THE MENTAL CAPACITY ACT 2005 AND THE DEPRIVATION OF LIBERTY SAFEGUARDS

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> "The granting of DOL standard authorisations is a matter for the local authority in its role as a supervisory body. The responsibilities of a supervisory body, correctly understood, require it to scrutinise the assessment it receives with independence and a degree of care that is appropriate to the seriousness of the decision and to the circumstances of the individual case that are or should be known to it. Where, as here, a supervisory body grants authorisations on the basis of perfunctory scrutiny of superficial best interests assessments, it cannot expect the authorisations to be legally valid."
> *London Borough of Hillingdon v Neary* [2011] EWHC 1377

1. BRIEF BACKGROUND TO DOLS

The right to liberty is protected by Article 5(1) ECHR which states:

> "Article 5(1): Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
> ... (e) The lawful detention … of persons of unsound mind ..."

For our purposes, it is therefore unlawful to deprive a person of their liberty unless one of the following procedures has been used:

(a) DOLS authorisation (hospitals and care homes only),
(b) Court of Protection DOL order (for virtually any care setting),
(c) By relying upon MCA s.4B while a decision is sought from the Court, or
(d) Mental Health Act 1983 (psychiatric hospital detention).

So by virtue of DOLS, a local authority in its role as 'supervisory body' can authorise an incapacitated person's deprivation of liberty in hospitals and care homes. This is implemented by the managers ('managing authority'). To do so is a serious matter. An interference with the right to liberty therefore comes with procedural and substantive safeguards. These include seeking the authorisation in advance; an independent assessment of best interests; a limit on the period of detention; a representative to challenge it; the appointment of an IMCA; and a review mechanism.

The right to challenge that deprivation of liberty is protected by Article 5(4) which states:

> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

Finally, Article 5(5) states, "Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation."

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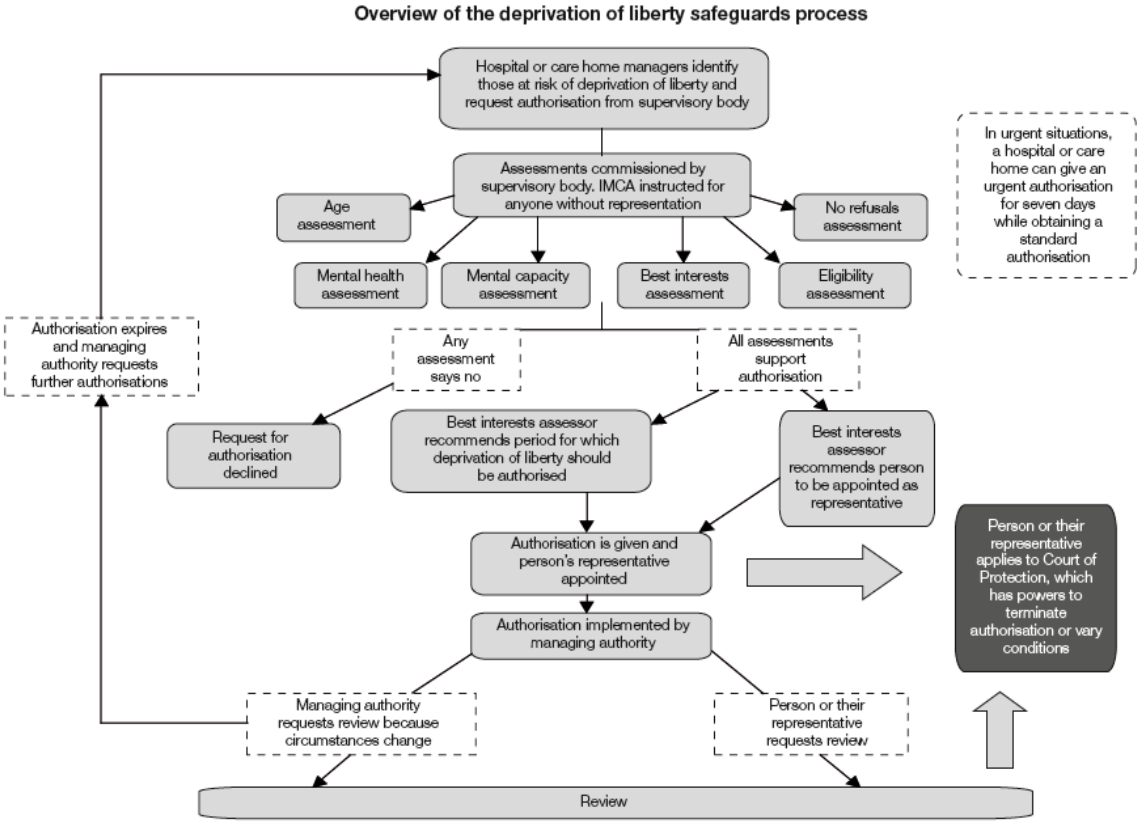

2. CORE DUTIES OF A SUPERVISORY BODY

- Respond to requests:
  - For a standard authorisation and for an extension of an urgent authorisation;
  - To investigate alleged unauthorised deprivations of liberty;
  - To review a standard authorisation.
- Commission the six standard authorisation assessments and the IMCA service when required.
- Grant the standard authorisation if all assessments are positive.
- Appoint the relevant person's representative ('RPR').
- Suspend for up to 28 days and, where appropriate, terminate a standard authorisation if the person is detained under the MHA 1983: Code paras 8.19-8.21.[1]
- Terminate the standard authorisation and the appointment of the RPR when appropriate.

3. WHAT MAKES A GOOD SUPERVISORY BODY?[2]

1. **Structural governance** – Is there clarity about who holds corporate responsibility for MCA / DOLS functions; and clarity that the DOLS supervisory body functions need to be independent of service delivery?

2. **Regulatory compliance** – Is there good understanding and compliance with regulations? Are assessors trained, supervised and commissioned in accordance with regulatory

[1] MCA Schedule A1 para 93(2) does not state who should suspend but DOLS COP para 8.30 states it is the supervisory body.
[2] DoH, DOLS Funding Fact-Sheet for 2013/14.

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requirements? Is information available on how many times a managing authority has been asked to extend an urgent authorisation and the reasons for this? Do Local Authority contracts specify compliance with the DOLS regulations? How are unauthorised deprivations of liberty managed (ie where best interests assessments find that deprivation is occurring though not in P's best interests)?

3. **Use of case law** – Is there evidence that case law decisions are incorporated into assessments and authorisations and training?

4. **Monitoring and evaluating the DOLS process** – Is this done, possibly by peer authorities with an independent component, for example an IMCA? Are the results of the process shared with senior management and concerns acted on? How is it evidenced that the signatory has scrutinised the authorisation forms? Is information kept on instances where the signatory has varied conditions or timescales? Is information kept on referrals and outcomes of assessments of unauthorised deprivations of liberty?

5. **Do the assessments demonstrate empowerment?** Is there evidence that P has been empowered and assisted to share his/her views; that P's wishes and feelings have been listened to and actively considered as key components of each assessment and review? How empowering is the DOLS process for 'P' and the family? Do capacity assessments and best interests assessments record attempts made to maximise residual capacity and involvement in care/treatment arrangements?

6. **Reviews** - Is the DOLS service certain that P and the RPR understand that they can request reviews of any of the assessments at any time? Does the DOLS service facilitate such requests eg by accepting telephone requests? Does the DOLS service offer reviews where assessors, the managing authority, s39D IMCA, P or relatives, friends, RPRs show disquiet? Does the DOLS service have a policy of sending different assessors to review? Is information available on how many reviews are requested, how many carried out, and how many result in changes such as lifting of the authorisation?

7. **Partnership working** - Is there evidence of good relationships/ partnerships with P, RPRs and IMCAs? Does the DOLS office inform and support RPRs and IMCAs to carry out their roles? Does the supervisory body check with the managing authority that the RPR role is being fulfilled in practice? What support is offered to RPRs who may have difficulty fulfilling the requirements of the role? How is the appointment of the RPR scrutinised by the Supervisory Body signatory? Are section 39D IMCAs commissioned for each authorisation granted?

8. **Feedback and learning for local authorities** – Is the learning from MCA and DOLS identified? Is this learning fed back into care management by authorisers and others, to improve social work and care management in local authorities? How is data on DOLS activity shared and used within the organisation?

9. **Feedback and learning for managing authorities -** Is the learning fed back into improving the care offered in managing authorities - in both care homes and hospitals? Does it become part of MCA training? What mechanisms are used to facilitate learning in managing authorities?

10. **Is there joint local strategic leadership from LAs, CCGs, Hospital Clinical Governance teams and the CQC, related to the MCA and DOLS?** Does this leadership

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provide clear messages on the importance of using a human rights framework within both health and social care? Are there forums to facilitate relationships and the on-going implementation of the DOL safeguards?

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

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

4. THE DOLS PROCESS

4.1 MANAGING AUTHORITY DUTIES

- To request a standard authorisation if they believe a person is likely to be deprived of liberty within the next 28 days: Form 1; Code paras 3.4 and 3.7.
    - If they apply too soon, they can re-submit later: Code para 3.20.
    - If they apply to the wrong supervisory body, they can pass the paperwork to the correct one: Code para 3.13.
- To issue an urgent authorisation in certain circumstances (see below).
- To initiate a review of the authorisation in certain circumstances (see below).
- To comply with any authorisation conditions.
- Notify the HIC/CSSIW of the requests and outcomes.

4.2 THIRD PARTY REQUESTS

If someone (eg family member, social or health professional, HIC/CSSIW inspector etc) is concerned that a person is being unlawfully deprived, the following process can be used:

- Must first raise their concern with the managing authority who should respond within 24 hours: Code para 9.1.
- If managing authority refuse to request an authorisation, the person can then contact the supervisory body directly: Code paras 9.2-3.
- Supervisory body must appoint a BIA to investigate (unless frivolous/vexatious or no change since last investigation).
- Investigation must be completed within 7 days (Code paras 9.4 and 9.8) and the outcome must be recorded (Code para 9.9).
- Supervisory body must record its response to the request: Code para 9.5.
- Supervisory body must inform the managing authority, P, third party and any appointed IMCA of the request and the response: Code para 9.6.
- If there is a deprivation, the supervisory body must:
    - Initiate the full assessment process unless the managing authority adapts the care plan to avoid a deprivation. Managing authority may need an urgent authorisation in the interim: Code paras 9.12 and 9.13.

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- Direct the managing authority to request a standard authorisation. If they refuse, the supervisory body must initiate a formal investigation regarding the unlawful deprivation: Code para 9.7.

4.3 URGENT AUTHORISATIONS

The hospital or care home management can authorise themselves to deprive if a standard authorisation is required but the deprivation is so urgent that it must being before the request is made or dealt with. It lasts for a maximum of 7 days, during which all assessments must be completed. According to the Code:

> Intro to chapter 3: "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."
>
> "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)."

Note that in *NHS Trust v FG* [2014] EWCOP 30, Keehan J, giving guidance that should be followed in cases where a patient may need to be subjected to the deprivation of liberty regime in a hospital for purposes of undergoing obstetric care, observed at paragraph 101 that:

> "ii) if the need for the deprivation of liberty in relation to the proposed obstetric care was foreseeable but the Trusts omit to seek a standard authorisation, the use of an urgent authorisation may be unlawful: see paragraphs 6.2 and 6.3 of Deprivation of Liberty Safeguards Code of Practice which provides that urgent authorisations should normally only be used in response to sudden unforeseen events and they should not be used where there is no expectation that a standard authorisation will be required; and
>
> iii) the mere fact that a deprivation of liberty could be authorised under Schedule A1 does not absolve the Trusts from making an application to the court where the facts of the individual case would otherwise merit the same."

The managing authority may request an extension (using form 1) if there are exceptional reasons and the supervisory body records its decision in form 1.

> "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.
> …
> 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

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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."

The Court of Protection in the conjoined cases reported (in part) at *Re X (Deprivation of Liberty)* [2014] EWCOP 25 was asked to consider whether it had the power (under s.21A MCA 2005) to extend urgent authorisations beyond the statutory maximum of 14 days – as to permit the local authority to carry out the necessary assessments to consider whether to grant standard authorisations in circumstances where it was unable to do so in a timely fashion because of the number of applications made to it. We suggest that even if it does (which would be contrary to comments made by Charles J in *Re UF* ([2013] EWCOP 4289), it will only do so for a very limited period of time and upon the basis of sufficient evidence that the deprivation of liberty is in the person's best interests.

4.4 WHICH SUPERVISORY BODY?

The managing authority make the request to the supervisory body in the area where the person is ordinarily resident: Code para 3.3. The supervisory body should seek to appoint assessors from area in which the person currently is: Code 4.3.

4.5 WHEN A STANDARD AUTHORISATION REQUEST IS RECEIVED

Supervisory body must keep records of all requests: Code para 4.12. There must be a procedure to identify how requests will be dealt with and recorded: Code paras 6.7 and 6.10. An appropriately senior person should scrutinise the paperwork for errors or omissions and seek any necessary clarification.

"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."

A key duty of the supervisory body is to identify the RPR and to support the relevant person. The process to identify the RPR should begin as soon as the request for a standard authorisation is received. The initial task is given to the BIA: Code paras 5.6, 7.1, 7.9 and 7.10.

The supervisory body arranges the 6 assessments which must be completed within 21 days of receipt (England). But if (as is more common) there is an urgent authorisation, the assessments must be completed before its expiry: Code paras 4.1, 4.9 and 4.10. Sequence the assessments in the following order: age, no refusals, mental capacity, mental health, best interests, eligibility. Note that the best interests assessment is the most time consuming.

4.6 ASSESSORS

The supervisory body is responsible for ensuring that best interests assessors meet statutory requirements and are trained: Code para 4.60. Assessors must have protection against liabilities: Code para 4.18. Moreover:

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> "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."

The mental capacity and mental health assessor should be already familiar with the person:

> "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.
> …
> 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."

Authorising a deprivation of liberty is a serious matter and due care is required in scrutinising the assessments. The authoriser must be satisfied that there is enough evidence that this deprivation of liberty is in the person's best interests, and that the removal of liberty is both necessary and proportionate. The authoriser should be alert to indicators of possible poor practice in case planning or practice, and should have sufficient seniority to raise these where appropriate through operational governance frameworks, including those in hospitals or CCGs.

4.7 RPRs

The person's representative must be at least 18 years old, be able to keep in contact with the person and be willing to act as RPR. The best interests assessor needs to ensure there is no conflict between the proposed RPR and the person (eg financial interest in the care): Code para 7.6. They should also take into account the cultural and communication needs of the relevant person: Code para 7.20.

Important guidance on the identification of proposed RPRs was given in *AJ v A Local Authority* [2015] EWCOP 5:

> "115. Thirdly, a RPR should only be selected or confirmed by a BIA where he or she satisfies not only the criteria in regulation 3 of the Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008 but also the requirements of paragraph 140 of Schedule A1 of the MCA. This requires that the BIA not only checks that the facts set out in regulation 3 are satisfied but also carries out an analysis and reaches a judgment as to whether the prospective representative would, if appointed, (a) maintain contact with the relevant person; (b) represent the relevant person in matters relating to or connected with the Schedule and (c) support the relevant person in matters relating to or connected with the Schedule.
> 116. Fourthly, the local authority is under an obligation to satisfy itself that a person selected for appointment as RPR meets the criteria in regulation 3 and in paragraph 140 of Schedule A1. If the local authority concludes that the person selected for appointment does not meet the criteria, it should refer the matter back to the BIA.
> 117. Fifthly, it is likely to be difficult for a close relative or friend who believes that it is in P's best interests to move into residential care, and has been actively involved in arranging such a move, into a placement that involves a deprivation of liberty, to fulfil the functions of RPR,

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which involve making a challenge to any authorisation of that deprivation. BIAs and local authorities should therefore scrutinise very carefully the selection and appointment of RPRs in circumstances which are likely to give rise to this potential conflict of interest.
118. Sixthly, an IMCA appointed under section 39 D must act with diligence and urgency to ensure that any challenge to an authorisation under schedule A1 is brought before the court expeditiously. Failure to do so will lead to the evaporation of P's Article 5 rights.
119. Seventhly, the appointment of a RPR and IMCA does not absolve the local authority from responsibility for ensuring that P's Article 5 rights are respected. The local authority must monitor whether the RPR is representing and supporting P in accordance with the duty under paragraph 140 and, if not, consider terminating his appointment on the grounds that he is no longer eligible. The local authority must make sufficient resources available to assist an IMCA and keep in touch with the IMCA to ensure that all reasonable steps are being taken to pursue P's Article 5 rights.
120. Finally, in circumstances where a RPR and an IMCA have failed to take sufficient steps to challenge the authorisation, the local authority should consider bringing the matter before the court itself. This is likely, however, to be a last resort since in most cases P's Article 5 rights should be protected by the combined efforts of a properly selected and appointed RPR and an IMCA carrying out their duties with appropriate expedition."

4.8 RESOLVING DISPUTES

The Code states:

> "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."

Part 8 Reviews

In terms of the review process, the statutory grounds for review are at para 8.3 of the Code. Thus a review must take place if a requirement is not met or a change in situation requires change in conditions or the reasons for now meeting a requirement differ to when the standard authorisation was given. The deprivation can end before a formal review: it "only **permits** deprivation of liberty: it does not mean that the person **must be** deprived of liberty where circumstances no longer necessitate it": Code para 8.8. An IMCA can request a review: Code para 7.39.

The supervisory body arranges a separate assessment for each of the requirements under review: Code paras 8.11, 8.13. Conditions can be reviewed and varied without a full scale best interests reassessment if there has been no significant change in overall circumstances: Code para 8.14. Note, however, that Part 8 reviews are unlikely to satisfy Article 5(4) because they lack the necessary 'judicial character'.

Court of Protection Challenges

Note that Article 5(4) provides that the person is entitled to challenge their detention. A comprehensive summary of the principles was provided in *AJ v A Local Authority* [2015] EWCOP 5:

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(1) "There is a positive obligation on the state to protect the liberty of those within its jurisdiction. Otherwise, there would be a sizeable gap in the protection from arbitrary detention, which would be inconsistent with the importance of personal liberty in a democratic society. The state is therefore obliged to take measures providing effective protection of vulnerable persons, including reasonable steps to prevent a deprivation of liberty of which the authorities have or ought to have knowledge": *Stanev v Bulgaria* at paragraph 120.
(2) The procedure required by Article 5(4) must have a judicial character and be independent of the detaining authority: *X v United Kingdom*, supra, para 53, *MH v UK*, supra, para 77(c).
(3) Article 5(4) guarantees a remedy that must be accessible to the person concerned: *MH v UK*, supra, para 76.
(4) The state has an obligation to ensure that a mentally incapacitated adult is afforded independent representation, enabling them to have their Convention complaints examined before a court or other independent body: *Ivinovic v Croatia*, supra, para 45.
(5) Special procedural safeguards may be called for in order to protect the interests of persons who, on account of mental disabilities, are not fully capable of acting for themselves. Where a person lacks the capacity to instruct lawyers directly, the safeguards required may include empowering or even requiring some other person to act on that person's behalf: *Winterwerp v The Netherlands*, supra, para 60, *MH v UK*, supra, paras 77(e) and 92.
(6) Article 5(4) may not be complied with where access to a court is dependent on the exercise of discretion by a third party, rather than an automatic entitlement. Where the third party supports the deprivation of liberty, reliance on the third party to initiate proceedings may not satisfy the requirements of Article 5(4): *Shtukatarov v Russia*, supra, para 124.
(7) An initial period of detention may be authorised by an administrative authority as an emergency measure provided it is of short duration and the individual is able to bring judicial proceedings speedily to challenge the lawfulness of any such detention including, where appropriate, its lawful justification as an emergency measure: *MH v UK*, supra, para 77(a).
(8) The likelihood of the judicial hearing leading to release from detention is irrelevant. Article 5(4) is first and foremost a guarantee of a fair procedure for reviewing the lawfulness of detention – an applicant is not required, as a precondition of enjoying that protection, to show that on the facts of his case he stands any particular chance of success in obtaining his release: *Waite v UK*, supra, para 59.
36. In domestic law, the fundamental principle to be applied by the Court of Protection in cases of deprivation of liberty was summarised by Peter Jackson J in *Neary v LB of Hillingdon* [2011] EWHC 1377 (COP) at para 202:

> "… there is an obligation on the State to ensure that a person deprived of liberty is not only entitled but enabled to have the lawfulness of his detention reviewed speedily by a court".

The following guidance from *Re RD and others* [2016] EWCOP 49 sets out how to determine when a DoLS authorisation needs to be challenged via s.21A to the Court of Protection:

> 86…
> (1) The RPR must consider whether P wishes, or would wish, to apply to the Court of Protection. This involves the following steps:
> (a) Consider whether P has capacity to ask to issue proceedings. This simply requires P to understand that the court has the power to decide that he/she should not be subject to his/her current care arrangements. It is a lower threshold than the capacity to conduct proceedings.
> (b) If P does not have such capacity, consider whether P is objecting to the arrangements for his/her care, either verbally or by behaviour, or both, in a way that indicates that he would wish to apply to the Court of Protection if he had the capacity to ask.
> (2) In considering P's stated preferences, regard should be had to:
> (a) any statements made by P about his/her wishes and feelings in relation to issuing proceedings,
> (b) any statements made by P about his/her residence in care,
> (c) P's expressions of his/her emotional state,
> (d) the frequency with which he/she objects to the placement or asks to leave,

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(e) the consistency of his/her express wishes or emotional state; and
(f) the potential alternative reasons for his/her express wishes for emotional state.
(3) In considering whether P's behaviour constitutes an objection, regard should be had to:
(a) the possible reasons for P's behaviour,
(b) whether P is being medicated for depression or being sedated,
(c) whether P actively tries to leave the care home,
(d) whether P takes preparatory steps to leave, e.g. packing bags,
(e) P's demeanour and relationship with staff,
(f) any records of challenging behaviour and the triggers for such behaviour.
(g) whether P's behaviour is a response to particular aspects of the care arrangements or to the entirety of those arrangements.
(4) In carrying out this assessment, it should be recognised that there could be reason to think that P would wish to make an application even if P says that he/she does not wish to do so or, conversely, reason to think that P would not wish to make an application even though he/she says that she does wish to, since his/her understanding of the purpose of an application may be very poor.
(5) When P does not express a wish to start proceedings, the RPR, in carrying out his duty to represent and support P in matters relating to or connected with the Schedule, may apply to the Court of Protection to determine any of the four questions identified in s.21A(2) i.e. on the grounds that P does not meet one or more of the qualifying requirements for an authorisation under Schedule A1; or that the period of the standard authorisation or the conditions subject to which the standard authorisation is given are contrary to P's best interests; or that the purpose of the standard authorisation could be as effectively achieved in a way that is less restrictive of P's rights and freedom of action.
(6) Consideration of P's circumstances must be holistic and usually based on more than one meeting with P, together with discussions with care staff familiar with P and his/her family and friends. It is likely to be appropriate to visit P on more than one occasion in order to form a view about whether proceedings should be started.
(7) By way of an alternative to proceedings, it may be appropriate to instigate a Part 8 review, or to seek to work collaboratively with the family and the commissioning authority to see whether alternate arrangements can be put in place. Such measures should not, however, prevent an application to the court being made where it appears that P would wish to exercise a right of appeal.
(8) The role of the IMCA appointed under s.39D is to take such steps as are practicable to help P and the RPR understand matters relating to the authorisation set out in s.39D(7)(a) to (e), and the rights to apply the Court of Protection and for a Part 8 review, and how to exercise those rights. Where it appears to the IMCA that P or the RPR wishes to exercise the right, the IMCA must take all practical steps to assist them to do so. In considering P's apparent wishes, the IMCA should follow the guidance set out above so far as relevant.
87. Finally, on the general issues arising, although I have in these proceedings considered, as a preliminary issue, the question whether applications in these proceedings are properly brought, this question should not normally be raised as a preliminary issue in every case, either on an application by the respondents to strike out the application or by some other process. Such a course would lead to unnecessary satellite litigation and would only add to the delays in, and burdens on, the Court of Protection.

Under the provisions of s.21A MCA 2005, the Court can terminate or vary the standard authorisation or direct the managing authority or supervisory body to do so: Code para 10.10. Note that it was held in *Re UF* [2013] EWCOP 4289 that the Court's power to vary a standard authorisation includes the power as to extend a standard authorisation beyond the period stated in the best interest assessment, at least so long as the extended authorisation does not run for more than one year. Charles J in that case expressed doubt as to whether the court could extend the authorisation to run for any longer period; he also emphasised that the court in extending a standard authorisation is in effect carrying out its own interim best interests assessment.

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The decision in *Re UF* is important because of the consequences for legal aid for the detained person. In brief terms, so long as the standard authorisation remains in force, it is likely that the detained person will receive non-means tested legal aid. If the standard authorisation is terminated or lapses and the deprivation of liberty is authorised by the court on an interim basis until all the questions raised in the application are resolved, there is a very real risk that the person will only be eligible to receive means-tested legal aid. In any case where there is a dispute before the court brought under s.21A MCA 2005 it will usually be appropriate that a standard authorisation continues in force (whether by being varied by the court or by a fresh standard authorisation being granted).

5. THE QUALIFYING REQUIREMENTS ('ARCHIE')

Qualifying Requirement	Criterion	Assessor
Age	18 or over?	Best interests assessor
No **R**efusals	Would authorisation conflict with a valid and applicable **advance decision** refusing some or all of the relevant treatment or a valid decision of a **donee** or **deputy** refusing to be so accommodated?	Best interests assessor
Mental **C**apacity	Do they lack capacity 'in relation to the question **whether or not he should be accommodated in the relevant hospital or care home for the purpose of being given the relevant care or treatment'?** 1. Unable to: - **U**nderstand the information relevant to the decision (includes information about the reasonably foreseeable consequences of deciding one way or another, or failing to make the decision), OR - **R**etain that information (retention for short period does not prevent him from being regarded as able to decide), OR - **U**se or weigh that information as part of the process of making the decision, OR - **C**ommunicate the decision (whether by talking, using sign language or any other means)? 3. Is this inability because of the impairment/ disturbance of the mind or brain?	Mental health or **best interests assessor**
Mental **H**ealth	Any disorder or disability of the mind (disregarding any exclusion for persons with learning disabilities)?	S. 12 doctor or a registered medical practitioner with specialist experience. Must have completed

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		DoLS training.
Best **I**nterests	a) Detained resident? b) In best interests to deprive liberty? c) Deprivation of liberty necessary to prevent him suffering harm? d) Deprivation of liberty is a proportionate response to (a) likelihood of harm and (b) seriousness of that harm?	AMHP or suitably qualified professional who has completed the DoLS best interest assessor training.
Eligibility	MHA detained in-patient or inconsistent with MHA obligation?	S.12 approved and eligible for mental health assessment or **AMHP and eligible for best interests assessment.**

6. CHECKLIST FOR AUTHORISERS: FORM 5

Scrutinise the assessments with independence and the degree of care commensurate to the seriousness of the decision. It is not your role to overrule the assessor's findings but you can require further evidence to justify their opinion.

The background information and P's views in Form 3 are particularly important. The former should explain why P is in the particular place, what other options were first considered, why they were rejected, and what else has been tried (or not). The background should give a decent pen portrait of P which is person centred.

- What are/were P's home circumstances/social support networks? What were they like before the onset of dementia etc?
- Do they still have a home to return to?
- Family circumstances?
- Significant health conditions?
- Comment on previous authorisations (dates started / ceased) plus prior conditions and how they have been implemented (or not).

In relation to P's views in Form 3, the assessor should use P's own words wherever possible. What are/were P's past and present wishes, feelings, values and beliefs and matters which they would consider if they could? Did they choose this care home for themselves? Whether the person is expressing an objection by any means, or whether they would do so if they could, may usefully be recorded here to assist with the issue of best interests and also selection of representative later. What are other people's versions of P's views, past and present? It is good practice for the BIA to read at least the past month of daily records to gauge how consistent the person's views are.

6.1 AGE ASSESSMENT

Form 3 + DOLS COP paras 4.23-4.24

6.2 NO REFUSALS ASSESSMENT

Form 3 + DOLS COP paras 4.25-4.28

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- If there is an LPA, has the assessor identified whether it is for (a) property and financial affairs or (b) health and welfare? Only the health and welfare LPA/deputy can veto the authorisation.
- If there is an advance decision, has the assessor investigated the circumstances of its creation?
    - Did P have capacity at the time? Why/not?
    - What exactly was being refused?

Note that a welfare LPA may select the RPR (which may be themselves).

6.3 MENTAL CAPACITY ASSESSMENT
Form 3 (BIA) or 4 (medic) + DOLS COP paras 4.29-4.32

- Has the assessor been clear about the DoLS capacity decision being assessed?
    - Has the assessor ensured that P (and they) have the concrete details of the choices available (eg between living in a care home and living at home with a realistic package of care)?
        - No blank canvass – is there elsewhere to reside? If so, what package of care would or might be available there?
    - Has the assessor identified what are the salient details necessary for P to understand/comprehend (ignoring the peripheral and minor details)?
        - Eg "*The information relevant to Mrs White's decision includes* [*where she lives, what kind of establishment it is, what care she needs and receives and why she is there*]."
    - Has the assessor avoided the protection imperative?
- Has the assessor demonstrated the efforts taken to promote P's ability to decide?
    - Goes beyond the time, location, and setting for the assessment.
    - What have they and others done to help P make the decision? Eg assistive technology, support from SALT, communication aids.
    - Helpful for assessor to have discussed practicable steps with the managing authority, social worker etc.
    - Can use standard authorisation conditions in respect of capacity to decide on the care arrangements giving rise to the deprivation of liberty.
- Has the assessor evidenced each element of the capacity assessment? Have they given examples from the assessment?
    - What is the impairment/disturbance? Need not be a formal diagnosis but must be a reasonable belief in it. Is it temporary or permanent?
    - Why could P not understand, and/or retain, and/or use/weigh, and/or communicate in spite of the assistance given?
        - Assessor should not use phrases which suggest P has failed to prove something: s/he need not prove anything as the burden is on the assessor. So check the burden and standard of proof is correctly used.
        - Is there evidence to support their view?
    - How is the inability because of the impairment/disturbance (as opposed to something else)? An inability "related to" an impairment is insufficient: it must be "because of" it to establish incapacity.
    - Why is this an incapacitated decision as opposed to an unwise one?

Important:

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- We should not ask more of those whose capacity is doubted than of those whose capacity is unquestioned.
- Focus on the decision-making process, not the wisdom of the outcome of that process.
- The weighing element looks at whether P can see the various sides of the issue. It is not the same as insight. P may legitimately disagree with another person's view of the risks.
- The communication element is really only for those unable to communicate at all.

6.4 MENTAL HEALTH ASSESSMENT

Form 4 + DOLS COP paras 4.33-4.39

A person cannot be detained unless they have a mental disorder (ie a 'disorder or disability of the mind' as per the Mental Health Act 1983). The MHA Code states that the following conditions "could fall" within that definition:

- affective disorders, such as depression and bipolar disorder
- schizophrenia and delusional disorders
- neurotic, stress-related and somatoform disorders, such as anxiety, phobic disorders, obsessive compulsive disorders, post-traumatic stress disorder and hypochondriacal disorders
- organic mental disorders such as dementia and delirium (however caused)
- personality and behavioural changes caused by brain injury or damage (however acquired)
- personality disorders
- mental and behavioural disorders caused by psychoactive substance use
- eating disorders, non-organic sleep disorders and non-organic sexual disorders
- learning disabilities
- autistic spectrum disorders (including Asperger's syndrome)
- behavioural and emotional disorders of children and adolescents

Note: this list is not exhaustive and DSM-V/ICD-10 are not conclusive.

6.5 BEST INTERESTS ASSESSMENT

Forms 3, 3A (if deprived without an authorisation) + DOLS COP paras 4.58-4.76 and MCA COP chapter 5

As with all the assessments, it is crucial for the assessor to document what they have seen and to whom they have spoken (and, crucially, what was said!). MCA s4 and the main Code chapter 5 discuss how to determine what is in someone's best interests. The following factors are summarised at para 5.13:

- Working out what is in someone's best interests cannot be based simply on someone's age, appearance, condition or behaviour (see paras 5.16–5.17).
- All relevant circumstances should be considered when working out someone's best interests (paras 5.18–5.20).
- Every effort should be made to encourage and enable the person who lacks capacity to take part in making the decision (paras 5.21–5.24).
- If there is a chance that the person will regain the capacity to make a particular decision, then it may be possible to put off the decision until later if it is not urgent (paras 5.25–5.28).
- Special considerations apply to decisions about life-sustaining treatment (paras 5.29–5.36).
- The person's past and present wishes and feelings, beliefs and values should be taken into account (paras 5.37–5.48).

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- The views of other people who are close to the person who lacks capacity should be considered, as well as the views of an attorney or deputy (paras 5.49–5.55).

For best interests in the context of a DOL, 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.

Remember that the purpose of the person's deprivation of liberty must be to give them care or treatment. You must consider whether any care or treatment the person needs can be provided effectively in a way that is less restrictive of their rights and freedom of action.

Form 3 best interests assessment consists of 4 key questions:

(1) Is P a detained resident (ie deprived of liberty)?

- Has the assessor established whether the 3 components of a deprivation of liberty are satisfied:
  - (i). Objective element: confined to a particular restricted place for a not negligible length of time? The acid test or essential ingredients for this is whether P is (a) under continuous (or complete) supervision and control, and (b) not free to leave (in the sense of removing themselves permanently in order to live where and with whom s/he chooses). Has the assessor clearly set out the ways in which the care arrangements are affecting P's liberty? Eg:
    - Number of hours of supervision;
    - Type of control exercised by staff;
    - Descriptions of all personal care and how this is provided;
    - A description of choices which the person is able to exercise;
    - The environment around the person and in which they receive care;
    - Medication and in particular any sedative or antipsychotic medication: describe the type being administered, dosage, regularity (PRN?), and the method of administration; does it affect mood, alertness, behaviour?
    - Use of behaviour methods, charts and monitoring;
    - Situations when physical restraint is used; the type of restraint the frequency and duration;
    - Whether staff ratios vary by day and night;
    - Any limits on movement or contacts;
    - Particular risk management plans.
  - (ii). Subjective element: not validly consented to the confinement? If a person lacks the relevant capacity they cannot validly consent.
  - (iii). State is responsible: is the local or health authority in some way involved (either directly or indirectly)?

(2) Is the deprivation necessary to prevent P suffering harm?

Has the assessor:

- Included particulars of the harm (both physical and psychological) that will be avoided by depriving the person of their liberty? It is useful to consider matters such as the type,

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likelihood, severity, and frequency of harm the person would otherwise suffer were it not for the measures which cumulatively amount to a deprivation of liberty.

- Evidenced whether an alternative less restrictive regime would prevent the harm and whether this is available/been trialled?
- Evidence is crucial – eg if falls risk, what evidence is there to support that risk assertion?

(3) Is the deprivation a proportionate response to (a) the likelihood of harm occurring and (b) the serious of that harm?

Has the assessor:

- Included whether the risk of harm (both physical and psychological), its likelihood and seriousness justifies the deprivation of liberty?
- Evidenced whether the risks justify the intensity of the care arrangements?
- Evidenced whether less restrictive alternatives are available to respond to the risk of harm?
- Considered what else has been explored and why have other options been discounted?

(4) Is it in P's best interests?

Has the assessor:

- Documented what they have seen and to whom they have spoken (and, crucially, what was said!)?
- Recorded P's past and present wishes, feelings, values, beliefs?
- Evidenced how they have engaged P and improved their ability to participate in the assessment?
- Evidenced how they have engaged consultees, their views, and what they know about P?
- Demonstrated an application of the Code and the best interests checklist?
- Been clear about the concrete available options (eg between living in a care home and living at home with a realistic package of care)?
- Evidenced their balance sheet of those options (with indication of the factors' weight and likelihood)?

Length

When setting the best interests maximum length of authorisation, the assessor should explain why their rationale and what, if anything, needs to be achieved within that time frame. In determining the duration, take into account any prior period of unlawful detention. If putting forward conditions, remember to allow time for those conditions to be met.

Conditions

If possible, require evidence to be provided of adherence with the conditions. Assessors will tick the box if their non-inclusion (or non-compliance) may affect their conclusions. Any conditions should be negotiated with and achievable by the managing authority as they "must" comply with them and have no defence to liability for breaching them. The supervisory body owes a legal duty to monitor condition compliance: *Re W* (2016).

Recommendations

Use this section to highlight other care management issues. Things which need to be done or observations which may impact on the care planning process. This may include consideration of options which appear to be available to the person.

6.6 ELIGIBILITY ASSESSMENT

Form 4 + DOLS COP paras 4.40-4.57

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In essence, P is eligible for DOLS unless:

- He subject to and detained under MHA ss 2, 4, 3, 35, 36, 37, 38, 44, 45A, 47, 48, or 51 (*Case A*); OR
- He is subject to s.17 leave or conditional discharge (*Case B*), or CTO (*Case C*), or guardianship (*Case D*), **and** DOLS detention would be **incompatible** with a MHA requirement; OR
- He could be detained under MHA ss2 or 3 and is an "objecting" "mental health patient" (*Case E*).

Has the assessor:

- Been clear about the purpose of the deprivation of liberty? Note that P can be subject to DOLS in a care home for either psychiatric or physical treatment, even if they object.
- Appreciated (particularly for case E) that "medical treatment" has a very broad definition (including nursing and care)?
- If it is a hospital setting, identified the separate packages of physical and psychiatric treatment, noting the overlapping treatment, and answered the "but for" question? Have they considered whether DOLS or the MHA is the least restrictive way of best achieving the proposed care and treatment?
- Documented P's objections, noting that P objects if you think s/he would if able to. What are the objections to?
- Written a report to accompany the DoLS form? Not mandatory but helpful, given the inadequacy of the forms.

7. THE BALANCE SHEET APPROACH

We encourage all BIAs to insert a balance sheet in their Form 3. Where there are two available options, the basic structure would be:

BENEFITS OF A		**BENEFITS OF B**
PLUS BURDENS OF B		**PLUS BURDENS OF A**

Whichever side of the balance is in significant credit is best. Note, however, that you are not looking at which list has the most factors. Each factor will have a different weight.

Example 1

This case involved a 80 year old female with a diagnosis of dementia, physically well, very active and mobile but without mental capacity to make care, treatment, risk or financial decisions or to litigate. She was constantly asking to go home and had tried to leave respite care. The balance sheet approach was used in this complex case with the following outcomes:

BENEFITS OF OWN HOME (A)	**BENEFITS OF CARE HOME (B)**
1. Continues to remain in a familiar place. 2. *She does not feel unsafe.* 3. She wants to be independent. 4. She wonders why she is in a hotel and not	1. Regular meals/hydration. 2. Prompting with medication. 3. Prompting with personal care/hygiene. 4. Pressure/skin area support/treatment.

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at home. 5. More family contact and maintaining community contacts. 6. Increased care package. **7. <u>This is where she is happiest.</u>**	5. Physical safety improved. 6. Staff available 24/7 to deal with crisis. 7. Ongoing reassurance for her anxieties. 8. Improved dignity. 9. Release strain on family members. 10. Anti-depressants and anti-psychotics can be administered. 11. <u>She enjoys the company of others.</u> 12. TLC and treatment may slow her decline. 13. Less need for her to contact emergency services. 14. Reduced possibility of exploitation/cold callers.
<u>PLUS BURDENS OF CARE HOME (B)</u>	**<u>PLUS BURDENS OF OWN HOME (A)</u>**
8. Likely to be affected by not being in own home. **9. <u>Loss of independence.</u>** 10. Inevitable short term anger/distress. 11. Stronger possibility of depression. 12. She may just give up. 13. Problems with contact and community activities.	**15. Not eating or drinking enough.** 16. Insufficient/irregular medication. *17. Deteriorating personal hygiene.* 18. Deteriorating pressures areas. 19. Risks of wandering/falls. *20. Increased psychological distress.* 21. Community/family support has failed.

<u>Example 2</u>
22-year-old woman with a mild learning disability used to live with family but is currently in a respite residential placement. Lacked capacity to decide whether to remain or to return to the family home. Best interests as to residence?

<u>BENEFITS OF PLACEMENT</u>	**<u>BENEFITS OF RETURNING TO MUM</u>**
• P has been there since 7 March 2011 and has a degree of security of tenure. • **<u>Reflects P's consistently expressed wish to stay at the placement and to not move.</u>** • P's social need is for a sense of permanence in relation to (a) her accommodation, (b) access to the local community, and (c) stability in her life. • Prior to April 2012, there was progress and positive change as expressed verbally and non-verbally by P, eg reduction in challenging behaviour.	• P has experienced commitment from her family but there has been inconsistency and ambiguity in the way relationships have developed**.** • Easier contact with her siblings, although according to MUM they do not want contact with P**.** • MUM supports a return home. • Re-establishment of familiar bonds. • May reduce P's potential sense of guilt and responsibility for the separation from the family unit. • May enhance P's social network with

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• Structured plan of activities and social interaction satisfy her social care need for a sense of purpose and involvement, enabling her to develop social skills and possibly enhance her independence; eg now uses public transport to attend day services. • **She has developed positive relationships, some emotional security and further improved her practical daily living skills.** • She is encouraged to eat more healthily, with 7lb weight loss to 16 stone in August 2011. P seems to recognise that confectionary is not needed in quantity. • Although the nature of her learning disability will dictate the speed and direction of the developmental process, she is likely to continue to develop positively. Social and emotional development may be nurtured with consistent and long term support. • P has access to a full range of community activities.	family and friends, although MUM's address is unknown. P is particularly fond of X's son, Ben.
PLUS BURDENS OF RETURNING TO MUM	**PLUS BURDENS OF PLACEMENT**
• Has been living away from MUM since December 2010. • **MUM struggles to understand the impact of P's difficulties on her ability to process information and make decisions and the kind of support she will need**. • **Risks of undermining progress made.** • Risk of social and emotional isolation (eg resulting from inadequate finances being provided by MUM). • Increased vulnerability. • **Risk of disengagement (eg previous respite refusal by MUM).** • Potential inconsistent support and implementation. • **P may lose the present consistency and predictability she has to understand social situations and relationships which is likely to cause confusion, agitation and emotional vulnerability.** • Risk of potential emotional and	• There is a lack of flexibility for P to exercise choice in the evenings due to low staffing ratio: there is only one member of staff available to support the three residents during the evening on Mondays, Wednesdays and Fridays. • MUM is worried that P will lose relationships with her parents and siblings**.** • It prevents, what MUM considers to be, "normal family life"**.** • The other two residents in the placement are considerably older than P and are not present at weekends. • MUM believes P should be with people of her own age**.** • *MUM believes the placement is near a main road and fears that P will run out and be injured.* In fact it is in a quiet cul-de-sac, about 2-3 minutes walk to the main road. • *MUM is concerned that the Council as appointee is not purchasing clothes and toiletries appropriately for P.* In fact, P has been buying new clothes for her holiday.

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psychological harm**.** • *Risk of further moves.* • Concerns about MUM's ability and willingness to appropriately communicate and co-operate with professionals.	

Example 3

BENEFITS OF CARE HOME (A)	**BENEFITS OF RETURNING HOME (B)**
1. Staff are able to facilitate regular contact with her son. 2. Encouraged to engage in leisure and social activities routinely with support. 3. Is able to attend local church, go shopping and see friends. 4. **Familiar environment where she has mostly resided for more than 1 year.** 5. **Mental health and associated symptoms can be effectively monitored and deterioration minimised.** 6. Accurate standardised and functional assessments can be offered and more effectively completed. 7. Readily available support to maintain self care and activities of daily living. P will accept help with self care in the nursing home, and in fact will demand it, whereas will refuse it at home. 8. Nursing home staff are able to manage her emotional responses to promote positive mental health and well being. 9. **Staff are able to manage her diet, fluid intake and prescribed medication in respect of her physical ill health.** 10. Encouraged to use walking frame to maintain mobility and to minimise risk of falls. 11. Minimises risk of financial exploitation. 12. Friend now believes that she requires 24 hour support.	1. **Recognises her Article 8 right to respect for her home, private and family life.** 2. **This is where she feels most content and where she probably feels as though she belongs.** 3. During trial was observed as being able to use her mobility scooter safely. 4. She believes that she can cope at home. 5. Accepted breakfast being prepared by care team during trial. Friend indicates that she will eat if not eating alone. 6. Able to use local shops independently during trial to purchase fast food. Was supported by shop staff to put her purse away safely and to carry items to her scooter. 7. Was mostly able to manage her medication during trial. 8. During trial was able to wash her own clothes and attend to self-care, although care staff observed that personal care was not attended to.
PLUS Burdens of returning home (B)	**PLUS Burdens of care home (A)**

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13. Does not realise the risks to health and safety. 14. **History of refusing to engage with assessments and community care services** (eg declined occupational therapy assessment during trial). 15. **History of neglecting her diet** (eg did not engage in meal preparation during trial. 16. History of overusing telephone). 17. Gets anxious in the community. 18. Likely to misuse her medication with consequent risks such as aggressive outbursts. 19. Was aggressive with friend during trial when she tried to assist with medication monitoring. 20. **Has previously been aggressive to care staff who have been unable to support her**. 21. GP has also previously voiced concerns over P returning home, believing she should be in 24 hour care due to vulnerability and care needs. 22. Previously refusing medication and over-using A&E and GP, calling for ambulances inappropriately.	9. **Reflects her clearly and consistently expressed wish is to return home.** 10. **Has previously indicated her dislike with the nursing home and that she felt like a prisoner.** 11. **Emotional and psychological distress caused by having her requests to return home overruled by her guardian.** 12. Proportionate restrictions are placed on her liberty in her best interests. 13. Risk of losing her home. 14. Not able to access the community without support. 15. Risk of losing her independence. 16. Risk of becoming deskilled. 17. Has on occasion been aggressive to other residents and staff.

8. EXAMPLES OF BEST PRACTICE

The following are drawn from sources such as SCIE's *DOLS: Putting them into practice* (2013) and the CQC reports on DOLS:

- Pro-active involvement by the assessors of relatives in the assessment of the person's application, and in deciding what is in the person's best interests.
- Regular meetings between local authorities (commissioners and professionals) and IMCAs to explore any practice issues.
- For supervisory bodies to carry out a review, particularly for longer periods of authorisation, if they think it might be necessary and to be assured that it is easy for the detained resident (or their representative) to request a review whenever they want one.
- A quality assurance team developed standards to assess whether the MCA principles are embedded in care planning.
- Having agreements with neighbouring local authorities to use BIAs from elsewhere, for example, if the person was in a local authority managed home, such arrangement would be essential as a BIA employed by the local authority is forbidden to carry out assessments if that local authority is also the service provider.
- Having agreements with neighbouring local authorities so they can call on BIAs from elsewhere if there is an unexpected surge of requests accompanied by urgent authorisations
- Quarterly reports to MCA/Deprivation of Liberty Safeguards committees or multi-agency local networks, to oversee and analyse activity, numbers and deadlines.

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- Applying lessons learned from the Steven Neary case – making sure the authoriser is not a commissioner responsible for the service where the person is living.
- Making sure the authoriser is not also responsible for agreeing funding for the person.

Support for managing authorities:
- MCA helplines and clear web-based information.
- Regular e-bulletins.
- Provider forums where the MCA and the Deprivation of Liberty Safeguards are regularly discussed.
- Focused training on care homes and hospitals where monitoring data shows low activity.
- Commissioning contracts which include knowledge requirements around the MCA and the Deprivation of Liberty Safeguards.
- Audits to check hospital staff knowledge of the MCA, including the Deprivation of Liberty Safeguards, with follow up workplace-based information provided.
- 'Train the trainer' programmes for hospital and care home staff so MCA and Deprivation of Liberty Safeguards training can be run in-house.
- Placing the Deprivation of Liberty Safeguards clearly in terms of a personalisation and human rights context when training, to enable them to be viewed more positively.
- Ensure that the managing authority understands its responsibility to notify the CQC of the authorisation request and outcome, and that they know how to do this.

Examples of proactive practice:
- Rather than wait for the managing authority to request a further authorisation, many supervisory bodies notify them formally a month before the expiry of a current authorisation (or in good time if the authorisation is shorter than this), and discuss with them whether they think another authorisation is needed or whether the circumstances of the person have changed, so that they are no longer being deprived of their liberty (in which case they must be advised to request a review).
- Some supervisory bodies provide ongoing briefing sessions for local managing authority staff (hospitals as well as care homes).
- Some supervisory bodies target 'likely candidates' (such as homes specialising in dementia or where residents have learning disabilities and challenging behaviour) where the Safeguards are not being invoked and visit them to explain how and when they should consider their use.

9. DEPARTMENT OF HEALTH CONCERNS

9.1 THE CHOICE OF THE RELEVANT PERSON'S REPRESENTATIVE (RPR)

Some family members have not been selected to be the RPR where they have not been supportive of the deprivation of liberty. But DoLS CoP paragraph 7.17 states: "It should not be assumed that the representative needs to be someone who supports the deprivation of liberty."

9.2 WHERE A DOL IS NOT AUTHORISED

All managing authorities and supervisory bodies should have a mechanism that permits the swiftest possible response to these circumstances.

9.3 SETTING CONDITIONS AND EFFECTIVE CARE PLANNING

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Best interests assessors need to recommend and supervisory bodies to set conditions that reflect the advice in paragraphs 4.74-4.75.

9.4 NO CONTACT ISSUES

The Court should be the arbiter for matters of no contact and a DoLS authorisation other than as a very short-term measure, should not be relied upon to manage no contact cases.

9.5 WHERE AN AUTHORISATION FAILS TO RESOLVE A DISPUTE

Where an authorisation and/or any of its conditions fails to stop the continuing or new opposition of a family member, then the dispute will require the last resort determination of the Court of Protection.

10. USEFUL HYPERLINKS

Case law:
www.39essex.com/resources-and-training/mental-capacity-law/
www.scie.org.uk/mca-directory/index.asp
www.mentalhealthlaw.co.uk
www.mclap.org.uk

COP applications:
https://www.gov.uk/apply-to-the-court-of-protection
http://courtofprotectionhandbook.com

MCA Code:
https://www.justice.gov.uk/downloads/protecting-the-vulnerable/mca/mca-code-practice-0509.pdf

DOLS Code:
http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087309.pdf

Supervisory body forms and guidance:
http://www.adass.org.uk/deprivation-of-liberty-safeguards-guidance/
https://www.lawsociety.org.uk/support-services/advice/articles/deprivation-of-liberty/

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