challenging behaviour) where the Safeguards are not being invoked and visit them to explain how and when they should consider their use.

The CQC pilot found that 10 out of the 13 supervisory bodies interviewed offered some kind of planned, continuous support to managing authorities in relation to the MCA in general and the Safeguards in particular:

> Of these, seven offered telephone support throughout the working day. Two offered an e-learning course, two others gave individual feedback to applicants after each request for authorisation; four analysed applications and gave specific remedial training to applicants where needed … One supervisory body stood out as working in a number of ways to help the managing authority understand their role and meet requirements relating to it, including making sure they understood any conditions.

When an authorisation comes into effect

A standard authorisation comes into force when it is given, though it may be given in advance (within a month) of being required (see MCA Schedule A1[38] 50–53.) An authorisation is 'given' when it is signed by the authoriser and communicated to the managing authority, since only then does it come into existence. Case law has clarified that an authoriser's role is:

- to scrutinise with rigour the grounds for the authorisation
- to add or remove conditions and shorten the authorisation period as required
- to request if necessary further information from the assessors to support their decision-making.

See also the 'Checklist for authorisers' in this resource.

Supervisory bodies should not tell managing authorities that an authorisation has been given before it has been signed, on the basis that the supervisory body office has had sight of the required written assessments and supports the authorisation.

Purpose of an authorisation

An authorisation can only be given with regard to somebody who lacks capacity to decide 'whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment' (MCA Schedule A1,[39] paragraph 15) and the person does not have an advance decision to refuse treatment (ADRT) and is not subject to a lasting power of attorney that would conflict with the proposed treatment. (MCA code of practice[40] 4.26).

An authorisation cannot be used by a local authority or NHS trust to 'get its own way', nor to prevent the relevant person having contact with relatives or friends This is a clear breach of Article 8 of the Human Rights Act 1998, and cannot be authorised through the DoLS process. Such a situation, which has the potential to lead to a major dispute between family members and the local authority, must be the subject of urgent local mediation and, if this fails to achieve consensus, the local authority should speedily seek resolution from the Court of Protection.

Support for people who use services and their representative

It is essential that the relevant person, and their relatives or friends, are consulted and are at the heart of the process of assessment. Any concerns expressed by them about the care plan and the prospective authorisation should be taken with the utmost seriousness. Otherwise, it is impossible to assess how proportionate any restrictions are. If a best interests assessor is selecting a relevant person's representative, it is essential to remember that the purpose of the Safeguards is to ensure that the person, or someone acting on their behalf, can challenge the authorisation as laid down in the European Convention on Human Rights[41] Article 5(4). It is a serious distortion of the role of a representative if someone is omitted from selection because it is known that they disapprove of the authorisation or it is thought likely they will challenge it. Indeed, some supervisory bodies proactively select from possible candidates the representative who disapproves of the authorisation as they are more likely to maintain a strong interest in the relevant person's human rights and the process itself.

As well as being crucial to the process, the relevant person and their representative must be sent information and copies of assessments, together with the outcome of all assessments and reviews.

Example from practice

Some supervisory bodies send out 'easy-read' explanations of the Safeguards to all people for whom authorisation is sought. If authorisation is granted, they send information to the representative, and also routinely make contact by telephone as well as providing the name of the manager of the Safeguards and their direct telephone line. They routinely refer all standard authorisations to the IMCA service under Section 39D of the MCA.

It is good practice to give the relevant person and their representative the contact details of a named person, such as the manager of the DoLS service, who can if necessary help them understand any aspects of the process they find bewildering. In selecting the relevant person's representative, the best interests assessor must remember that, if the person can choose for themselves, every effort must be made to enable them to do so (even if their choice is expressed simply).

Example from practice

Mr R has dementia. When the best interests assessor explained about the authorisation, and his right to choose someone to be his representative, he said: 'If you want someone to be on my side, you ask our Mabel; she's always been a good friend to me and won't let them mess me about.'

The supervisory body is in a good position, via the authoriser, to note issues of care management that should be shared with adult social care professionals or the contracts and commissioning team.

The use of IMCAs within the Safeguards

The Independent Mental Capacity Advocacy service is a crucial support for those at the heart of the process: the people deprived of their liberty in their best interests and their

families. IMCAs are provided by and accessible through the supervisory body. The IMCA role is an important safeguard to ensure that both the relevant person and their representative understand their rights when an authorisation is in place. The fifth annual IMCA report[42] shows the range of usage among local authorities of Section 39D IMCAs. The report quotes the ADASS/SCIE good practice guide covering this area,[43] which recommends:

> Supervisory bodies to instruct s39D IMCAs at the start of all standard authorisations where a person has a family member or friend appointed as their representative. This gives the person and their representative the opportunity to meet a s39D IMCA and so that they are in a better position to decide if they need the support of one at that point, or sometime in the future.

The Department of Health IMCA report[44] also shows an increase of 18 per cent from the previous year (2010/11) in the number of IMCA instructions associated with the use of DoLS. In total there were nearly 2,000 DoLS referrals to IMCA services in 2011/12.

The local authority has the responsibility to commission an effective and sufficient IMCA service within its boundaries as well as ensuring that sufficient assessors are available to carry out their required supervisory functions in a lawful and timely way.

A local audit of provision will highlight problems, including, for example, lack of sufficient IMCAs to work when required (see Appendix 1). Local authorities should ensure that management structures, in particular commissioning teams, are capable of responding to evidence of service delivery problems that may affect the local authority's ability to meet its supervisory functions.

Relationships with safeguarding teams

Following problems identified in case law, the CQC's pilot study of supervisory bodies[45] explored the relationships between supervisory bodies and adult safeguarding teams. It was found that 10 DoLS services were co-located with adult safeguarding teams, and shared staff over both functions. The remaining three had separate teams but shared a manager. The report comments:

> On the face of it, the case for a link between the management of safeguarding and the Safeguards is attractive, but there are some risks. For smaller authorities in particular, the question is raised about how to maintain the conceptual distance between their safeguarding and their MCA (including the Safeguards) functions.
>
> The approach taken by safeguarding teams tends to focus on protection from abuse, whether a person has capacity or not, whereas the Safeguards are a measure specifically located within human rights law to protect the human rights of people lacking capacity. While human rights should be and often is an important dimension to safeguarding and protection, some court cases have shown that professionals can focus on protection to the detriment of autonomy and rights, and fail sometimes to work within the best interests framework of the MCA.

In the same study, when asked generally about barriers to good practice, at least one respondent commented on 'lack of understanding among colleagues of the human

rights agenda as opposed to adult safeguarding'. Some local authorities have deliberately kept their DoLS teams separate and independent from safeguarding, while others ensure separation of decision-making rather than of location.

Lord Justice Munby has warned local authorities about the dangers of intervention against people's wishes and against their human rights. In a recent speech he expanded on this:

> The local authority is a servant and not a master – a truth which on occasions is too easily overlooked. Vulnerable adults look to the state – to the local authority – for the support, the assistance and provision of services, to which the law entitles them. They do not seek to be controlled by the state or by the local authority. And it is not for the state, in the guise of the local authority, to seek to exercise such control.[46]

As a result, one of the important roles of effective DoLS teams is to act as local authority scrutineers of safeguarding interventions when the interventions are against the wishes of people, or where they involve the control of compliant people who lack the capacity to agree to the intervention.

Example from practice

One local authority has introduced automatic referrals from safeguarding to the DoLS team when a person who lacks capacity is removed to a place of safety, and/or when there is significant interference with family relationships. The DoLS team decides whether and when an urgent application to the Court of Protection is necessary.

Core duties of the supervisory body

The core duties and responsibilities of the supervisory body are to:

- Respond to requests for standard authorisation.
- Respond to requests for an extension of an urgent authorisation.
- Commission the relevant IMCA service when required to do so.
- Commission the six assessments required for a standard authorisation.
- Grant the standard authorisation of deprivation of liberty if all assessments are positive, or not grant if one or more assessment is not met.
- Appoint the relevant person's representative.
- Respond to requests to review a standard authorisation and carry out a review when appropriate.
- Suspend and, where appropriate, terminate a standard authorisation if the person is detained under the MHA 1983 for up to 28 days (Schedule A1 of the MCA 2005[47] para. 93(2) does not specify who holds the responsibility to suspend the standard authorisation). The standard forms 14 and 15 issued for the suspension of standard authorisation and the lifting of the suspension are listed as forms for the managing authority to complete. This guidance follows paragraph 8.30 of the DoLS code of practice[48] which specifies that the

standard authorisation is suspended, and the suspension lifted, by the supervisory body.

- Terminate the deprivation of liberty standard authorisation when appropriate.
- Terminate the appointment of a relevant person's representative when appropriate.
- Respond to requests to investigate alleged unauthorised deprivations of liberty.

Equivalent assessments

An equivalent assessment is explained in the DoLS code of practice[49]chapter 4 (following MCA Schedule A1[50] paragraph 49) as an assessment carried out within the previous 12 months, not necessarily for the purpose of a deprivation of liberty authorisation, that meets all the requirements of a DoLS assessment, is still accurate, and of which the supervisory body has a written copy. (A common-sense exception to the 12-month time-limit is the age assessment, which has no time limit.). The code gives as an example a recent assessment carried out for the purposes of the Mental Health Act 1983, which could serve as an equivalent to a mental health assessment for DoLS purposes.

The CQC pilot study[8] found a range of practice relating to the use of equivalent assessments:

- Eight (of the 13 respondents) would consider accepting an assessment that was up to a year old on a case-by-case basis, but one of these eight normally only uses assessments if they are less than six months old, and one only accepts assessments if they are less than three months old.
- Four said that they would always commission fresh assessments if there had been a change of circumstances since the last assessment; three said they commissioned fresh assessments for each application.

Good practice

With the exception of the age assessment, some supervisory bodies have formulated policies governing the use of equivalent assessments, in particular time limits on reusing assessments. These policies differ widely, from only using assessments carried out within the previous month, to reusing assessments carried out over 11 months previously. Although the Schedule allows for reuse of assessments carried out within the previous 12 months, it is generally agreed that the longer the period of time since the assessment was made, the more wary a supervisory body should be of reusing it rather than commissioning a fresh assessment. In particular, many supervisory bodies would only reuse a capacity assessment under very exceptional circumstances, referring to the requirement in MCA Section 2 that assessment of capacity must be decision- and time-specific. European case law suggests that, when using previous mental health assessments, supervisory bodies should be careful to ensure they provide evidence that the person's mental disorder still persists.

A supervisory body should take care to avoid any suggestion of 'rubber-stamping' repeat authorisations without revisiting the circumstances of the person. For example, a fresh, formal look at the mental health assessment might, while agreeing with the previous diagnosis of mental disorder, find differently in answer to a question about the effect of deprivation of liberty on the person's mental health.

Every time a repeat authorisation is requested, and the supervisory body is considering using equivalent assessments, it must consider whether the reuse of any of these might pose a risk to the relevant person's right to expect that any decision to deprive someone of their liberty is made following defined processes and taking all the current relevant factors into account.

Supervisory bodies should record the reasons why they have used any equivalent assessment: standard form 11 is recommended for this purpose.

Peer support

Most of the support available to supervisory bodies when the Safeguards were first implemented (such as regional leads and a dedicated DH team) no longer exist. However, many of the original regional groups have continued informally, and provide an invaluable source of advice and best practice in this area.

Several law firms and chambers of barristers put out free, regular updates on case law in this developing area, and there are national and regional conferences and masterclasses; it is essential for supervisory body management staff, managing authorities and best interests assessors to be aware of these.

When the CQC explored this area[51] it found that, while seven of the 13 supervisory bodies were active participants in their regional MCA/DoLS network, one reported only informal contact with neighbouring authorities, and two reported no peer support contacts at all. It is recommended good practice for local authorities to support the DoLS manager to be actively involved with the regional group, as well as seeking out other mechanisms for their continued learning.

Emerging practice for supervisory bodies

A supervisory body can only authorise a deprivation of liberty if it takes place in a care home or hospital. If it takes place elsewhere, it can only be authorised by the Court of Protection. Authority can never be given under a Lasting Power of Attorney to make a deprivation of liberty lawful.

The community

There is a potential role for supervisory bodies in assessing whether a care plan or the care provided in the community to a person lacking capacity to consent might be approaching a deprivation of liberty. Their role is to examine the care plan and the care provided and to seek an assessment by a best interests assessor about whether a) there might be a deprivation of liberty; b) the care could be provided in a less restrictive way that removes the danger of the situation being a deprivation of liberty; and c) an application to the Court of Protection may be necessary.

Examples from practice

One local authority has its reviewing officers working very closely with the DoLS team. The reviewing officers refer clients who receive their care in their own homes or in other community settings to the DoLS office if they have concerns about restrictions. The DoLS office then sends out a best interests assessor to establish whether there may be a deprivation, whether it is in the person's best interests (or whether it could be made less restrictive) and whether an application to the Court of Protection is needed.

Another local authority has introduced procedures to ensure that particular care is taken in planning clear pathways for people with a learning disability at the point of transition to adult services. The restrictions which may be appropriate for a child may no longer be appropriate for a young adult and may amount to a deprivation of liberty unless challenged. Where such restrictions may be thought necessary in the person's best interests, and the person will be in a care home or hospital setting when they reach the age of 18, they require assessment and authorisation under the Safeguards. If the person is likely to be in supported living accommodation, or living in their own or the family home, deprivation of liberty can only be authorised through an application to the Court of Protection.

Wider local authority strategy based on learning from DoLS

DoLS teams, in particular best interests assessors and authorisers of DoLS, are becoming the key experts in care planning in a human rights framework. They are developing knowledge, skills and understanding which are relevant and important for the majority of social care people who use services. Local authorities could build on this expertise in developing their wider human rights strategy and practice.

Example from practice

Mr J (23) has learning disabilities and Asperger's syndrome, with behavioural difficulties including aggression when frustrated or anxious.

He was admitted in an emergency to a local residential care home, after a violent incident at home connected both to his problems and to his mother's mental health issues and substance abuse. The local unit was unable to manage his behaviour, so he was placed in a specialist home 50 miles away.

He lacked capacity at this time to consent to arrangements made by the home for his care. The staff in the unit brought him back in his pyjamas from several attempts to go home at bedtime, when he was missing his mum, and additionally refused to allow his mother to visit.

The unit gave itself an urgent authorisation and requested a standard one. The best interests assessor identified breaches of Article 5 and Article 8 of the Human Rights Act 1998 and decided that Mr J had been deprived of his liberty. She found the level of restriction to be disproportionate to the risk and seriousness of harm to Mr J and decided that this deprivation of liberty could not be authorised as it stood. She informed the commissioners of the service that a serious dispute between Mr J's mother and the unit should be mediated and, if intractable, referred rapidly, by the local authority, to the Court of Protection.

A formal best interests meeting was convened urgently. As part of this, contact between Mr J and his mother was reinstated, including facilitating visits from his mother to the care home. These visits were successful. A care plan was agreed that worked towards moving Mr J into a supported living setting, close to his mother's home. Care staff are now working to give him increased daily living skills and Mr J is no longer deprived of his liberty, but looking forward to a more independent lifestyle.

Assessors and assessments

Mental health assessment (standard form 4)

What makes a good mental health assessor

Mental health assessors must first of all meet the regulatory requirements of the MCA DoLS Regulations 2008.[52] They must be medical doctors experienced in mental health: either approved under section 12 of the Mental Health Act 1983, or be registered medical practitioners with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as GPs with a special interest. It includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983. They must have completed the standard training as laid out by the Royal College of Psychiatrists. Like best interests assessors, they must complete annual refresher training that satisfies the supervisory body of their fitness to continue to practice as a mental health assessor. Some supervisory bodies encourage mental health and best interests assessors to attend joint refresher training, often consisting of case-law updates, case scenarios, and discussions of recent local assessments that have raised issues of good, or poor, practice.

A good mental health assessor should have experience relevant to the person's condition. The supervisory body should consider whether, if possible, the use of a mental health assessor who knows the person professionally will be of benefit. Usually this will reduce the stress for the relevant person and the assessor may be best placed to assess them thoroughly. An assessor who has prior knowledge of the person may be better able to predict what effect deprivation of liberty would have on their mental health.

The local authority is responsible for ensuring that sufficient mental health assessors are available. A good relationship with local CCGs might enable authorities to initiate a dialogue with mental health services to encourage doctors approved under Section 12 of the Mental Health Act (particularly those with expertise with older people or learning disabilities) to train and practise as mental health assessors under DoLS.

Mental health assessors carry out assessments under the Safeguards in both care homes and hospitals. In some areas a small number of assessors do all – or almost all – of the appropriate assessment work for a range of local authorities. This situation carries some risk, as retirement or other events can lead to a sudden shortage of assessors. There is also a potential risk to the integrity of the Safeguards when the opinion and interpretation of a small number of assessors, however well informed, is relied upon. It may also become harder to identify a suitable different mental health assessor to carry out a review of previous assessments.

If local authorities identify problems in either the quantity or quality of mental health assessors, these should be discussed with the local CCG(s) and MCA lead(s).

The possibility and advantages of training as a DoLS mental health assessor can be promoted locally among, in particular, MHA Section 12 approved doctors working in the areas of older adults' mental health, learning disability and acquired brain injury. The advantages include an enhanced knowledge of human rights law in general and of

deprivation of liberty in particular, which will benefit people who use services while also updating the practitioners' essential knowledge. A business case for local or regional training might be presented for the use of joint local authority/CCG resources available for implementing the Mental Capacity Act.

What makes a good mental health assessment

Case law reminds medical assessors and supervisory bodies that for the lawful detention of a 'person of unsound mind' within the meaning of Article 5(1)(e) of the European Convention on Human Rights, a true mental disorder must be established before a competent authority on the basis of objective medical expertise. The mental disorder must be of a kind or degree warranting compulsory confinement and the validity of continued confinement depends upon the persistence of such a disorder.

Mental health assessors and supervisory bodies should be cautious that, if an equivalent assessment is used, they are certain that these criteria are met, in particular that they are sure the person's disorder has continued to be as it was previously described.

For the purposes of DoLS, the person meets the mental health requirement if suffering from mental disorder within the meaning of the Mental Health Act, but disregarding any exclusion for persons with learning disability. The MHA defines a mental disorder as 'any disorder or disability of the mind'. Although the Act does not define these terms any further, it is likely that conditions falling within the definition could include:

- organic mental disorders such as dementia, or personality and behavioural changes due to brain injury and damage
- mental and behavioural disorders due to psychoactive substance use, schizophrenia and other delusional disorders
- affective disorders, such as depression and bipolar disorder
- neurotic, stress-related and somatoform disorders such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- eating disorders, non-organic sleep disorders and non-organic sexual disorders
- personality disorders, such as antisocial personality disorder, borderline personality disorder
- autistic spectrum disorder
- learning disabilities (but with the exception that, for the Safeguards, there is no need for this to be associated with abnormally aggressive or seriously irresponsible conduct).

As Section 4.33 of the DoLS code of practice[53] explains:

> The purpose of the mental health assessment is to establish whether the relevant person has a mental disorder within the meaning of the Mental Health Act 1983. That means any disorder or disability of mind, apart from dependence on alcohol

or drugs. It includes all learning disabilities. This is not an assessment to determine whether the person requires mental health treatment.

The DoLS code of practice goes on to highlight the distinction between a mental **health** assessment and a mental **capacity** assessment:

- although a person must have an impairment or disturbance of the functioning of the mind or brain in order to lack capacity, it does not follow that they automatically have a mental disorder within the meaning of the Mental Health Act 1983
- the objective of the mental health assessment is to ensure that the person is medically diagnosed as being of 'unsound mind' and so comes within the scope of Article 5 of the European Convention on Human Rights.

When carrying out a mental health assessment, the standard form reminds the assessor to:

(a) consider how (if at all) the relevant person's mental health is likely to be affected by him being a detained resident, and
(b) notify the best interests assessor of his conclusion (Schedule A1 to the Mental Capacity Act 2005[54] paragraph. 36)
(c) consult with IMCA under section 39A of the Mental Capacity Act if applicable.

If the person is being assessed for a second or subsequent authorisation, the mental health assessor should consider how the person responded to any previous period of authorisation. If the person shows little sign of being reconciled to the authorisation, it is important that the best interests assessor is fully aware of this, in order to decide whether the restrictions are proportionate to the risk and seriousness of harm, in the light of the person's evident unhappiness.

The Deprivation of Liberty Safeguards code of practice[55] reminds both best interests assessors and mental health assessors that it is a mark of good practice for them to discuss their findings and their opinions. In case of divergent opinions, this is particularly important: if the relevant person fails any assessment, the Safeguards cannot be used to protect their rights.

Example from practice

Isabel (28) has a mild learning disability, and suffered an accidental brain injury two years ago. Since the injury she has been very impulsive, putting herself at risk by rushing across roads, trying to jump out of cars and climbing out of windows. The triggers are usually pet animals or small children. She is being assessed for her second period of authorisation, in a specialist nursing home. The mental health assessor is concerned about the effect deprivation of liberty is having on Isabel's mental health: there are signs of depression, and Isabel's self-esteem appears lower than at the time of the earlier authorisation. She says nobody listens to her. The assessor explains his findings to the managing authority and the best interests assessor, and queries whether a less restrictive care plan, perhaps involving access to pets, is possible.

Checklist for mental health assessors

- The assessor is able to diagnose a defined mental disorder, with the assistance of clinical notes if available, or from interview and observation.
- If there is no formal diagnosis, the assessor is satisfied that there is a mental disorder as defined in the MHA, and has supported that opinion with description of relevant signs and symptoms.
- If there is a disorder, the assessor has described the signs and symptoms in sufficient detail to bear out the diagnosis.
- If the assessor considers that there is no mental disorder in the meaning of the Act, they have notified the supervisory body immediately, as there is no need for any further assessment to take place.
- The assessor has considered and described their opinion of the likely effect of a deprivation of liberty on this person's mental health, with reasons for that opinion.
- The assessor has informed the best interests assessor of their opinion of the likely effect of a deprivation of liberty on this person's mental health.
- The assessor has consulted with any IMCA appointed under MCA section 39A if applicable.
- The assessor has completed the form legibly, signed and dated it.
- The assessor will return the form to the supervisory body office, in a secure format, as soon as possible.

For an audit monitoring tool for mental health assessments, see Appendix.

Mental capacity assessment (standard form 4)

What makes a good mental capacity assessor

The assessor[56] must be eligible to be either a best interests assessor or a medical assessor. Consideration should be given to using an assessor who already knows the person if this is possible, since it is likely to reduce the stress of being assessed, and enable the relevant person to be at their most relaxed. The assessor should also have professional experience and knowledge of the possibly incapacitating disorder the person lives with – for example, learning disability, dementia, multiple sclerosis or acquired brain injury.

Example from practice

A supervisory body audited the skills of its best interests assessors and mental health assessors, and found a lack of expertise relating to acquired brain injury and neurological conditions. The governance group identified professionals with the appropriate skills and professional knowledge, and encouraged them to train in order to join the pool of assessors.

What makes a good mental capacity assessment

It is crucial for the assessor to be clear that they are assessing the person's capacity about a specific question whether or not he or she should be accommodated in this particular hospital or care home, for the purpose of being given some specific care or treatment.

Assessors must be clear that this is a separate assessment from that relating to the capacity to engage in contact with family and friends: a person may have capacity to decide who they want to socialise with, but lack capacity to consent to the question of accommodation in a care home or a hospital.

Section 4.29 of the DoLS code of practice[57] emphasises that 'the assessment refers specifically to the relevant person's capacity to make this decision at the time it needs to be made. The starting assumption should always be that a person has the capacity to make the decision'. Chapter 3 of the main MCA code of practice discusses in detail ways to empower people to make their own decisions. Any assessment of capacity must also demonstrate that every effort has been made to enable a person to make their own decision.

The assessment must give evidence, at every stage, of how the person was assessed for the two-part test, and which elements of the 'four functional tasks' they could not manage, even with every assistance and support given as required under the second principle of the MCA. (As described in the MCA code of practice, Chapter 4, these four tasks are: to *understand* relevant information appropriately presented, *retain* it for long enough to *use and weigh* it to reach a decision, then to *communicate* by any means possible that decision)The fourth step, inability to communicate, specifically refers to someone who cannot communicate in any way whatever, such as a person in a coma or with locked-in syndrome (see Section 4.15 of the MCA code of practice[58]).

When considering a person who is self-neglecting, it can sometimes appear that a series of small decisions, each taken with capacity, could incrementally lead to a situation that was not chosen but which the individual did not have the capacity to understand and change. The distinction in the literature between decisional and executive capacity is seldom found in practice and its importance for determining responses to self-neglect needs to be considered further and be more fully understood in practice.

The emotional components of capacity are hard to identify, but may prevent the person from using and weighing information through, for example, fear of 'the state' or shame at not coping.[59]

Checklist for mental capacity assessors

- The assessor is satisfied that the first part of the two-stage test, the diagnostic stage, is met.
- The assessor is clear about the concrete details of the choice facing the person, for example, between living in a care home and living at home with a realistic package of care (rather than just 'going home' with no clear outline of available support).

- The assessor is clear that the person has been given enough information about their options, expressed appropriately, and at their best time of day, to empower them to make this decision if at all possible (while not expecting them to necessarily retain peripheral and minor details).
- The person has been given all practical support as stated in the second principle of the Act.
- The assessor has taken into account any relevant factors relating to the person's diagnosis – for example, that a person with a brain injury may have a good theoretical understanding of the choice before him or her, while having great difficulty using and weighing information.
- Bearing in mind a person's right to make unwise decisions with capacity, the assessor has taken care to avoid inadvertently attaching excessive weight to their own views of how this person's physical safety may be best protected, and insufficient weight to the person's own views of how their emotional needs may best be met.
- The assessor is satisfied about which of the first three functions (understand, retain, use and weigh) the person is unable, on the balance of probabilities, to carry out, or whether the person is unable in any way to communicate a decision.
- The recording is clear and is there evidence to bear out the assessor's assertions.

For an example of an audit tool to scrutinise DoLS assessments of mental capacity, see Appendix 3.

No Refusals assessment (standard form 3)

What makes a good no refusals assessor

This assessment must be carried out by a best interests assessor, who must be clear about the legal standing, and authority, of lasting powers of attorney, court-appointed deputies and Advance Decisions to Refuse Treatment. These matters are covered in the MCA code of practice,[60] Chapters 7, 8 and 9. A best interests assessor who finds that there is a lasting power of attorney in place, if there is no relevant refusal, must be aware that, if the relevant person lacks capacity to choose their own representative, the attorney may select the relevant person's representative and may if they wish select themselves.

What makes a good no refusals assessment

The relevant person meets the no refusals requirement unless there is a refusal within the meaning of Schedule A1 to the Mental Capacity Act 2005[61] paragraph 19 or 20:

> 19(1) There is a refusal if these conditions are met:
>
> (a) the relevant person has made an advance decision
>
> (b) the advance decision is valid

(c) the advance decision is applicable to some or all of the relevant treatment.

20(1) There is a refusal if it would be in conflict with a valid decision of a done or deputy for the relevant person to be accommodated in the relevant hospital or care home for the purpose of receiving some or all of the relevant care or treatment:

(a) in circumstances which amount to deprivation of the person's liberty, or

(b) at all.

Example from practice

Josef's niece, Clara, has lasting power of attorney for health and welfare; Josef has lost capacity to consent to treatment. Josef is diagnosed as needing surgery on his foot, and the local hospital has applied for a standard authorisation in order to keep him in hospital against his will in order to operate on him. Clara informs the best interests assessor, who is carrying out the no refusals assessment, that Josef always chose to attend a specific different hospital, run by a religious organisation, for any surgical procedures: he recognises this hospital as a safe place and has been happy and compliant with treatment there since losing capacity. Clara therefore refuses her permission for him to be admitted to the local hospital, and requests Josef's doctor to arrange a consultation with Josef's preferred hospital.

Eligibility assessment (standard form 4)

What makes a good eligibility assessor

The assessor must be either a doctor with specific psychiatric expertise, often approved under Section 12 of the Mental Health Act, who has undergone appropriate training to be a medical assessor, or an AMHP who is also a best interests assessor. Either of them must if relevant have completed annual refresher training that satisfies the supervisory body as fulfilling this requirement.

What makes a good eligibility assessment

The assessor must be clear about what makes a person ineligible for the Safeguards (see the next section for problems that may arise in psychiatric hospitals). This is detailed in Schedule 1A[62] to the Mental Capacity Act 2005 and the rule is spelled out, helpfully, in the eligibility form (form 9).

The Safeguards cannot be used as the mechanism for protecting the rights of a person if:

- the person objects to being in this hospital in order to be given treatment for their mental disorder or to be given some or all of the mental health treatment **and**
- no donee (person given rights under a Lasting Power of Attorney) or deputy appointed by the Court of Protection has made a valid decision to consent to each matter to which the person objects **and**

- the person meets the criteria for being detained under Sections 2 or 3 of the Mental Health Act.

It will sometimes happen that a person is referred for authorisation under the Safeguards, for example, in a community hospital or care home, but before the assessors can get there, the person's psychiatrist has admitted them to a psychiatric hospital under the Mental Health Act. This will be because, as above, the person requires treatment in a hospital, for a mental disorder, and is objecting to some or all of this. The MCA however cautions[63] that it cannot replace the Mental Health Act, or be seen as an optional 'less restrictive option' to the Mental Health Act. It is spelled out that nothing in the MCA authorises anyone:

> (a) to give a patient **medical treatment for mental disorder**, or
>
> (b) to consent to a patient's being given medical treatment for mental disorder if, at the time when it proposed to treat the patient, **his treatment is regulated by Part 4 of the Mental Health Act**.

The relationship between the MHA and the MCA relating to **treatment of a detained patient for a mental disorder** is that, generally, the MHA is the preferred legal mechanism to protect the human rights of the person:

An Advance Decision to Refuse Treatment relating to a mental disorder, or a decision by a health and welfare attorney refusing **treatment of a mental disorder,** can be overridden by use of the Mental Health Act 1983.
An exception relates to ECT (Electro-Convulsive Therapy), in that an advance refusal of **ECT**, or refusal of its use by a Lasting Power of Attorney donee, cannot be overridden except in specified emergency situations:

> s62(a) MHA: immediately necessary to prevent death
>
> s62(b) MHA: immediately necessary to prevent deterioration[64]

A valid and applicable advance decision to refuse treatment, or a decision made by a health and welfare attorney acting within their powers (provided the decision is in the person's best interests) re **physical treatment** must be respected.

Eligibility assessments in psychiatric hospitals

Particular problems can arise in mental health settings if a deprivation of liberty has been identified and there is disagreement on the appropriate legal mechanism to use to protect the relevant person's rights under the European Convention on Human Rights.[65]

Considering whether to use the Mental Health Act is the most appropriate first step in almost all circumstances, as the relevant person will have been admitted for assessment and treatment of a mental disorder.

However, if a person is no longer a mental health patient (because, for example, minimal improvement to their condition brought about by medicating them against their will is no longer proportionate), but needs to stay in hospital to be given medication for a physical disorder and lacks the capacity to be safely in charge of their own medication, that person may be deprived of their liberty because staff will not let them leave in their own best interests. In such a case the Safeguards are the appropriate route to protect the relevant person's rights.

The supervisory body and local mental health trusts (together with the CCG MCA lead) are advised to establish a protocol to address situations when a deprivation of liberty has been identified and the person has been assessed as ineligible for both the Safeguards and the formal powers of the MHA. Such situations typically occur when different groups of assessors have assessed the person separately. Where a deprivation of liberty is found, it is important that, if there is any doubt about the correct route to protect the person's rights, the responsible professionals discuss which is the appropriate framework to achieve this protection. MCA and MHA leads from the relevant trust or the local authority are often able to be consulted or involved in such discussions.

Checklist for eligibility assessors

- If the eligibility assessor is not the best interests assessor, that person's views have been sought.
- The eligibility assessor is clear what is the **purpose** of this hospital admission (treatment for a mental disorder or treatment for a physical disorder) in order to determine whether or not the person is eligible for DoLS.
- If the eligibility assessor needs further information to decide if the person is eligible for the Safeguards, they are aware of where to find it (the supervisory body or best interests assessor may hold such information).

Example from practice

Mr T is a 64-year-old with a diagnosis of alcohol-related dementia leading to hallucinations, paranoia, continued drinking, self-neglect, exploitation, assaults in the community and outbursts of violence and aggression.

He had briefly been detained under Section 2 of the MHA 1983, but his dementia did not respond to treatment. He remained on the ward since there was nowhere else for him to go, and his considerable physical health problems meant that he needed help with medication.

Mr T kept trying to escape from the ward and join his unit as he thought that he was still in the armed forces. Following a best interests meeting it was decided to seek a specialist care home placement. In the interim, it was identified that Mr T's rights needed protecting, and a request was made for a DoLS authorisation. The eligibility assessor examined carefully the nature of his treatment, and decided that, but for his physical condition and the need to manage this, combined with the difficulty of finding a suitable care home, Mr T would not have needed to remain in the mental health unit. Therefore he was not a mental health patient, and 'not ineligible' for DoLS.

Mr T remained on the ward, with the protection of an authorisation, until he was placed in a small specialist unit. During his time on the ward, his paid relevant person's representative, supported by an IMCA, requested that the supervisory body review the eligibility requirement, since they felt Mr T should have been detained again under the MHA. A different eligibility assessor came to the same conclusions as the first, that the DoLS authorisation was the appropriate legal framework to protect Mr T's rights.

Best interests assessment (standard form 3)

What makes a good best interests assessor

Eligibility to be a best interests assessor is described in the DoLS Regulations.[66]

Best interests assessors are the lynchpin on which the entire edifice of DoLS rests, and they have a range of duties that fall to them within the operation of the Safeguards.

Best interests assessors are often the main assessors though a mental health assessor may also assess capacity. They are responsible for ascertaining that the person is 18 or older (the age assessment, now generally incorporated as part of the best interests assessment). They are solely responsible for assessing whether there are any lawful decision-makers who object to what is proposed (the 'no refusals' assessment). If qualified also as Approved Mental Health Professionals under the Mental Health Act 1983 (as amended), they are able to carry out the eligibility assessment, to decide whether this person's rights should be protected by the use of the MHA or the MCA, via the Safeguards.

Most significantly, they must carry out two vital tasks: they are responsible for deciding whether a restrictive situation is authorised by Sections 5 and 6 of the MCA, or whether it amounts to a deprivation of the person's liberty. If they conclude, given all evidence and scrutiny of the concrete situation of the person, and in the light of current case law, that the person is deprived of their liberty, they must assess holistically whether the restrictions are in the person's best interests, and proportionate to the risk and seriousness of harm to that person without the proposed restrictions. They must keep abreast of developments in case law to carry out these tasks correctly.

It is the role of the best interests assessor to:

- suggest any conditions that might reduce the need for ongoing deprivation of liberty, or lessen the impact of the deprivation on the relevant person
- frame any conditions so that they apply to such matters that the managing authority can control (rather than general care planning)
- discuss any conditions in advance of setting them with the managing authority, to ensure that the managing authority can comply
- suggest a maximum length for which authorisation can be granted – this can be for up to a year, although many supervisory bodies are reluctant to authorise for such a long period (however, an authoriser can shorten the period from that suggested by the best interests assessor, but cannot lengthen it).

Example from practice

Millie (39) has a learning disability, and following the death of her mother, who cared for her, has been placed in a care home as an emergency. The home has sought an authorisation under the Safeguards because Millie is distressed and resisting personal care in a very challenging way. The other residents are all older people with dementia. Both the best interests assessor and the IMCA, who was commissioned when the supervisory body found that Millie no longer had no close relatives or friends, feel the placement is wrong for her. The best interests assessor recommends authorisation for a maximum of four weeks to allow a best interests process to take place and somewhere more suitable to be found. She suggests a condition that the managing authority should recognise Millie's bereavement, and work with her to create a life story book.

If the person cannot choose their own representative, and there is no holder of a lasting power of attorney who can do this, it falls to the best interests assessor to suggest somebody. This is usually a fairly simple matter, and should be discussed when other matters are being explored as part of the assessment process. Where there are a number of children, for example, all aged over 18 and living quite locally, any of whom would be an ideal representative for their parent, best interests assessors often make a point of involving them (and the parent where possible) in the decision. Given the time-limited nature of the authorisation, some best interests assessors suggest that the adult children agree to take it in turns to carry out the representative role. The supervisory body administrators need to be careful in such a circumstance to comply with the regulatory framework and terminate one appointment before appointing another person, which must always be with the agreement of the person proposed (standard forms 25, 26 and 27).

The best interests assessor must come to an opinion on this wide range of matters, and provide sufficient evidence to enable the authoriser to understand how they reached their conclusions and recommendations. The evidence must be detailed, and gained from:

- discussion of the restrictions, and possible less restrictive options that have tried or might be available, with the person and their relatives or friends if any (and in the light of a report commissioned by the supervisory body from an IMCA if they have nobody other than paid carers to be consulted)
- examination of care plans and discussion with paid staff caring for the relevant person
- discussion with the mental health assessor, including gaining their opinion on the possible effects on the person's mental health of the authorisation
- contact with the eligibility assessor to share relevant information.

Support

It is the duty of the supervisory body to support the continued learning and practice development of best interests assessors. This is currently done in a range of ways. As well as the mandatory annual refresher training, many supervisory bodies:

- arrange regular meetings of best interests assessors with the DoLS lead, to discuss practice and case law;
- send out regular bulletins to assessors with highlights from Court of Protection or European Court of Human Rights judgements;
- encourage best interests assessors to attend regional or national assessor forums;
- have an MCA DoLS panel to which best interests assessors submit a set number of anonymised assessments per year, which are used to feed back individually or to groups of assessors;
- encourage recognition of best interests assessors by managers and peers as MCA and human rights champions;
- ensure that the DoLS lead supports them by being available for discussion if needed.

Assessments in hospitals

The best interests assessor's role is not to authorise or scrutinise clinical decision-making in any way. It is to look at the conditions surrounding the provision of care or treatment and decide whether or not those conditions deprive the relevant person of their rights to liberty and security of under Article 5 of the Human Rights Act 1998.

Most supervisory bodies have experienced little or no difficulty in identifying competent best interests assessors to carry out assessments in hospitals, even where all the best interests assessors are local authority staff. Many best interests assessors from the four qualifying professions (social work, occupational therapy, nursing and psychology) have experience in hospital settings, often across a range of specialist health provisions.

However, although the task is essentially the same and similar issues will arise, some local authority best interests assessors may be carrying out assessments in hospitals for the first time. As with care homes, the assessor will need to understand the environment in which the assessment is taking place.

The best interests assessor must recognise that there is a wide spectrum of different hospitals which might apply for an authorisation, ranging from small community hospitals often used for rehabilitation, to large acute hospitals with many specialities, to mental health units designed for compulsory detention. The nature of the specific hospital is relevant to a finding of deprivation of liberty, which is probably more likely within a setting where people are customarily detained than in a smaller more homely one.

The assessor should understand the legal context of hospital treatment and case law relevant to hospital settings. A best interests assessor should also be able to recognise when it may be appropriate for the hospital to make an application to the Court of Protection under Practice Direction 9e[67] (applications relating to serious medical treatment) ref to PD9e.

Example from practice

Molly (91) was admitted to a large general hospital from her home with a chest infection. She had advanced dementia, and her daughter Jean had given up her work as a hospital nurse to care for her, with the help of two other nurses funded by a direct payment. The family belonged to a minority religious group, and often felt misunderstood by the wider community.

Molly lacked capacity to consent to admission, or to treatment: her admission, and the treatment for her chest infection, were agreed to be in her best interests. Molly also had a pressure sore and an infected toe. Jean and the other nurses had been treating these under the supervision of the GP, who agreed that Molly was probably approaching the end of her life.

Relations between ward staff and Jean were poor. Jean was seen as bossy and interfering, and in her turn she felt staff ignored her greater knowledge of her mother's condition. She also complained about staff being slow to provide essential personal care. Voices were raised on both sides. Staff then criticised Jean's previous care of her mother, citing the pressure sore, and raised a safeguarding alert. They allowed other relatives, and religious leaders, to visit Molly, but barred Jean from the ward. Jean's solicitor queried this and the hospital then gave itself an urgent DoLS authorisation, and requested a standard authorisation.

The best interests assessor, Frank, spoke to the other nurses who had looked after Molly at home, and to the GP. They praised Jean's nursing skills and commitment to her mother's wellbeing, while commenting on her perfectionism and tendency to micro-manage. Molly's elderly husband, and other relatives and friends, all wanted Molly home as soon as she was well enough, to be cared for by Jean, the other nurses and the GP, for the rest of her life. The hospital's position was that Molly should remain there, so her other medical problems could be treated. Staff said that if the deprivation of liberty was not authorised they would still prevent Jean from seeing her mother, under the umbrella of safeguarding. Frank explained that where relatives and professionals disagreed, if mediation was unsuccessful the hospital must apply to the Court of Protection for a best interests decision. He shared his opinion that it was disproportionate to the risk and seriousness of harm to Molly to refuse to allow Jean to visit, and to refuse to consider whether, and how, Molly might return home.

After discussions with the hospital's legal department, and with the GP, it was decided that Molly's treatment could safely continue in her own home, with additional input from the district nurses.

What makes a good best interests assessment

The key questions for a best interests assessment is what the person wishes for and where they want to be. Lord Justice Munby, lecturing in different parts of the country to Safeguards Adults leads from local authorities and health settings,[68] has often stressed that, fundamental to the process of properly engaging the person in the decision-making process, is listening to and taking account of their wishes and feelings. The fact that people lack the relevant capacity does not mean that their wishes and feelings simply fall out of account. It is elementary that decisions are made by reference to the

vulnerable adult's best interests. It is equally elementary that in determining where the best interests of these people truly lie it is necessary to have regard to their wishes and feelings, whether verbalised or articulated or not. To have regard to their wishes and feelings is not merely something mandated by the European Convention on Human Rights and the Mental Capacity Act. It is surely fundamental to treating P as a human being and with dignity.

The second key question is assessing whether any restriction or restraint is covered under Sections 5 and 6 of the MCA or whether it goes beyond this and amounts to a deprivation of liberty. This entails a good understanding of case law, both from the UK courts and from the European Court of Human Rights.

These two tasks require best interests assessors to follow the best interests checklist in Section 4 of the MCA. This includes interviewing the person and their relatives if any (or, if they have no relatives or friends apart from paid staff, taking account of the IMCA's views and findings) and also considering whether the proposed restrictions are proportionate **both** to the likelihood of harm to the person and to the seriousness of that harm.

Authorisers

What makes a good authoriser

Who can be an authorising signatory is not defined within Schedule A1[69] to the Mental Capacity Act 2005 or the Regulations. However, while the limitations of the role are laid down in Schedule A1, case law has amplified and illuminated its importance. The authoriser represents the local authority, and it is a role of great responsibility. The authoriser must not be in a position of conflict (for example, they must not manage the managing authority in addition to the DoLS service).

Example from practice

One local authority has a policy that authorisers must be of sufficient seniority that they would authorise guardianship under the Mental Health Act 1983 or deputyship (Court of Protection). Their authorisers are appointed in writing by a minute of a senior governance committee. Newly-appointed authorisers are invited to shadow more experienced colleagues.

Similarly, local authorities should be aware of, and pre-empt, any conflicts of interest within their authorising roles – for example, if they, as managers who may authorise care packages, also line-manage a best interests assessor who may be asked to assess an individual who is in receipt of such a care package.

Limitations of the authoriser's role

- A supervisory body **must** give a standard authorisation if all assessments support this and it has them in writing (with provisos) (Schedule A1 50(1) (a) and (b)).
- A supervisory body **can** shorten the time suggested by the best interests assessor but not lengthen it (Schedule A1 51 (1) (1) and (2)).
- A supervisory body **must** consider any conditions suggested by the best interests assessor: the authoriser **may** also add or remove conditions (Schedule A1 53 (1) (2)). Note that it is good practice that they consult with the best interests assessor if considering adding or removing conditions, and that the best interests assessor is allowed to request that they be informed if the authoriser removes or changes any conditions they have suggested, and if they have concerns that such a change might affect their conclusions.
- Any conditions that are set **must** relate solely to the deprivation of liberty and must relate to the managing authority. The managing authority **must** be able to comply with them (Schedule A1 53(3)).

If an assessor asserts that an ongoing situation does deprive a person of liberty but is not in their best interests, and there is no identified alternative place for the person where they would be safe, an authoriser should be alerted to the evident risks to the person's safety if the authorisation is not granted. If this situation arises, the authoriser

should discuss with the assessor the possibility of authorising deprivation of liberty for a short period, while arrangements are made for a less restrictive alternative.

Example from practice

Mrs M, who has dementia, was moved from her home to a care home as an emergency following the sudden death of her husband, who had cared for her. Since she was continuously asking to go home, and unable to comprehend her husband's death, the care home gave itself an urgent authorisation, and applied for a standard one.

When the best interests assessor visited, he found that there was a deprivation of liberty, and that it was in Mrs M's best interests to remain in the home in the short term while other options were explored: the authorisation was granted for four weeks. When this authorisation was about to expire, the assessor re-visited, and was very concerned to find that Mrs M had not settled, and had lost a considerable amount of weight. He discussed with the authoriser and with the care home manager his view that the ongoing deprivation of liberty was evidently not in Mrs M's best interests since she was so unhappy, although no less restrictive options for her care had been identified.

The care home manager rang the authoriser to say she would have no authority to keep Mrs M safely at the home over the weekend if the authorisation was not granted. She felt it was impossibly risky to let Mrs M, who was extremely confused, return home to an empty house: she had found that Mrs M's daughter was away for the weekend, and unable to return home immediately to care for her mother. The authoriser consulted with the assessor and the relevant service manager, who agreed to arrange a best interests meeting (to include Mrs M and her daughter) for the following week to explore how best to ascertain and meet Mrs M's best interests. The assessor recommended a maximum length for a subsequent authorisation of a further three weeks, and the authoriser agreed.

Scrutiny of assessments

A supervisory body would be 'essentially passive' if it accepted poor assessments: if not satisfied, the person in the role of authoriser could either ask the best interests assessor to re-visit, or request a review of the authorisation, or apply to court.

Decisions to be made, and documents scrutinised, by the authoriser

It is a matter for local decision whether an authoriser is used to ratify an 'authorisation not granted' (form 13) or not, though increasingly supervisory bodies are asking them to do so:

- in order that the authoriser can understand the reasons for the decision
- as a protection for the supervisory body since this form is described as signed on behalf of that body.

If the granting of an authorisation is recommended, authoriser will **always** be asked to sign form 12, 'authorisation granted': by doing this they create the authorisation. All the assessments are summarised or copied into this form.

Authorisers may wish to see the originals, and if so they should be easily available to them (i.e. part of the bundle of material substantiating the authorisation). If hand-written, they must be legible.

Care plans should be appended: there should be evidence of the managing authority trying to minimise restrictions, awareness of the human rights of the person, and of the principles of the MCA.

Assessors as independent professionals are responsible for their decisions, but there must be sufficient evidence for the authoriser to understand how they have reached those decisions. Authorisers must be able to gain as full a picture as possible of the assessment process, on the basis of which they are confident to authorise the deprivation of this person's liberty. If any of the assessments fail to give evidence for the decisions made, or if it is clear that the correct process has not been carried out (for example, close relatives were available for consultation but were not approached by the best interests assessor), it is the authoriser's responsibility to request further evidence to substantiate the decisions reached.

An authorisation for signature may contain conditions, often suggested by the best interests assessor, which are intended to reduce the restraint so that the person is no longer deprived of their liberty or to lessen the impact of the deprivation.

The conditions must relate to the issues that mean a person is deprived of liberty, rather than general matters of care management. Conditions are binding upon the managing authority, and should be matters they can achieve. Aspects of care management can, if relevant, be discussed with appropriate service managers who are outside the DoLS process, but a DoLS authorisation, or its conditions, cannot be used to enforce care management or commissioning actions.

The authoriser can add further conditions, or remove conditions suggested by the assessor. A best interests assessor can insist on being notified if conditions they have suggested are removed, since this may in certain circumstances alter their opinion about whether the authorisation remains in the person's best interests. It is general good practice for this consultation to take place.

Example from practice

Jehan has a learning disability and physical disabilities that make it hard for him to communicate. Staff have learned, from Jehan's parents, that when he is stressed it calms him to play with balloons: his sign that he wants to do this is that he blows out little puffs of breath. Jehan's care plan explains to staff that they should blow up balloons for him when he does this, and that they should also explore what might have caused him to feel stressed. The aim of this is to enable them to reduce incidents when they have to restrain him in his best interests. The best interests assessor finds inconsistency in staff awareness of this. She suggests a condition that the managing authority monitors staff training about Jehan's care plan, and records adherence to it. She adds the requirement that, if the authoriser removes this condition, she wants to be informed since she does not think the authorisation could be said to represent the least restrictive option and be in Jehan's best interests, without this condition to ensure his care plan is complied with.

Checklist for authorisers

The ‘authorisation granted’ (form 5)

The authoriser's role is to scrutinise the authorisation, to look for a convincing narrative, giving a clear picture of the person and ‘how we got to where we are’. It is not their role to overrule the findings of an assessor acting within their prescribed role who has provided evidence to justify their opinion: but the authoriser may, and should, require further evidence if that provided appears too scanty to justify action is such a serious matter as depriving fellow citizens of their liberty.

Form 12 must detail evidence of:

- the person’s past and present views and wishes
- the views of their relatives/friends or the opinion of an IMCA
- the restrictions being both necessary and proportionate
- less restrictive options having been tried/explored
- why less restrictive restrictions are not enough
- the case being made that the authorisation is proportionate to the likelihood of harm to the person and the seriousness of that harm.

Conditions relating to an authorisation

The authoriser can add or remove conditions, which must relate to reducing deprivation of liberty, not simply to better care planning. Conditions are binding on the managing authority, so must be achievable by them (rather than by others such as the commissioning authorities).

- If there are conditions, do they reduce the likelihood of the person being deprived of their liberty?
- Can the authoriser identify further conditions that might reduce deprivation of liberty?

Length of authorisation

- An authoriser can shorten an authorisation but not lengthen it.
- In such cases authorisers must clear why the period is to be shortened and what they hope to achieve by this.

Conclusion

The authoriser must be satisfied that there is enough evidence that this deprivation of liberty is in the person’s best interests, and that the removal of liberty is both warranted and **proportionate**. The authoriser should be alert to indicators of possible poor practice in case planning or practice, and should have sufficient seniority to raise these where appropriate through operational governance frameworks, including those in hospitals or CCGs.

Useful links

Court of Protection

Court of Protection case reports

Court of Protection newsletters

Care Quality Commission (CQC)

CQC DoLS report 2014/15

CQC – MCA DoLS guidance for providers

CQC – MCA guidance for providers

Death of a person subject to an MCA DoLS authorisation

Department of Health (DH)

DH MCA archived pages
Some of the historical information regarding the MCA and DoLS has been placed in an archive by the Department of Health but the pages remain relevant.

European Convention on Human Rights

European Court of Human Rights

NHS Digital

Human Rights Act 1998

IMCA Service – 7th Annual Report

Lasting Power of Attorney

Lucy Series, Mental Capacity Act and DoLS blog

UK General Public General Acts from 2005

MCA 2005

MCA Code of practice

Office of the Public Guardian

Mental Capacity Act: making decisions

MCA/Deprivation of Liberty Safeguards, Schedule A1, and associated regulations

MCA Deprivation of Liberty Safeguards

MCA DoLS standard forms (alternatively forms can be obtained from local authority DoLS offices)

Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2015–16

Mental Capacity Law and Policy blog

Mental Capacity Act (MCA) Directory
The MCA Directory helps to raise awareness about the MCA, including the Deprivation of Liberty Safeguards. You will find useful information and various tools to help understand or implement it. There is material here for people who may be subject to the Act's provisions, and for professionals from a range of backgrounds.

Mental Health Act 2007

Mental Health Act 1983 Code of Practice

Mental Health Foundation MCA literature review

Mental Health Law Online

Ministry of Justice

National Institute for Health and Care Excellence (NICE) quality standard and guidance for patient experience in adult NHS services

NICE quality standard for service user experience in adult mental health

Neary judgement
This is of crucial importance to the workings of a supervisory body.

NHS Commissioning Board: 'Commissioning for quality and innovation' guidance

Patient Experience Framework
This has been agreed by the National Quality Board and describes the aspects of a health care experience which people who use services have said matter most to them. Clearly different people in different settings will have different priorities for what is important within this framework.

Post Legislative Assessment – Mental Health Act 2007 (also covers the amendments to Mental Capacity Act to include DoLS)

Social Care Institute for Excellence – MCA and DoLS resources

Supreme Court judgement in the cases of P v Cheshire West and Chester City Council and P and Q v Surrey County Council

Transforming Patient Experience
A guide published in February 2013 by the NHS Institute

UK Human Rights blog

Universal Declaration of Human Rights (UDHR)

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3. MCA DoLS Code of Practice
http://www.tsoshop.co.uk/
www.publicguardian.gov.uk/mca/code-practice.htm
http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

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5. Mental Capacity Act 2005, Deprivation of Liberty Safeguards (England), Annual Report 2015–16, NHS Digital, 2016

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7. CQC MCA and DoLS pages
http://www.cqc.org.uk ;
http://www.cqc.org.uk/search/apachesolr_search/Mental%20Capacity%20Act

8. HL v. UK (2004) - App no 45508/99; 40 EHRR 761;
http://www.bailii.org/eu/cases/ECHR/2004/720.html

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13. See e.g., Engel & Ors v the Netherlands (no 1) (1979-80) 1 E.H.R.R 47 and Guzzardi v Italy (1981) 3 E.H.R.R 333.

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19. NHS Commissioning Board (2013), 'Commissioning for quality and innovation' guidance, London: Department of Health. **http://www.commissioningboard.nhs.uk/files/2013/02/cquin-guidance.pdf**

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Deprivation of Liberty Safeguards: putting them into practice

This resource describes good practice in the management and implementation of the Deprivation of Liberty Safeguards (DoLS; the Safeguards). It includes the roles of clinical commissioning groups (CCGs) and wider local authority governance.

The resource is structured with freestanding sections on hospitals, care homes, supervisory bodies, assessors and authorisers, hence there is some inevitable repetition between them.

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