA patients. The flowchart below identifies which regime is applicable. It is important to bear in mind:

**Purpose**

- No distinction is drawn in the legislation between “active” and “passive” psychiatric treatment.
- The primary purpose of the deprivation of liberty is to provide either physical or psychiatric treatment. There are no other alternatives: it is one or the other.

- Where the person may regain capacity or where it fluctuates, this is likely to indicate use of the MHA (see MHA Code of Practice (2015), para 13.54).

#### Medical treatment for mental disorder

- “Medical treatment for mental disorder” means medical treatment which is for the purpose of alleviating, or preventing a worsening of, a mental disorder or one or more of its symptoms or manifestations.
- “Medical treatment” includes nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. Habilitation means equipping someone with skills and abilities they have never had, whereas rehabilitation means helping them recover skills and abilities they have lost.
- “Symptoms and manifestations” include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person’s thoughts, emotions, communication, behaviour and actions. Not every thought or emotion or every aspect of the behaviour, of a patient suffering from mental disorder will be a manifestation of that disorder.

#### ‘Could’

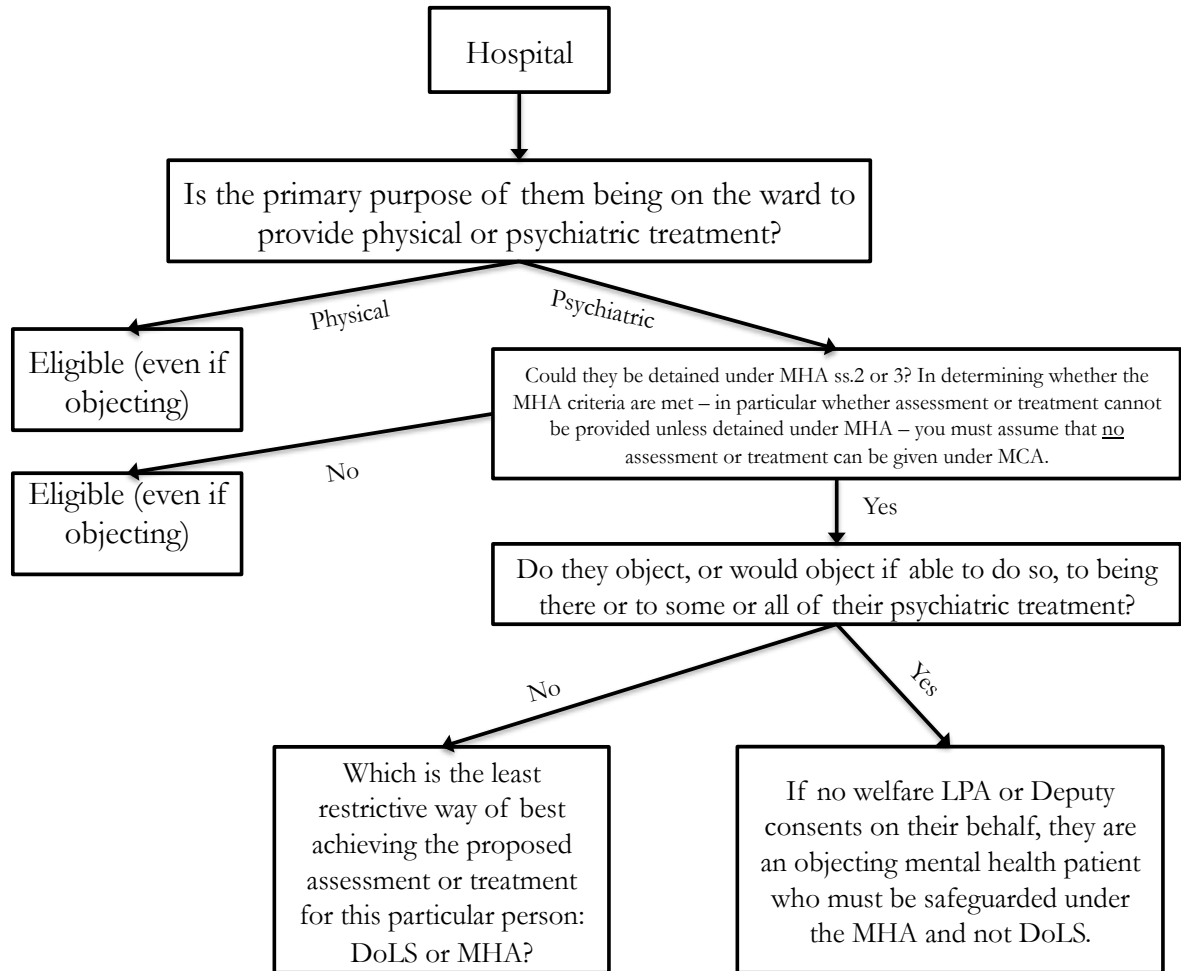
- In determining whether the person ‘could’ be detained under MHA ss 2 or 3, you must assume that absolutely no care or treatment could be provided under the MCA in their best interests.

#### ‘Objects’

- A person ‘objects’ if they are objecting (or would object if able to) to either being accommodated in hospital for psychiatric treatment or to some or all of their medical treatment for mental disorder.
- Bearing in mind that the person lacks capacity to make the decision, in determining whether they object (or would object if able to), regard must be had to all the circumstances so far as they are reasonably ascertainable including the person’s behaviour and their wishes, feelings, views, beliefs and values at present and from the past (if it is still appropriate to have regard to them).
- Decision-makers should err on the side of caution and, where in doubt, take the position that a patient is objecting (see MHA Code of Practice (2015) para 13.51).

#### Choice of regime?

- Where the person is deprived of liberty for the primary purpose of giving medical treatment for mental disorder, could be detained under MHA ss2 or 3, and is not objecting, and would not object if able, to any of that treatment, only then is there a choice.
- Neither DoLS nor the MHA has primacy over the other in this context.
- The choice should never be based on a general preference for one regime or the other. Nor should it be assumed in the abstract that one regime is less restrictive than the other. Both are based on the need to impose as few restrictions as possible and both provide safeguards, albeit of a differing nature.
- In deciding in the particular circumstances of the individual’s case which regime is the least restrictive way of best achieving the proposed assessment or treatment, consider:
  - What is in their best interests;
  - Likelihood of continued compliance and triggers to possible non-compliance and their effect on the regimes’ suitability;
  - Whether DoLS is practically/actually available.
- Crucially, the person must be safeguarded under one of the regimes.



## **FORM 5: STANDARD AUTHORISATION GRANTED**

This is the formal Authorisation which is given by the Supervisory Body and authorises that the deprivation of liberty is in the person's best interests and will state for how long.

### **Page 1: Name, address and most importantly the purpose of the Authorisation.**

The Supervisory Body will add detail here from assessments they have received, and from Form 1 which resulted in the assessment, as to why the person needs to be in the care home or hospital. This will usually describe the care or treatment the person needs.

The date and time the authorisation commences will be stated along with the date it will cease to be in force.

There should be a clear rationale given for the time period. If the Supervisory Body has reduced the time recommended by the BIA they should offer an explanation as to why, so that those receiving the assessments and paperwork are able to understand why the time period granted is different than that recommended by the BIA.

### **Page 2: Conditions and also allows for actions needed by other to be noted**

**Conditions** - There are spaces for the conditions recommended by a BIA and these can be modified by the Supervisory Body.

The Supervisory Body may decide not to accept some recommendations as to conditions but must check whether the BIA has asked to be consulted about this. Removing a condition may in some cases affect the BIA's view as to best interests.

The Supervisory Body may add conditions itself and there is a space to note these.

Useful guidance can be found here relating to conditions:

[https://www.merton.gov.uk/conditions\\_guidance\\_v1.pdf](https://www.merton.gov.uk/conditions_guidance_v1.pdf)

Conditions must relate to the deprivation of liberty and should not relate to care planning issues. To determine whether the condition is legitimate, a useful question to ask is:

*"If the person were not deprived of liberty would they still need this?"*

If the answer is "No", it is a legitimate condition; if the answer is "Yes" it is likely to relate to basic care planning and not be legitimate.

### **Recommendations, actions and / or observations for care manager / social worker / commissioner / health professional**

BIAs often become aware of deficits in the care planning process which need to be addressed but are not legitimate conditions.

There is space to record these observations. Most Supervisory Bodies will have some assurance arrangements for such observations. It may be, for example, that a best interests decision has not been made regarding a long-term placement. The BIA may want to highlight this here. Another example would be where someone's medication needs reviewing.

**Page 3: Assessments and evidence received**

The Supervisory Body confirms it has received assessments and has seen evidence that each requirement has been met.

This is also where the Supervisory Body will note if it is relying on an equivalent assessment which has been carried out within the last 12 months and provides the evidence required.

**Page 4: Supervisory Body's Scrutiny of Assessments**

The most significant part of this form is the top of page 4 where the Supervisory Body (usually the person who will be called an 'Authoriser') notes its scrutiny of the assessments. It would be good practice for this scrutiny to contain reference to:

- why the authoriser agrees that a deprivation of liberty is occurring – what evidence has convinced them of this
- what harm the person would otherwise encounter
- why deprivation of liberty is proportionate to that harm
- why are there no less restrictive options available

The case of *London Borough of Hillingdon v Neary* emphasised the importance of proper scrutiny of assessments and criticised perfunctory perusal:

<http://www.bailii.org/ew/cases/EWHC/COP/2011/1377.html>

[http://www.39essex.com/cop\\_cases/london-borough-of-hillingdon-v-neary-2/](http://www.39essex.com/cop_cases/london-borough-of-hillingdon-v-neary-2/)

Appointment of Representative is now part of this form to save administrative time.

Firstly, it is necessary to identify who has proposed the person to be appointed as Representative. This will either be the person being deprived of liberty, or a person acting under a welfare LPA, or the BIA who will have identified a family member or confirmed that there is someone appointed to act for the person who will also carry out this role. These details will have been given on Form 3.

This should also contain evidence that the person selected is eligible for the role (see guidance above pages 12-13 for explanation) The BIA must confirm the representative's eligibility no matter who has selected the representative.

If the BIA was unable to identify anyone to carry out this role then a person will need to be paid to do it (this is known as a Paid Person's Representative (PPR)).

At this stage, if a PPR is to be appointed the Supervisory Body may not know the name of the person who will act in this role but will know the name of the agency to whom they will refer and so these details will go in here.

Those signing Authorisations on behalf of the Supervisory Body must be alert for any representatives who have been selected but do not appear to the "Authoriser" to be eligible. In this case the BIA must be asked to provide further scrutiny.

**Page 5: Duplicate for signature**

This page **repeats** the earlier information and allows for a signature. Once the RPR or PPR receive the authorisation paper work they will remove, sign and return this back page to the Supervisory Body.

EXTRACT FROM:

**THE MENTAL CAPACITY ACT 2005 AND THE DEPRIVATION OF LIBERTY SAFEGUARDS**

Neil Allen and Alex Ruck Keene  
Barristers (Thirty Nine Essex Street Chambers) and Lecturers (University of Manchester)

**WHAT MAKES A GOOD SUPERVISORY BODY?<sup>1</sup>**

1. **Structural governance** – Is there clarity about who holds corporate responsibility for MCA / DOLS functions; and clarity that the DOLS supervisory body functions need to be independent of service delivery?
2. **Regulatory compliance** – Is there good understanding and compliance with regulations? Are assessors trained, supervised and commissioned in accordance with regulatory requirements? Is information available on how many times a managing authority has been asked to extend an urgent authorisation and the reasons for this? Do Local Authority contracts specify compliance with the DOLS regulations? How are unauthorised deprivations of liberty managed (ie where best interests assessments find that deprivation is occurring though not in P's best interests)?
3. **Use of case law** – Is there evidence that case law decisions are incorporated into assessments and authorisations and training?
4. **Monitoring and evaluating the DOLS process** – Is this done, possibly by peer authorities with an independent component, for example an IMCA? Are the results of the process shared with senior management and concerns acted on? How is it evidenced that the signatory has scrutinised the authorisation forms? Is information kept on instances where the signatory has varied conditions or timescales? Is information kept on referrals and outcomes of assessments of unauthorised deprivations of liberty?
5. **Do the assessments demonstrate empowerment?** Is there evidence that P has been empowered and assisted to share his/her views; that P's wishes and feelings have been listened to and actively considered as key components of each assessment and review? How empowering is the DOLS process for 'P' and the family? Do capacity assessments and best interests assessments record attempts made to maximise residual capacity and involvement in care/treatment arrangements?
6. **Reviews** - Is the DOLS service certain that P and the RPR understand that they can request reviews of any of the assessments at any time? Does the DOLS service facilitate such requests eg by accepting telephone requests? Does the DOLS service offer reviews where assessors, the managing authority, s39D IMCA, P or relatives, friends, RPRs show disquiet? Does the DOLS service have a policy of sending different assessors to review? Is information available on how many reviews are requested, how many carried out, and how many result in changes such as lifting of the authorisation?
7. **Partnership working** - Is there evidence of good relationships/ partnerships with P, RPRs and IMCAs? Does the DOLS office inform and support RPRs and IMCAs to carry out their roles? Does the supervisory body check with the managing authority that the RPR role is being fulfilled in practice? What support is offered to RPRs who may have difficulty fulfilling the requirements of the role? How is the appointment of the RPR scrutinised by the Supervisory Body signatory? Are section 39D IMCAs commissioned for each authorisation granted?

---

<sup>1</sup> DoH, DOLS Funding Fact-Sheet for 2013/14.

8. **Feedback and learning for local authorities** – *Is the learning from MCA and DOLS identified? Is this learning fed back into care management by authorisers and others, to improve social work and care management in local authorities? How is data on DOLS activity shared and used within the organisation?*
9. **Feedback and learning for managing authorities** - *Is the learning fed back into improving the care offered in managing authorities - in both care homes and hospitals? Does it become part of MCA training? What mechanisms are used to facilitate learning in managing authorities?*
10. **Is there joint local strategic leadership from LAs, CCGs, Hospital Clinical Governance teams and the CQC, related to the MCA and DOLS?** *Does this leadership provide clear messages on the importance of using a human rights framework within both health and social care? Are there forums to facilitate relationships and the on-going implementation of the DOL safeguards?*

*Supervisory bodies and managing authorities need clear lines of communication. They need:*

- *Up to date, accurate contact information for their local authority DoLS team*
- *A policy/procedure agreed with the local authority that allows assessors to have access to P, their family, carers and relevant records (DoLS assessors have a statutory right to access relevant patient notes)*
- *To ensure staff know their organisation's procedure for arranging a deprivation of liberty authorisation*
- *To ensure there is a secure method for transferring identifiable information (e.g. encryption, secure network, safe haven, fax).*
- *To have a ready supply of DOLS forms available and to ensure staff know where to locate them and how to complete them accurately.*

**Copyright Neil Allen and Alex Ruck Keene. All rights reserved.**

## **FORM 6: STANDARD AUTHORISATION NOT GRANTED**

This form is issued if, after receiving some or all assessments, it is clear that the requirements are not met. This form should also be used when some, all or no assessments have been completed but the person dies or is discharged therefore the full authorisation process cannot be concluded as there will be no authority to proceed. Due to the backlog many Councils have experienced in processing their applications in the year 2014 -2015, it may be the case that by the time an application can be processed it is no longer actually needed. For example, because the individual's circumstances have changed in that time. These applications should be classed as not granted and Form 6 used indicating that the assessments were not carried out and clearly stating why the Standard Authorisation is no longer needed.

There are also a few situations where a request for Standard Authorisation can be withdrawn. A request for a Standard Authorisation would be classified as "withdrawn" only in rare situations. For example:

- Where an application has been submitted in error
- Where an application ceases due to an administrative matter rather than a substantive issue
- Where within the initial moments of an urgent authorisation (before any assessments have been conducted) the person dies or is discharged.

### ***Page 1: Contains the name and relevant addresses.***

The Supervisory Body's decision: the Supervisory Body will state why it is prohibited from giving a Standard Authorisation in relation to the named person and will detail which requirements were not met.

Not all assessments will be completed because when a person fails one requirement, a Standard Authorisation may not be given and all other on-going assessments must stop.

Due to the large number of applications following the Supreme Court Judgement many Supervisory Bodies are finding that a person may have died or been discharged before any or all assessments are carried out. Therefore, it is not possible to grant a Standard Authorisation as the person is no longer in the setting. In this case the Supervisory Body will note which assessments were not carried out and why.

### ***Page 2:***

There is space for the Supervisory Body to explain their scrutiny of the assessments (if they were carried out) and explain why they concur with the findings.

In some cases although the person may not be deprived of liberty there may be actions that raise Adult Safeguarding concerns. If the BIA has not already done so then the Supervisory Body should consider its actions in relation to this.



## **FORM 7: SUSPENSION OF AUTHORISATION**

Regulations allow for an Authorisation which is currently in force *to be suspended only when the person is no longer eligible for DoLS because of a conflict with the MHA.*

This is usually because the person has been detained in a hospital under the MHA but, as can be seen from the form, it can also be because there is now some conflict with a requirement imposed on the person by the MHA.

Note, therefore, that the Authorisation need not be suspended if, for example, the person is admitted to a general hospital on physical ill health grounds.

**Page 1:** *Allows you to give notice that the Authorisation is suspended.*

The Managing Authority must send this combined form to the Supervisory Body. This will enable the Managing Authority to report the position after 28 days using the same form.

**Page 2:**

After 28 days the Managing Authority should inform the Supervisory Body whether the person has returned within the time period and so the Authorisation is once again in force. If the person has not returned within this time period, the Authorisation will cease to be in force at the end of the 28 day period.

In practice this form is not used very often.

Most Managing Authorities seek guidance on what to do in other situations, such as, where a person who is subject to an Authorisation has been admitted to an acute hospital, or another temporary setting or is temporarily absent for another reason. There is currently no form to cover this scenario. However the most pragmatic approach seems to be as follows:

- If the new setting requests an Authorisation then the existing one is automatically ended and so you do not need to do anything.
- Alternatively if the absence is likely to be short and no DoLS Authorisation is requested by the new setting, again - do nothing.
- This will leave the Authorisation in place for when the person returns.
- If the absence is likely to be for a long period, or there is a likelihood the person will not return to your setting, use the relevant section in Form 10 - Review to inform the Supervisory Body so the DoLS Authorisation can be reviewed and ceased.

## **FORM 8:           TERMINATION OF REPRESENTATIVE**

This form is now a compilation of more than one form.

In some circumstances it may be necessary to terminate the role of the person who is acting as representative. The representative must be notified of this before it happens and given the opportunity to comment, they must not be told retrospectively.

The role of representative is a key role in the safeguards. However in some specific circumstances this appointment can be terminated:

- If the Authorisation ends and a further Authorisation is not requested or granted
- The person who is being deprived of liberty objects to the person appointed as representative and they have capacity to do so and wish someone else to take the role
- A donee or Deputy objects, and this is within their role and they identify someone else to be the representative
- The Supervisory Body becomes aware that the representative no longer wishes to continue with the role or that they are no longer eligible to
- The Supervisory Body becomes aware that the representative is not representing the person, they are not keeping in touch, not supporting them effectively or not acting in their best interests
- The representative has died

In situations where there is a question over whether the representative is keeping in touch or acting in the person's best interests, the Supervisory Body should seek clarification from the representative before terminating their appointment.

**Page 1:**           **This has names and addresses and allows the Supervisory Body to indicate the reason for the termination.**

**Page 2:**           **The Supervisory Body would give reasons in full if the representative is:**

- not maintaining contact
- no longer eligible
- no longer acting in the person's best interests

The representative is able to respond to the reasons given and add clarity by a date set on the form. If this is not forthcoming then the appointment will terminate as stated on page 1.

## **FORM 9: STANDARD AUTHORISATION CEASED**

This is a very useful form for the Supervisory Body and a necessary way to confirm that an Authorisation has ceased to be in force. It is one page only and is used for a variety of reasons.

Any DoLS Authorisation should technically be either reviewed to end it, or renewed if the person still needs to be deprived of their liberty.

It does not appear to have been the intention of the legislators that an Authorisation could simply “run out”.

Either the person continues to need the measures in question which amount to a deprivation of liberty and a further request will be made, or something has changed about their situation or care needs and they may no longer need such measures to be in place.

It would be strangely coincidental if such a reduction in restrictions occurred on the exact day the DoLS Authorisation came to an end. Therefore every Managing Authority must keep their DoLS Authorisation under constant review. Any change in the person’s care or treatment, or their overall situation, may mean they may no longer meet the requirements for an Authorisation and a review should be requested.

In practice there are often situations where this process does not happen. A person may be discharged from hospital or leave a care home without a review of the DoLS Authorisation.

This form covers the variety of circumstances whereby the Supervisory Body may need to cease an existing DoLS Authorisation.

### *The Authorisation has expired:*

In theory this should not happen. However, the Supervisory Body may be told after the event that a person is longer in a care home or hospital and the DoLS Authorisation is found to have expired.

### *This form confirms that it ceased to be in force:*

It has been reviewed and the person no longer meets the requirements for being deprived of their liberty, this is a more appropriate ending for an Authorisation. If, following a review, the person no longer meets the requirements, the Authorisation ceases from that date.

### *The person has moved and a new Standard Authorisation has been granted:*

If a person moves from a care home or hospital to another registered setting and the new setting applies for a DoLS Authorisation, this application will bring an existing Authorisation to an end.

There is, in this case, no need for the first Managing Authority to do anything. This is the simplest way a DoLS Authorisation is ceased following a move.

### *The person has died:*

Once notified of the death of a person subject to an Authorisation, this form should be used to terminate the Authorisation. The Supervisory Body should be notified of this, and the Coroner must also be informed using Form 12.

### *The person ceased to meet the eligibility requirement at least 28 days ago:*

This should link with Form 7 - Suspension of an Authorisation - and if this form has been completed to suspend an Authorisation but if the person has not returned to the relevant care

home or hospital within 28 days the Authorisation will cease to be in force and the Supervisory Body will confirm this.

*The Court of Protection has made an order that the Standard Authorisation is invalid or shall no longer have effect:*

If the Court of Protection is involved, due to the issue of deprivation of liberty or some other welfare issue, the Court may declare that an Authorisation is invalid. In this case the Supervisory Body will terminate the Authorisation from the date stated.

*Ceased to be in force for some other reason:*

Finally there is the option of “some other reason”. This section should be used if any other scenarios arise.

**FORM 10: REVIEW OF CURRENT AUTHORISATION  
(THIS FORM IS NOW SHARED WITH THE SUPERVISORY BODY)**

Previously the review process was cumbersome and required a number of forms to be completed. Not only was this arduous for the Supervisory Body but also meant the person being deprived of liberty and often their families / carers received numerous different forms.

The process is now captured on one form shared between the Managing Authority and the Supervisory Body.

**Page 1:**

This has details of the person being deprived of their liberty and also of the person or organisation requesting the review. It may be an IMCA who requests a review or it may be a family member. Sometimes a review request may come to the Supervisory Body in the form of a letter. If this is the case then the information about the person requesting the review can be transferred to the form.

The issue of grounds for review is stated at the bottom of page 1. In essence the grounds for a review of a DoLS authorisation are:

1. The person no longer meets one of the requirements
2. The reason why they meet one of the requirements is different
3. There has been a change in the person's circumstances and the conditions need to be varied.

This has been summarised on the form as:

- The person may no longer meet at least one of the requirements – in other words this incorporates the first two grounds by asking for a review of all the requirements or one of the requirements. The person may in fact at the end of the process still meet all of the requirements but if this is for a different reason that will be made clear through the assessment process.
- The conditions attached to the Authorisation need to be varied because there has been a change in the person's circumstances. This second option is for a review of conditions **only** and does not require a full best interests review.
- The person requesting the review will give details to support their request at the bottom of page one.

**Page 2: *This second page covers specific situations that do not always get reported to the Supervisory Body***

A DoLS Authorisation should not simply expire; it should be reviewed to bring it to an end. The exception to this is if a new setting has requested a new authorisation as described on page 27.

Very often in hospitals and care homes people are discharged without any action being taken in relation to the Authorisation.

This form provides, at page 2, a simple way for the Managing Authority to request a review to end an Authorisation for a person who is about to be discharged.

There must have been a change in the person's circumstances and the Managing Authority now believes that the person can be cared for elsewhere. This will generate a best interests decision and the Managing Authority can inform the Supervisory Body as soon as they have plans for the person's discharge.

The date when the person is due to leave and the new address of the person must be stated.

The new address is needed to determine whether the Supervisory Body need to make contact in relation to a subsequent Authorisation.

This should be accompanied by the best interests decision that has been made in relation to this decision.

There is room on the form to state for review purposes why it is no longer in the person's best interests to remain in the care home or hospital. This will allow the Supervisory Body to cease the DoLS authorisation using Form 9 – Standard Authorisation Ceased.

**Page 3:      *Supervisory Body's decision as to whether any qualifying requirements are reviewable***

The first section relates to whether there is information provided to suggest that one or more of the requirements may need to be reviewed.

First, there is the option that the Supervisory Body do not consider there are grounds for review. Therefore, the Authorisation will stay in place and the dates will be entered.

It is important to note that any review of an existing DoLS Authorisation can only be considered within the given time period.

Often Managing Authorities will request reviews when the Authorisation is almost at an end. In this scenario it is better to advise them to request a Further Authorisation using Form 2, when all requirements will be assessed again.

If the Supervisory Body has decided the grounds are met, it will have commissioned at least one assessment in relation to this and will indicate:

- which assessments were carried out
- whether the requirement was met or not met
- the reason why the requirement has changed

Outcome of the Review

There are three possible outcomes following the review:

1. At least one of the requirements was not met and therefore the Standard Authorisation will cease and the date of that will be entered;
2. Based on the assessments that were carried out, the reasons given in the Standard Authorisation as to why the person meets the requirements have been varied will have been described in summary in the table above but will also be supported by a full assessment;
3. All the review assessments carried out concluded that the person continues to meet the requirements to which they relate. Therefore the Standard Authorisation will continue to be in force until the date the Authorisation was originally given. This outcome may also be supplemented by a change in conditions.

**Page 4:      *Review of Conditions Only***

It is important to note that it is possible to request a review of conditions alone. Where the Supervisory Body decides that the best interests requirement should be reviewed solely because details of the conditions attached to the Authorisation need to be changed, and the review request does not include evidence that there is a significant change in the person's overall circumstances, then there is no need for a full reassessment of best interests. The Supervisory Body can vary the conditions attached as appropriate. In deciding whether a full reassessment is necessary, the Supervisory Body should consider whether the grounds for the Authorisation, or the nature of the conditions, are being contested by anyone as part of the review request. If the review relates to any of the other requirements, or to a significant change in the person's situation under the best interests requirement, the Supervisory Body must obtain a new assessment.

Once it is decided that this is a review of conditions only this situation the Supervisory Body has two options:

1. It may find that there has been a change in the person's case but this does not require a change in conditions *or*
2. There has been a change in the person's case as a result of which the conditions need to be varied and they are noted on this page.

It is hoped that by working with one form only for both request for reviews and outcomes of reviews this will simplify what is a key safety element of the process and reduce paperwork and bureaucracy for the person being deprived of liberty and their families and carers.

## **FORM 11: IMCA REFERRAL**

This form is relatively unchanged from the original form.

**Page 1**            ***This is for relevant names, addresses and contact details***  
**Page 2**            ***This allows for selection of the type of IMCA referral.***

There are three types of IMCA referrals.

*Type 1 – 39A - (commonly referred to as an assessment or authorisation IMCA)*

There two possible appointments under this heading:

- When an Urgent Authorisation has been given, or a request for a Standard Authorisation has been made, and the Managing Authority is satisfied that there is nobody whom it would be appropriate to consult in determining what would be in the person's best interests (excluding people engaged in providing care or treatment for the person in a professional capacity or for remuneration), then an IMCA must be appointed.
- An assessor has been appointed to determine whether or not there is an unauthorised deprivation of liberty, and the Managing Authority is satisfied that there is nobody whom it would be appropriate to consult in determining what would be in the person's best interests (excluding people engaged in providing care or treatment for the person in a professional capacity or for remuneration – that is paid staff).

*Type 2 - 39C - (commonly referred to as a cover IMCA)*

The person who is deprived of their liberty is temporarily without a relevant person's representative so an IMCA is needed to provide cover.

*Type 3 - 39D - (commonly referred to as a demand IMCA)*

There are three possible uses of on IMCA under this heading:

- The person who is deprived of their liberty has an unpaid representative who has requested the support of an advocate;
- The relevant person will benefit from the support of an advocate;
- The relevant person's representative will benefit from the support of an advocate.

If the referral is for a 39C or 39D IMCA, the duration that the IMCA will be required should be stated here. Any documentation provided can also be noted here.



**FORM 12: NOTIFICATION OF DEATH WHILST DEPRIVED OF LIBERTY**

There is a requirement for Managing Authorities to notify their local Coroner of a death when the person is subject to a DoLS authorisation.

<http://www.judiciary.gov.uk/wp-content/uploads/2013/10/guidance-no16-dols.pdf>

<http://www.mentalcapacitylawandpolicy.org.uk/wp-content/uploads/2014/04/DH-Letter-to-MCA-DoLS-Leads-14-January-2015-FINAL.pdf>

This form is intended to help with this process.

The form should be sent to the local Coroner and a copy sent to the Supervisory Body who has issued the DoLS Authorisation. This will result in the Authorisation being ceased.