



Mental Capacity Act 2005 Deprivation of liberty safeguards

Mental Capacity Act 2005

Deprivation of liberty safeguards

Code of Practice to supplement the main
Mental Capacity Act 2005 Code of Practice

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Mental Capacity Act 2005

Deprivation of liberty safeguards

Code of Practice to supplement the main
Mental Capacity Act 2005 Code of Practice

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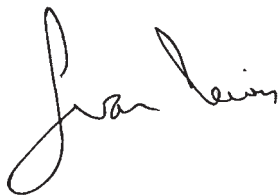
The Mental Capacity Act 2005 ('the Act') provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. It introduced a number of laws to protect these individuals and ensure that they are given every chance to make decisions for themselves. The Act came into force in October 2007.

The Government has added new provisions to the Act: the deprivation of liberty safeguards. The safeguards focus on some of the most vulnerable people in our society: those who for their own safety and in their own best interests need to be accommodated under care and treatment regimes that may have the effect of depriving them of their liberty, but who lack the capacity to consent.

The deprivation of a person's liberty is a very serious matter and should not happen unless it is absolutely necessary, and in the best interests of the person concerned. That is why the safeguards have been created: to ensure that any decision to deprive someone of their liberty is made following defined processes and in consultation with specific authorities.

The new provisions in the Act set out the legal framework of the deprivation of liberty safeguards. This Code of Practice is formally issued by the Lord Chancellor as a Code of Practice under the Mental Capacity Act 2005. It provides guidance and information for those implementing the deprivation of liberty safeguards legislation on a daily basis. In some cases, this will be paid staff, in others those who have been appointed in law to represent individuals who lack capacity to make decisions for themselves (such as deputies or donees of a Lasting Power of Attorney).

Because of this broad audience, the Code of Practice has been written so as to make it as user-friendly as possible – like the main Mental Capacity Act 2005 Code of Practice, issued in April 2007. We are grateful to all those who commented on earlier drafts of the Code to help it achieve that goal.

A handwritten signature in black ink, appearing to read 'Ivan Lewis', written in a cursive style.

Ivan Lewis

A handwritten signature in black ink, appearing to read 'Edwina Hart', written in a cursive style.

Edwina Hart

The Mental Capacity Act 2005 ('the Act'), covering England and Wales, provides a statutory framework for acting and making decisions on behalf of people who lack the capacity to make those decisions for themselves. These can be small decisions – such as what clothes to wear – or major decisions, such as where to live.

In some cases, people lack the capacity to consent to particular treatment or care that is recognised by others as being in their best interests, or which will protect them from harm. Where this care might involve depriving vulnerable people of their liberty in either a hospital or a care home, extra safeguards have been introduced, in law, to protect their rights and ensure that the care or treatment they receive is in their best interests.

This Code of Practice helps explain how to identify when a person is, or is at risk of, being deprived of their liberty and how deprivation of liberty may be avoided. It also **explains** the safeguards that have been put in place to ensure that deprivation of liberty, where it does need to occur, has a lawful basis. In addition, it provides guidance on what someone should do if they suspect that a person who lacks capacity is being deprived of their liberty unlawfully.

These safeguards are an important way of protecting the rights of many vulnerable people and should not be viewed negatively. Depriving someone of their liberty can be a necessary requirement in order to provide effective care or treatment. By following the criteria set out in the safeguards, and explained in this Code of Practice, the decision to deprive someone of their liberty can be made lawfully and properly.

How does this Code of Practice relate to the main Mental Capacity Act 2005 Code of Practice?

This document adds to the guidance in the main Mental Capacity Act 2005 Code of Practice ('the main Code'), which was issued in April 2007, and should be used in conjunction with the main Code. It focuses specifically on the deprivation of liberty safeguards added to the Act. These can be found in sections 4A and 4B of, and Schedules A1 and 1A to, the Act.

Though these safeguards were mentioned in the main Code (particularly in chapters 6 and 13), they were not covered in any detail. That was because, at the time the main Code was published, the deprivation of liberty safeguards were still going through the Parliamentary process as part of the Mental Health Bill.¹

Although the main Code does not cover the deprivation of liberty safeguards, the principles of that Code, and much of its content, are directly relevant to the deprivation of liberty safeguards. It is important that both the Act and the main Code are adhered to whenever capacity and best interests issues, and the deprivation of liberty safeguards, are being considered. The deprivation of liberty safeguards are in addition to, and do not replace, other safeguards in the Act.

How should this Code of Practice be used?

This Code of Practice provides guidance to anyone working with and/or caring for adults who lack capacity, but it particularly focuses on those who have a ‘duty of care’ to a person who lacks the capacity to consent to the care or treatment that is being provided, where that care or treatment may include the need to deprive the person of their liberty. This Code of Practice is also intended to provide information for people who are, or could become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as for anyone who believes that someone is being deprived of their liberty unlawfully.

In this Code of Practice, as throughout the main Code, references to ‘lack of capacity’ refer to the capacity to make a particular decision at the time it needs to be made. In the context of the deprivation of liberty safeguards, the capacity is specifically the capacity to decide whether or not to consent to care or treatment which involves being kept in a hospital or care home in circumstances that amount to a deprivation of liberty, at the time that decision needs to be made.

What is the legal status of this Code of Practice?

As with the main Code, this Code of Practice is published by the Lord Chancellor, under sections 42 and 43 of the Mental Capacity Act 2005. The purpose of the main Code is to provide guidance and information about how the Act works in practice.

¹ The Mental Health Bill was used as a vehicle to amend the Mental Capacity Act 2005 in order to introduce the deprivation of liberty safeguards. The Bill became the Mental Health Act 2007 following completion of its Parliamentary passage.

Both this Code and the main Code have statutory force, which means that certain people are under a legal duty to have regard to them. More details can be found in the Introduction to the main Code, which explains the legal status of the Code and who should have regard to it.

In addition to those for whom the main Code is intended, this Code of Practice specifically focuses on providing guidance for:

- people exercising functions relating to the deprivation of liberty safeguards, and
- people acting as a relevant person's representative² under the deprivation of liberty safeguards (see chapter 7).

Scenarios used in this Code of Practice

This Code of Practice includes boxes within the main text containing scenarios, using imaginary characters and situations. These are intended to help illustrate what is meant in the main text. They should not in any way be taken as templates for decisions that need to be made in similar situations. Decisions must always be made on the facts of each individual case.

Alternative formats and further information

This Code of Practice is also available in Welsh and can be made available in other formats on request.

² A 'relevant person' is a person who is, or may become, deprived of their liberty in accordance with the deprivation of liberty safeguards.

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1

What are the deprivation of liberty safeguards and why were they introduced?

The deprivation of liberty safeguards were introduced to provide a legal framework around the deprivation of liberty. Specifically, they were introduced to prevent breaches of the European Convention on Human Rights (ECHR) such as the one identified by the judgment of the European Court of Human Rights (ECtHR) in the case of *HL v the United Kingdom*³ (commonly referred to as the 'Bournewood' judgment). The case concerned an autistic man (HL) with a learning disability, who lacked the capacity to decide whether he should be admitted to hospital for specific treatment. He was admitted on an informal basis under common law in his best interests, but this decision was challenged by HL's carers. In its judgment, the ECtHR held that this admission constituted a deprivation of HL's liberty and, further, that:

- the deprivation of liberty had not been in accordance with 'a procedure prescribed by law' and was, therefore, in breach of Article 5(1) of the ECHR, and
- there had been a contravention of Article 5(4) of the ECHR because HL had no means of applying quickly to a court to see if the deprivation of liberty was lawful.

To prevent further similar breaches of the ECHR, the Mental Capacity Act 2005 has been amended to provide safeguards for people who lack capacity specifically to consent to treatment or care in either a hospital or a care home⁴ that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate for the person at that time. These safeguards are referred to in this Code of Practice as 'deprivation of liberty safeguards'.

What are the deprivation of liberty safeguards?

- 1.1 The deprivation of liberty safeguards provide legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 of the ECHR in a hospital or care home, whether placed under public or private arrangements. They do not apply to people detained under the Mental Health Act 1983. The safeguards exist to provide a proper legal process and suitable

³ (2004) Application No: 00045508/99

⁴ Throughout this document, the term 'care home' means a care home registered under the Care Standards Act 2000.

protection in those circumstances where deprivation of liberty appears to be unavoidable, in a person's own best interests.

- 1.2 Every effort should be made, in both commissioning and providing care or treatment, to prevent deprivation of liberty. If deprivation of liberty cannot be avoided, it should be for no longer than is necessary.
- 1.3 The safeguards provide for deprivation of liberty to be made lawful through 'standard' or 'urgent' authorisation processes. These processes are designed to prevent arbitrary decisions to deprive a person of liberty and give a right to challenge deprivation of liberty authorisations.
- 1.4 The deprivation of liberty safeguards mean that a 'managing authority' (i.e. the relevant hospital or care home – see paragraph 3.1) must seek authorisation from a 'supervisory body' in order to be able lawfully to deprive someone of their liberty. Before giving such an authorisation, the supervisory body must be satisfied that the person has a mental disorder⁵ and lacks capacity to decide about their residence or treatment. The supervisory body could be a primary care trust, a local authority, Welsh Ministers or a local health board (LHB) (see paragraph 3.3).
- 1.5 A decision as to whether or not deprivation of liberty arises will depend on all the circumstances of the case (as explained more fully in chapter 2). It is neither necessary nor appropriate to apply for a deprivation of liberty authorisation for everyone who is in hospital or a care home simply because the person concerned lacks capacity to decide whether or not they should be there. In deciding whether or not an application is necessary, a managing authority should carefully consider whether any restrictions that are, or will be, needed to provide ongoing care or treatment amount to a deprivation of liberty when looked at together.

⁵ As defined in section 1 of the Mental Health Act 1983, a mental disorder is any disorder or disability of the mind, apart from dependence on alcohol and drugs. This includes all learning disabilities. The distinction in the Mental Health Act 1983 between learning disabilities depending on whether or not they are associated with abnormally aggressive or seriously irresponsible behaviour is not relevant.

Chapter 1

What are the deprivation of liberty safeguards and why were they introduced?

1.6 The deprivation of liberty safeguards cover:

- how an application for authorisation should be applied for
- how an application for authorisation should be assessed
- the requirements that must be fulfilled for an authorisation to be given
- how an authorisation should be reviewed
- what support and representation must be provided for people who are subject to an authorisation, and
- how people can challenge authorisations.

Who is covered by these safeguards?

- 1.7 The safeguards apply to people in England and Wales who have a mental disorder and lack capacity to consent to the arrangements made for their care or treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty may be necessary to protect them from harm and appears to be in their best interests. A large number of these people will be those with significant learning disabilities, or older people who have dementia or some similar disability, but they can also include those who have certain other neurological conditions (for example as a result of a brain injury).
- 1.8 In order to come within the scope of a deprivation of liberty authorisation, a person must be detained in a hospital or care home, for the purpose of being given care or treatment in circumstances that amount to a deprivation of liberty. The authorisation must relate to the individual concerned and to the hospital or care home in which they are detained.
- 1.9 For the purposes of Article 5 of the ECHR, there is no distinction in principle between depriving a person who lacks capacity of their liberty for the purpose of treating them for a physical condition, and depriving them of their liberty for treatment of a mental disorder. There will therefore be occasions when people who lack capacity to consent to admission are taken to hospital for treatment of physical illnesses or injuries, and then need to be cared for in circumstances that amount to a deprivation of liberty. In these circumstances, a deprivation of liberty authorisation must be applied for. Consequently, this Code of Practice must be followed and applied in acute hospital settings as well as care homes and mental health units.

- 1.10 It is important to bear in mind that, while the deprivation of liberty might be for the purpose of giving a person treatment, a deprivation of liberty authorisation does not itself authorise treatment. Treatment that is proposed following authorisation of deprivation of liberty may only be given with the person's consent (if they have capacity to make the decision) or in accordance with the wider provisions of the Mental Capacity Act 2005. More details of this are contained in paragraphs 5.10 to 5.13 of this Code.
- 1.11 The safeguards cannot apply to people while they are detained in hospital under the Mental Health Act 1983. The safeguards can, however, apply to a person who has previously been detained in hospital under the Mental Health Act 1983. There are other cases in which people who are – or could be – subject to the Mental Health Act 1983 will not meet the eligibility requirement for the safeguards. Chapter 13 of the main Code contains guidance on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983 generally, as does the Code of Practice to the Mental Health Act 1983 itself. Paragraphs 4.40 to 4.57 of the present Code explain the relationship of the deprivation of liberty safeguards to the Mental Health Act 1983, and in particular how to assess if a person is eligible to be deprived of their liberty under the safeguards.
- 1.12 The safeguards relate only to people aged 18 and over. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered – such as the existing powers of the court, particularly those under section 25 of the Children Act 1989, or use of the Mental Health Act 1983.

When can someone be deprived of their liberty?

- 1.13 Depriving someone who lacks the capacity to consent to the arrangements made for their care or treatment of their liberty is a serious matter, and the decision to do so should not be taken lightly. The deprivation of liberty safeguards make it clear that a person may only be deprived of their liberty:
- in their own best interests to protect them from harm
 - if it is a proportionate response to the likelihood and seriousness of the harm, and
 - if there is no less restrictive alternative.

Chapter 1

What are the deprivation of liberty safeguards and why were they introduced?

- 1.14 Under no circumstances must deprivation of liberty be used as a form of punishment, or for the convenience of professionals, carers or anyone else. Deprivation of liberty should not be extended due to delays in moving people between care or treatment settings, for example when somebody awaits discharge after completing a period of hospital treatment.

Are there any cultural considerations in implementing the safeguards?

- 1.15 The deprivation of liberty safeguards should not impact in any different way on different racial or ethnic groups, and care should be taken to ensure that the provisions are not operated in a manner that discriminates against particular racial or ethnic groups. It is up to managing authorities and supervisory bodies to ensure that their staff are aware of their responsibilities in this regard and of the need to ensure that the safeguards are operated fairly and equitably.
- 1.16 Assessors who carry out deprivation of liberty assessments to help decide whether a person should be deprived of their liberty (see chapter 4) should have the necessary skills and experience to take account of people's diverse backgrounds. Accordingly, they will need to have an understanding of, and respect for, the background of the relevant person. Supervisory bodies must take these factors into account when appointing assessors and must seek to appoint the most suitable available person for each case.
- 1.17 Interpreters should be available, where necessary, to help assessors to communicate not only with the relevant person but also with people with an interest in their care and treatment. An interpreter should be suitably qualified and experienced to enable them to provide effective language and communication support in the particular case concerned, and to offer appropriate assistance to the assessors involved. Information should be made available in other languages where relevant.
- 1.18 Any decision about the instruction of Independent Mental Capacity Advocates (see paragraphs 3.22 to 3.28) or relevant person's representatives (see chapter 7) should take account of the cultural, national, racial or ethnic background of the relevant person.

Where do the safeguards apply?

- 1.19 Although the Bournemouth judgment was specifically about a patient who lacked capacity to consent to admission to hospital for mental health treatment, the judgment has wider implications that extend to people who lack capacity and who might be deprived of their liberty either in a hospital or in a care home.
- 1.20 It will only be lawful to deprive somebody of their liberty elsewhere (for example, in their own home, in supported living arrangements other than in a care home, or in a day centre) when following an order of the Court of Protection on a personal welfare matter. In such a case, the Court of Protection order itself provides a legal basis for the deprivation of liberty. This means that a separate deprivation of liberty authorisation under the processes set out in this Code of Practice is not required. More information about applying to the Court of Protection regarding personal welfare matters is given in chapter 10.

How do the safeguards apply to privately arranged care or treatment?

- 1.21 Under the Human Rights Act 1998, the duty to act in accordance with the ECHR applies only to public authorities. However, all states that have signed up to the ECHR are obliged to make sure that the rights set out in the ECHR apply to all of their citizens. The Mental Capacity Act 2005 therefore makes it clear that the deprivation of liberty safeguards apply to both publicly and privately arranged care or treatment.

How do the safeguards relate to the rest of the Mental Capacity Act 2005?

- 1.22 The deprivation of liberty safeguards are in addition to, and do not replace, other safeguards in the Mental Capacity Act 2005. This means that decisions made, and actions taken, for a person who is subject to a deprivation of liberty authorisation must fulfil the requirements of the Act in the same way as for any other person. In particular, any action taken under the deprivation of liberty safeguards must be in line with the principles of the Act:
- A person must be assumed to have capacity to make a decision unless it is established that they lack the capacity to make that decision.

- A person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because they make an unwise decision.
- An act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests.
- Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

These principles are set out in chapter 2 of the main Code and explained in more detail in chapters 3 to 6 of the same document. Paragraph 5.13 of the main Code contains a checklist of factors that need to be taken into account in determining a person's best interests.

Chapter 1

What are the deprivation of liberty safeguards and why were they introduced?

2

What is deprivation of liberty?

There is no simple definition of deprivation of liberty. The question of whether the steps taken by staff or institutions in relation to a person amount to a deprivation of that person's liberty is ultimately a legal question, and only the courts can determine the law. This guidance seeks to assist staff and institutions in considering whether or not the steps they are taking, or proposing to take, amount to a deprivation of a person's liberty. The deprivation of liberty safeguards give best interests assessors the authority to make recommendations about proposed deprivations of liberty, and supervisory bodies the power to give authorisations that deprive people of their liberty.

This chapter provides guidance for staff and institutions on how to assess whether particular steps they are taking, or proposing to take, might amount to a deprivation of liberty, based on existing case law. It also considers what other factors may be taken into account when considering the issue of deprivation of liberty, including, importantly, what is permissible under the Mental Capacity Act 2005 in relation to restraint or restriction. Finally, it provides a summary of some of the most important cases to date.

Further legal developments may occur after this guidance has been issued, and healthcare and social care staff need to keep themselves informed of legal developments that may have a bearing on their practice.

What does case law say to date?

- 2.1 The European Court of Human Rights (ECtHR) has drawn a distinction between the deprivation of liberty of an individual (which is unlawful, unless authorised) and restrictions on the liberty of movement of an individual.
- 2.2 The ECtHR made it clear that the question of whether someone has been deprived of liberty depends on the particular circumstances of the case. Specifically, the ECtHR said in its October 2004 judgment in *HL v the United Kingdom*:

'to determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of

Chapter 2

What is deprivation of liberty?

implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.’

- 2.3 The difference between deprivation of liberty and restriction upon liberty is one of degree or intensity. It may therefore be helpful to envisage a scale, which moves from ‘restraint’ or ‘restriction’ to ‘deprivation of liberty’. Where an individual is on the scale will depend on the concrete circumstances of the individual and may change over time. For more information on how the Act defines restraint, see paragraphs 2.8–2.12.
- 2.4 Although the guidance in this chapter includes descriptions of past decisions of the courts, which should be used to help evaluate whether deprivation of liberty may be occurring, each individual case must be assessed on its own circumstances. No two cases are likely to be identical, so it is important to be aware of previous court judgments and the factors that the courts have identified as important.
- 2.5 The ECtHR and UK courts have determined a number of cases about deprivation of liberty. Their judgments indicate that the following factors can be relevant to identifying whether steps taken involve more than restraint and amount to a deprivation of liberty. It is important to remember that this list is not exclusive; other factors may arise in future in particular cases.
- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
 - Staff exercise complete and effective control over the care and movement of a person for a significant period.
 - Staff exercise control over assessments, treatment, contacts and residence.
 - A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
 - A request by carers for a person to be discharged to their care is refused.
 - The person is unable to maintain social contacts because of restrictions placed on their access to other people.
 - The person loses autonomy because they are under continuous supervision and control.

There is more information on some relevant cases at the end of this chapter (paragraphs 2.17–2.23).

How can deprivation of liberty be identified?

2.6 In determining whether deprivation of liberty has occurred, or is likely to occur, decision-makers need to consider all the facts in a particular case. There is unlikely to be any simple definition that can be applied in every case, and it is probable that no single factor will, in itself, determine whether the overall set of steps being taken in relation to the relevant person amount to a deprivation of liberty. In general, the decision-maker should always consider the following:

- All the circumstances of each and every case
- What measures are being taken in relation to the individual? When are they required? For what period do they endure? What are the effects of any restraints or restrictions on the individual? Why are they necessary? What aim do they seek to meet?
- What are the views of the relevant person, their family or carers? Do any of them object to the measures?
- How are any restraints or restrictions implemented? Do any of the constraints on the individual's personal freedom go beyond 'restraint' or 'restriction' to the extent that they constitute a deprivation of liberty?
- Are there any less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether?
- Does the cumulative effect of all the restrictions imposed on the person amount to a deprivation of liberty, even if individually they would not?

What practical steps can be taken to reduce the risk of deprivation of liberty occurring?

2.7 There are many ways in which providers and commissioners of care can reduce the risk of taking steps that amount to a deprivation of liberty, by minimising the restrictions imposed and ensuring that decisions are taken with the involvement of the relevant person and their family, friends and carers. The processes for staff to follow are:

- Make sure that all decisions are taken (and reviewed) in a structured way, and reasons for decisions recorded.

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- Follow established good practice for care planning.
- Make a proper assessment of whether the person lacks capacity to decide whether or not to accept the care or treatment proposed, in line with the principles of the Act (see chapter 3 of the main Code for further guidance).
- Before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consider whether the person's needs could be met in a less restrictive way. Any restrictions placed on the person while in hospital or in a care home must be kept to the minimum necessary, and should be in place for the shortest possible period.
- Take proper steps to help the relevant person retain contact with family, friends and carers. Where local advocacy services are available, their involvement should be encouraged to support the person and their family, friends and carers.
- Review the care plan on an ongoing basis. It may well be helpful to include an independent element, possibly via an advocacy service, in the review.

What does the Act mean by 'restraint'?

2.8 Section 6(4) of the Act states that someone is using restraint if they:

- use force – or threaten to use force – to make someone do something that they are resisting, or
- restrict a person's freedom of movement, whether they are resisting or not.

2.9 Paragraphs 6.40 to 6.48 of the main Code contain guidance about the appropriate use of restraint. Restraint is appropriate when it is used to prevent harm to the person who lacks capacity and it is a proportionate response to the likelihood and seriousness of harm. Appropriate use of restraint falls short of deprivation of liberty.

2.10 Preventing a person from leaving a care home or hospital unaccompanied because there is a risk that they would try to cross a road in a dangerous way, for example, is likely to be seen as a proportionate restriction or restraint to prevent the person from coming to harm. That would be unlikely, in itself, to constitute a deprivation of liberty. Similarly, locking a door to guard against immediate harm is unlikely, in itself, to amount to a deprivation of liberty.

- 2.11 The ECtHR has also indicated that the duration of any restrictions is a relevant factor when considering whether or not a person is deprived of their liberty. This suggests that actions that are immediately necessary to prevent harm may not, in themselves, constitute a deprivation of liberty.
- 2.12 However, where the restriction or restraint is frequent, cumulative and ongoing, or if there are other factors present, then care providers should consider whether this has gone beyond permissible restraint, as defined in the Act. If so, then they must either apply for authorisation under the deprivation of liberty safeguards (as explained in chapter 3) or change their care provision to reduce the level of restraint.

How does the use of restraint apply within a hospital or when taking someone to a hospital or a care home?

Within a hospital

- 2.13 If a person in hospital for mental health treatment, or being considered for admission to a hospital for mental health treatment, needs to be restrained, this is likely to indicate that they are objecting to treatment or to being in hospital. The care providers should consider whether the need for restraint means the person is objecting (see paragraph 4.46 of this Code for guidance on how to decide whether a person is objecting for this purpose). A person who objects to mental health treatment, and who meets the criteria for detention under the Mental Health Act 1983, is normally ineligible for an authorisation under the deprivation of liberty safeguards. If the care providers believe it is necessary to detain the person, they may wish to consider use of the Mental Health Act 1983.

Taking someone to a hospital or a care home

- 2.14 Transporting a person who lacks capacity from their home, or another location, to a hospital or care home will not usually amount to a deprivation of liberty (for example, to take them to hospital by ambulance in an emergency.) Even where there is an expectation that the person will be deprived of liberty within the care home or hospital, it is unlikely that the journey itself will constitute a deprivation of liberty so that an authorisation is needed before the journey commences. In almost all cases, it is likely that a person can be lawfully taken to a hospital or a care home under the wider provisions of the Act, as long as it is considered that being in the hospital or care home will be in their best interests.

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- 2.15 In a very few cases, there may be exceptional circumstances where taking a person to a hospital or a care home amounts to a deprivation of liberty, for example where it is necessary to do more than persuade or restrain the person for the purpose of transportation, or where the journey is exceptionally long. In such cases, it may be necessary to seek an order from the Court of Protection to ensure that the journey is taken on a lawful basis.

How should managing authorities avoid unnecessary applications for standard authorisations?

- 2.16 While it is unlawful to deprive a person of their liberty without authorisation, managing authorities should take into consideration that unnecessary applications for standard authorisations in cases that do not in fact involve depriving a person of liberty may place undue stress upon the person being assessed and on their families or carers. Moreover, consideration must always be given to the possibility of less restrictive options for delivering care or treatment that avoid deprivation of liberty altogether.

Examples of case law

- 2.17 To provide further guidance, the following paragraphs contain short descriptions of what appear to be the significant features of recent or important cases in England and Wales and the ECtHR dealing with deprivation of liberty. Remember that:
- these descriptions are for guidance only
 - only the courts can authoritatively determine the law; and
 - the courts are likely to give judgments in cases after this guidance is issued. Staff will need to keep up to date and take account of further relevant legal developments.

Cases where the courts found that the steps taken did not involve a deprivation of liberty

- 2.18 *LLBC v TG* (judgment of High Court of 14 November 2007)

TG was a 78-year-old man with dementia and cognitive impairment. TG was resident in a care home, but was admitted to hospital with pneumonia and septicaemia. While he was in hospital, there was a dispute between the local authority and TG's daughter and granddaughter about TG's future. The daughter and granddaughter wanted TG to live with them, but the local authority believed that TG needed 24-hour care in a residential care home.

The council obtained an order from the court, directing that TG be delivered to the care home identified as appropriate by the council. Neither the daughter nor granddaughter was informed that a court hearing was taking place. That order was subsequently changed and TG was able to live with his daughter and granddaughter.

TG's daughter and granddaughter claimed that the period of time he had spent at the care home amounted to a deprivation of his liberty.

The judge considered that there was no deprivation of liberty, but the case was borderline. The key factors in his decision included:

- The care home was an ordinary care home where only ordinary restrictions of liberty applied.
- The family were able to visit TG on a largely unrestricted basis and were entitled to take him out from the home for outings.
- TG was personally compliant and expressed himself as happy in the care home. He had lived in a local authority care home for over three years and was objectively content with his situation there.
- There was no occasion where TG was objectively deprived of his liberty.

The judge said:

'Whilst I agree that the circumstances of the present case may be near the borderline between mere restrictions of liberty and Article 5 detention, I have come to the conclusion that, looked at as a whole and having regard to all the relevant circumstances, the placement of TG in Towerbridge falls short of engaging Article 5.'

2.19 *Nielsen v Denmark (ECtHR; (1988) 11 EHRR 175)*

The mother of a 12-year-old boy arranged for his admission to the state hospital's psychiatric ward. The boy had a nervous disorder and required treatment in the form of regular talks and environmental therapy. The treatment given, and the conditions under which it was administered, was appropriate. The duration of treatment was 5½ months. The boy, however, applied to the ECtHR, feeling that he had been deprived of his liberty.

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The restrictions placed on the applicant's freedom of movement and contacts with the outside world were not much different from restrictions that might be imposed on a child in an ordinary hospital. The door of the ward was locked to prevent children exposing themselves to danger or running around disturbing other patients. The applicant was free to leave the ward with permission and to go out if accompanied by a member of staff. He was able to visit his family and friends, and towards the end of his stay to go to school.

The Court held:

'The restrictions imposed on the applicant were not of a nature or degree similar to the cases of deprivation of liberty specified in paragraph (1) of Article 5. In particular, he was not detained as a person of unsound mind. Indeed, the restrictions to which the applicant was subject were no more than the normal requirements for the care of a child of 12 years of age receiving treatment in hospital. The conditions in which the applicant stayed thus did not, in principle, differ from those obtaining in many hospital wards where children with physical disorders are treated.'

It concluded:

'the hospitalisation of the applicant did not amount to a deprivation of liberty within the meaning of Article 5, but was a responsible exercise by his mother of her custodial rights in the interests of the child.'

2.20 *HM v Switzerland (ECtHR; (2002) 38 EHRR 314)*

An 84-year-old woman was placed indefinitely in a nursing home by state authorities. She had had the possibility of staying at home and being cared for there, but she and her son had refused to co-operate with the relevant care association, and her living conditions had subsequently deteriorated. The state authorities placed her in the home in order to provide her with necessary medical care and satisfactory living conditions and hygiene.

The woman was not placed in the secure ward of the home but was free to move within the home and to have social contacts with the outside world. She was initially undecided as to what solution she preferred and, after moving into the home, the applicant had agreed to stay there. However, she subsequently applied to the courts saying that she had been deprived of her liberty.

The Court held that she had not been deprived of her liberty:

‘Bearing these elements in mind, in particular the fact that [the authorities] had ordered the applicant’s placement in the nursing home in her own interests in order to provide her with the necessary medical care and satisfactory living conditions and standards of hygiene, and also taking into consideration the comparable circumstances of *Nielsen v Denmark* [see case summary above], the Court concludes that in the circumstances of the present case the applicant’s placement in the nursing home did not amount to a deprivation of liberty within the meaning of Article 5(1), but was a responsible measure taken by the competent authorities in the applicant’s best interests.’

Cases where the courts have found that the steps taken involve a deprivation of liberty

2.21 *DE and JE v Surrey County Council (SCC)* (High Court judgment of 29 December 2006)

DE was a 76-year-old man who, following a major stroke, had become blind and had significant short-term memory impairment. He also had dementia and lacked capacity to decide where he should live, but was still often able to express his wishes with some clarity and force.

DE was married to JE. In August 2003, DE was living at home with JE. There was an occasion when JE felt that she could not care for DE, and placed him on a chair on the pavement in front of the house and called the police. The local authority then placed him in two care homes, referred to in the judgment of the court as the X home and the Y home.

Within the care homes, DE had a very substantial degree of freedom and lots of contact with the outside world. He was never subject to physical or chemical restraint.

DE repeatedly expressed the wish to live with JE, and JE also wanted DE to live with her. SCC would not agree to DE returning to live with, or visit, JE and made it clear that if JE were to persist in an attempt to remove DE, SCC would contact the police. DE and JE applied to the courts that this was a deprivation of his liberty.

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In his judgment, Justice Munby said:

‘The fundamental issue in this case ... is whether DE has been and is deprived of his liberty to leave the X home and whether DE has been and is deprived of his liberty to leave the Y home. And when I refer to leaving the X home and the Y home, I do not mean leaving for the purpose of some trip or outing approved by SCC or by those managing the institution; I mean leaving in the sense of removing himself permanently in order to live where and with whom he chooses, specifically removing himself to live at home with JE.’

He then said:

‘DE was not and is not “free to leave”, and was and is, in that sense, completely under the control of [the local authority], because, as [counsel for DE] put it, it was and is [the local authority] who decides the essential matters of where DE can live, whether he can leave and whether he can be with JE.’

He concluded:

‘The simple reality is that DE will be permitted to leave the institution in which [the local authority] has placed him and be released to the care of JE only as and when, – if ever; probably never, – [the local authority] considers it appropriate. [The local authority’s] motives may be the purest, but in my judgment, [it] has been and is continuing to deprive DE of his liberty.’

2.22 *HL v United Kingdom (ECtHR; (2004) 40 EHRR 761)*

A 48-year-old man who had had autism since birth was unable to speak and his level of understanding was limited. He was frequently agitated and had a history of self-harming behaviour. He lacked the capacity to consent to treatment.

For over 30 years, he was cared for in Bournemouth Hospital. In 1994, he was entrusted to carers and for three years he lived successfully with his carers. Following an incident of self-harm at a day centre on 22 July 1997, the applicant was taken to Bournemouth Hospital where he was re-admitted informally (not under the Mental Health Act 1983).

The carers wished to have the applicant released to their care, which the hospital refused. The carers were unable to visit him.

In its judgment in *HL v the United Kingdom*, the ECtHR said that:

‘the key factor in the present case [is] that the health care professionals treating and managing the applicant exercised complete and effective control over his care and movements from the moment he presented acute behavioural problems on July 22, 1997 to the date when he was compulsorily detained on October 29, 1997.

‘His responsible medical officer (Dr M) was clear that, had the applicant resisted admission or tried to leave thereafter, she would have prevented him from doing so and would have considered his involuntary committal under s. 3 of the 1983 Act; indeed, as soon as the Court of Appeal indicated that his appeal would be allowed, he was compulsorily detained under the 1983 Act. The correspondence between the applicant’s carers and Dr M reflects both the carer’s wish to have the applicant immediately released to their care and, equally, the clear intention of Dr M and the other relevant health care professionals to exercise strict control over his assessment, treatment, contacts and, notably, movement and residence; the applicant would only be released from hospital to the care of Mr and Mrs E as and when those professionals considered it appropriate. ... it was clear from the above noted correspondence that the applicant’s contact with his carers was directed and controlled by the hospital, his carers visiting him for the first time after his admission on 2 November 1997.

‘Accordingly, the concrete situation was that the applicant was under continuous supervision and control and was not free to leave.’

2.23 *Storck v Germany* (ECtHR; (2005) 43 EHRR 96)

A young woman was placed by her father in a psychiatric institution on occasions in 1974 and 1975. In July 1977, at the age of 18, she was placed again in a psychiatric institution. She was kept in a locked ward and was under the continuous supervision and control of the clinic personnel and was not free to leave the clinic during her entire stay of 20 months. When she attempted to flee, she was shackled. When she succeeded one time, she was brought back by the police. She was unable to maintain regular contact with the outside world.

She applied to the courts on the basis that she had been deprived of her liberty. There was a dispute about whether she consented to her confinement.

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The Court noted:

‘the applicant, on several occasions, had tried to flee from the clinic. She had to be shackled in order to prevent her from absconding and had to be brought back to the clinic by the police when she managed to escape on one occasion. Under these circumstances, the Court is unable to discern any factual basis for the assumption that the applicant – presuming that she had the capacity to consent – agreed to her continued stay in the clinic. In the alternative, assuming that the applicant was no longer capable of consenting following her treatment with strong medication, she cannot, in any event, be considered to have validly agreed to her stay in the clinic.’

- 2.24 These cases reinforce the need to carefully consider all the specific circumstances of the relevant individual before deciding whether or not a person is being deprived of their liberty. They also underline the vital importance of involving family, friends and carers in this decision-making process: a significant feature of a number of the cases that have come before the courts is a difference of opinion or communication issue between the commissioners or providers of care and family members and carers.

3

How and when can deprivation of liberty be applied for and authorised?

There are some circumstances in which depriving a person, who lacks capacity to consent to the arrangements made for their care or treatment, of their liberty is necessary to protect them from harm, and is in their best interests.

Deprivation of liberty can be authorised by supervisory bodies (primary care trusts (PCTs), local authorities, Welsh Ministers or local health boards (LHBs)). To obtain authorisation to deprive someone of their liberty, managing authorities have to apply for an authorisation following the processes set out in this chapter.⁶ Once an application has been received, the supervisory body must then follow the assessment processes set out in chapter 4 before it can authorise deprivation of liberty. It should be borne in mind that a deprivation of liberty authorisation does not, in itself, give authority to treat someone. This issue is covered in paragraphs 5.10 to 5.13.

In the vast majority of cases, it should be possible to plan in advance so that a standard authorisation can be obtained before the deprivation of liberty begins. There may, however, be some exceptional cases 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. In that case, the care home or hospital may give an urgent authorisation for up to seven days (see chapter 6).

How, in summary, can deprivation of liberty be authorised?

3.1 A **managing authority** has responsibility for applying for authorisation of deprivation of liberty for any person who may come within the scope of the deprivation of liberty safeguards:

- In the case of an NHS hospital, the managing authority is the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident.

⁶ If a person is lawfully deprived of liberty in a care home or hospital as **a consequence of an order of the Court of Protection**, there is no need to apply for an authorisation. However, once the order of the Court of Protection has expired, for lawful deprivation of liberty to continue authorisation must be obtained by following the processes set out in this chapter.

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- In the case of a care home or a private hospital, the managing authority will be the person registered, or required to be registered, under part 2 of the Care Standards Act 2000 in respect of the hospital or care home.
- 3.2 If a healthcare or social care professional thinks that an authorisation is needed, they should inform the managing authority. This might be as a result of a care review or needs assessment but could happen at any other time too. (See chapter 9 for guidance on action to take if there is a concern that a person is already being deprived of their liberty, without authorisation.)
- 3.3 A **supervisory body** is responsible for considering requests for authorisations, commissioning the required assessments (see chapter 4) and, where all the assessments agree, authorising the deprivation of liberty:
- Where the deprivation of liberty safeguards are applied to a person in a hospital situated in England, the supervisory body will be:
 - if a PCT commissions⁷ the relevant care or treatment (or it is commissioned on the PCT's behalf), that PCT
 - if the Welsh Ministers or an LHB commissions the relevant care and treatment in England, the Welsh Ministers, or
 - in any other case, the PCT for the area in which the hospital is situated.
 - Where the deprivation of liberty safeguards are applied to a person in a hospital situated in Wales, the supervisory body will be the Welsh Ministers or an LHB **unless** a PCT commissions the relevant care and treatment in Wales, in which case the PCT will be the supervisory body.

⁷ Guidance on establishing the responsible commissioner can be found at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078466

- Where the deprivation of liberty safeguards are applied to a person in a care home, whether situated in England or Wales, the supervisory body will be the local authority for the area in which the person is ordinarily resident. However, if the person is not ordinarily resident in the area of any local authority (for example a person of no fixed abode), the supervisory body will be the local authority for the area in which the care home is situated.⁸

3.4 There are two types of authorisation: standard and urgent. A managing authority must request a standard authorisation when it appears likely that, at some time during the next 28 days, someone will be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the European Convention on Human Rights. The request must be made to the supervisory body. Whenever possible, authorisation should be obtained in advance. Where this is not possible, and the managing authority believes it is necessary to deprive someone of their liberty in their best interests **before** the standard authorisation process can be completed, the managing authority must itself give an urgent authorisation and then obtain standard authorisation within seven calendar days (see chapter 6).

3.5 The flowchart at Annex 1 gives an overview of how the deprivation of liberty safeguards process should operate.

How should managing authorities decide whether to apply for an authorisation?

3.6 Managing authorities should have a procedure in place that identifies:

- whether deprivation of liberty is or may be necessary in a particular case
- what steps they should take to assess whether to seek authorisation

⁸ To work out the place of ordinary residence, the usual mechanisms under the National Assistance Act 1948 apply (see http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Ordinaryresidence/DH_079346). Any unresolved questions about the ordinary residence of a person will be handled by the Secretary of State or by the Welsh Ministers. Until a decision is made, the local authority that received the application must act as the supervisory body. After the decision is made, the local authority of ordinary residence must become the supervisory body. Regulations 17 to 19 of the Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008 set out, for England, arrangements that are to have effect while any question as to the ordinary residence of a person is determined in a case in which a local authority has received a request for a standard authorisation or a request to decide whether there is an unauthorised deprivation of liberty.

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- whether they have taken all practical and reasonable steps to avoid a deprivation of liberty
- what action they should take if they do need to request an authorisation
- how they should review cases where authorisation is or may be necessary, and
- who should take the necessary action.

A flowchart that can be used to help develop such a procedure is at Annex 2.

What is the application process?

- 3.7 A managing authority must apply for a standard authorisation. The application should be made in writing to the supervisory body. A standard form is available for this purpose.
- 3.8 In England, the request from a managing authority for a standard authorisation must include:
- the name and gender of the relevant person
 - the age of the relevant person or, where this is not known, whether the managing authority reasonably believes that the relevant person is aged 18 years or older
 - the address at which the relevant person is currently located, and the telephone number at the address
 - the name, address and telephone number of the managing authority and the name of the person within the managing authority who is dealing with the request
 - the purpose for which the authorisation is requested
 - the date from which the authorisation is sought, and
 - whether the managing authority has given an urgent authorisation and, if so, the date on which it expires.
- 3.9 A request for a standard authorisation must also include, if it is available or could reasonably be obtained by the managing authority:
- any medical information relating to the relevant person's health that the managing authority reasonably considers to be relevant to the proposed restrictions to their liberty
 - the diagnosis of the mental disorder (within the meaning of the Mental Health Act 1983 but disregarding any exclusion for persons with learning disability) from which the relevant person is suffering

- any relevant care plans and needs assessments
- the racial, ethnic or national origins of the relevant person
- whether the relevant person has any special communication needs
- details of the proposed restrictions on the relevant person's liberty
- whether it is necessary for an Independent Mental Capacity Advocate (IMCA) to be instructed
- where the purpose of the proposed restrictions to the relevant person's liberty is to give treatment, whether the relevant person has made an advance decision that may be valid and applicable to some or all of that treatment
- whether there is an existing standard authorisation in relation to the detention of the relevant person and, if so, the date of the expiry of that authorisation
- whether the relevant person is subject to any requirements of the Mental Health Act 1983, and
- the name, address and telephone number of:
 - anyone named by the relevant person as someone to be consulted about their welfare
 - anyone engaged in caring for the person or interested in their welfare
 - any donee of a Lasting Power of Attorney ('donee') granted by the person
 - any deputy appointed for the person by the court, and
 - any IMCA who has already been instructed.

If there is an existing authorisation, information that has not changed does not have to be resupplied.

3.10 In Wales, the request from a managing authority for a standard authorisation must include:

- the name of the relevant person
- the name, address and telephone number of the managing authority
- the reasons why the managing authority considers that the relevant person is being or will be detained in circumstances which amount to a deprivation of liberty
- the reasons why the managing authority considers that the relevant person satisfies the qualifying requirements
- details of any urgent authorisation

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- information or documents in support of why the relevant person satisfies the qualifying requirements
- the name, address and telephone number of any person who has an interest in the welfare of the relevant person, and
- details of any relevant valid and applicable advance decision.

Where should applications be sent?

- 3.11** If the application is being made by a care home, the application must be sent to the local authority for the area in which the relevant person is ordinarily resident. If the relevant person is not ordinarily resident in the area of any local authority (for example, is of no fixed abode), if the care home does not know where the person currently lives, or if the person does not live in England or Wales, the application should be sent to the local authority in whose area the care home is located.
- 3.12** When the application is being made by a hospital:
- if the care is commissioned by a PCT, the application should be sent to that PCT
 - if the care is commissioned by the Welsh Ministers, the application should be sent to the LHB for the area in which the relevant person is ordinarily resident
 - if the care is commissioned by an LHB, the application should be sent to that LHB, and
 - in any other case (for example, care that is commissioned privately), the application should be sent to the PCT for the area in which the relevant hospital is situated.
- 3.13** An application sent to the wrong supervisory body can be passed on to the correct supervisory body without the managing authority needing to reapply. But the managing authority should make every effort to establish which is the correct supervisory body to minimise delays in handling the application. (Footnote 8 explains how place of ordinary residence is determined and how disputes about the place of ordinary residence will be resolved.)
- 3.14** The managing authority must keep a written record of each request made for a standard authorisation and the reasons for making the request.

Who should be informed that an application has been made?

- 3.15 The managing authority should tell the relevant person’s family, friends and carers, and any IMCA already involved in the relevant person’s case, that it has applied for an authorisation of deprivation of liberty, unless it is impractical or impossible to do so, or undesirable in terms of the interests of the relevant person’s health or safety. Anyone who is engaged in caring for the relevant person or interested in their welfare, or who has been named by them as a person to consult, must be given the opportunity to input their views on whether deprivation of liberty is in the best interests of the relevant person, as part of the best interests assessment (see paragraphs 4.58 to 4.76), as far as is practical and appropriate. The views of the relevant person about who to inform and consult should be taken into account.
- 3.16 The managing authority must notify the supervisory body if it is satisfied that there is no one who should be consulted in determining the relevant person’s best interests, except those providing care and treatment for the relevant person in a professional capacity or for remuneration. In such a case, the supervisory body must instruct an IMCA to represent and support the relevant person before any assessments take place (see paragraphs 3.22 to 3.27 regarding the rights and role of an IMCA instructed in these circumstances).

What action does the supervisory body need to take when it receives an application for authorisation?

- 3.17 When it receives an application for authorisation of deprivation of liberty, the supervisory body must, as soon as is practical and possible:
- consider whether the request is appropriate and should be pursued, and
 - seek any further information that it requires from the managing authority to help it with the decision.

If the supervisory body has any doubts about proceeding with the request, it should seek to resolve them with the managing authority.

- 3.18 Supervisory bodies should have a procedure in place that identifies the action they should take, who should take it and within what timescale. As far as practical and possible, they should communicate the procedure to managing authorities and give them the relevant contact details for making an application. The flowchart at Annex 3 summarises

the process that a supervisory body should follow on receipt of a request from a managing authority for a standard deprivation of liberty authorisation.

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Can an application for authorisation be made in advance?

- 3.19** A standard authorisation comes into force when it is given, or at any later time specified in the authorisation. Paragraph 3.4 refers to the timescales for initially applying for authorisations: 28 days are allowed so that authorisations can usually be sought as part of care planning (such as planning of discharge from hospital). There is no statutory limit on how far in advance of the expiry of one authorisation a fresh authorisation can be sought. Clearly, however, an authorisation should not be applied for too far in advance as this may prevent an assessor from making an accurate assessment of what the person's circumstances will be at the time the authorisation will come into force.
- 3.20** If a supervisory body considers that an application for an authorisation has been made too far in advance, it should raise the matter with the managing authority. The outcome may be an agreement with the managing authority that the application should be withdrawn, to be resubmitted at a more appropriate time.

What happens when the managing authority and the supervisory body are the same organisation?

- 3.21** In some cases, a single organisation will be both supervisory body and managing authority – for example, where a local authority itself provides a residential care home, rather than purchasing the service from another organisation. This does not prevent it from acting in both capacities. However, in England the regulations specify that in such a situation the best interests assessor cannot be an employee of the supervisory body/managing authority, or providing services to it. For example, in a case involving a local authority care home, the best interests assessor could be an NHS employee or an independent practitioner. (See paragraphs 4.13 and 4.60 for full details of who can be a best interests assessor.) There are similar provisions for Wales.

When should an IMCA be instructed?

- 3.22 If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity⁹ or for remuneration, the managing authority must notify the supervisory body when it submits the application for the deprivation of liberty authorisation. The supervisory body must then instruct an IMCA straight away to represent the person. It is particularly important that the IMCA is instructed quickly if an urgent authorisation has been given, so that they can make a meaningful input at a very early stage in the process. (See paragraph 3.28 for other stages in the deprivation of liberty safeguards process when an IMCA must or may be instructed.)
- 3.23 Chapter 10 of the main Code ('What is the new Independent Mental Capacity Advocate service and how does it work?') describes the wider rights and role of an IMCA. Supervisory bodies should follow the guidance in that chapter in identifying an IMCA who is suitably qualified to represent the relevant person. However, it is also important to note that an IMCA instructed at this initial stage of the deprivation of liberty safeguards process has additional rights and responsibilities compared to an IMCA more generally instructed under the Mental Capacity Act 2005. IMCAs in this context have the right to:
- as they consider appropriate, give information or make submissions to assessors, which assessors must take into account in carrying out their assessments
 - receive copies of any assessments from the supervisory body
 - receive a copy of any standard authorisation given by the supervisory body
 - be notified by the supervisory body if they are unable to give a standard authorisation because one or more of the deprivation of liberty assessments did not meet the qualifying requirements
 - receive a copy of any urgent authorisation from the managing authority
 - receive from the managing authority a copy of any notice declining to extend the duration of an urgent authorisation
 - receive from the supervisory body a copy of any notice that an urgent authorisation has ceased to be in force, and

⁹ A friend or family member is **not** considered to be acting in a professional capacity simply because they have been appointed as the person's representative for a previous authorisation.

Chapter 3

How and when can deprivation of liberty be applied for and authorised?

- apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with a matter relating to the giving or refusal of a standard or urgent authorisation (in the same way as any other third party can).

The assessment and authorisation processes are described in chapters 4 and 5.

- 3.24** IMCAs will need to familiarise themselves with the relevant person's circumstances and to consider what they may need to tell any of the assessors during the course of the assessment process. They will also need to consider whether they have any concerns about the outcome of the assessment process.
- 3.25** Differences of opinion between an IMCA and an assessor should ideally be resolved while the assessment is still in progress. Where there are significant disagreements between an IMCA and one or more of the assessors that cannot be resolved between them, the supervisory body should be informed before the assessment is finalised. The supervisory body should then consider what action might be appropriate, including perhaps convening a meeting to discuss the matter. Wherever possible, differences of opinion should be resolved informally in order to minimise the need for an IMCA to make an application to the Court of Protection. However, an IMCA should not be discouraged from making an application to the Court of Protection should they consider it necessary. (Chapter 15 of the main Code ('What are the best ways to settle disagreements and disputes about issues covered in the Act?') contains general guidance about the resolution of disputes arising under the Act.)
- 3.26** An IMCA will also need to consider whether they have any concerns about the giving of an urgent authorisation (see chapter 6), and whether it would be appropriate to challenge the giving of such an authorisation via the Court of Protection.
- 3.27** Once a relevant person's representative is appointed (see chapter 7), the duties imposed on the IMCA cease to apply. The IMCA may, however, still apply to the Court of Protection for permission to take the relevant person's case to the Court in connection with the giving of a standard authorisation; but, in doing so, the IMCA must take account of the views of the relevant person's representative.

Other circumstances in which an IMCA must or may be instructed

3.28 An IMCA must also be instructed during gaps in the appointment of a relevant person's representative (for instance, if a new representative is being sought – see paragraphs 7.34 to 7.36). In addition, an IMCA may be instructed at any time where:

- the relevant person does not have a paid 'professional' representative
- the relevant person or their representative requests that an IMCA is instructed to help them, or
- a supervisory body believes that instructing an IMCA will help to ensure that the person's rights are protected (see paragraphs 7.37 to 7.41).

4

What is the assessment process for a standard authorisation of deprivation of liberty?

When a supervisory body gives a standard authorisation of deprivation of liberty, the managing authority may lawfully deprive the relevant person of their liberty in the hospital or care home named in the authorisation.

This chapter describes the assessments that have to be undertaken in order for a standard authorisation to be given. It also sets out who is eligible to undertake the assessments.

What assessments are required before giving a standard authorisation?

4.1 As soon as the supervisory body has confirmed that the request for a standard authorisation should be pursued, it must obtain the relevant assessments to ascertain whether the qualifying requirements of the deprivation of liberty safeguards are met. The supervisory body has a legal responsibility to select assessors who are both suitable and eligible. Assessments must be completed within 21 days for a standard deprivation of liberty authorisation, or, where an urgent authorisation has been given, before the urgent authorisation expires.

4.2 The assessments (described in paragraphs 4.23 to 4.76) are:

- age assessment (paragraphs 4.23 and 4.24)
- no refusals assessment (paragraphs 4.25 to 4.28).
- mental capacity assessment (paragraphs 4.29 to 4.32)
- mental health assessment (paragraphs 4.33 to 4.39)
- eligibility assessment (paragraphs 4.40 to 4.57), and
- best interests assessment (paragraphs 4.58 to 4.76).

Standard forms are available for completion by each of the assessors.

4.3 If the person being assessed is not currently in the supervisory body's area, the supervisory body should seek, as far as is practical and possible, to arrange to use assessors based near where the person currently is.

Using equivalent assessments

4.4 The Act states that where an ‘equivalent assessment’ to any of these assessments has already been obtained, it may be relied upon instead of obtaining a fresh assessment.

4.5 An equivalent assessment is an assessment:

- that has been carried out in the last 12 months, not necessarily for the purpose of a deprivation of liberty authorisation (where the required assessment is an age assessment, there is no time limit on the use of an equivalent assessment)
- that meets all the requirements of the deprivation of liberty assessment,
- of which the supervisory body is satisfied that there is no reason to believe that it is no longer accurate, and
- of which the supervisory body has a written copy.

An example would be 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.

4.6 Great care should be taken in deciding to use an equivalent assessment and this should not be done routinely. The older the assessment is, even if it took place within the last 12 months, the less likely it is to represent a valid equivalent assessment (unless it is an age assessment). For example, only a very recent mental capacity assessment would be appropriate where capacity is known to fluctuate, since one of the principles of the Act is that a person must be assumed to have capacity unless it is established that they lack capacity.

4.7 If an equivalent best interests assessment is used, the supervisory body must also take into account any information given, or submissions made, by the relevant person’s representative or an Independent Mental Capacity Advocate (IMCA) instructed under the deprivation of liberty safeguards.

4.8 Supervisory bodies should record the reasons why they have used any equivalent assessment. A standard form is available for this purpose.

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What is the assessment process for a standard authorisation of deprivation of liberty?

When must assessments take place?

- 4.9 The regulations for England¹⁰ specify that all assessments required for a standard authorisation must be completed within 21 calendar days from the date on which the supervisory body receives a request from a managing authority. The regulations for Wales specify that all assessments required for a standard authorisation must be completed within 21 days from the date the assessors were instructed by the supervisory body.
- 4.10 However, if an urgent authorisation is already in force, the assessments must be completed before the urgent authorisation expires. The regulations for Wales specify that, where the managing authority has given itself an urgent authorisation and applies for a standard authorisation, the assessors must complete the assessments within five days of the date of instruction.
- 4.11 Urgent authorisations may be given by managing authorities for an initial period not exceeding seven days. If there are exceptional reasons why it has not been possible to deal with the request for a standard authorisation within the period of the urgent authorisation, they may be extended **by the supervisory body** for up to a further seven days. It is for the supervisory body to decide what constitutes an ‘exceptional reason’, taking into account all the circumstances of an individual case.
- 4.12 Supervisory bodies must keep a record of all requests for standard authorisations that they receive and should acknowledge the receipt of requests from managing authorities for standard authorisations.

How should assessors be selected?

- 4.13 The six assessments do not have to be completed by different assessors. In fact, it is highly unlikely that there will be six separate assessors – not least because it is desirable to minimise the burden on the person being assessed. However, each assessor must make their own decisions, and to ensure that an appropriate degree of objectivity is brought to the assessment process:
- there **must** be a minimum of two assessors
 - the mental health and best interests assessors **must** be different people

¹⁰ The Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008.

- the best interests assessor can be an employee of the supervisory body or managing authority, but **must not** be involved in the care or treatment of the person they are assessing nor in decisions about their care
- a potential best interests assessor should not be used if they are in a line management relationship with the professional proposing the deprivation of liberty or the mental health assessor
- none of the assessors may have a financial interest in the case of the person they are assessing (a person is considered to have a financial interest in a case where that person is a partner, director, other office-holder or major shareholder of the managing authority that has made the application for a standard authorisation)
- an assessor **must not** be a relative of the person being assessed, nor of a person with a financial interest in the person's care. For this purpose, a 'relative' is:
 - a. a spouse, ex-spouse, civil partner or ex-civil partner
 - b. a person living with the relevant person as if they were a spouse or a civil partner
 - c. a parent or child
 - d. a brother or sister
 - e. a child of a person falling within definitions a, b or d
 - f. a grandparent or grandchild
 - g. a grandparent-in-law or grandchild-in-law
 - h. an aunt or uncle
 - i. a sister-in-law or brother-in-law
 - j. a son-in-law or daughter-in-law
 - k. a first cousin, or
 - l. a half-brother or half-sister.

These relationships include step-relationships

- where the managing authority and supervisory body are both the same body (see paragraph 3.21), the supervisory body may not select to carry out a best interests assessment a person who is employed by the body, or providing services to it, and
- the supervisory body should seek to avoid appointing assessors in any other possible conflict of interests situations that might bring into question the objectivity of an assessment.

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What is the assessment process for a standard authorisation of deprivation of liberty?

- 4.14 Other relevant factors for supervisory bodies to consider when appointing assessors include:
- the reason for the proposed deprivation of liberty
 - whether the potential assessor has experience of working with the service user group from which the person being assessed comes (for example, older people, people with learning disabilities, people with autism, or people with brain injury)
 - whether the potential assessor has experience of working with people from the cultural background of the person being assessed, and
 - any other specific needs of the person being assessed, for example communication needs.
- 4.15 Supervisory bodies should ensure that sufficient assessors are available to meet their needs, and must be satisfied in each case that the assessors have the skills, experience, qualifications and training required by regulations to perform the function effectively. The regulations also require supervisory bodies to be satisfied that there is an appropriate criminal record certificate issued in respect of an assessor. It will be useful to keep a record of qualified assessors and their experience and availability. Supervisory bodies should consider making arrangements to ensure that assessors have the necessary opportunities to maintain their skills and knowledge (of legal developments, for example) and share, audit and review their practice.
- 4.16 Assessors act as individual professionals and are personally accountable for their decisions. Managing authorities and supervisory bodies must not dictate or seek to influence their decisions.
- 4.17 There is no reason in principle why interviews, examinations and fact-finding required as part of any deprivation of liberty safeguards assessment cannot serve more than one purpose, in order to avoid unnecessary burdens both on the person being assessed and on staff. However, if this does happen, all purposes of the interview or examination should be made clear to the relevant person, and to any family members, friends, carers or advocates supporting them.

Protection against liability

4.18 Nobody can or should carry out an assessment unless they are protected against any liabilities that might arise in connection with carrying out the assessment. Individual assessors will need to satisfy themselves, and any supervisory body that selects them as an assessor, that they are appropriately covered by either employers' or personal insurance.

What is the assessment process?

4.19 As indicated in paragraph 4.2, there are six assessments that must be conducted before a supervisory body can give an authorisation.

4.20 The assessments are set out in the order in which it will normally be most appropriate to complete them. In particular, it is recommended that the best interests assessment, which is likely to be the most time-consuming, is not started until there is a reasonable expectation that the other five qualifying requirements will be met.

4.21 But, ultimately, it is for the supervisory body to decide on the order in which the assessments should be undertaken and, in the light of the time available to complete the overall assessment process, the extent to which they should be undertaken to separate or simultaneous timescales. The supervisory body's decision about how many assessors will undertake the assessments (see paragraph 4.13) will also be a relevant factor.

4.22 The following paragraphs explain the assessment process.

Age assessment

4.23 The purpose of the age assessment is simply to confirm whether the relevant person is aged 18 or over. This is because, as paragraph 1.12 explains, the deprivation of liberty safeguards apply only to people aged 18 or over. For people under the age of 18, a different safeguards process applies. In most cases, this is likely to be a fairly straightforward assessment. If there is any doubt, age should be established by a birth certificate or other evidence that the assessor considers reliable. Where it is not possible to verify with any certainty whether a person is aged 18 or over, the assessor should base the assessment on the best of their knowledge and belief.

4.24 This assessment can be undertaken by anybody whom the supervisory body is satisfied is eligible to be a best interests assessor.

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No refusals assessment

- 4.25 The purpose of the no refusals assessment is to establish whether an authorisation to deprive the relevant person of their liberty would conflict with other existing authority for decision-making for that person.
- 4.26 The following are instances of a conflict that would mean that a standard authorisation could not be given:
- If the relevant person has made **an advance decision to refuse treatment** that remains valid and is applicable to some or all of the treatment that is the purpose for which the authorisation is requested, then a standard authorisation cannot be given. See sections 24 to 26 of the Mental Capacity Act 2005 and chapter 9 of the main Code ('What does the Act say about advance decisions to refuse treatment?') for more information about advance decisions and when they are valid and applicable. Remember too that the deprivation of liberty authorisation does not, in itself, provide authority to treat the person (see paragraphs 5.10 to 5.13 of this Code).
 - If any part of the proposal to deprive the person of their liberty (including any element of the care plan) would be in conflict with a **valid decision of a donee or a deputy** made within the scope of their authority, then a standard authorisation cannot be given. For example, if a donee or deputy decides that it would not be in the best interests of the relevant person to be in a particular care home, and that decision is within the scope of their authority, then the care plan will need to be reviewed with the donee or deputy.
- 4.27 If there is any such conflict, the no refusals assessment qualifying requirement will not be met and a standard authorisation for deprivation of liberty cannot be given.
- 4.28 The no refusals assessment can be undertaken by anybody that the supervisory body is satisfied is eligible to be a best interests assessor.

Mental capacity assessment

- 4.29 The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to decide whether or not they should be accommodated in the relevant hospital or care home to be given care or treatment. 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.

- 4.30 Sections 1 to 3 of the Act set out how a person's capacity to make decisions should be determined. Chapter 4 of the main Code ('How does the Act define a person's capacity to make a decision and how should capacity be assessed?') gives further guidance on ways to assess capacity. When assessing the capacity of a person being considered for the deprivation of liberty safeguards, these guidelines should be followed.
- 4.31 The regulations for England specify that the mental capacity assessment can be undertaken by anyone who is eligible to act as a mental health or best interests assessor. In deciding who to appoint for this assessment, the supervisory body should take account of the need for understanding and practical experience of the nature of the person's condition and its impact on decision-making.
- 4.32 Supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this assessment, if they think it would be of benefit. This will primarily arise if somebody involved in the person's care is considered best placed to carry out a reliable assessment, using their knowledge of the person over a period of time. It may also help in reducing any distress that might be caused to the person if they were assessed by somebody they did not know.

Mental health assessment

- 4.33 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.
- 4.34 A distinction can be drawn between the mental health assessment and the 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.

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- 4.35 In both England and Wales, the regulations specify that:
- the mental health assessment must be carried out by a doctor, and
 - the assessing doctor has to either be approved under section 12 of the Mental Health Act 1983, or be a registered medical practitioner with at least three years' post-registration experience in the diagnosis or treatment of mental disorder, such as a GP with a special interest. This includes doctors who are automatically treated as being section 12 approved because they are approved clinicians under the Mental Health Act 1983.
- 4.36 To be eligible to undertake assessments, in England a doctor will need to have completed the standard training for deprivation of liberty mental health assessors. Except in the 12 month period beginning with the date the doctor has successfully completed the standard training, the regulations for England also require the supervisory body to be satisfied that the doctor has, in the 12 months prior to selection, completed further training relevant to their role as a mental health assessor. In Wales, a doctor will need to have completed appropriate training and have appropriate skills and experience.
- 4.37 Supervisory bodies must consider the suitability of the assessor for the particular case (for example, whether they have experience relevant to the person's condition).
- 4.38 As with the mental capacity assessment, supervisory bodies may wish to consider using an eligible assessor who already knows the relevant person to undertake this assessment, if they think it would be of benefit.
- 4.39 The mental health assessor is required to consider how the mental health of the person being assessed is likely to be affected by being deprived of their liberty, and to report their conclusions to the best interests assessor. The mental health and best interests assessments cannot be carried out by the same person.

Eligibility assessment

- 4.40 This assessment relates specifically to the relevant person's status, or potential status, under the Mental Health Act 1983.
- 4.41 A person is not eligible for a deprivation of liberty authorisation if:
- they are detained as a hospital in-patient under the Mental Health Act 1983, or

- the authorisation, if given, would be inconsistent with an obligation placed on them under the Mental Health Act 1983, such as a requirement to live somewhere else. This will only affect people who are on leave of absence from detention under the Mental Health Act 1983 or who are subject to guardianship, supervised community treatment or conditional discharge.

- 4.42 Where the proposed authorisation relates to a care home, or to deprivation of liberty in a hospital for non-mental health treatment, the eligibility assessment will simply be a matter of checking that authorisation would not be inconsistent with an obligation placed on the person under the Mental Health Act 1983.
- 4.43 When a person is subject to guardianship under the Mental Health Act 1983, their guardian can decide where they are to live, but cannot authorise deprivation of liberty and cannot require them to live somewhere where they are deprived of liberty unless that deprivation of liberty is authorised.
- 4.44 Occasionally, a person who is subject to guardianship and who lacks capacity to make the relevant decisions may need specific care or treatment in a care home or hospital that cannot be delivered without deprivation of liberty. This may be in a care home in which they are already living or in which the guardian thinks they ought to live, or it may be in a hospital where they need to be for physical health care. It may also apply if they need to be in hospital for mental health care. The process for obtaining a deprivation of liberty authorisation and the criteria to be applied are the same as for any other person.
- 4.45 If the proposed authorisation relates to deprivation of liberty in a hospital **wholly or partly for the purpose of treatment of mental disorder**, then the relevant person will not be eligible if:
- they object to being admitted to hospital, or to some or all the treatment they will receive there for mental disorder, **and**
 - they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983 (unless an attorney or deputy, acting within their powers, had consented to the things to which the person is objecting).
- 4.46 In many cases, the relevant person will be able to state an objection. However, where the person is unable to communicate, or can only communicate to a limited extent, assessors will need to consider the person's behaviour, wishes, feelings, views, beliefs and values, both present and past, so far as they can be ascertained (see paragraphs

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5.37 to 5.48 of the main Code for guidance on how to do this). If there is reason to think that a person would object if able to do so, then the person should be assumed to be objecting. Occasionally, it may be that the person's behaviour initially suggests an objection, but that this objection is in fact not directed at the treatment at all. In that case, the person should **not** be taken to be objecting.

- 4.47 Assessors should always bear in mind that their job is simply to establish whether the person objects to treatment or to being in hospital: whether that objection is reasonable or not is not the issue.
- 4.48 Even where a person does not object and a deprivation of liberty authorisation is possible, it should not be assumed that such an authorisation is invariably the correct course. There may be other factors that suggest that the Mental Health Act 1983 should be used (for example, where it is thought likely that the person will recover relevant capacity and will then refuse to consent to treatment, or where it is important for the hospital managers to have a formal power to retake a person who goes absent without leave). Further guidance on this is given in the Mental Health Act 1983 Code of Practice.
- 4.49 The eligibility assessor is not required to decide (or even consider) whether an application under the Mental Health Act 1983 would be in the person's best interests.
- 4.50 If the proposed authorisation relates to deprivation of liberty in a hospital **wholly or partly for the purpose of treatment of mental disorder**, then the person will also not be eligible if they are:
- currently on leave of absence from detention under the Mental Health Act 1983
 - subject to supervised community treatment, or
 - subject to conditional discharge,
- in which case powers of recall under the Mental Health Act 1983 should be used.
- 4.51 People on leave of absence from detention under the Mental Health Act 1983 or subject to supervised community treatment or conditional discharge are, however, eligible for the deprivation of liberty safeguards if they require treatment in hospital for a physical disorder.

Who can conduct an eligibility assessment?

- 4.52 The regulations for England specify that the eligibility assessment must be completed by:
- a mental health assessor who is also a section 12 doctor, or
 - a best interests assessor who is also an approved mental health professional (AMHP).
- 4.53 The assessment cannot be carried out by a non-section 12 doctor, even if they are qualified to be a mental health assessor, nor by a non-AMHP, even if they are qualified to be a best interests assessor. This will ensure that the eligibility assessor is sufficiently familiar with the Mental Health Act 1983, which will be particularly important in cases in which it appears that the powers available under the Mental Health Act 1983 may be more appropriate than the deprivation of liberty safeguards.
- 4.54 The eligibility assessment will often be carried out by the best interests assessor but, where this is not the case, the eligibility assessor must request the best interests assessor to provide any relevant eligibility information that the best interests assessor may have, and the best interests assessor must comply with this request.

What happens when people are assessed as ineligible?

- 4.55 If the eligibility assessor believes that the relevant person is not eligible, but (on the basis of the report of the best interests assessor) that they should nevertheless be deprived of liberty in their best interests, the eligibility assessor should immediately inform the supervisory body.
- 4.56 In the case of someone already subject to the Mental Health Act 1983, the eligibility assessor should inform the supervisory body with a view to contact being made with the relevant responsible clinician (i.e. the clinician in overall charge of the person's treatment) or, if the person is subject to guardianship, the relevant local social services authority. Otherwise, the assessor or supervisory body should take steps to arrange for the person to be assessed further with a view to an application being made for admission to hospital under the Mental Health Act 1983. Assessors will need to be familiar with local arrangements for doing this.

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- 4.57 In some cases, even before the eligibility assessment is undertaken, it may be known that there is a chance that the person will have to be assessed with a view to an application under the Mental Health Act 1983 because the eligibility assessment might conclude that they are ineligible for a deprivation of liberty authorisation. In such cases, steps should be taken, where practical and possible, to arrange assessments in a way that minimises the number of separate interviews or examinations the person has to undergo.

Best interests assessment

- 4.58 The purpose of the best interests assessment is to establish, firstly, whether deprivation of liberty is occurring or is going to occur and, if so, whether:
- it is in the best interests of the relevant person to be deprived of liberty
 - it is necessary for them to be deprived of liberty in order to prevent harm to themselves, and
 - deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.
- 4.59 The best interests assessor is the person who is responsible for assessing what is in the best interests of a relevant person.
- 4.60 In both England and Wales, the best interests assessment must be undertaken by an AMHP, social worker, nurse, occupational therapist or chartered psychologist with the skills and experience specified in the regulations. In England, this includes at least two years' post-registration experience. In England, the supervisory body must also be satisfied that the assessor:
- is not suspended from the register or list relevant to the person's profession
 - has successfully completed training that has been approved¹¹ by the Secretary of State to be a best interests assessor
 - except in the 12 month period beginning with the date the person has successfully completed the approved training, has, in the 12 months prior to selection, completed further training relevant to their role as a best interests assessor, and

¹¹ Approved courses can be found at:
<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

- has the skills necessary to obtain, evaluate and analyse complex evidence and differing views and to weigh them appropriately in decision-making.

4.61 Section 4 of the Mental Capacity Act 2005 sets out the best interests principles that apply for the purpose of the Act. Chapter 5 of the main Code ('What does the Act mean when it talks about "best interests"?') explains this in more detail, and, in particular, paragraph 5.13 of the main Code includes a checklist of factors that need to be taken into account in working out what is in a person's best interests. These principles and guidance apply equally to working out a person's best interests for the purpose of the deprivation of liberty safeguards. However, when it comes to best interests around deprivation of liberty, additional factors apply, including:

- whether any harm to the person could arise if the deprivation of liberty does not take place
- what that harm would be
- how likely that harm is to arise (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?)
- what other care options there are which could avoid deprivation of liberty, and
- if deprivation of liberty is currently unavoidable, what action could be taken to avoid it in future.

Establishing whether deprivation of liberty is occurring

4.62 The first task of a best interests assessor is to establish whether deprivation of liberty is occurring, or is likely to occur, since there is no point in the assessment process proceeding further if deprivation of liberty is not at issue. If the best interests assessor concludes that deprivation of liberty is **not** occurring and is not likely to occur, they should state in their assessment report to the supervisory body that deprivation of liberty is not in the person's best interests because there is obviously a less restrictive option available. The best interests requirement will therefore not be met in such a case.

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- 4.63 To establish whether deprivation of liberty is occurring, or is likely to occur, the best interests assessor must consult the managing authority of the hospital or care home where the person is, or will be, accommodated and examine any relevant needs assessments and care plans prepared for the person. The best interests assessor must consider whether the care plan and the manner in which it is being, or will be, implemented constitutes a deprivation of liberty. If not, then no deprivation of liberty authorisation is required for that care plan.
- 4.64 The managing authority and supervisory body must provide the best interests assessor with any needs assessments or care plans that they have undertaken or which have been undertaken on their behalf.

The best interests assessment process

- 4.65 If the best interests assessor considers that deprivation of liberty is occurring, or is likely to occur, they should start a full best interests assessment. In line with section 4(7) of the Act this involves seeking the views of a range of people connected to the relevant person to find out whether they believe that depriving the relevant person of their liberty is, or would be, in the person's best interests to protect them from harm or to enable them to follow the care plan proposed. The best interests assessor should, as far as is practical and possible, seek the views of:
- anyone the person has previously named as someone they want to be consulted
 - anyone involved in caring for the person
 - anyone interested in the person's welfare (for example, family carers, other close relatives, or an advocate already working with the person), and
 - any donee or deputy who represents the person.
- 4.66 This may mean that the best interests assessor needs to explain key aspects of the care plan and what it aims to do to the people being consulted. The best interests assessor should then take the views received into account as far as is practical and appropriate. It is essential that the best interests assessor provides an independent and objective view of whether or not there is a genuine justification for deprivation of liberty, taking account of all the relevant views and factors.

- 4.67 The best interests assessor must state in their assessment the name and address of every interested person whom they have consulted in carrying out the assessment.
- 4.68 Family and friends may not be confident about expressing their views: it is the responsibility of the best interests assessor to enable them to do so – using support to meet communication or language needs as necessary.

Scenario: Consulting around best interests

Mr Simpson is 60 and has dementia with particularly poor short-term memory, which clinicians agree is most likely to be related to chronic excessive alcohol intake. After initial treatment in hospital, he has been admitted to a care home – a decision which he consented to.

However, though he had the mental capacity to consent to hospital admission, he has no insight into his dementia. He is unable to understand the health and safety implications of continuing to drink, and will do so heavily whenever he has access to alcohol and the money to buy it.

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Scenario: Consulting around best interests *(continued)*

Although Mr Simpson had no access to alcohol in hospital, there is a pub within walking distance of the care home, which he visits and drinks in. When he returns to the home intoxicated, his behaviour can be very distressing and potentially dangerous to other residents. The care home staff believe that if this continues, there may be no other option than to return him to hospital under the Mental Health Act 1983.

The care home staff have asked Mr Simpson to drink only in moderation, but this has not proved successful; and the landlord has been asked not to serve him more than one drink but has refused to do so. The manager of the home is now considering a care plan to prevent Mr Simpson from leaving the home without an escort, and to prevent visits from friends who bring alcohol. He believes this would be in Mr Simpson's best interests.

As the pub is open all day, if this new care plan was adopted, Mr Simpson would be stopped from going out at all without an escort, even though he often goes to the shops and the park as well as the pub. Staffing levels are such that an escort would only be available on some days and for limited periods.

Mr Simpson's daughter, his closest relative, is concerned that these restrictions are excessive and would amount to a deprivation of liberty. She believes that having a drink and socialising in the pub is her father's 'only remaining pleasure', and is sure that, if he still had capacity, he would choose to carry on drinking, regardless of the health risks.

She requests a best interests meeting to consider whether a less restrictive care plan could still meet his needs.

At this meeting, Mr Simpson's community mental health nurse confirms that Mr Simpson is likely to lack capacity in relation to this particular issue, and advises that if he continues to drink to excess his dementia is likely to advance rapidly and his life expectancy will be reduced. However, small amounts of alcohol will not be significantly harmful.

Scenario: Consulting around best interests *(continued)*

The consensus is that the proposed restrictions would severely limit Mr Simpson's ability to maintain social contact and to carry on the life he has been used to, and that this would amount to deprivation of liberty. Bearing in mind his daughter's view, it is felt that it would not be in Mr Simpson's best interests to prevent him from having any alcohol at all. However, in view of the health risks and the likelihood that he would otherwise have to be detained in hospital, it would be in Mr Simpson's best interests to ensure that he does not get intoxicated. (The possibility of limiting his access to his money would be unacceptable since he retains the capacity to decide how to spend it in other ways.)

Discussion then focuses on ways of minimising restrictions so that he is still able to visit the pub, but drinks in moderation. The care home key worker says that when she has gone to the pub with Mr Simpson he has been fully co-operative and has had just one drink before coming back with her. It is therefore agreed that the home will provide an escort for him to visit the pub at least three times a week, and the shops and the park at other times, and that his daughter will be able to take him out at any time.

It is agreed that care home staff (in consultation with his daughter) will review Mr Simpson's care plan in two months' time and, if it is felt that increased restrictions are required, consider whether it is then necessary to request an authorisation for deprivation of liberty.

- 4.69 The best interests assessor must involve the relevant person in the assessment process as much as is possible and practical, and help them to participate in decision-making. The relevant person should be given the support needed to participate, using non-verbal means of communication where needed (see paragraphs 3.10 and 3.11 of the main Code) or the support of speech and language therapists. It may also help to involve others whom the relevant person already trusts and who are used to communicating with the relevant person.
- 4.70 The best interests assessor will need to consider the conclusions of the mental health assessor about how the person being assessed is likely to be affected by being deprived of their liberty. If the proposed care would involve the person being moved, then the assessor should consider the impact of the upheaval and of the journey itself on the person.

Chapter 4

What is the assessment process for a standard authorisation of deprivation of liberty?

- 4.71 If the best interests assessment supports deprivation of liberty in the care home or hospital in question, the assessor must state what the maximum authorisation period should be in the case concerned. This must not exceed 12 months. The assessor should set out the reasons for selecting the period stated. This decision will be based on the information obtained during the consultation process – but should also reflect information from the person’s care plan about how long any treatment or care will be required in circumstances that amount to a deprivation of liberty. It should also take into account any available indication of how likely it is that the relevant person’s circumstances will change, including the expected progression of the illness or disability. The underlying principle is that deprivation of liberty should be for the minimum period necessary so, for the maximum 12-month period to apply, the assessor will need to be confident that there is unlikely to be a change in the person’s circumstances that would affect the authorisation within that timescale.

The report of the best interests assessor

- 4.72 The best interests assessor must provide a report that explains their conclusion and their reasons for it. If they do not support deprivation of liberty, then their report should aim to be as useful as possible to the commissioners and providers of care in deciding on future action (for example, recommending an alternative approach to treatment or care in which deprivation of liberty could be avoided). It may be helpful for the best interests assessor to discuss the possibility of any such alternatives with the providers of care **during the assessment process**.
- 4.73 If the best interests assessor does not support deprivation of liberty, it would be good practice for their report to be included in the relevant person’s care plan or case notes, to ensure that any views about how deprivation of liberty can be avoided are made clear to the providers of care and all relevant staff on an ongoing basis.
- 4.74 The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they may make recommendations around contact issues, issues relevant to the person’s culture or other major issues related to the deprivation of liberty, which – if not dealt with – would mean that the deprivation of liberty would cease to be in the person’s best interests. The best interests assessor may also recommend conditions in order to work towards avoiding deprivation of liberty in future. But it is not the best interests assessor’s role to specify conditions that do not directly relate to the issue of deprivation of liberty.

- 4.75 Conditions should not be a substitute for a properly constructed care plan (see paragraph 2.7 on good practice for care planning). In recommending conditions, best interests assessors should aim to impose the minimum necessary constraints, so that they do not unnecessarily prevent or inhibit the staff of the hospital or care home from responding appropriately to the person's needs, whether they remain the same or vary over time. It would be good practice for the best interests assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment, and to make clear in their report whether the rejection or variation of recommended conditions by the supervisory body would significantly affect the other conclusions they have reached.
- 4.76 Where possible, the best interests assessor should recommend someone to be appointed as the relevant person's representative (see chapter 7). The assessor should be well placed, as a result of the consultation process, to identify whether there is anybody suitable to take on this role. The appointment of the relevant person's representative cannot take place unless and until an authorisation is given. However, by identifying someone to take on this role at an early stage, the best interests assessor can help to ensure that a representative is appointed as soon as possible.

Scenario: Application for standard authorisation

Mrs Jackson is 87 years old and lives by herself in an isolated bungalow in a rural area. Over the past few years, staff at her local health centre have become increasingly concerned about her wellbeing and ability to look after herself. Her appearance has become unkempt, she does not appear to be eating properly and her house is dirty.

The community mental health team have attempted to gain her trust, but she is unwilling to engage with them. She has refused care workers entry to her home and declined their help with personal hygiene and household chores.

Because it is believed that she is a potential risk to herself, she is admitted to psychiatric hospital under section 2 of the Mental Health Act 1983 for assessment of her mental disorder.

Chapter 4

What is the assessment process for a standard authorisation of deprivation of liberty?

Scenario: Application for standard authorisation *(continued)*

Following the assessment, it is felt that Mrs Jackson requires further treatment for mental disorder. An application is made for her detention to be continued under section 3 of the Mental Health Act 1983. She is prescribed antipsychotic medication, but this seems to have little effect on her behaviour. She remains extremely suspicious of people to the point of being delusional. She is assessed as potentially having mild dementia, most probably of the Alzheimer type, but because there is no obvious benefit from anti-dementia medication, further treatment for mental disorder is felt unnecessary.

Mrs Jackson insists that she wishes to return to her own home, but given past failed attempts to gain her acceptance of support at home and her likely future mental deterioration, transfer to a care home is believed to be most appropriate.

A best interests meeting is held by the mental health team to consider her future care and placement, and the team's approved social worker and the instructed IMCA are invited. The meeting concludes that Mrs Jackson does not have sufficient mental capacity to make an informed decision on her stated wish to return home. There is no advance decision in existence, no Lasting Power of Attorney or court deputy appointed and no practical way of contacting her immediate family.

An appropriate care home is identified. A care plan is developed to give Mrs Jackson as much choice and control over her daily living as possible. However, it is felt that the restrictions still necessary to ensure Mrs Jackson's wellbeing will be so intense and of such duration that a request for a standard deprivation of liberty authorisation should be made by the care home manager (the relevant managing authority).

The best interests assessor agrees that the proposed course of action is in Mrs Jackson's best interests and recommends a standard authorisation for six months in the first instance.

What guidelines are there relating to the work of assessors?

Access to records

4.77 All assessors may, at any reasonable time, examine and take copies of:

- any health record
- any record of, or held by, a local authority that was compiled in accordance with a social services function, and
- any record held by a care home

which they consider may be relevant to their assessment. Assessors should list in their assessment report what records they examined.

Recording and reporting assessments

4.78 As soon as possible after carrying out their assessments, assessors must keep a written record of the assessment and must give copies of their assessment report(s) to the supervisory body. The supervisory body must in turn give copies of the assessment report(s) to:

- the managing authority
- the relevant person and their representative, and
- any IMCA instructed

at the same time that it gives them copies of the deprivation of liberty authorisation or notification that an authorisation is not to be given (see paragraphs 5.7 and 5.18 respectively).

5 What should happen once the assessments are complete?

If all the assessments in the standard authorisation assessment process indicate that the relevant person meets all the qualifying requirements, then the supervisory body will give a deprivation of liberty authorisation. If any of the qualifying requirements are not met, however, different actions will need to be taken, depending on the circumstances of the individual case.

This chapter identifies potential outcomes of the assessment process and offers guidance on what should happen next.

What action should the supervisory body take if the assessments conclude that the person meets the requirements for authorisation?

- 5.1 If all the assessments conclude that the relevant person meets the requirements for authorisation, and the supervisory body has written copies of all the assessments, it must give a standard authorisation. A standard form is available for this purpose.
- 5.2 The supervisory body cannot give a standard authorisation if any of the requirements are not fulfilled.
- 5.3 The supervisory body must set the period of the authorisation, which may not be longer than that recommended by the best interests assessor (see paragraph 4.71).
- 5.4 When the supervisory body gives a standard authorisation, it must do so in writing and must state the following:
 - the name of the relevant person
 - the name of the relevant hospital or care home
 - the period during which the authorisation is to be in force (which may not exceed the period recommended by the best interests assessor)
 - the purpose for which the authorisation is given (i.e. why the person needs to be deprived of their liberty)

- any conditions subject to which the authorisation is given (see paragraph 5.5), and
- the reason why each qualifying requirement is met.

5.5 The supervisory body may attach conditions to the authorisation. Before deciding whether to give the authorisation subject to conditions, the supervisory body must consider any recommendations made by the best interests assessor (see paragraph 4.74). Where the supervisory body does not attach conditions as recommended by the best interests assessor, it should discuss the matter with the best interests assessor in case the rejection or variation of the conditions would significantly affect the other conclusions the best interests assessor reached in their report.

5.6 It is the responsibility of the supervisory body to appoint a representative for the relevant person (see chapter 7).

5.7 As soon as possible after giving the authorisation, the supervisory body must give a copy of the authorisation to:

- the managing authority
- the relevant person
- the relevant person's representative
- any Independent Mental Capacity Advocate (IMCA) involved, and
- every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

The supervisory body must also keep a written record of any standard authorisation that it gives and of the matters referred to in paragraph 5.4.

5.8 The managing authority must take all practical and possible steps to ensure that the relevant person understands the effect of the authorisation and their rights around it. These include their right to challenge the authorisation via the Court of Protection, their right to request a review, and their right to have an IMCA instructed, along with the process for doing so (see paragraphs 7.37 to 7.41). Appropriate information must be given to the relevant person both orally and in writing. Any written information must also be given to the relevant person's representative. This must happen as soon as possible and practical after the authorisation is given.

Chapter 5

What should happen once the assessments are complete?

How long can an authorisation last?

- 5.9 A deprivation of liberty should last for the shortest period possible. The best interests assessor should only recommend authorisation for as long as the relevant person is likely to meet all the qualifying requirements. The authorisation may be for quite a short period. A short period may, for example, be appropriate if:
- the reason that the deprivation of liberty is in the person's best interests is because their usual care arrangements have temporarily broken down, or
 - there are likely to be changes in the person's mental disorder in the relatively near future (for example, if the person is in rehabilitation following brain injury).

What restrictions exist on authorisations?

- 5.10 A deprivation of liberty authorisation – whether urgent or standard – relates solely to the issue of deprivation of liberty. It does not give authority to treat people, nor to do anything else that would normally require their consent. The arrangements for providing care and treatment to people in respect of whom a deprivation of liberty authorisation is in force are subject to the wider provisions of the Mental Capacity Act 2005.
- 5.11 This means that any treatment can only be given to a person who has not given their consent if:
- it is established that the person lacks capacity to make the decision concerned
 - it is agreed that the treatment will be in their best interests, having taken account of the views of the person and of people close to them, and, where relevant in the case of serious medical treatment, of any IMCA involved
 - the treatment does not conflict with a valid and applicable advance decision to refuse treatment, and
 - the treatment does not conflict with a decision made by a donee of Lasting Power of Attorney or a deputy acting within the scope of their powers.
- 5.12 In deciding what is in a person's best interests, section 4 of the Act applies in the same way as it would if the person was not deprived of liberty. The guidance in chapter 5 of the main Code on assessing best interests is also relevant.

- 5.13 Life-sustaining treatment, or treatment to prevent a serious deterioration in the person's condition, may be provided while a decision in respect of any relevant issue is sought from the Court of Protection. The need to act in the best interests of the person concerned will continue to apply in the meantime.

Can a person be moved to a different location under a standard authorisation?

- 5.14 If a person who is subject to a standard authorisation moves to a different hospital or care home, the managing authority of the new hospital or care home must request a new standard authorisation. The application should be made **before** the move takes place.
- 5.15 If the move has to take place so urgently that this is impossible, the managing authority of the new hospital or care home will need to give an urgent authorisation (see chapter 6).
- 5.16 The only exception is if the care regime in the new facility will not involve deprivation of liberty.
- 5.17 These arrangements are not an alternative to applying the provisions of sections 38 and 39 of the Act regarding change of residence.

What happens if an assessment concludes that one of the requirements is not met?

- 5.18 If any of the assessments conclude that one of the requirements is not met, then the assessment process should stop immediately and authorisation may not be given. The supervisory body should:
- inform anyone still engaged in carrying out an assessment that they are not required to complete it
 - notify the managing authority, the relevant person, any IMCA involved and every interested person consulted by the best interests assessor that authorisation has not been given (a standard form is available for this purpose), and
 - provide the managing authority, the relevant person and any IMCA involved with copies of those assessments that have been carried out. This must be done as soon as possible, because in some cases different arrangements will need to be made for the person's care.

Chapter 5

What should happen once the assessments are complete?

- 5.19 If the reason the standard authorisation cannot be given is because the eligibility requirement is not met, it may be necessary to consider making the person subject to the Mental Health Act 1983. If this is the case, it may be possible to use the same assessors to make that decision, thereby minimising the assessment processes.

What are the responsibilities of the managing authority and the commissioners of care if a request for an authorisation is turned down?

- 5.20 The managing authority is responsible for ensuring that it does not deprive a person of their liberty without an authorisation. The managing authority must comply with the law in this respect: where a request for an authorisation is turned down, it will need to review the relevant person's actual or proposed care arrangements to ensure that a deprivation of liberty is not allowed to either continue or commence.
- 5.21 Supervisory bodies and other commissioners of care will need to purchase care packages in a way that makes it possible for managing authorities to comply with the outcome of the deprivation of liberty safeguards assessment process when a request for a standard authorisation is turned down.
- 5.22 The actions that both managing authorities and commissioners of care should consider if a request for an authorisation is turned down will depend on the reason why the authorisation has not been given:
- If the best interests assessor concluded that the relevant person was not in fact being, or likely to be, deprived of liberty, no action is likely to be necessary.
 - If the best interests assessor concluded that the proposed or actual deprivation of liberty was not in the relevant person's best interests, the managing authority, in conjunction with the commissioner of the care, will need to consider how the care plan could be changed to avoid deprivation of liberty. (See, for example, the guidance on practical ways to reduce the risk of deprivation of liberty in paragraph 2.7.) They should examine carefully the reasons given in the best interests assessor's report, and may find it helpful to discuss the matter with the best interests assessor. Where appropriate, they should also discuss the matter with family and carers. If the person is not yet a resident in the care home or hospital, the revised care plan may not involve admission to that facility unless the conditions of care are adapted to be less restrictive and deprivation of liberty will not occur.

- If the mental capacity assessor concluded that the relevant person **has** capacity to make decisions about their care, the care home or hospital will need to consider, in conjunction with the commissioner of the care, how to support the person to make such decisions.
- If the relevant person was identified as not eligible to be subject to a deprivation of liberty authorisation, it may be appropriate to assess whether an application should be made to detain the person under the Mental Health Act 1983.
- If the relevant person does not have a mental disorder as defined in the Mental Health Act 1983, the care plan will need to be modified to avoid a deprivation of liberty, since there would be no lawful basis for depriving a person of liberty in those circumstances.
- Where there is a valid refusal by a donee or deputy, or an applicable and valid advance decision (see paragraphs 4.25 to 4.28), alternative care arrangements will need to be made. If there is a question about the refusal, a decision may be sought from the Court of Protection.
- If the person is under 18, use of the Children Act 1989 may be considered.

5.23 Working out what action should be taken where a request for a standard deprivation of liberty authorisation is turned down in respect of a ‘self-funder’ may present particular problems, because the managing authority may not be able to make alternative care arrangements without discussing them with those controlling the funding, whether relatives of the person concerned or others. The desired outcome should be the provision of a care regime that does not constitute deprivation of liberty.

5.24 Where the best interests assessor comes to the conclusion that the best interests requirement is not met, but it appears to the assessor that the person being assessed is already being deprived of their liberty, the assessor must inform the supervisory body and explain in their report why they have reached that conclusion. The supervisory body must then inform the managing authority to review the relevant person’s care plan immediately so that unauthorised deprivation of liberty does not continue. Any necessary changes must be made urgently to stop what would be an unlawful deprivation of liberty. The steps taken to stop the deprivation of liberty should be recorded in the care plan. Where possible, family, friends and carers should be involved in deciding how to prevent the unauthorised deprivation of liberty from continuing. If the supervisory body has any doubts about whether the matter is being satisfactorily resolved within an appropriately urgent timescale, it should alert the inspection body (see chapter 11).

6

When can urgent authorisations of deprivation of liberty be given?

Wherever possible, applications for deprivation of liberty authorisations should be made before the deprivation of liberty commences. However, where deprivation of liberty unavoidably needs to commence before a standard authorisation can be obtained, an urgent authorisation can be given which will make the deprivation of liberty lawful for a short period of time.

This chapter contains guidance on the rules around urgent authorisations.

When can an urgent authorisation be given?

6.1 A managing authority can itself give an urgent authorisation for deprivation of liberty where:

- it is required to make a request to the supervisory body for a standard authorisation, but believes that the need for the person to be deprived of their liberty is so urgent that deprivation needs to begin before the request is made, or
- it has made a request for a standard authorisation, but believes that the need for a person to be deprived of liberty has now become so urgent that deprivation of liberty needs to begin before the request is dealt with by the supervisory body.

This means that an urgent authorisation can never be given without a request for a standard authorisation being made simultaneously. Therefore, before giving an urgent authorisation, a managing authority will need to have a reasonable expectation that the six qualifying requirements for a standard authorisation are likely to be met.

6.2 Urgent authorisations should normally only be used in response to sudden unforeseen needs. However, they can also be used in care planning (for example, to avoid delays in transfer for rehabilitation, where delay would reduce the likely benefit of the rehabilitation).

6.3 However, an urgent authorisation should not be used where there is no expectation that a standard deprivation of liberty authorisation will be needed. Where, for example:

- a person who lacks capacity to make decisions about their care and treatment has developed a mental disorder as a result of a physical illness, and
- the physical illness requires treatment in hospital in circumstances that amount to a deprivation of liberty, and
- the treatment of that physical illness is expected to lead to rapid resolution of the mental disorder such that a standard deprivation of liberty authorisation would not be required,

it would not be appropriate to give an urgent authorisation simply to legitimise the short-term deprivation of liberty.

6.4 Similarly, an urgent deprivation of liberty authorisation should not be given when a person is, for example, in an accident and emergency unit or a care home, and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment.

6.5 Any decision to give an urgent authorisation and take action that deprives a person of liberty must be in the person's best interests, as set out in section 4 of the Mental Capacity Act 2005. Where restraint is involved, all actions must comply with the additional conditions in section 6 of the Act (see chapter 6 of the main Code).

6.6 The managing authority must decide the period for which the urgent authorisation is given, but this must not exceed seven days (see paragraphs 6.20 to 6.28 regarding the possible extension of the seven-day period). The authorisation must be in writing and must state:

- the name of the relevant person
- the name of the relevant hospital or care home
- the period for which the authorisation is to be in force, and
- the purpose for which the authorisation is given.

A standard form is available for a managing authority to use to notify a supervisory body that it has given an urgent authorisation.

Chapter 6

When can urgent authorisations of deprivation of liberty be given?

- 6.7 Supervisory bodies and managing authorities should have a procedure in place that identifies:
- what actions should be taken when an urgent authorisation needs to be made
 - who should take each action, and
 - within what timescale.

What records should be kept about urgent authorisations?

- 6.8 The managing authority must keep a written record of any urgent authorisations given, including details of why it decided to give an urgent authorisation. They must give a copy of the authorisation to the relevant person and any IMCA instructed, and place a copy in the relevant person's records. The managing authority must also seek to ensure that, as far as possible, the relevant person understands the effect of the authorisation and the right to challenge the authorisation via the Court of Protection. Appropriate information must be given both orally and in writing.
- 6.9 The managing authority should, as far as possible and appropriate, notify the relevant person's family, friends and carers when an urgent authorisation is given in order to enable them to offer informed support to the person.
- 6.10 The processes surrounding the giving and receiving of urgent authorisations should be clearly recorded, and regularly monitored and audited, as part of a managing authority's or supervisory body's governance structure.

Who should be consulted before giving an urgent authorisation?

- 6.11 If the managing authority is considering depriving a person of liberty in an emergency and giving an urgent authorisation, they must, as far as is practical and possible, take account of the views of anyone engaged in caring for the relevant person or interested in their welfare. The aim should be to consult carers and family members at as early a stage as possible so that their views can be properly taken into account before a decision to give an urgent authorisation is taken.
- 6.12 The steps taken to involve family, friends or carers should be recorded in the relevant person's records, along with their views. The views of the carers will be important because their knowledge of the person will

put them in a good position to gauge how the person will react to the deprivation of their liberty, and the effect it will have on their mental state. It may also be appropriate to consult any staff who may have some involvement in the person's case.

- 6.13 The ultimate decision, though, will need to be based on a judgement of what is in the relevant person's best interests. The decision-maker from the managing authority will need to be able to show that they have made a reasonable decision based on their professional judgement and taking account of all the relevant factors. This is an important decision, because it could mean the deprivation of a person's liberty without, at this stage, the full deprivation of liberty safeguards assessment process having taken place. The decision should therefore be taken at a senior level within the managing authority.

Scenario: Urgent authorisation followed by short-term standard authorisation

Mr Baker is 75, widowed and lives near his only family – his daughter. He is admitted to hospital having been found by his daughter on his kitchen floor. He is uncharacteristically confused and is not able to give a reliable history of what has happened. He has a routine physical examination, as well as blood and urine investigations, and is diagnosed as having a urinary tract infection. He is given antibiotics, but his nursing care is complicated by his fluctuating confusion. Once or twice he removes his clothes and walks through the ward naked, and at times he tries to leave the ward, unaware that he is in hospital, and believing that he is late for an important work meeting. During more lucid moments, however, he knows where he is and accepts the need for investigation and treatment in hospital.

The responsible consultant, in consultation with ward nursing staff and Mr Baker's daughter, feels that it would be in his best interests to place him in a side room to protect his dignity, and restrict his movements to ensure he remains on the ward.

However, after two days, his confusion appears to worsen: he starts having hallucinations and has to be restrained more often by staff to prevent him leaving the ward. After assessment by a doctor from the liaison psychiatry team, Mr Baker is prescribed antipsychotic medication for his own and other patients' safety. He does not resist taking this medication. The likely benefits and possible side effects are discussed with his daughter and, on balance, the medication is felt to be in his best interests in order to continue his medical investigations.

Chapter 6

When can urgent authorisations of deprivation of liberty be given?

Scenario: Urgent authorisation followed by short-term standard authorisation *(continued)*

Staff become concerned about the level of restriction of liberty Mr Baker is now subject to. In particular, they are concerned about the duration of the restrictions; the fact that Mr Baker no longer has lucid intervals when he can give his consent to ongoing care and treatment in hospital; and the physical restraint that is still being required on occasion.

After discussion between the ward manager and Mr Baker's daughter, the managing authority gives an urgent authorisation and submits a request for a standard authorisation to the supervisory body (PCT). A best interests assessor is appointed, and the liaison psychiatrist provides the mental health and mental capacity assessments. In making all the deprivation of liberty safeguards assessments to see whether the qualifying requirements are met, it is considered that although restraint is being used, this does not mean he is objecting having regard to all the circumstances, so he is not ineligible and a standard authorisation is given.

Can a person be moved into care under an urgent authorisation?

- 6.14 There may be cases in which managing authorities are considering giving an urgent authorisation to enable them to move the relevant person to a new type of care. This may occur, for example, when considering whether to admit a person living at home or with relatives into a hospital care regime that would deprive them of their liberty, and when the need for admission appears to be so urgent that there would not be enough time to follow the standard authorisation process.
- 6.15 For some people, such a change of location may have a detrimental effect on their mental health, which might significantly distort the way they come across during any assessment process. In such a case, managing authorities should consider whether giving the urgent authorisation and admitting the person to hospital would outweigh the benefits of leaving the person in their existing location, where any assessment of their needs might be more accurate. This will involve looking carefully at the existing care arrangements and consulting with any carers involved, to establish whether or not the person could safely and beneficially be cared for in their home environment while the

assessment process takes place. Where the relevant person is already known to statutory care providers, for example the community mental health team or social services, it will be important to involve them in this decision-making process. The relevant person's GP may also be an important source of knowledge about the person's situation, and may be able to offer a valuable opinion when the appropriateness of moving the person into a different care setting is under consideration.

What happens at the end of an urgent authorisation period?

- 6.16 An urgent authorisation will terminate at the end of the period for which it is given. As noted above, this is normally a maximum of seven days, but in exceptional circumstances an urgent authorisation can be extended to a maximum of 14 days **by the supervisory body**, as explained in paragraphs 6.20 to 6.28.
- 6.17 An urgent authorisation will terminate before this time if the standard authorisation applied for is given.
- 6.18 An urgent authorisation will also terminate if a managing authority receives notice from the supervisory body that the standard authorisation will not be given. It will not then be lawful to continue to deprive the relevant person of their liberty.
- 6.19 The supervisory body must inform the relevant person and any IMCA instructed that the urgent authorisation has ended. This notification can be combined with the notification to them of the outcome of the application for standard authorisation.

Scenario: Considering an urgent authorisation

Mr Watson is 35. He has autism and learning disabilities. He lives in the family home with his parents. Although he is well settled and generally calm at home, Mr Watson sometimes becomes disturbed when in an unfamiliar and crowded environment.

While his parents are away for a couple of days, and Mr Watson is in the care of a paid carer, he has an accident at home. His carer is concerned that he may have broken his arm and takes him to the A&E department at the local hospital, where it is decided that his arm needs to be X-rayed to check for a break. The outcome is that there is no break, just bad bruising, so there is no medical need to admit him.

Chapter 6

When can urgent authorisations of deprivation of liberty be given?

Scenario: Considering an urgent authorisation (*continued*)

However, because of the pain he is in and the crowded environment, Mr Watson has become very agitated to the extent that hospital security personnel feel a need to control him physically. The carer tries to restrain him and lead him outside where she says he is likely to be more settled and calm down.

Because restraint is being used, the A&E doctor wonders whether it is his duty to use an urgent authorisation or other measure to detain Mr Watson in hospital if he believes it is in his best interests.

He consults a liaison psychiatry nurse, who reassures him that such restraint is permitted under the Mental Capacity Act 2005 where it is necessary to prevent harm to the person himself and so long as it is a proportionate response. The nurse assists the carer with gentle restraint to take Mr Watson to a quieter area. She suggests the doctor phone Mr Watson's parents for further information, and obtains painkillers for Mr Watson.

The doctor speaks to Mr Watson's parents, who believe that Mr Watson does not have the mental capacity to decide on his care and treatment in the current circumstances. They have experienced similar situations many times, and are confident that Mr Watson will calm down once he is back in his home environment. They state that if any more detailed assessment of his mental state is required it should take place there, in the company of the carer whom they know and trust. They reassure the doctor that Mr Watson is highly unlikely to present a danger to himself, his carer or the general public.

The doctor decides that it will be in Mr Watson's best interests to return home with his carer.

How and when can an urgent authorisation be extended?

- 6.20 If there are exceptional reasons why the request for a standard authorisation cannot be dealt with within the period of the original urgent authorisation, the managing authority may ask the supervisory body to extend the duration of the urgent authorisation for a maximum of a further seven days. The managing authority must keep a written record of the reason for making the request and must notify the relevant person, in writing, that they have made the request. Standard

forms are available for managing authorities to request the extension of an urgent authorisation from a supervisory body and for supervisory bodies to record their decision in response to such a request.

- 6.21 Unless the duration of the urgent authorisation is extended by the supervisory body, or a standard authorisation is given before the urgent authorisation expires, the authority to deprive the person of liberty will cease once the urgent authorisation period has expired. It is therefore essential that any request for an extension of an urgent authorisation is made promptly. This will necessitate good communication between the managing authority and the supervisory body regarding the progress of the standard authorisation assessment process. Particular care may need to be taken where an urgent authorisation is due to expire over the weekend or on a bank holiday, when appropriate people at the managing authority and supervisory body may not be immediately available.
- 6.22 The supervisory body may only extend the duration of the urgent authorisation if:
- the managing authority has made a request for a standard authorisation
 - there are exceptional reasons why it has not yet been possible to make a standard authorisation, and
 - it is essential for the deprivation of liberty to continue while the supervisory body makes its decision.
- 6.23 Extensions can only be granted for exceptional reasons. An example of when an extension would be justified might be where:
- it was not possible to contact a person whom the best interests assessor needed to contact
 - the assessment could not be relied upon without their input, and
 - extension for the specified period would enable them to be contacted.
- 6.24 It is for the supervisory body to decide what constitutes an ‘exceptional reason’, but because of the seriousness of the issues involved, the supervisory body’s decision must be soundly based and defensible. It would not, for example, be appropriate to use staffing shortages as a reason to extend an urgent authorisation.
- 6.25 An urgent authorisation can only be extended once.

- 6.26 The supervisory body must notify the managing authority of the length of any extension granted and must vary the original urgent authorisation so that it states the extended duration. The supervisory body must also keep a written record of the outcome of the request and the period of the extension.
- 6.27 The managing authority must give a copy of the varied urgent authorisation to the relevant person and any IMCA instructed, and must seek to ensure that, as far as possible, the relevant person understands the effect of the varied authorisation and the right to challenge the authorisation via the Court of Protection. The appropriate information must be given both orally and in writing.
- 6.28 If the supervisory body decides not to extend the urgent authorisation, it must inform the managing authority of its decision and the reasons for it. The managing authority must give a copy of the notice to the relevant person and any IMCA involved.

Chapter 6

When can urgent authorisations of deprivation of liberty be given?

7 What is the role of the relevant person's representative?

Once a standard deprivation of liberty authorisation has been given, supervisory bodies must appoint the relevant person's representative as soon as possible and practical to represent the person who has been deprived of their liberty.

This chapter explains the role of the relevant person's representative and gives guidance on their selection and appointment.

What is the role of the relevant person's representative?

7.1 The supervisory body must appoint a relevant person's representative for every person to whom they give a standard authorisation for deprivation of liberty. It is important that the representative is appointed at the time the authorisation is given or as soon as possible and practical thereafter.

7.2 The role of the relevant person's representative, once appointed, is:

- to maintain contact with the relevant person, and
- to represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedure on the person's behalf or making an application to the Court of Protection.

This is a crucial role in the deprivation of liberty process, providing the relevant person with representation and support that is independent of the commissioners and providers of the services they are receiving.

7.3 The best interests principle of the Act applies to the relevant person's representative in the same way that it applies to other people acting or making decisions for people who lack capacity.

How should managing authorities work with the relevant person's representative?

- 7.4 As soon as possible and practical after a standard deprivation of liberty authorisation is given, the managing authority must seek to ensure that the relevant person and their representative understand:
- the effect of the authorisation
 - their right to request a review (see chapter 8)
 - the formal and informal complaints procedures that are available to them
 - their right to make an application to the Court of Protection to seek variation or termination of the authorisation (see chapter 10), and
 - their right, where the relevant person does not have a paid 'professional' representative, to request the support of an Independent Mental Capacity Advocate (IMCA) (see paragraphs 7.37 to 7.41).
- 7.5 When providing information to the person and their representative, the managing authority should take account of the communication and language needs of both the person and their representative. Provision of information should be seen as an ongoing responsibility, rather than a one-off activity.

Who can be the relevant person's representative?¹²

- 7.6 To be eligible to be the relevant person's representative, a person must be:
- 18 years of age or over
 - able to keep in contact with the relevant person, and
 - willing to be appointed.

The person must not be:

- financially interested in the relevant person's managing authority (a person is considered to be financially interested where that person is a partner, director, other office-holder or major shareholder of the managing authority)

¹² Requirements relating to the eligibility, selection and appointment of relevant person's representatives are covered in regulations. The regulations for England are The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008. The regulations for Wales are The Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) (Wales) Regulations 2008.

- a relative of a person who has a financial interest in the relevant person's managing authority (paragraph 4.13 explains what is meant by 'relative')
- employed by, or providing services to, the care home in which the person relevant person is residing
- employed by the hospital in a role that is, or could be, related to the treatment or care of the relevant person, or
- employed to work in the relevant person's supervisory body in a role that is, or could be, related to the relevant person's case.

7.7 The appointment of the relevant person's representative is in addition to, and does not affect, any appointment of a donee or deputy. Similarly, the functions of the representative are in addition to, and do not affect, the authority of any donee, the powers of any deputy or any powers of the court. A donee or deputy may themselves be appointed as the relevant person's representative if they meet the eligibility criteria set out in paragraph 7.6.

7.8 There is no presumption that the relevant person's representative should be the same as the person who is their nearest relative for the purposes of the Mental Health Act 1983, even where the relevant person is likely to be subject simultaneously to an authorisation under these safeguards and a provision of the Mental Health Act 1983. This is because the relevant person's representative is not selected in the same way as the nearest relative under the Mental Health Act 1983, nor do they perform the same role. However, there is nothing to stop the relevant person's representative being the same as their nearest relative under the Mental Health Act 1983.

When should the relevant person's representative be identified?

7.9 The process of identifying a representative must begin as soon as possible.

7.10 Normally, this should be when the best interests assessor is appointed – even if one or more of the other assessments has not yet been completed. This is because the best interests assessor must, as part of the assessment process, identify if there is anyone they would recommend to become the relevant person's representative. The best interests assessor should discuss the representative role with the people interviewed as part of the assessment.

Chapter 7

What is the role of the relevant person's representative?

7.11 This does leave a risk that the process to identify a representative might begin in cases where authorisation is not given. Nevertheless, it is important that the process begins, so that the representative can be appointed immediately the authorisation is given or as soon as possible and practical thereafter.

How should the relevant person's representative be selected?

7.12 The best interests assessor should first establish whether the relevant person has the capacity to select their own representative and, if so, invite them to do so. If the relevant person has capacity and selects an eligible person (according to the criteria set out in paragraph 7.6), the best interests assessor must recommend that person to the supervisory body for appointment.

7.13 Alternatively, if the relevant person lacks capacity and there is a donee or deputy with the appropriate authority, the donee or deputy may select the person to be recommended as the relevant person's representative, again subject to the criteria set out in paragraph 7.6. If a donee or deputy selects an eligible person, then the best interests assessor must recommend that person to the supervisory body for appointment.

7.14 It is up to the best interests assessor to confirm whether any representative proposed by the relevant person, a donee or a deputy is eligible. If the best interests assessor decides that a proposed representative is not eligible, they must advise the person who made the selection and invite them to make a further selection.

7.15 If neither the relevant person, nor a donee or deputy, selects an eligible person, then the best interests assessor must consider whether they are able to identify someone eligible who could act as the relevant person's representative.

7.16 In making a recommendation, the assessor should consider, and balance, factors such as:

- Does the relevant person have a preference?
- If they do not have the capacity to express a preference now, is there any written statement made by the relevant person when they had capacity that indicates who they may now want to be their representative?

- Will the proposed representative be able to keep in contact with the relevant person?
- Does the relevant person appear to trust and feel comfortable with the proposed representative?
- Would the proposed representative be able to represent the relevant person effectively?
- Is the proposed representative likely to represent the relevant person's best interests?

In most cases, the best interests assessor will be able to check at the same time that the proposed representative is willing to take on the role.

- 7.17 It should not be assumed that the representative needs to be someone who supports the deprivation of liberty.
- 7.18 The best interests assessor must not select a representative where the relevant person, if they have the capacity to do so, or a donee or a deputy acting within the scope of their authority, states they are not content with that selection.
- 7.19 If the best interests assessor is unable to recommend anybody to be the relevant person's representative, they must notify the supervisory body accordingly. The supervisory body must then itself identify an eligible person to be appointed as the representative. In doing so, the supervisory body may select a person who:
- would be performing the role in a professional capacity
 - has satisfactory skills and experience to perform the role
 - is not a family member, friend or carer of the relevant person
 - is not employed by, or providing services to, the relevant person's managing authority, where the relevant person's managing authority is a care home
 - is 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
 - is 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, and
 - the supervisory body is satisfied that an appropriate criminal record certificate has been issued in respect of.

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What is the role of the relevant person's representative?

- 7.20 The supervisory body may pay a person they select to be the relevant person's representative in the circumstances set out in paragraph 7.19. This service could be commissioned, for example, through an advocacy services provider, ensuring that the service provides effective independent representation for the relevant person.
- 7.21 When selecting a suitable representative for the relevant person, the best interests assessor or supervisory body should pay particular attention to the communication and cultural needs of the relevant person.

How should the relevant person's representative be appointed?

- 7.22 The supervisory body must invite, in writing, the person recommended by the best interests assessor to become the relevant person's representative. If the best interests assessor does not recommend anyone, then the supervisory body should identify and appoint someone to undertake the role. If the person is willing to become the representative, the supervisory body must formally appoint them. If the person refuses, a further eligible person must be identified and invited to become the representative. This process must continue until an eligible person is appointed.
- 7.23 The appointment of the relevant person's representative by the supervisory body must be in writing and set out the role and responsibilities of the relevant person's representative. The letter of appointment should also state the name of the appointed person and the date of expiry of the appointment, which must be for the period of the standard authorisation that has been given. The supervisory body must send copies of the written appointment to:
- the appointed person
 - the relevant person
 - any donee or deputy of the relevant person
 - any IMCA involved
 - every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment, and
 - the managing authority of the relevant hospital or care home.

- 7.24 The relevant person's representative must confirm to the supervisory body in writing that they are willing to accept the appointment and have understood their roles and responsibilities in respect of the relevant person.

How should the work of the relevant person's representative be supported and monitored?

- 7.25 It is important that the representative has sufficient contact with the relevant person to ensure that the relevant person's best interests are being safeguarded. In order to fulfil their role, therefore, the representative will need to be able to have face-to-face contact with the relevant person. That means that the care home or hospital should accommodate visits by the representative at reasonable times. The name of the person's representative should be recorded in the person's health and social care records.
- 7.26 Managing authorities and supervisory bodies should inform the relevant person's representative about sources of support and information available to help them in the role, including how to access the support of an IMCA (see paragraphs 7.37 to 7.41).
- 7.27 If the representative has insufficient contact with the relevant person, for whatever reason, the person may effectively be unable to access important review and appeal rights. For this reason, if the representative does not maintain an appropriate level of contact with the person, the managing authority will need to consider informing the supervisory body. When the managing authority is reviewing the person's care plan, it should consider whether the representative is in sufficient contact with the relevant person to offer effective support. Records kept by managing authorities about frequency of contact will support this consideration.
- 7.28 Because the appropriate levels and methods of contact between a relevant person and their representative will vary from case to case, this is a matter about which the managing authority will need to exercise discretion. If the managing authority has any concerns, it may be best to raise the matter with the representative initially to see whether any perceived problems can be resolved informally. If after this the representative still does not maintain what the managing authority considers to be an appropriate level of contact with the relevant person, then the managing authority should notify the supervisory body.

When can the appointment of the relevant person's representative be terminated?

- 7.29 The appointment of the relevant person's representative will be terminated in any of the following circumstances:
- The standard authorisation comes to an end and a new authorisation is not applied for or, if applied for, is not given.
 - The relevant person, if they have capacity to do so, objects to the representative continuing in their role and a different person is selected to be their representative instead.
 - A donee or deputy, if it is within their authority to do so and the relevant person lacks the capacity to decide, objects to the representative continuing in their role and a different person is selected to be the representative instead.
 - The supervisory body becomes aware that the representative is no longer willing or eligible to continue in the role.
 - The supervisory body becomes aware that the relevant person's representative is not keeping in touch with the person, is not representing and supporting them effectively or is not acting in the person's best interests.
 - The relevant person's representative dies.
- 7.30 If the supervisory body becomes aware that the representative may not be keeping in touch with the person, is not acting in the relevant person's best interests, or is no longer eligible, it should contact the representative to clarify the position before deciding whether to terminate the appointment.
- 7.31 When the appointment of the relevant person's representative ends, the supervisory body must give notice to all those listed in paragraph 7.23. This notice should be given as soon as possible, stating when the appointment ended and the reason why.
- 7.32 When the appointment of a relevant person's representative ends but the lawful deprivation of liberty continues, the supervisory body must appoint a suitable replacement to be the relevant person's representative as soon as possible and practical after they become aware of the vacancy. As before, a person qualified to be a best interests assessor should make a recommendation to the supervisory body and the supervisory body should take account of any such recommendations.

- 7.33 If the reason for the termination of the former representative's appointment is that they are no longer eligible, the views of the former representative on who might replace them should be sought. The person identified as most suitable should then be invited to accept the appointment. This process should continue until an eligible person is willing to accept appointment.

What happens when there is no relevant person's representative available?

- 7.34 A person who is being deprived of their liberty will be in a particularly vulnerable position during any gaps in the appointment of the relevant person's representative, since there may be nobody to represent their interests or to apply for a review on their behalf. In these circumstances, if there is nobody who can support and represent the person (other than a person engaged in providing care and treatment for the relevant person in a professional capacity or for remuneration), the managing authority must notify the supervisory body, who must instruct an IMCA to represent the relevant person until a new representative is appointed.
- 7.35 The role of an IMCA instructed in these circumstances is essentially the same as that of the relevant person's representative. The role of the IMCA in this situation ends when the new relevant person's representative is appointed.
- 7.36 At any time when the relevant person does not have a representative, it will be particularly important for supervisory bodies to consider exercising their discretion to carry out a review if there is any significant change in the person's circumstances.

When should an IMCA be instructed?

- 7.37 Both the person who is deprived of liberty under a standard authorisation and their representative have a statutory right of access to an IMCA. It is the responsibility of the supervisory body to instruct an IMCA if the relevant person or their representative requests one. The intention is to provide extra support to the relevant person or a family member or friend acting as their representative if they need it, and to help them make use of the review process or access the Court of Protection safeguards. Where the relevant person has a paid 'professional' representative (see paragraphs 7.19 and 7.20), the need for additional advocacy support should not arise and so there is no requirement for an IMCA to be provided in those circumstances.

- 7.38 The role of the IMCA is to help represent the relevant person and, in particular, to assist the relevant person and their representative to understand the effect of the authorisation, what it means, why it has been given, why the relevant person meets the criteria for authorisation, how long it will last, any conditions to which the authorisation is subject and how to trigger a review or challenge in the Court of Protection. The IMCA can also provide support with a review (see chapter 8) or with an application to the Court of Protection (see chapter 10), for example to help the person to communicate their views.
- 7.39 The IMCA will have the right to make submissions to the supervisory body on the question of whether a qualifying requirement should be reviewed, or to give information, or make submissions, to any assessor carrying out a review assessment. Both the person and their representative must be told about the IMCA service and how to request an IMCA.
- 7.40 An IMCA must be instructed whenever requested by the relevant person or their representative. A request may be made more than once during the period of the authorisation. For example, help may be sought at the start of the authorisation and then again later in order to request a review.
- 7.41 In addition, if the supervisory body has reason to believe that the review and Court of Protection safeguards might not be used without the support of an IMCA, then they must instruct an IMCA. For example, if the supervisory body is aware that the person has selected a representative who needs support with communication, it should consider whether an IMCA is needed.

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What is the role of the relevant person's representative?

8

When should an authorisation be reviewed and what happens when it ends?

When a person is deprived of their liberty, the managing authority has a duty to monitor the case on an ongoing basis to see if the person's circumstances change – which may mean they no longer need to be deprived of their liberty.

The managing authority must set out in the care plan clear roles and responsibilities for monitoring and confirm under what circumstances a review is necessary. For example, if a person's condition is changing frequently, then their situation should be reviewed more frequently.

This chapter explains the duties of managing authorities and supervisory bodies in relation to reviewing cases, and what happens when an authorisation ends. The review process is set out in flowchart form at Annex 4.

When should a standard authorisation be reviewed?

- 8.1 A standard authorisation can be reviewed at any time. The review is carried out by the supervisory body.
- 8.2 There are certain statutory grounds for carrying out a review. If the statutory grounds for a review are met, the supervisory body must carry out a review. If a review is requested by the relevant person, their representative or the managing authority, the supervisory body must carry out a review. Standard letters are available for the relevant person or their representative to request a review. There is also a standard form available for the managing authority to request a review. A supervisory body can also decide to carry out a review at its own discretion.
- 8.3 The statutory grounds for a review are:
 - The relevant person no longer meets the age, no refusals, mental capacity, mental health or best interests requirements.
 - The relevant person no longer meets the eligibility requirement because they now object to receiving mental health treatment in hospital and they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983 (see paragraphs 4.45 to 4.48).

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When should an authorisation be reviewed and what happens when it ends?

- There has been a change in the relevant person's situation and, because of the change, it would be appropriate to amend an existing condition to which the authorisation is subject, delete an existing condition or add a new condition.
- The reason(s) the person now meets the qualifying requirement(s) is(are) different from the reason(s) given at the time the standard authorisation was given.

- 8.4 Different arrangements apply if the person no longer meets the eligibility requirement because they have been detained under the Mental Health Act, or become subject to a requirement under that Act that conflicts with the authorisation. (See paragraphs 8.19 to 8.21 regarding the short-term suspension of a standard authorisation.)
- 8.5 A managing authority must request a review if it appears to it that one or more of the qualifying requirements is no longer met, or may no longer be met.

What happens when a review is going to take place?

- 8.6 The supervisory body must tell the relevant person, their representative and the managing authority if they are going to carry out a review. This must be done either before the review begins or as soon as possible and practical after it has begun. A standard form is available for this purpose.
- 8.7 The relevant person's records must include information about any formal reviews that have been requested, when they were considered, and the outcome. These records must be retained by the supervisory body.
- 8.8 Deprivation of liberty can be ended before a formal review. An authorisation only **permits** deprivation of liberty: it does not mean that a person **must be** deprived of liberty where circumstances no longer necessitate it. If a care home or hospital decides that deprivation of liberty is no longer necessary then they must end it immediately, by adjusting the care regime or implementing whatever other change is appropriate. The managing authority should then apply to the supervisory body to review and, if appropriate, formally terminate the authorisation.

How should standard authorisations be reviewed?

- 8.9 When a supervisory body receives a request for a review, it must first decide which, if any, of the qualifying requirements need to be reviewed. A standard form is available for recording this decision.
- 8.10 If the supervisory body concludes that none of the qualifying requirements need to be reviewed, no further action is necessary. For example, if there has been a very recent assessment or review and no new evidence has been submitted to show that the relevant person does not meet the criteria, or that circumstances have changed, no review is required.
- 8.11 If it appears that one or more of the qualifying requirements should be reviewed, the supervisory body must arrange for a separate review assessment to be carried out for each of these requirements.
- 8.12 The supervisory body must record when a review is requested, what it decides to do (whether it decides to carry out a review or not) and the reasons for its decision.
- 8.13 In general, review processes should follow the standard authorisation processes – so supervisory bodies should conduct the assessments outlined in chapter 4 of this Code of Practice for each of the qualifying requirements that need to be reviewed.
- 8.14 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 relevant person's overall circumstances, there is no need for a full reassessment of best interests. The supervisory body can simply vary the conditions attached to the authorisation 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.
- 8.15 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.
- 8.16 If the assessment shows that the requirement is still met, the supervisory body must check whether the reason that it is met has changed from the reason originally stated on the authorisation. If it

has, the supervisory body should make any appropriate amendments to the authorisation. In addition, if the review relates to the best interests requirement, the supervisory body must consider whether any conditions should be changed following the new assessment.

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When should an authorisation be reviewed and what happens when it ends?

Scenario: The review process

Jo is 29 and sustained severe brain damage in a road traffic collision that killed her parents. She has great difficulty in verbal and written communication. Jo can get very frustrated and has been known to lash out at other people in the nursing care home where she now lives. At first, she regularly attempted to leave the home, but the view of the organisation providing Jo's care was that such a move would place her at serious risk, so she should be prevented from leaving.

Jo was assessed under the deprivation of liberty safeguards and an authorisation was made for six months. That authorisation is not due to end for another three months. However, Jo has made huge progress at the home and her representative is no longer sure that the restrictions are necessary. Care home staff, however, do not think that her improvement reduces the best interests requirement of the deprivation of liberty authorisation.

Jo is assisted by her representative to request a review, in the form of a letter with pictures. The pictures appear to describe Jo's frustration with the legal processes that she perceives are preventing her from moving into her own accommodation.

The supervisory body appoints a best interests assessor to coordinate the review. The best interests assessor considers which of the qualifying requirements needs to be reviewed and by whom. It appears that the best interests assessment, as well as possibly the mental health and mental capacity assessments, should be reviewed.

To assess Jo's mental capacity and her own wishes for the best interests assessment, the best interests assessor feels that specialist help would be beneficial. A speech and language therapist meets with Jo and uses a visual communication system with her. Using this system, the therapist is able to say that in her view Jo is unlikely to have capacity to make the decision to leave the care home. The mental health assessment also confirmed that Jo was still considered to have a mental disorder.

Scenario: The review process *(continued)*

The best interests assessor was uncertain, however, whether it was still in Jo's best interests to remain under the deprivation of liberty authorisation. It was not possible to coordinate full updated assessments from the rehabilitation team, who knew her well, in the time limits required. So, because the care home believed that the standard authorisation was still required, and it was a complex case, the best interests assessor recommended to the supervisory body that two conditions should be applied to the standard authorisation:

- assessments must be carried out by rehabilitation specialists on Jo's clinical progress, and
- a full case review should be held within one month.

At this review meeting, to which Jo's representative and the best interests assessor were invited, it was agreed that Jo had made such good progress that deprivation of liberty was no longer necessary, because the risks of her having increased freedom had reduced. The standard authorisation was therefore terminated, and a new care plan was prepared which focused on working towards more independent living.

What happens if any of the requirements are not met?

- 8.17 If any of the requirements are not met, then the authorisation must be terminated immediately.
- 8.18 The supervisory body must give written notice of the outcome of a review and any changes that have been made to the deprivation of liberty authorisation to:
- the managing authority and the care home or hospital itself
 - the relevant person
 - the relevant person's representative, and
 - any Independent Mental Capacity Advocate (IMCA) involved.

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When should an authorisation be reviewed and what happens when it ends?

Short-term suspension of authorisation

- 8.19 There are separate review arrangements for cases in which the eligibility requirement ceases to be met for a short period of time for reasons other than that the person is objecting to receiving mental health treatment in hospital. For example, if the relevant person is detained as a hospital in-patient under the Mental Health Act 1983, the managing authority must notify the supervisory body, who will suspend the authorisation.
- 8.20 If the relevant person then becomes eligible again within 28 days, the managing authority must notify the supervisory body who will remove the suspension. If no such notice is given within 28 days, then the authorisation will be terminated. Standard forms are available for managing authorities to notify supervisory bodies about the need for suspension of an authorisation, or that a suspension should be lifted.
- 8.21 If the person ceases to meet the eligibility requirement because they begin to object to receiving mental health treatment in hospital and they meet the criteria for an application for admission under section 2 or section 3 of the Mental Health Act 1983, a review should be started immediately (see paragraph 8.3).

Is a review necessary when the relevant person's capacity fluctuates?

- 8.22 Guidance about people with fluctuating or temporary capacity is contained in paragraphs 4.26 and 4.27 of the main Code. In the context of deprivation of liberty safeguards, where a relevant person's capacity to make decisions about the arrangements made for their care and treatment fluctuates on a short-term basis, a balance needs to be struck between:
- the need to review and terminate an authorisation if a person regains capacity, and
 - spending time and resources constantly reviewing, terminating and then seeking fresh deprivation of liberty authorisations as the relevant person's capacity changes.
- 8.23 Each case must be treated on its merits. Managing authorities should keep all cases under review: where a person subject to an authorisation is deemed to have regained the capacity to decide about the arrangements made for their care and treatment, the managing authority must assess whether there is consistent evidence of the regaining of capacity on a longer-term basis. This is a clinical judgement that will need to be made by a suitably qualified person.

- 8.24 Where there is consistent evidence of regaining capacity on this longer-term basis, deprivation of liberty should be lifted immediately, and a formal review and termination of the authorisation sought. However, it should be borne in mind that a deprivation of liberty authorisation carries with it certain safeguards that the relevant person will lose if the authorisation is terminated. Where the regaining of capacity is likely to be temporary, and the authorisation will be required again within a short period of time, the authorisation should be left in place, but with the situation kept under ongoing review.

Scenario: Fluctuating capacity

Walter, an older man with severe depression, is admitted to hospital from a care home. He seems confused and bewildered, but does not object. His family are unable to look after him at home, but they would prefer him to go into a different care home rather than stay in hospital. However, there is no alternative placement available, so when the assessment concludes that Walter lacks capacity to make decisions about his care and treatment, the only option seems to be that he should stay on the ward,

Because the care regime in the ward is extremely restrictive – Walter is not allowed to leave the hospital and his movement within the hospital is restricted for his own safety – ward staff think that they need to apply for a deprivation of liberty authorisation which is subsequently given.

However, over time Walter starts to experience lucid passages, during which he expresses relief at being on the ward rather than in the care home. A review meeting is convened and the participants agree that Walter now sometimes has capacity to make decisions about the arrangements made for his care and treatment. As this capacity fluctuates, it is decided, in consultation with his family, that the deprivation of liberty authorisation should remain in place for the time being.

Walter remains on the ward and his progress is such that his family feel they could look after him at home. Walter seems happy with this proposal and the consultant psychiatrist with responsibility for his care agrees to this. The deprivation of liberty authorisation is reviewed and terminated.

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When should an authorisation be reviewed and what happens when it ends?

What happens when an authorisation ends?

- 8.25 When an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty.
- 8.26 If the managing authority considers that a person will still need to be deprived of liberty after the authorisation ends, they need to request a further standard authorisation to begin immediately after the expiry of the existing authorisation.
- 8.27 There is no statutory time limit on how far in advance of the expiry of one authorisation the managing authority can apply for a renewal authorisation. It will need to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends (but see paragraphs 3.19 and 3.20 about not applying for authorisations too far in advance).
- 8.28 Once underway, the process for renewing a standard authorisation is the same as that for obtaining an original authorisation, and the same assessment processes must take place. However, the need to instruct an IMCA will not usually arise because the relevant person should at this stage have a representative appointed.
- 8.29 When the standard authorisation ends, the supervisory body must inform in writing:
- the relevant person
 - the relevant person's representative
 - the managing authority, and
 - every interested person named by the best interests assessor in their report as somebody they have consulted in carrying out their assessment.

9

What happens if someone thinks a person is being deprived of their liberty without authorisation?

It is a serious issue to deprive someone of their liberty without authorisation if they lack the capacity to consent. If anyone believes that a person is being deprived of their liberty without authorisation, they should raise this with the relevant authorities.

If the conclusion is that the person is being deprived of their liberty unlawfully, this will normally result in a change in their care arrangements, or in an application for a deprivation of liberty authorisation being made.

This chapter explains the process for reporting concerns and for assessing whether unauthorised deprivation of liberty is occurring. The flowchart at Annex 3 summarises the process that a supervisory body should follow when it receives a request from somebody other than the managing authority to examine whether or not there is a current unauthorised deprivation of liberty.

What action should someone take if they think a person is being deprived of their liberty without authorisation?

- 9.1 If the relevant person themselves, any relative, friend or carer or any other third party (such as a person carrying out an inspection visit or a member of an advocacy organisation) believes that a person is being deprived of liberty without the managing authority having applied for an authorisation, they should draw this to the attention of the managing authority. A standard letter is available for this purpose. In the first instance, they should ask the managing authority to apply for an authorisation if it wants to continue with the care regime, or to change the care regime immediately. Given the seriousness of deprivation of liberty, a managing authority must respond within a reasonable time to the request. This would normally mean within 24 hours.
- 9.2 It may be possible for the managing authority to resolve the matter informally with the concerned person. For example, the managing authority could discuss the case with the concerned person, and perhaps make some adjustment to the care arrangements so that concerns that a deprivation of liberty may be occurring are removed. However, if the managing authority is unable to resolve the issue with the concerned person quickly, they should submit a request for a standard authorisation to the supervisory body.

Chapter 9

What happens if someone thinks a person is being deprived of their liberty without authorisation?

- 9.3 If the concerned person has raised the matter with the managing authority, and the managing authority does not apply for an authorisation within a reasonable period, the concerned person can ask the supervisory body to decide whether there is an unauthorised deprivation of liberty. They should:
- tell the supervisory body the name of the person they are concerned about and the name of the hospital or care home, and
 - as far as they are able, explain why they think that the person is deprived of their liberty.

A standard letter is available for this purpose.

- 9.4 In such circumstances, the supervisory body must select and appoint a person who is suitable and eligible to carry out a best interests assessment to consider whether the person is deprived of liberty.
- 9.5 The supervisory body does not, however, need to arrange such an assessment where it appears to the supervisory body that:
- the request they have received is frivolous or vexatious (for example, where the person is very obviously not deprived of their liberty) or where a very recent assessment has been carried out and repeated requests are received, or
 - the question of whether or not there is an unauthorised deprivation of liberty has already been decided, and since that decision, there has been no change of circumstances that would merit the question being considered again.

The supervisory body should record the reasons for their decisions. A standard form is available for this purpose.

- 9.6 The supervisory body must notify the person who raised the concern, the relevant person, the managing authority of the relevant hospital or care home and any IMCA involved:
- that it has been asked to assess whether or not there is an unauthorised deprivation of liberty
 - whether or not it has decided to commission an assessment, and
 - where relevant, who has been appointed as assessor.

What happens if somebody informs the supervisory body directly that they think a person is being deprived of their liberty without authorisation?

9.7 If a person raises concerns about a potential unauthorised deprivation of liberty directly with the supervisory body, the supervisory body should immediately arrange a preliminary assessment to determine whether a deprivation of liberty is occurring. The supervisory body should then immediately notify the managing authority, rather than asking the concerned person to contact the managing authority themselves, to ask them to request a standard authorisation in respect of the person who is possibly deprived of liberty. The supervisory body should agree with the managing authority what is a reasonable period within which a standard authorisation should be requested (unless the managing authority is able to resolve the matter informally with the concerned person as described in paragraph 9.2). If the managing authority does not submit an application within the agreed period, and the matter has not been resolved informally, the supervisory body should follow the process set out in paragraphs 9.3 to 9.6 to assess whether unlawful deprivation of liberty is occurring. Even if the concerned person prefers to deal directly with the managing authority, the supervisory body should monitor what happens very closely to ensure that no unlawful deprivation of liberty may be occurring without proper action being taken.

How will the assessment of unlawful deprivation of liberty be conducted?

9.8 An assessment of whether an unlawful deprivation of liberty is occurring must be carried out within seven calendar days. Although the assessment must be completed by somebody who is suitable and eligible to carry out a best interests assessment, it is not a best interests assessment as such. The purpose of the assessment is simply to establish whether unlawful deprivation of liberty is occurring.

9.9 The person nominated to undertake the assessment must consult the managing authority of the relevant hospital or care home, and examine any relevant needs assessments and care plans to consider whether they constitute a deprivation of liberty. They should also speak to the person who raised the concern about why they believe that the relevant person is being deprived of their liberty and consult, as far as is possible, with the relevant person's family and friends. If there is nobody appropriate to consult among family and friends, they should inform the supervisory body who must arrange for an IMCA to be instructed to support and represent the person. A standard form is available for the assessor to record the outcome of their assessment.

Chapter 9

What happens if someone thinks a person is being deprived of their liberty without authorisation?

What happens once the assessment has been conducted?

- 9.10 There are three possible outcomes of this assessment. The assessor may conclude that:
- the person is not being deprived of their liberty
 - the person is being lawfully deprived of their liberty because authorisation exists (this, though, is an unlikely outcome since the supervisory body should already be aware if any authorisation exists, thus rendering any assessment in response to a third party request unnecessary), or
 - the person is being deprived of their liberty unlawfully.
- 9.11 The supervisory body must notify the following people of the outcome of the assessment:
- the concerned third party who made the request
 - the relevant person
 - the managing authority of the relevant hospital or care home, and
 - any IMCA involved.
- A standard form is available for this purpose.
- 9.12 If the outcome of the assessment is that there is an unauthorised deprivation of liberty, then the full assessment process should be completed as if a standard authorisation for deprivation of liberty had been applied for – unless the managing authority changes the care arrangements so that it is clear that there is no longer any deprivation of liberty.
- 9.13 If, having considered what could be done to avoid deprivation of liberty, the managing authority decides that the need to continue the deprivation of liberty is so urgent that the care regime should continue while the assessments are carried out, it must give an urgent authorisation and seek a standard authorisation within seven days. The managing authority must supply the supervisory body with the same information it would have had to include in a request for a standard authorisation.
- 9.14 If the concerned person does not accept the outcome of their request for assessment, they can apply to the Court of Protection to hear their case. See chapter 10 for more details of the role of the Court of Protection.

To comply with Article 5(4) of the European Convention on Human Rights, anybody deprived of their liberty in accordance with the safeguards described in this Code of Practice is entitled to the right of speedy access to a court that can review the lawfulness of their deprivation of liberty. The Court of Protection, established by the Mental Capacity Act 2005, is the court for this purpose. Chapter 8 of the main Code provides more details on its role, powers and responsibilities.

When can people apply to the Court of Protection about the deprivation of liberty safeguards and who can apply?

Applying before an authorisation is given

10.1 The relevant person, or someone acting on their behalf, may make an application to the Court of Protection **before** a decision has been reached on an application for authorisation to deprive a person of their liberty. This might be to ask the court to declare whether the relevant person has capacity, or whether an act done or proposed to be done in relation to that person is lawful (this may include whether or not the act is or would be in the best interests of the relevant person). It is up to the Court of Protection to decide whether or not to consider such an application in advance of the decision on authorisation.

Applying after an authorisation has been given

10.2 Once a standard authorisation has been given, the relevant person or their representative has the right to apply to the Court of Protection to determine any question relating to the following matters:

- whether the relevant person meets one or more of the qualifying requirements for deprivation of liberty
- the period for which the standard authorisation is to be in force
- the purpose for which the standard authorisation is given, or
- the conditions subject to which the standard authorisation is given.

10.3 Where an urgent authorisation has been given, the relevant person or certain persons acting on their behalf, such as a donee or deputy, has the right to apply to the Court of Protection to determine any question relating to the following matters:

Chapter 10

What is the Court of Protection and when can people apply to it?

- whether the urgent authorisation should have been given
- the period for which the urgent authorisation is to be in force, or
- the purpose for which the urgent authorisation has been given.

10.4 Where a standard or urgent authorisation has been given, any other person may also apply to the Court of Protection for permission to take the relevant person's case to court to determine whether an authorisation should have been given. However, the Court of Protection has discretion to decide whether or not to consider an application from these people.

10.5 Wherever possible, concerns about the deprivation of liberty should be resolved informally or through the relevant supervisory body's or managing authority's complaints procedure, rather than through the Court of Protection. Chapter 15 of the main Code ('What are the best ways to settle disagreements and disputes about issues covered in the Act?') contains general guidance on how to settle disputes about issues covered in the Mental Capacity Act 2005. The review processes covered in chapter 8 of this Code also provide a way of resolving disputes or concerns, as explained in that chapter.

10.6 The aim should be to limit applications to the Court of Protection to cases that genuinely need to be referred to the court. However, with deprivation of liberty at stake, people should not be discouraged from making an application to the Court of Protection if it proves impossible to resolve concerns satisfactorily through other routes in a timely manner.

How should people apply to the Court of Protection?

10.7 Guidance on the court's procedures, including how to make an application, is given in the Court of Protection Rules and Practice Directions issued by the court.¹³

10.8 The following people have an automatic right of access to the Court of Protection and do not have to obtain permission from the court to make an application:

- a person who lacks, or is alleged to lack, capacity in relation to a specific decision or action

¹³ There will usually be a fee for applications to the court. Details of the fees charged by the court and the circumstances in which fees may be waived or remitted are available from the Office of the Public Guardian (<http://www.publicguardian.gov.uk/>)

- the donor of a Lasting Power of Attorney to whom an application relates, or their donee
- a deputy who has been appointed by the court to act for the person concerned
- a person named in an existing court order¹⁴ to which the application relates, and
- the person appointed by the supervisory body as the relevant person's representative.

10.9 All other applicants must obtain the permission of the court before making an application. (See section 50 of the Mental Capacity Act 2005, as amended.) This can be done by completing the appropriate application form.

What orders can the Court of Protection make?

10.10 The court may make an order:

- varying or terminating a standard or urgent authorisation, or
- directing the supervisory body (in the case of a standard authorisation) or the managing authority (in the case of an urgent authorisation) to vary or terminate the authorisation.

What is the role of the Court of Protection in respect of people lacking capacity who are deprived of their liberty in settings other than hospitals or care homes?

10.11 The deprivation of liberty safeguards relate only to circumstances where a person is deprived of their liberty in a hospital or care home. Depriving a person who lacks capacity to consent to the arrangements made for their care or treatment of their liberty in other settings (for example in a person's own home, in supported living arrangements other than in care homes or in a day centre) will only be lawful following an order of the Court of Protection on a best interests personal welfare matter (see paragraph 6.51 of the main Code).

¹⁴ Examples of existing court orders include orders appointing a deputy or declarations made by the court in relation to treatment issues.

10.12 In such a case, application to the Court of Protection should be made before deprivation of liberty begins. A Court of Protection order will then itself provide a legal basis for the deprivation of liberty. A separate deprivation of liberty authorisation under the processes set out in this Code will not be required.

Is legal aid available to support applications to the Court of Protection in deprivation of liberty safeguards cases?

10.13 Legal aid will be available both for advice and representation before the Court of Protection.

Chapter 10

What is the Court of Protection and when can people apply to it?

The deprivation of a person's liberty is a significant issue. The deprivation of liberty safeguards are designed to ensure that a person who lacks capacity to consent to the arrangements made for their care or treatment is suitably protected against arbitrary detention. In order to provide reassurance that the safeguards processes are being correctly operated, it is important for there to be an effective mechanism for monitoring the implementation of the safeguards.

Who will monitor the safeguards?

- 11.1 Regulations¹⁵ will confer the responsibility for the inspection process of the operation of the deprivation of liberty safeguards in England on a new regulator, the Care Quality Commission, bringing together functions from the existing Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission. The new body will be established during 2008, subject to the passage of the relevant legislation through Parliament, and is expected to be fully operational by 2009/10 in line with the deprivation of liberty safeguards coming into force.
- 11.2 In Wales, the functions of monitoring the operation of the deprivation of liberty safeguards will fall to Welsh Ministers. These functions will be performed on their behalf by Healthcare Inspectorate Wales and the Care and Social Services Inspectorate Wales.

What will the inspection bodies do and what powers will they have?

- 11.3 The inspection bodies for care homes and hospitals will be expected to:
- monitor the manner in which the deprivation of liberty safeguards are being operated by:
 - visiting hospitals and care homes in accordance with their existing visiting programme

¹⁵ Draft regulations for England will be consulted upon later. Welsh Ministers are currently considering how they will use their regulation-making powers for Wales.

Chapter 11

How will the safeguards be monitored?

- interviewing people accommodated in hospitals and care homes to the extent that they consider it necessary to do so, and
 - requiring the production of, and inspecting, relevant records relating to the care or treatment of people accommodated in hospitals and care homes
 - report annually, summarising their activity and their findings about the operation of the deprivation of liberty safeguards. In England this report will be made to the Secretary of State for Health, and in Wales the report will be made to the Welsh Ministers. It will be for each monitoring body to decide whether there should be a deprivation of liberty safeguards specific report or whether the report should form part of a wider report on the monitoring body's activities.
- 11.4 The inspection bodies will have the power to require supervisory bodies and managing authorities of hospitals or care homes to disclose information to them.
- 11.5 The inspection process will not cover the revisiting of individual assessments (other than by way of a limited amount of sampling).
- 11.6 The inspection process will not constitute an alternative review or appeal process. However, if the inspection body comes across a case where they believe deprivation of liberty may be occurring without an authorisation, they should inform the supervisory body in the same way as any other third party may do.
- 11.7 The inspection bodies will look at the deprivation of liberty protocols and procedures in place within managing authorities and supervisory bodies. The aim is to use a small amount of sampling to evaluate the effect of these protocols and procedures on individual cases. Monitoring should take place at a time when the monitoring body is visiting the care home or in-patient setting as part of routine operations, not as an exception.
- 11.8 Supervisory bodies and managing authorities should keep their protocols and procedures under review and supervisory bodies should assess the nature of the authorisations they are giving in light of their local population. This information may be relevant to policy decisions about commissioning care and support services.

Key points for care homes and hospitals (managing authorities)

- Managing authorities need to adapt their care planning processes to incorporate consideration of whether a person has capacity to consent to the services which are to be provided and whether their actions are likely to result in a deprivation of liberty.
- A managing authority must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation has been given by the supervisory body for that specific situation, and remains in force.
- It is up to the managing authority to request such authorisation and implement the outcomes.
- Authorisation should be obtained from the supervisory body in advance of the deprivation of liberty, except in circumstances considered to be so urgent that the deprivation of liberty needs to begin immediately. In such cases, authorisation must be obtained within seven calendar days of the start of the deprivation of liberty.
- A managing authority must ensure that they comply with any conditions attached to the authorisation.
- A managing authority should monitor whether the relevant person's representative maintains regular contact with the person.
- Authorisation of deprivation of liberty should only be sought if it is genuinely necessary for a person to be deprived of liberty in their best interests in order to keep them safe. It is not necessary to apply for authorisations for all admissions to hospitals and care homes simply because the person concerned lacks capacity to decide whether to be admitted.

Key points for local authorities and NHS bodies (supervisory bodies)

- Supervisory bodies will receive applications from managing authorities for standard authorisations of deprivation of liberty. Deprivation of liberty cannot lawfully begin until the supervisory body has given authorisation, or the managing authority has itself given an urgent authorisation.
- Before an authorisation for deprivation of liberty may be given, the supervisory body must have obtained written assessments of the relevant person in order to ensure that they meet the qualifying requirements (including that the deprivation of liberty is necessary to protect them from harm and will be in their best interests).
- Supervisory bodies will need to ensure that sufficient assessors are available to meet the needs of their area and that these assessors have the skills, qualifications, experience and training to perform the function.
- Authorisation may not be given unless all the qualifying requirements are met.
- In giving authorisation, the supervisory body must specify its duration, which may not exceed 12 months and may not be for longer than recommended by the best interests assessor. Deprivation of liberty should not continue for longer than is necessary.
- The supervisory body may attach conditions to the authorisation if it considers it appropriate to do so.
- The supervisory body must give notice of its decision in writing to specified people, and notify others.
- The supervisory body must appoint a relevant person's representative to represent the interests of every person for whom they give a standard authorisation for deprivation of liberty.
- When an authorisation is in force, the relevant person, the relevant person's representative and any IMCA representing the individual have a right at any time to request that the supervisory body reviews the authorisation.

Checklist

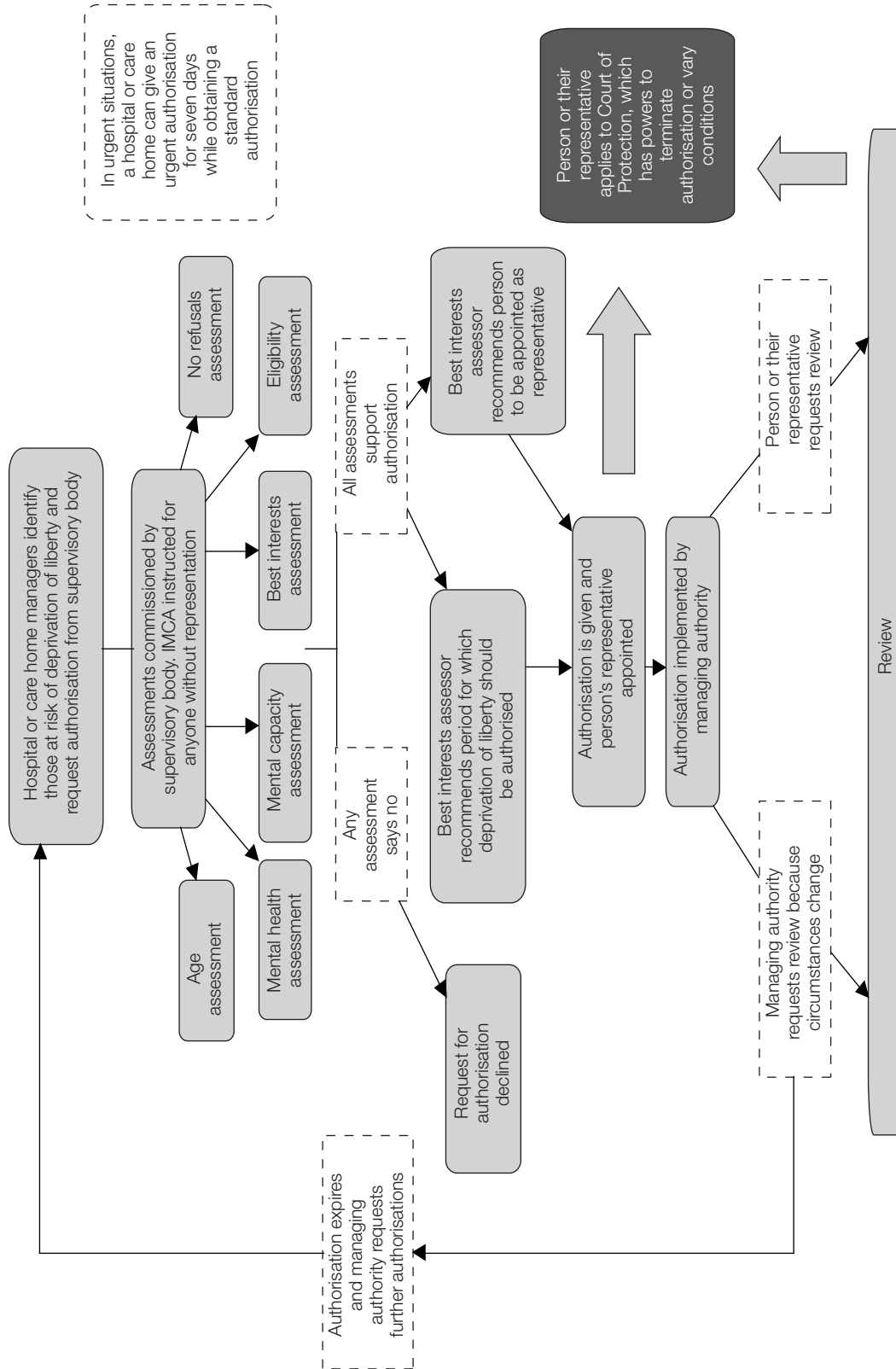
Key points for managing authorities and supervisory bodies

In addition to the above, both managing authorities and supervisory bodies should be aware of the following key points:

- An authorisation may last for a maximum period of 12 months.
- Anyone engaged in caring for the person, anyone named by them as a person to consult, and anyone with an interest in the person's welfare must be consulted in decision-making.
- Before the current authorisation expires, the managing authority may seek a fresh authorisation for up to another 12 months, provided it is established, on the basis of further assessment, that the requirements continue to be met.
- The authorisation should be reviewed, and if appropriate revoked, before it expires if there has been a significant change in the person's circumstances. To this end, the managing authority will be required to ensure that the continued deprivation of liberty of a person remains necessary in the best interests of the person.
- A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by an application to the Court of Protection. However, managing authorities and supervisory bodies should always be prepared to try to resolve disputes locally and informally. No one should be forced to apply to the court because of failure or unwillingness on the part of a managing authority or supervisory body to engage in constructive discussion.
- If the court is asked to decide on a case where there is a question about whether deprivation of liberty is lawful or should continue to be authorised, the managing authority can continue with its current care regime where it is necessary:
 - for the purpose of giving the person life-sustaining treatment, or
 - to prevent a serious deterioration in their condition while the court makes its decision.
- The complete process of assessing and authorising deprivation of liberty should be clearly recorded, and regularly monitored and audited, as part of an organisation's governance structure.
- Management information should be recorded and retained, and used to measure the effectiveness of the deprivation of liberty processes. This information will also need to be shared with the inspection bodies.

Annex 1

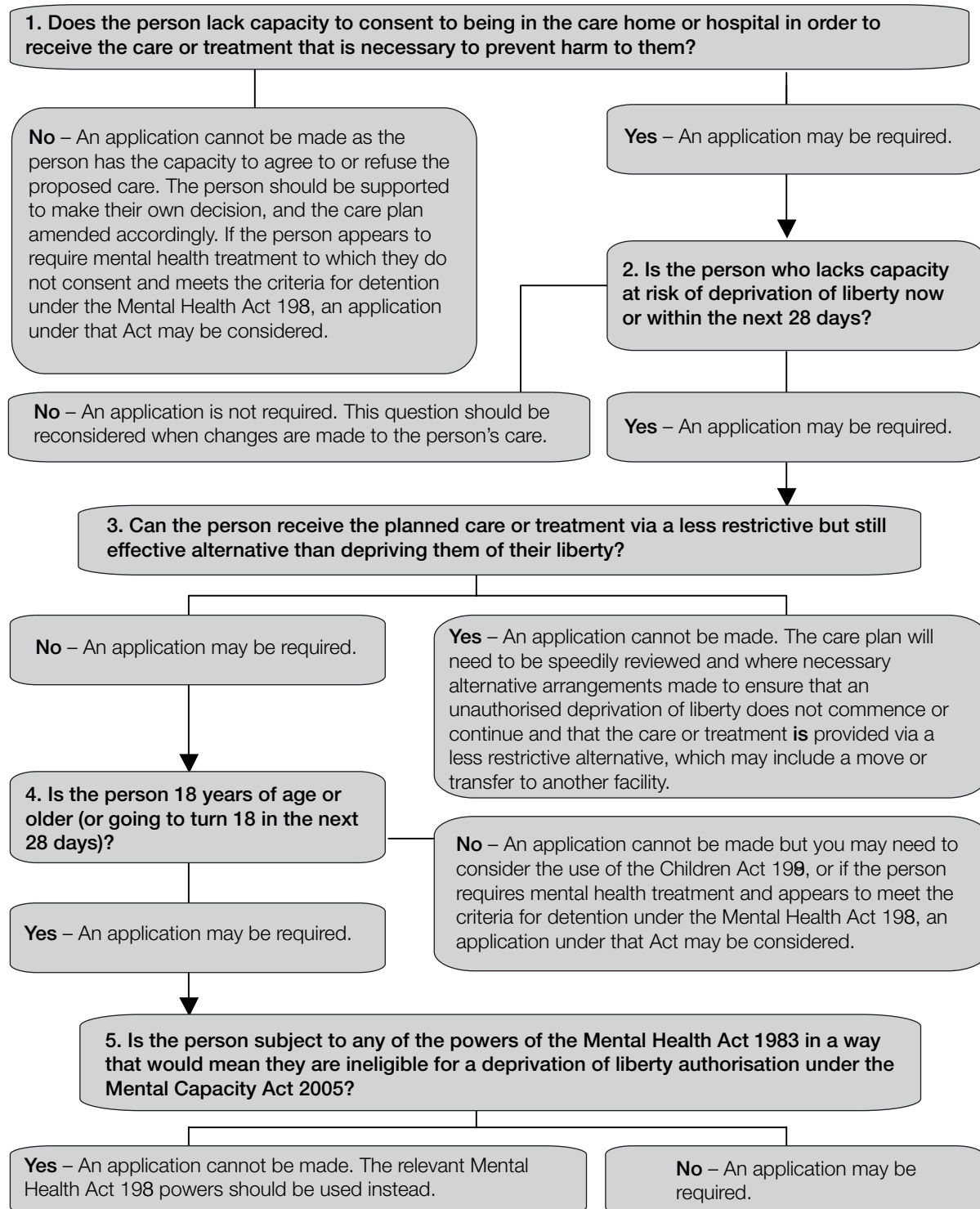
Overview of the deprivation of liberty safeguards process

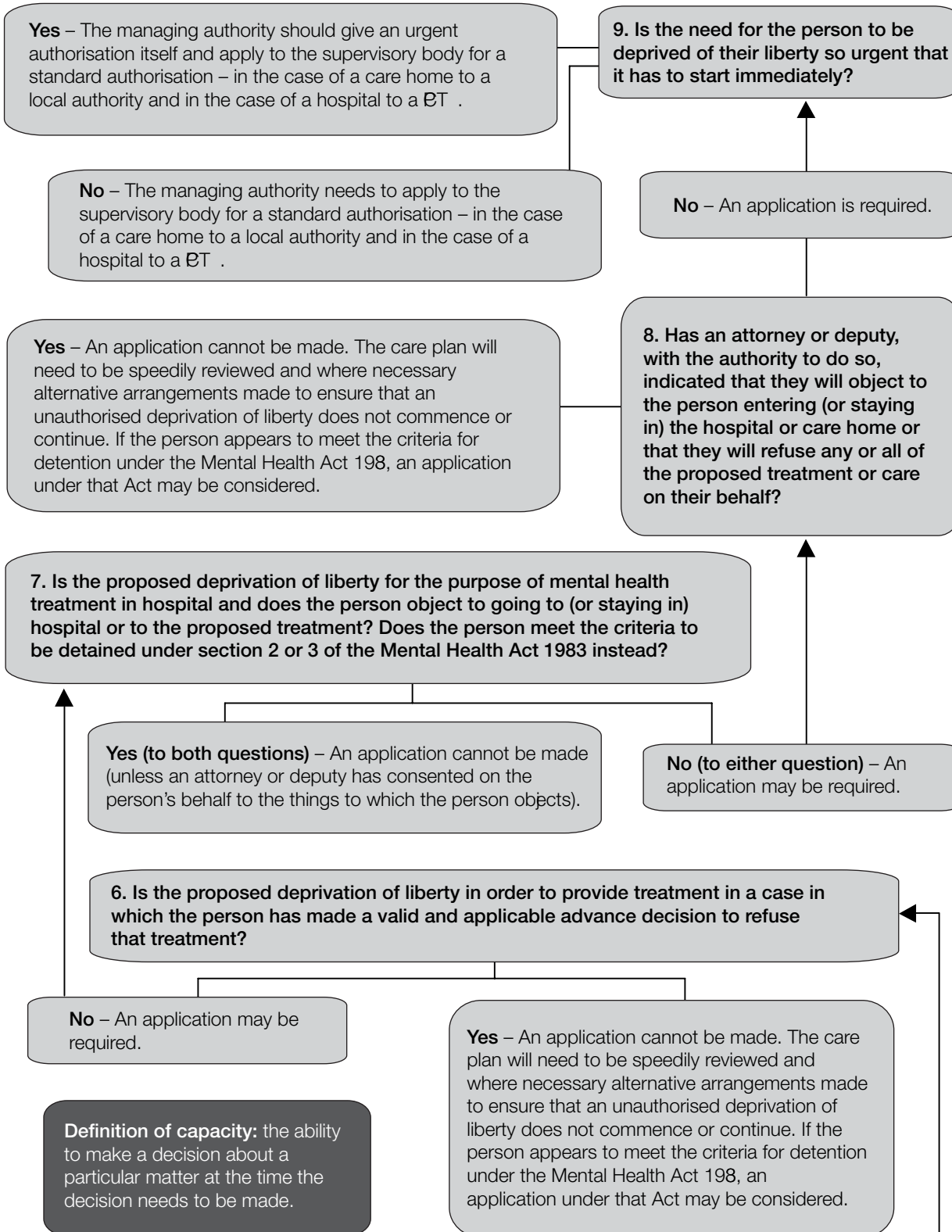


Annex 2

What should a managing authority consider before applying for authorisation of deprivation of liberty?

These questions are relevant **both** at admission **and** when reviewing the care of patients and residents. By considering the following questions in the following order, a managing authority will be helped to know whether an application for authorisation is required.



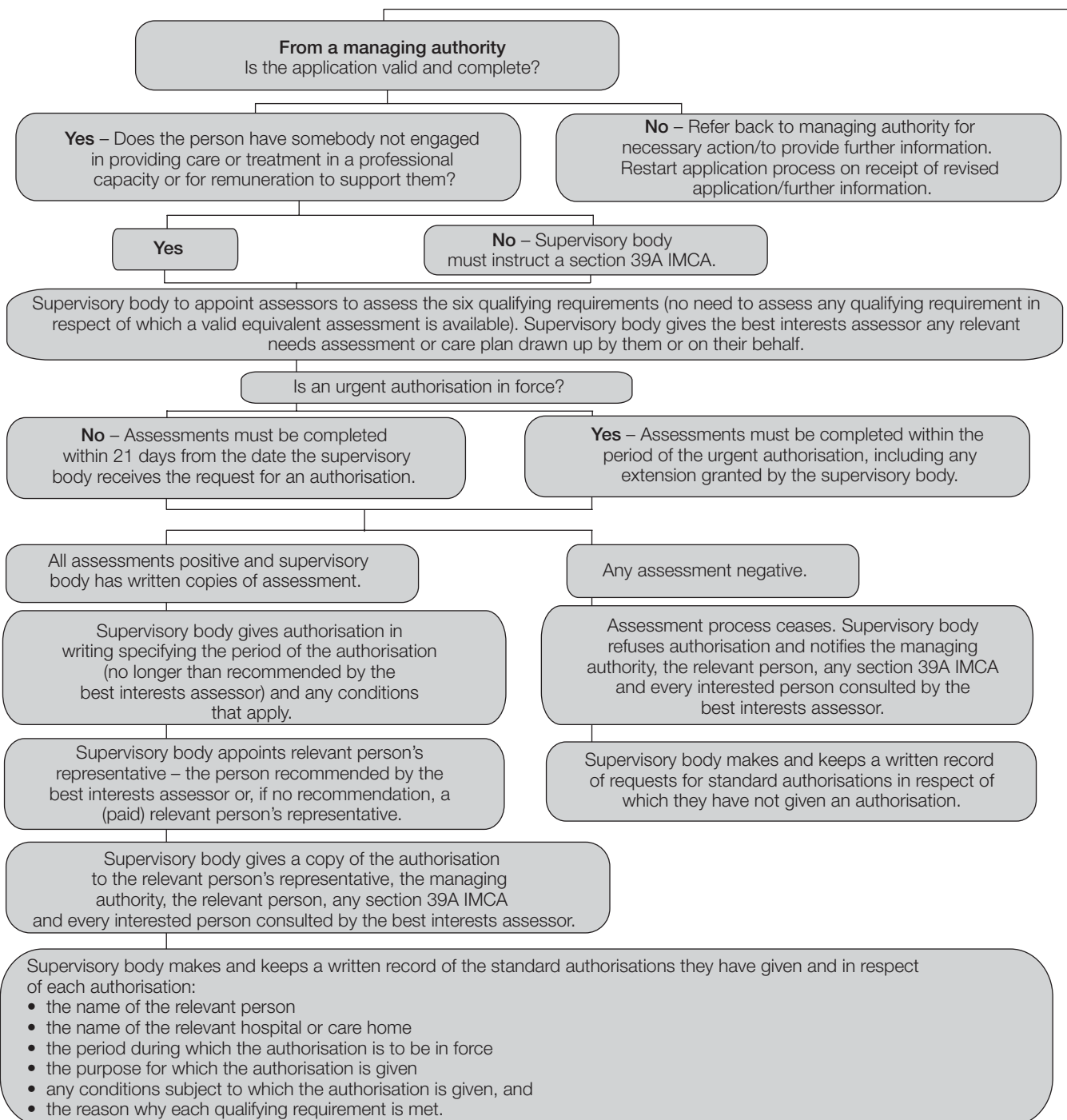


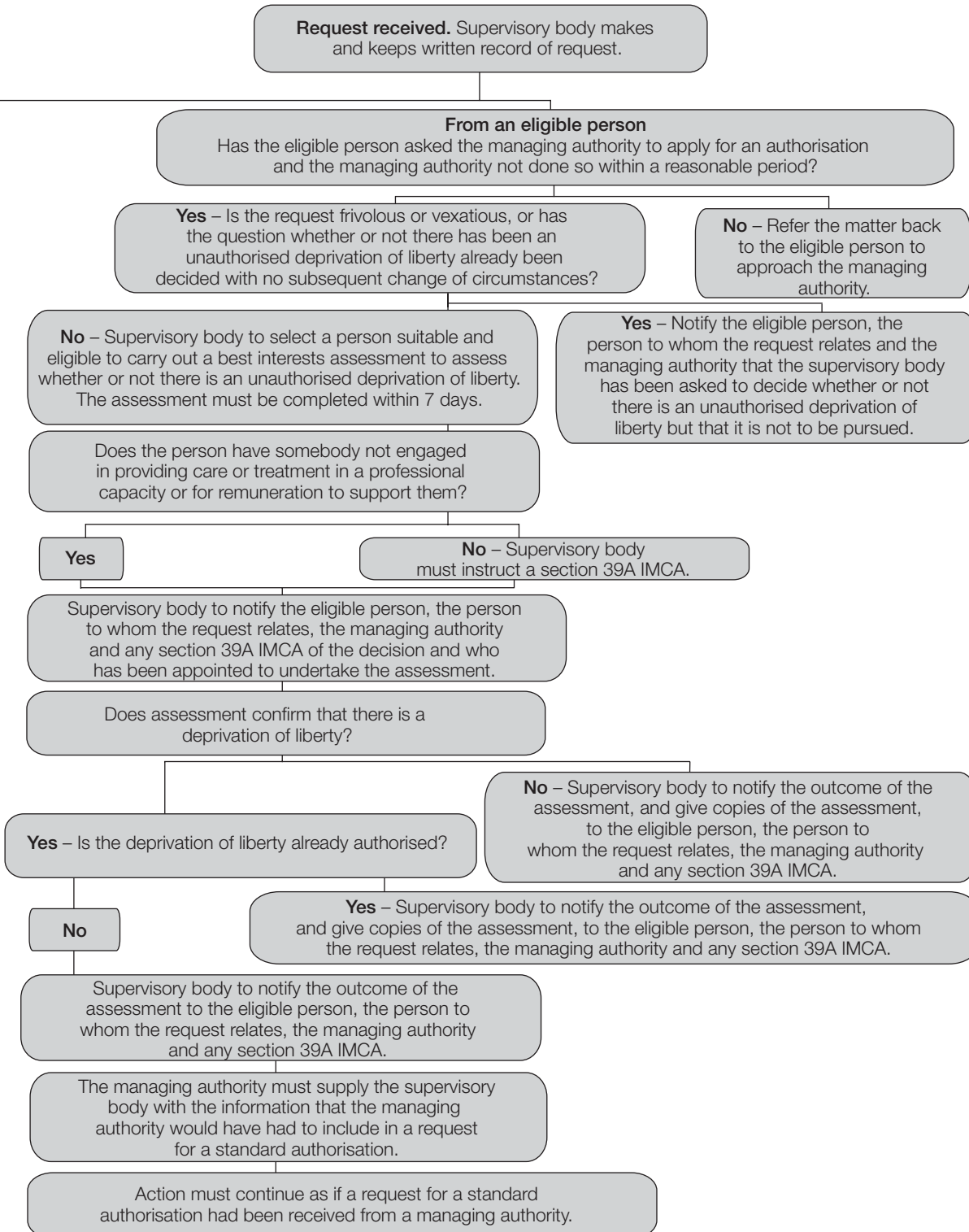
NB: An authorisation only relates to deprivation of liberty and does not give authority for any course of treatment.

Annex 3

Supervisory body action on receipt of a request from:

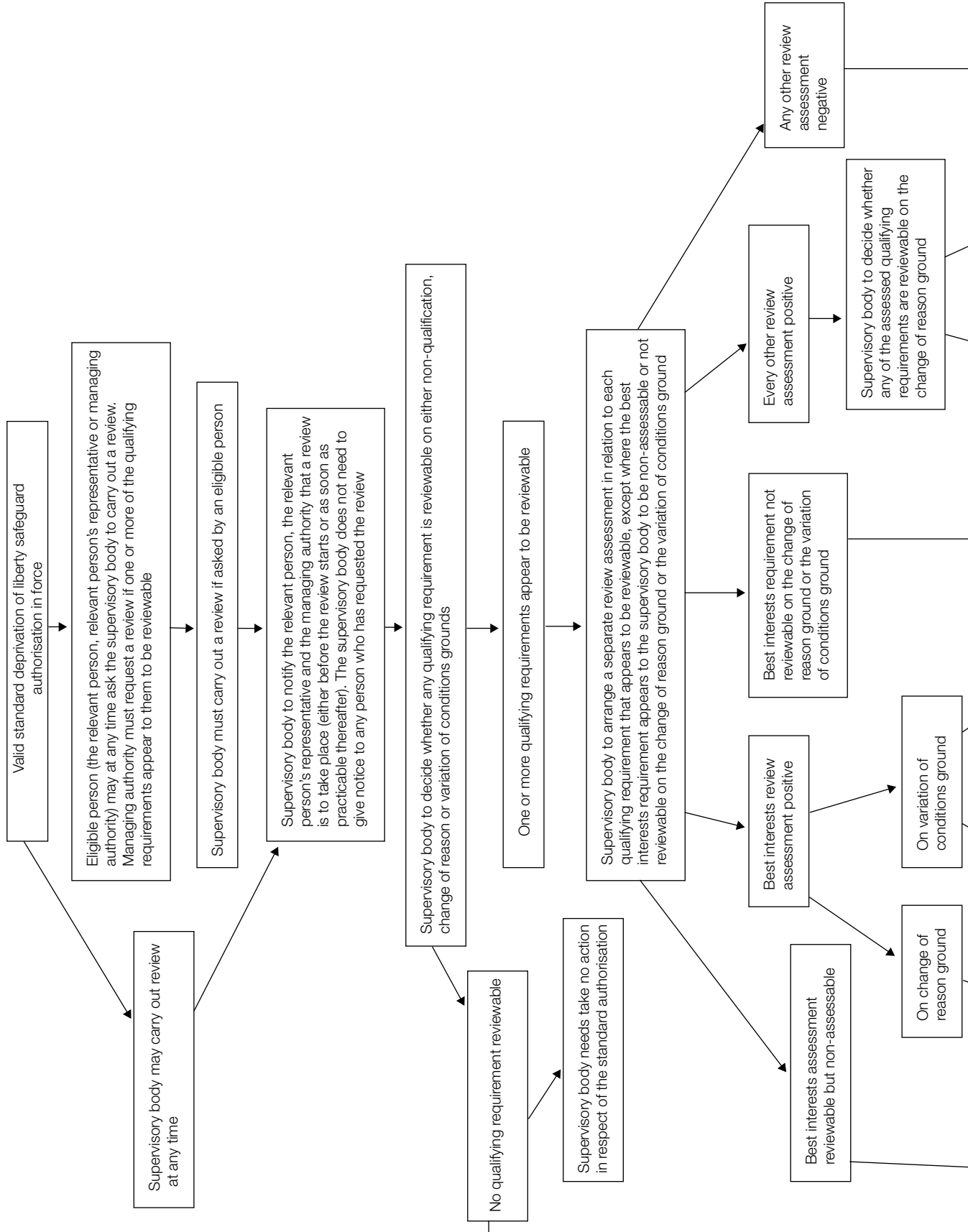
- a) a managing authority for a standard deprivation of liberty authorisation**
- b) somebody other than a managing authority (an eligible person) to determine whether or not there is a current unauthorised deprivation of liberty**

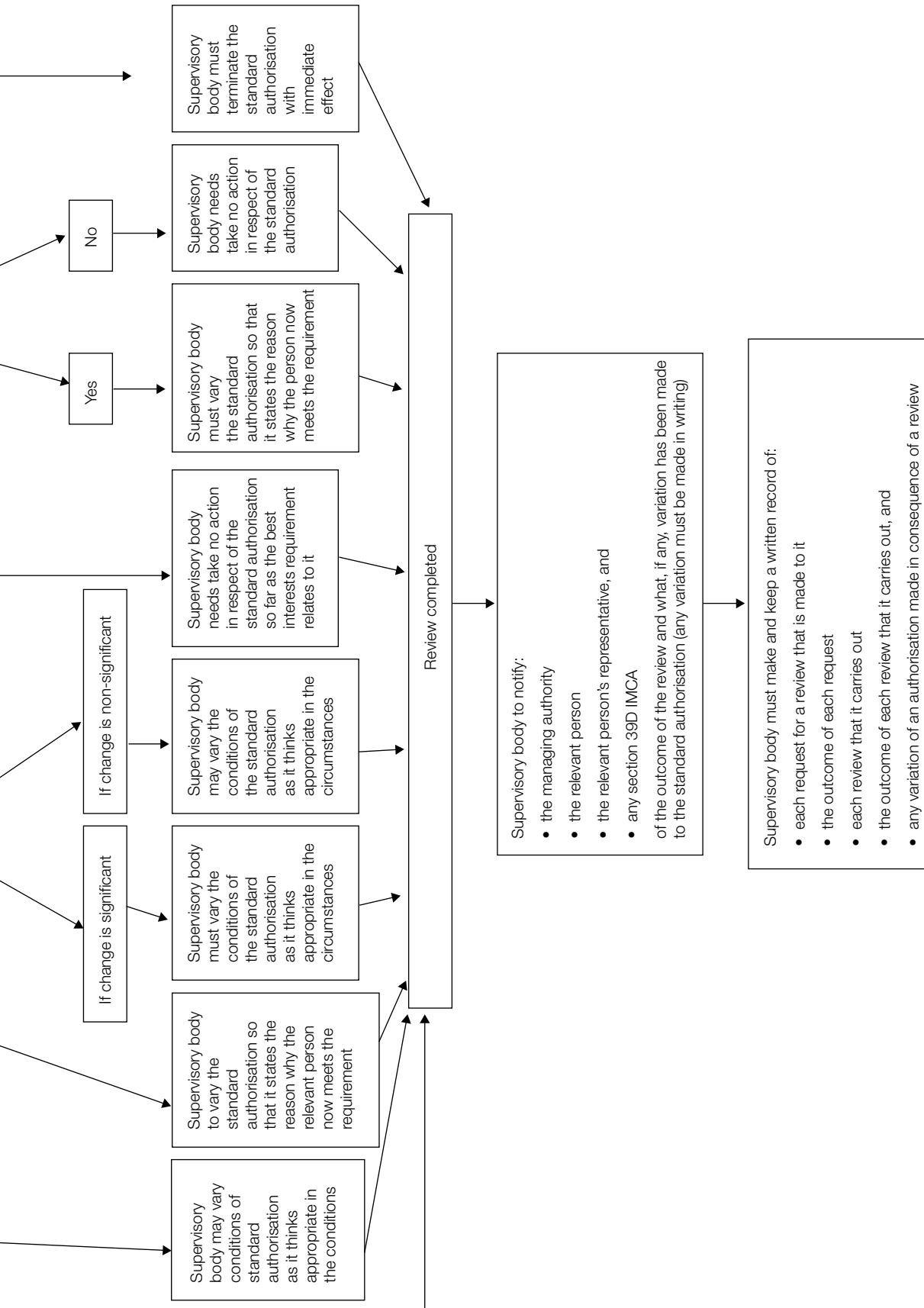




Annex 4

Standard authorisation review process





Key words and phrases used in the Code of Practice

The table below is not a full index or glossary. Instead, it is a list of key terms used in this Code of Practice. References in bold indicate particularly valuable content for that term.

Advance decision to refuse treatment	A decision to refuse specified treatment made in advance by a person who has capacity to do so. This decision will then apply at a future time when that person lacks capacity to consent to, or refuse, the specified treatment. Specific rules apply to advance decisions to refuse life sustaining treatment.	4.26
Advocacy	Independent help and support with understanding issues and putting forward a person's own views, feelings and ideas.	2.7
Age assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether the relevant person has reached age 18.	4.23–4.24
Approved mental health professional	A social worker or other professional approved by a local social services authority to act on behalf of a local social services authority in carrying out a variety of functions.	4.52, 4.53, 4.60
Assessor	A person who carries out a deprivation of liberty safeguards assessment.	Chapter 4 (all) 1.16–1.17, 3.21, 5.22, 9.10 Best interests, and appointing a relevant person's representative: 7.10–7.23
Best interests assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether deprivation of liberty is in a detained person's best interests, is necessary to prevent harm to the person and is a proportionate response to the likelihood and seriousness of that harm.	4.58–4.76 Best interests, and appointing a relevant person's representative: 7.10–7.23

Bournemouth judgment	The commonly used term for the October 2004 judgment by the European Court of Human Rights in the case of <i>HL v the United Kingdom</i> that led to the introduction of the deprivation of liberty safeguards.	Introduction to chapter 1 1.19, 2.2, 2.22
Capacity	Short for mental capacity. The ability to make a decision about a particular matter at the time the decision needs to be made. A legal definition is contained in section 2 of the Mental Capacity Act 2005.	Throughout
Care home	A care facility registered under the Care Standards Act 2000.	Throughout
Care Quality Commission	The new integrated regulator for health and adult social care that, subject to the passage of legislation, will take over regulation of health and adult social care from 1 April 2009.	Chapter 11
Carer	Someone who provides unpaid care by looking after a friend or neighbour who needs support because of sickness, age or disability. In this document, the term carer does not mean a paid care worker.	Throughout
Children Act 1989	A law relating to children and those with parental responsibility for children.	1.12, 5.22
Conditions	Requirements that a supervisory body may impose when giving a standard deprivation of liberty authorisation, after taking account of any recommendations made by the best interests assessor.	4.74–4.75 5.5 Review of: 8.14, 8.16
Consent	Agreeing to a course of action – specifically in this document, to a care plan or treatment regime. For consent to be legally valid, the person giving it must have the capacity to take the decision, have been given sufficient information to make the decision, and not have been under any duress or inappropriate pressure.	Throughout
Court of Protection	The specialist court for all issues relating to people who lack capacity to make specific decisions.	Chapter 10
Deprivation of liberty	Deprivation of liberty is a term used in the European Convention on Human Rights about circumstances when a person's freedom is taken away. Its meaning in practice is being defined through case law.	Chapter 2 Throughout

Key words

Deprivation of liberty safeguards	The framework of safeguards under the Mental Capacity Act 2005 for people who need to be deprived of their liberty in a hospital or care home in their best interests for care or treatment and who lack the capacity to consent to the arrangements made for their care or treatment.	Throughout
Deprivation of liberty safeguards assessment	Any one of the six assessments that need to be undertaken as part of the standard deprivation of liberty authorisation process.	Chapter 4
Deputy	Someone appointed by the Court of Protection with ongoing legal authority, as prescribed by the Court, to make decisions on behalf of a person who lacks capacity to make particular decisions.	4.26, 4.65, 5.11, 5.22, 7.7, 7.13–7.15, 7.18, 7.23, 7.29, 10.3, 10.8
Donee	Someone appointed under a Lasting Power of Attorney who has the legal right to make decisions within the scope of their authority on behalf of the person (the donor) who made the Lasting Power of Attorney.	3.9, 4.26, 4.65, 5.11, 5.22, 7.7, 7.13–7.15, 7.18, 7.23, 7.29, 10.3, 10.8
Eligibility assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether or not a person is rendered ineligible for a standard deprivation of liberty authorisation because the authorisation would conflict with requirements that are, or could be, placed on the person under the Mental Health Act 1983.	4.40–4.57
European Convention on Human Rights	A convention drawn up within the Council of Europe setting out a number of civil and political rights and freedoms, and setting up a mechanism for the enforcement of the obligations entered into by contracting states.	Chapter 1, Chapter 2
European Court of Human Rights	The court to which any contracting state or individual can apply when they believe that there has been a violation of the European Convention on Human Rights.	Introduction to Chapter 1, 2.1–2.2
Guardianship under the Mental Health Act 1983	The appointment of a guardian to help and supervise patients in the community for their own welfare or to protect other people. The guardian may be either a local authority or a private individual approved by the local authority.	4.43, 4.44

Independent Mental Capacity Advocate (IMCA)	Someone who provides support and representation for a person who lacks capacity to make specific decisions, where the person has no-one else to support them. The IMCA service was established by the Mental Capacity Act 2005 and is not the same as an ordinary advocacy service.	3.22–3.28, 7.34–7.41 3.16, 4.7, 5.7–5.8, 5.18, 6.8, 6.19, 6.27–6.28, 7.4, 7.23, 7.26, 8.18, 8.28, 9.6, 9.9
Lasting Power of Attorney	A Power of Attorney created under the Mental Capacity Act 2005 appointing an attorney (donee), or attorneys, to make decisions about the donor's personal welfare, including health care, and/or deal with the donor's property and affairs.	10.8
Life-sustaining treatment	Treatment that, in the view of the person providing health care, is necessary to keep a person alive.	5.13
Local authority	In the deprivation of liberty safeguards context, the local council responsible for social services in any particular area of the country.	1.4, 2.18, 2.21, 3.3, 3.11, 3.21, 4.77
Local health board (LHB)	Local health boards cover the same geographic areas as local authorities in Wales. They work alongside their respective local authorities in planning long-term strategies for dealing with issues of health and wellbeing in their areas.	1.4, 3.3
Main Code	The Code of Practice for the Mental Capacity Act 2005.	Throughout
Managing authority	The person or body with management responsibility for the hospital or care home in which a person is, or may become, deprived of their liberty.	1.4–1.5, 3.1 Throughout
Maximum authorisation period	The maximum period for which a supervisory body may give a standard deprivation of liberty authorisation, which must not exceed the period recommended by the best interests assessor, and which cannot be for more than 12 months.	4.71
Mental Capacity Act 2005	Legislation that governs decision-making for people who lack capacity to make decisions for themselves or who have capacity and want to make preparations for a time when they may lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this.	Throughout

Key words

Mental capacity assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given care or treatment.	4.29–4.32
Mental disorder	Any disorder or disability of the mind, apart from dependence on alcohol or drugs. This includes all learning disabilities.	1.4, 1.7, 1.9, 3.9, 4.33–4.35, 4.45, 4.50, 5.9, 5.22, 6.3
Mental Health Act 1983	Legislation mainly about the compulsory care and treatment of patients with mental health problems. It covers detention in hospital for mental health treatment, supervised community treatment and guardianship.	4.33–4.57 1.1, 1.11–1.12, 2.13, 4.5, 5.19, 5.22, 7.8, 8.3, 8.19–8.21
Mental health assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether a person has a mental disorder.	4.33–4.39
No refusals assessment	An assessment, for the purpose of the deprivation of liberty safeguards, of whether there is any other existing authority for decision-making for the relevant person that would prevent the giving of a standard deprivation of liberty authorisation. This might include any valid advance decision, or valid decision by a deputy or donee appointed under a Lasting Power of Attorney.	4.25–4.28
Qualifying requirement	Any one of the six qualifying requirements (age, mental health, mental capacity, best interests, eligibility and no refusals) that need to be assessed and met in order for a standard deprivation of liberty authorisation to be given.	4.1
Relevant hospital or care home	The hospital or care home in which the person is, or may become, deprived of their liberty.	Throughout
Relevant person	A person who is, or may become, deprived of their liberty in a hospital or care home.	Throughout
Relevant person's representative	A person, independent of the relevant hospital or care home, appointed to maintain contact with the relevant person, and to represent and support the relevant person in all matters relating to the operation of the deprivation of liberty safeguards.	Chapter 7

Restraint	The use or threat of force to help carry out an act that the person resists. Restraint may only be used where it is necessary to protect the person from harm and is proportionate to the risk of harm.	2.8–2.15
Restriction of liberty	An act imposed on a person that is not of such a degree or intensity as to amount to a deprivation of liberty.	Chapter 2
Review	A formal, fresh look at a relevant person's situation when there has been, or may have been, a change of circumstances that may necessitate an amendment to, or termination of, a standard deprivation of liberty authorisation.	Chapter 8
Standard authorisation	An authorisation given by a supervisory body, after completion of the statutory assessment process, giving lawful authority to deprive a relevant person of their liberty in the relevant hospital or care home.	Chapter 4 Throughout
Supervised community treatment	Arrangements under which people can be discharged from detention in hospital under the Mental Health Act 1983, but remain subject to the Act in the community rather than in hospital. Patients on supervised community treatment can be recalled to hospital if treatment in hospital is necessary again.	4.41, 4.50, 4.51
Supervisory body	A primary care trust, local authority, Welsh Ministers or a local health board that is responsible for considering a deprivation of liberty request received from a managing authority, commissioning the statutory assessments and, where all the assessments agree, authorising deprivation of liberty.	1.4, 3.3 Throughout
Unauthorised deprivation of liberty	A situation in which a person is deprived of their liberty in a hospital or care home without the deprivation being authorised by either a standard or urgent deprivation of liberty authorisation.	Chapter 9

Keywords

Urgent authorisation	An authorisation given by a managing authority for a maximum of seven days, which may subsequently be extended by a maximum of a further seven days by a supervisory body, that gives the managing authority lawful authority to deprive a person of their liberty in a hospital or care home while the standard deprivation of liberty authorisation process is undertaken.	Chapter 6 Throughout
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