THE MENTAL CAPACITY ACT 2005

DEPRIVATION OF LIBERTY SAFEGUARDS

DRAFT ADDENDUM TO THE MENTAL CAPACITY ACT 2005 CODE OF PRACTICE

Introduction

The Mental Capacity Act 2005, covering England and Wales, provides a statutory framework for people who lack capacity to make decisions for themselves.

When someone lacks capacity to make decisions or take actions for themselves, others may have to make those decisions on their behalf. When they do this, they should not deprive the person who lacks capacity of their liberty, unless it is essential to do so in the person's best interests and for their own safety.

This document 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. The document also provides guidance on what to do if someone suspects that a person who lacks capacity is being deprived of their liberty unlawfully.

How does this addendum 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, which was issued in April 2007. It is an addendum to, and should be used in conjunction with, the main Code. It focuses particularly on the deprivation of liberty safeguards added to the Mental Capacity Act 2005 (the Act).

Though these safeguards were mentioned in the main Code (particularly in chapter 6 and chapter 13), they were not covered in any detail. That was because, at the time the 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.

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[1] The Mental Health Bill was used as a vehicle to amend the Mental Capacity Act 2005 to introduce the deprivation of liberty safeguards.

References in this addendum

In this addendum, the Mental Capacity Act 2005 is sometimes referred to as 'the Act' and any sections quoted refer to this Act unless otherwise stated. References are shown as follows: section 4(1). This refers to the section of the Act. The subsection number is in brackets.

Where reference is made to provisions from other legislation, the full title of the relevant Act will be set out, for example 'the Mental Health Act 1983', unless otherwise stated.

Any reference to the 'main Code' refers to the main Mental Capacity Act 2005 Code of Practice.

How should this addendum be used?

This addendum provides guidance to anyone who is working with and/or caring for adults who may lack capacity to make particular decisions, and is in a situation where the possibility that there may be deprivation of liberty arises. It describes the responsibilities of these workers or carers when acting or making decisions on behalf of individuals who lack the capacity to act or make these decisions for themselves, specifically:

- how to avoid deprivation of liberty
- how to identify deprivation of liberty, and
- what to do when a person may need to be deprived of liberty.

In particular, this addendum focuses on those who have a **duty of care** to someone who lacks the capacity to consent to the care that is being provided, where that care may include the need to deprive the person of their liberty.

This addendum is also intended to provide information for people who are, or could potentially become, subject to the deprivation of liberty safeguards, and for their families, friends and carers, as well as to anyone who believes that someone is being deprived of their liberty unlawfully.

What does 'lacks capacity' mean?

One of the most important terms in the main Code and this addendum is 'a person who lacks capacity'. In this addendum, as throughout the main Code, a person's capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made.

What is the legal status of this addendum?

As with the main Code, this addendum is published by the Lord Chancellor under section 42 of the Mental Capacity Act 2005. It covers both England and Wales.

It is intended for the guidance of persons exercising functions in relation to the deprivation of liberty safeguards contained in Schedule A1 to the Act, and for people who are appointed as relevant person's representatives under that Schedule.

The statutory requirements surrounding the deprivation of liberty safeguards to which this addendum relates are contained in the Mental Capacity Act 2005. They must be complied with in order to give deprivation of liberty under the Mental Capacity Act 2005 a lawful basis.

The Act does not impose a legal duty on anyone to 'comply' with the Code of Practice – it should be viewed as guidance rather than instruction. But if they have not followed relevant guidance contained in the Code then they will be expected to give good reasons why they have departed from it.

Who is this addendum for?

Certain categories of people are legally required to 'have regard to' relevant guidance in the Code of Practice. That means they must be aware of the Code of Practice and in most circumstances follow it when acting or making decisions on behalf of someone who lacks capacity to make a decision for themselves. They should also be able to explain how their actions or decisions follow the Code. They are required to have regard to this addendum to the Code in the same way.

The categories of people that are required to have regard to the Code of Practice include anyone who is:

- an attorney under a Lasting Power of Attorney (LPA)
- a deputy appointed by the Court of Protection
- acting as an Independent Mental Capacity Advocate (IMCA)
- carrying out research approved in accordance with the Act
- acting in a professional capacity for, or in relation to, a person who lacks capacity, or
- being paid for acts for, or in relation to, a person who lacks capacity.

The last two categories cover a wide range of people. People acting in a professional capacity may include:

- a variety of healthcare staff (doctors, dentists, nurses, therapists, radiologists, paramedics etc)

- social care staff (social workers, care managers, etc), and
- others who may occasionally be involved in the care of people who lack capacity to make the decision in question, such as ambulance crew, housing workers, or police officers.

People who are being paid for acts for or in relation to a person who lacks capacity may include:

- care assistants in a care home
- care workers providing domiciliary care services, and
- others who have been contracted to provide a service to people who lack capacity to consent to that service.

Scenarios used in this addendum

This document includes boxes within the text in which there are scenarios, using imaginary characters and situations. These are intended to help illustrate what is meant in the main text. The scenarios 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 addendum is also available in Welsh and can be made available in other formats on request.

Contents

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

On 5 October 2004, the European Court of Human Rights (ECtHR) announced its judgment in the case of *HL v the United Kingdom* (commonly referred to as the 'Bournewood' judgment). HL is a profoundly autistic man with a learning disability, who lacked the capacity to consent to, or to refuse, admission to hospital for treatment. The ECtHR held that he was **deprived of his liberty** when he was admitted, informally, to Bournewood Hospital. The ECtHR further held that:

- the manner in which HL was deprived of liberty was not in accordance with 'a procedure prescribed by law' and was, therefore, in breach of Article 5(1) of the European Convention on Human Rights (ECHR), and
- there had been a contravention of Article 5(4) of the ECHR because HL was not able to apply to a court quickly 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 additional safeguards for people who lack mental capacity and whose care or treatment necessarily involves a deprivation of liberty within the meaning of Article 5 of the ECHR, but who either are not, or cannot be, detained under the Mental Health Act 1983. These safeguards are referred to in this addendum as '**deprivation of liberty safeguards**'.

What are the deprivation of liberty safeguards?

1.1 In summary, the deprivation of liberty safeguards mean that a hospital or care home (a 'managing authority') must seek authorisation from a 'supervisory body' in order to be able to deprive someone who has a mental disorder,[2] and who lacks capacity to consent, of their liberty, within the meaning of Article 5 of the ECHR. The 'supervisory body' could be a Primary Care Trust (PCT), local authority, the National Assembly for Wales or a Local Health Board (LHB).

See chapter 2 of this document for further explanation of what is meant by deprivation of liberty.

[2] As defined in section 1 of the Mental Health Act 1983, a mental disorder is a disorder or disability of the mind.

1.2 The safeguards also cover:

- how an application for authorisation should be assessed
- the criteria determining when an authorisation should be granted
- how any authorisation to deprive someone of their liberty must be reviewed
- under what circumstances an authorisation can be renewed
- what support and representation must be provided for people who are subject to an authorisation, and
- how people can challenge authorisations.

1.3 The Government's aim in providing these additional safeguards is to bring UK law into compliance with the ECHR and to focus additional scrutiny on the care arrangements for those who may be deprived of their liberty, with the aim of avoiding it whenever possible.

1.4 The deprivation of liberty safeguards apply specifically to deprivation of liberty within the meaning of Article 5 of the ECHR. Chapter 2 of this addendum provides guidance on what factors need to be considered to help decide what constitutes deprivation of liberty for these purposes.

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

1.5 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 unless it is established that he lacks capacity.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes 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 his 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 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.

1.6 It is important that the Mental Capacity Act 2005 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. This means that decisions taken and actions done 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. An authorisation only relates to deprivation of liberty and does not, for example, give authority for any course of treatment.

When can someone be deprived of their liberty?

1.7 Depriving someone who lacks capacity to make decisions 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, and
- when there is no less restrictive alternative.

This means that deprivation of liberty must not be used as a form of punishment.

1.8 The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty is unavoidable in a person's own best interests. Every effort should be made, both in commissioning and providing care, to prevent deprivation of liberty becoming unavoidable.

1.9 If deprivation of liberty cannot be avoided, it should be for the shortest period necessary.

1.10 A decision as to whether or not deprivation of liberty arises will depend on all the circumstances of the case.

1.11 It is not necessary or appropriate to apply for a deprivation of liberty authorisation for everyone who is in hospital or a registered care home[3] simply because the person concerned lacks capacity to decide whether they should be there. In deciding whether or not application is necessary, managing authorities should carefully consider whether any restrictions that are, or will be, needed to provide ongoing care amount to a deprivation of liberty when looked at together. If the person is at risk of deprivation of liberty, the managing authority needs to consider whether the criteria for authorisation are met and, if so, apply for an authorisation.

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

Who is covered by these safeguards?

1.12 The safeguards apply to people who are, or are likely to be, deprived of their liberty so that they can be given care or treatment in hospitals or care homes. These are people who lack capacity to consent to the arrangements made for their care and treatment, but for whom receiving care or treatment in circumstances that amount to a deprivation of liberty is necessary to protect them from harm and is in their best interests. Such people are largely those with significant learning disabilities, or older people suffering from dementia or some similar disability, but will also include other causes such as neurological conditions (for example, if someone has a brain injury).

1.13 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 may be cared for in circumstances that amount to a deprivation of liberty.

1.14 The safeguards will not apply to those people who are made subject to the provisions of the Mental Health Act 1983. Separate safeguards are provided to protect anyone detained under that Act. Chapter 13 of the main Code contains guidance on the relationship between the Mental Capacity Act 2005 and the Mental Health Act 1983. The safeguards might apply to a person who had previously been detained for treatment under the Mental Health Act 1983 (in which case, any entitlement to aftercare, under section 117 of the Mental Health Act 1983, would not be affected).

1.15 The safeguards relate only to people aged 18 and over who meet the criteria for authorisation. If the issue of depriving a person under the age of 18 of their liberty arises, other safeguards must be considered. In these circumstances, the existing powers of the court, particularly those under section 25 of the Children Act 1989, provide safeguards which meet the requirements of Article 5 of the ECHR. Use of the Mental Health Act 1983 may also be considered if the relevant criteria are met. Applying the deprivation of liberty safeguards from the Mental Capacity Act 2005 to people under the age of 18 is not therefore necessary.

1.16 The safeguards apply across England and Wales. Where people come from other countries into England or Wales, the safeguards will apply to them if they meet the relevant criteria while in England or Wales.

How do cultural issues impact on the safeguards?

1.17 The deprivation of liberty safeguards should not impact in any different way on different racial or ethnic groups. 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 respect and of the need to ensure that the safeguards are operated fairly and equitably.

1.18 When carrying out deprivation of liberty assessments, assessors must take account of cultural issues. Therefore they will need to have an understanding of how to take account of the cultural background of the relevant person. Supervisory bodies will need to bear this in mind when appointing a suitable assessor.

1.19 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. Information should be made available in other languages where relevant.

1.20 Any decision about the instruction of Independent Mental Capacity Advocates (IMCAs) or relevant person's representatives in accordance with the deprivation of liberty safeguards should take account of the cultural, racial and ethnic background of the relevant person.

Where do the safeguards apply?

1.21 Although the Bournewood 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 in other settings.

1.22 The safeguards to which this Code relates will apply wherever a process of assessment has identified a need for a person who lacks capacity to be cared for in hospital or care home regimes that deprive them of their liberty within the meaning of Article 5 of the ECHR.

1.23 These deprivation of liberty safeguards should cover the vast majority of people who are affected by the Bournewood judgment. Under the Mental Capacity Act 2005, an authorisation to deprive a person who lacks capacity of their liberty can only be granted to a hospital or registered care home. It will only be lawful to deprive somebody of their liberty elsewhere (for example, in a person's own home, in supported living arrangements other than in registered care homes or

in a day centre) when following an order of the Court of Protection on a welfare question.

How do the safeguards apply to private care placements?

1.24 Under the Human Rights Act 1998, the duty to act in accordance with the ECHR applies only to public authorities. However, all states are obliged to make sure that the rights set out in the ECHR apply to all of their citizens. The deprivation of liberty safeguards therefore apply to both publicly and privately arranged placements and so deprivation of liberty in any hospital or registered care home, as a result of either a public or a private arrangement, will not be lawful unless covered by an authorisation. However, if the deprivation of liberty results from an order of the Court of Protection on a personal welfare matter, separate authorisation is not needed.

2. What is deprivation of liberty?

The meaning of deprivation of liberty is a question for the courts and this document provides a summary of case law to date.

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 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.'**

In establishing whether deprivation of liberty arises, it is necessary to consider all the circumstances of each case. It is not possible to say that any single factor alone would always or could never amount to a deprivation of liberty. Therefore no simple definition can be produced that would apply in every case.

This guidance seeks to summarise the factors identified as relevant by the ECtHR in cases to date. Staff using this guidance will need to take account of these factors in assessing whether a person in their care may be deprived of liberty.

While it is important to ensure that deprivation of liberty within the meaning of Article 5 of the ECHR is identified, and the safeguards applied where appropriate, it is also important to bear in mind that deprivation of liberty does not arise simply because the person concerned lacks capacity to take decisions about their care. Section 6 of the Act provides authority for using restraint, where necessary, in order to provide care for a person who lacks capacity to consent. Careful consideration needs to be given to whether restrictions placed on a person go beyond restraint and actually deprive them of liberty and, if so, whether those restrictions are genuinely necessary.

How can deprivation of liberty be identified?

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

> **'the key factor in the present case [is] that the healthcare professionals treating and managing the applicant exercised complete and effective control over his care and movements'**
>
> and that
>
> **'the applicant was under continuous supervision and control and was not free to leave'.**

2.2 In judgments on *HL v the United Kingdom* and other cases, the ECtHR has identified the following factors as contributing to deprivation of liberty:

- Restraint was used, including sedation, to admit a person who was resisting.
- Staff exercised complete and effective control over care and movement for a significant period.
- Staff exercised control over assessments, treatment, contacts and residence.
- A decision has been taken that the person would be prevented from leaving if they made a meaningful attempt to do so.
- A request by carers for the person to be discharged to their care was refused.
- The person was unable to maintain social contacts because of restrictions placed on access to other people.
- The person lost autonomy because they were under continuous supervision and control.

2.3 Deprivation of liberty in ECHR terms may only result from restrictions placed on a person by actions or omissions of the staff providing care and treatment. The physical or psychological effects of illness or disability alone would not in themselves mean that a person is being deprived of their liberty.

2.4 The ECtHR has also indicated that duration of any restrictions is a relevant factor when considering whether or not a person is deprived of their liberty.

2.5 The fact that restrictions may be justified because they are necessary for the person's safety does not prevent them from leading to a deprivation of liberty in ECHR terms.

2.6 The fact that a person who lacks capacity is living in a hospital or care home does not necessarily mean that the person is deprived of liberty, even if the unit is locked or staff would not allow the person to leave unescorted for their own protection. For example, if someone was only able to leave when accompanied

by a friend, family member or carer, or was not allowed to leave in the middle of the night, or there is a lock or electronic keypad on the door, this alone would not necessarily amount to deprivation of liberty.

2.7 When assessing whether a person is, or may be, deprived of their liberty, it is necessary to consider the combined impact of **all** restrictions placed upon them.

2.8 Based on existing case law, the following factors may be considered by the courts to be relevant when considering whether or not deprivation of liberty is occurring:

- The person is not allowed to leave the facility.
- The person has no, or very limited, choice about their life within the care home or hospital.
- The person is prevented from maintaining contact with the world outside the care home or hospital.

The following paragraphs give examples to illustrate each of these factors.

The person is not allowed to leave the facility

2.9 If a person is, or would be, prevented from leaving the facility at all, whether by distraction, locked doors or restraint, or because they are led to believe that they would be prevented from leaving if they tried, that would be a relevant factor in considering whether or not there is deprivation of liberty.

2.10 A person is not deprived of their liberty simply because they lack the physical ability to leave, or the mental capacity to form a genuine intention to leave. But someone who lacks either physical ability or mental capacity in these terms and whose behaviour does not indicate a wish to leave could still be deprived of their liberty if:

- family, friends or carers, who might reasonably expect to take decisions under the Mental Capacity Act 2005 in relation to the person, are prevented from moving them to another care setting or from taking them out at all
- taking account of the limitations of their condition, the person in care is not given reasonable opportunity to go outside of the home or hospital (escorted or otherwise) even though it would be possible for them to do so and it seems likely that they would enjoy it, it would reduce their distress or anxiety, or it would be beneficial in some other way, or
- a decision has already been taken to prevent the person from leaving.

2.11 In the case of *DE and JE v Surrey County Council (SCC)*, DE was found to be deprived of his liberty on the facts of the case. These are summarised below.

JE wished to have her husband DE discharged from the care home to live with and be cared for by her, while DE continually requested to be permitted to return to live with his wife.

SCC decided that this should not happen in any circumstances and took steps to prevent it, primarily by leading JE and DE to believe that JE would be stopped from taking her husband home, and DE would be stopped from leaving the home if he tried to do so.

The court found that SCC was exercising complete and effective control over where DE could live, whether he could leave the home permanently, and whether he could be with JE.

In those circumstances, the court found that DE was being deprived of his liberty.

In this case, the care regime at the home was not restrictive in other respects.

The person has no, or very limited, choice about their life within the care home or hospital

2.12 Deprivation of liberty can arise when a person is not allowed to make any choices at all about issues such as:

- where they can be within the care home or hospital
- what they can do
- who they can associate with, or
- when and what they can eat.

This could equally apply if choices were available but the care given to the person did not enable them to make any choices.

2.13 If a person is not allowed any freedom of movement within the care home or hospital, for example if they are not allowed to leave their room for long periods of time, they are probably deprived of their liberty. Similarly, controlling a person's behaviour and movement through regular use of medication or seating from which a person cannot get up may constitute deprivation of liberty.

2.14 Restrictions that are unavoidable in a group living situation, and which apply to all residents, would be unlikely in themselves to constitute a deprivation of liberty but this would depend on the context and the extent of other restrictions imposed on the person concerned.

The person is prevented from maintaining contact with the world outside the care home or hospital

2.15 Deprivation of liberty may occur if restrictions are placed on who the person in the care home may contact, who may visit them or when they can use the telephone. This does not in general apply to proportionate restrictions for the benefit of the running of the unit and the other patients/residents, such as general restrictions on early morning or late evening visits, or on numbers of visitors at any one time.

2.16 However, if the effect of these restrictions would be to cut the particular individual off from people with whom they would otherwise keep in contact, this may be deemed to be a deprivation of liberty. For example, if someone's family or friends are realistically only ever able to visit late in the evening, then restrictions on visiting times could cut them off from their family and so lead to a decision that they are being deprived of their liberty.

Restraint

2.17 Restraint may lawfully be used on admission or to administer treatment or care under section 6 of the Act. If this is necessary, it should be seen as an indicator that a person's wishes **may** be being over-ridden. Therefore in these circumstances the managing authority should consider whether or not the person is being deprived of their liberty (in which case they are doing more than restraining the person and authorisation is needed).

2.18 In the case of a person in hospital for mental health treatment, the need for restraint is likely to indicate that they are objecting to treatment or to being in hospital. A person who objects to mental health treatment is ineligible for an authorisation under the deprivation of liberty safeguards. If it is necessary to detain them, use of the Mental Health Act 1983 should be considered.

What should be done to avoid unlawful deprivation of liberty?

2.19 Anyone involved in the provision of residential accommodation that might be affected by the deprivation of liberty safeguards should, to the greatest possible extent that safety considerations will allow, seek to operate care regimes that promote a person's control over their daily living and maximise their autonomy. This will both reduce the likelihood of deprivation of liberty arising and enhance the person's quality of life.

2.20 The principles of person-centred planning – finding ways of listening to people to find out what is most important to them and what they want from their lives, and helping them to get those things – should be applied to all people who lack mental capacity, whether or not a deprivation of liberty authorisation is being applied for.

2.21 The involvement of family, friends and carers is valuable at every stage of decision-making. Section 4(7)(b) of the Act requires that when trying to work out what is in the best interests of a person who lacks capacity, the views of anyone engaged in caring for that person or interested in their welfare must be taken into account.

2.22 Hospitals, care homes and authorities commissioning care need to ensure that they have systems in place so that, when they make arrangements to provide care to a person who lacks capacity to consent to those arrangements, they:

- consider whether or not the person is being deprived of their liberty within the meaning of Article 5 of the ECHR, taking account of the guidance in paragraphs 2.1 to 2.18 above, and
- ensure that authorisation for deprivation of liberty is obtained when needed.

2.23 The question of whether the person is deprived of their liberty will need to be kept under review and addressed explicitly whenever a change is made to the care plan. Details of each review should be recorded in the person's health and care records.

2.24 If it is identified that a person is being deprived of their liberty (or is at risk of it), consideration should be given as to whether the person could be cared for safely with fewer restrictions on them. If this is not considered feasible, then an authorisation must be sought **in advance of the restrictions being introduced**, except in an emergency when an urgent authorisation must be issued at the time the application is made (see paragraph 3.98).

Practical steps to reduce the risk of deprivation of liberty

2.25 There are lots of ways in which providers and commissioners of care can reduce the risk of deprivation of liberty, by minimising restrictions and ensuring that decisions are taken involving the person concerned and their family, friends and carers. The following list highlights elements of good practice that are likely to assist in this and to help avoid the risk of legal challenge.

- All decisions should be taken (and reviewed) in a structured way, and reasons for decisions should be recorded. Protocols for decision-making should include consideration of whether deprivation of liberty may arise and how it could be avoided.
- Providers should follow good practice for care planning (including the Care Programme Approach, Single Assessment Process, Person-Centred Planning, and Unified Assessment Process as relevant) for any people in their care who lack capacity. This includes documenting all elements of the plan, including the involvement of family, friends, carers (both paid and unpaid) and others interested in the welfare of a person who lacks capacity.

- There should be a proper assessment of whether the person lacks capacity to decide whether or not to accept the care proposed. In line with the principles of the Act, a person should not be assumed to lack capacity to make a decision. Instead, they should be given all practical and appropriate support to make the decision in question. Chapter 3 of the main Code provides detailed guidance on this. It is also important to identify if a person's condition has deteriorated and they no longer have capacity to make a decision for themselves.
- All decisions about whether a person should be deprived of their liberty must be made in line with the five principles of the Act and the requirements for establishing what is in someone's best interests.
- Before admitting a person to hospital or residential care in circumstances that may amount to a deprivation of liberty, consideration must always be given to identifying ways to meet the person's needs 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 in all the circumstances of the case.
- An authorisation for deprivation of liberty is not an alternative to the proper application of the rest of the Act.
- The person who lacks capacity and their family, friends and carers must have access to appropriate information about their care. This includes information about the purpose and reasons for the admission, proposals to review the care plan and the outcome of such reviews, and the way in which they can challenge decisions (for example through the relevant complaints procedure). The involvement of local advocacy services where these are available should be encouraged to support the person and their family, friends and carers.
- Proper steps should be taken to help the person to retain contact with family, friends and carers. If, exceptionally, there are good reasons why maintaining contact is **not** in the person's best interests, those reasons should be properly documented and explained to the people they affect. It should be made clear how long the restrictions will be maintained and how the decision can be challenged.
- Both the assessment of capacity and the care plan should be kept under review. It may well be helpful to include an independent element in the review. Such a second opinion will be particularly important where family, friends or carers do not agree with the authority's decisions. But even where there is no dispute, all involved must ensure that their decision-making stands up to scrutiny and complies with the principles of the Act.

3. How and when can deprivation of liberty be authorised?

There are some circumstances in which depriving someone who lacks capacity of their liberty is necessary to protect them from harm and would be in their best interests. In some cases, depriving someone of their liberty to enable treatment to take place will protect them from harm. However, it is important to note that a deprivation of liberty authorisation does not, in itself, give authority to treat someone. This is covered in paragraphs 3.82 to 3.85 of this chapter.

Deprivation of liberty can be authorised by supervisory bodies (PCTs, local authorities, the National Assembly for Wales or an LHB in Wales). To obtain authorisation to deprive someone of their liberty, managing authorities (the hospital or care home in which the person will be deprived of their liberty) have to apply for an authorisation following the processes set out in this chapter.

A standard authorisation must be obtained before the deprivation of liberty begins, except in 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.[4] In that case, the care home or hospital may issue an urgent authorisation for up to seven days (see paragraphs 3.98 to 3.116).

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

3.1 A managing authority has responsibility for applying for authorisation of deprivation of liberty.

- In the case of an NHS hospital, the managing authority is the NHS body responsible for the running of the hospital in which a person potentially coming within the scope of the deprivation of liberty safeguards is, or is to be, a resident.
- 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.

[4] 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** in relation to a matter concerning the person's personal welfare, 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 following the processes set out in this chapter.

If a healthcare or social care professional considers, for example as a result of a care review or needs assessment, that an application for authorisation should be made they should inform the managing authority. See chapter 6 for guidance on action to take if there is a concern about a possible unauthorised deprivation of liberty.

3.2 A supervisory body is responsible for considering requests, commissioning assessments and, where all the assessments agree, authorising 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 commissions the relevant care or treatment, that PCT
    - if the National Assembly for Wales or an LHB in Wales commissions the relevant care and treatment in England, the National Assembly for Wales, 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 National Assembly for Wales or an LHB **unless** a PCT commissions the relevant care and treatment in Wales, in which case the PCT will be the supervisory body.
- 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 of no fixed abode), the supervisory body is the local authority for the area in which the care home is situated.[5]

3.3 There are two types of authorisation: standard and urgent. A managing authority must request a standard authorisation when it appears likely that, either currently or at some time during the next 28 days, someone will be accommodated in their hospital or care home in circumstances that amount to a deprivation of liberty within the meaning of Article 5 of the ECHR. 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

[5] To determine place of ordinary residence, the usual mechanisms under the National Assistance Act 1948 apply. Any unresolved questions about the ordinary residence of a person will be determined by the Secretary of State or by the Welsh ministers. Prior to determination the local authority that received the application must act as the supervisory body, after determination the local authority of ordinary residence must become the supervisory body.

managing authority must itself grant an urgent authorisation and then obtain standard authorisation within seven calendar days (see paragraphs 3.98 to 3.116).

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

3.4 Managing authorities should have a procedure/protocol in place that identifies:

- what steps they should take to assess whether to seek authorisation
- what action they should take if they do need to request an authorisation
- how such matters should be kept under review, and
- who should take the necessary action.

Before applying for an authorisation, the managing authority needs to consider whether the person meets the qualifying requirements. A flowchart that could be used for this purpose is at Annex A.

What is the application process?

3.5 When a managing authority applies for a standard authorisation, it must do so in writing to the supervisory body. Regulations for England[6] require that the request from a managing authority for a standard authorisation must include:

- the person's name
- the name, address and telephone number of the care home or hospital
- details of the person's mental disorder
- the purpose of the proposed deprivation of liberty, including relevant care plans and needs assessment
- a summary of the restrictions considered to amount to deprivation of liberty (i.e. why the application is needed)
- the date from which the deprivation of liberty authorisation is sought
- whether there is anyone to consult who is not paid to provide care for the person (in order to inform the supervisory body whether an IMCA is needed), and
- whether an urgent authorisation has been issued and, if so, the date of expiry.

[6] Draft regulations for England are the Mental Capacity (Deprivation of Liberty: Eligibility, Selection of Assessors, Assessments, Requests for Standard Authorisations and Disputes about the Place of Ordinary Residence) Regulations 2008. Welsh ministers are currently considering how they will use their regulation-making powers for Wales; details will be inserted once finalised.

3.6 In addition, the regulations require that the request include the following information if it is available or could reasonably be obtained by the managing authority without delaying the application:

- the person's current address and telephone number if relevant (for example, if the person is currently residing somewhere else)
- their age, gender and ethnic group
- other health information relevant to the deprivation of liberty
- issues relevant to carrying out the assessments, for example communications and language needs
- the names, contact addresses, telephone numbers and e-mail addresses of lead professionals involved. If the deprivation of liberty involves a change of care setting, for example a move from another care home or discharge from hospital, then contact details should include those for the professional responsible for the person's care in the previous care setting
- names and contact details for family, friends and day-to-day decision-makers to contact for the best interests assessment (to the extent that this information is available)
- name and contact details of any IMCA currently instructed for the person
- name and contact details of anyone with Lasting Power of Attorney for the person
- name and contact details of any deputy appointed by the Court of Protection for the person
- whether the person has made a relevant advance decision to refuse treatment
- whether the person has previously been subject to a standard authorisation (in which case the date of expiry of the previous authorisation should be supplied)
- whether the person is currently detained or liable to detention under the Mental Health Act 1983, subject to guardianship or Supervised Community Treatment, or is conditionally discharged from detention under the Mental Health Act 1983.

A standard form will be available for this purpose.[7]

If the request relates to renewal of an authorisation, information that has not changed does not have to be resupplied.

Where should applications be sent?

3.7 If the application is being made by a care home:

[7] Titles of forms for England and Wales to be inserted in final document.

- If the care is known to be commissioned by or on behalf of a local authority, then the application should be sent to that local authority.
- If the care is not commissioned by or on behalf of a local authority, the application should be sent to the local authority where the person currently resides.
- 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 care home's local authority.

If 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 National Assembly for Wales or an LHB, the application should be sent to the National Assembly for Wales.
- 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.

An application sent to the wrong supervisory body can be passed on to the correct supervisory body without the managing authority needing to reapply. Every effort should be made to ensure that there are no delays in handling the application.

3.8 The managing authority should tell the relevant person's family, friends and carers that it has applied for an authorisation for deprivation of liberty. 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 to the best interests assessor (see paragraphs 3.43 to 3.58 about the best interests assessment process) as far as is practical and appropriate. The views of the relevant person about who to inform and consult should be taken into account.

3.9 The managing authority must notify the supervisory body if it concludes that there is nobody appropriate to consult in determining the person's best interests, except people 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 (see paragraphs 3.25 to 3.30 below).

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

3.10 Supervisory bodies should have a procedure/protocol in place that identifies what action they should take on receipt of a request for a standard

authorisation, who should take it and within what timescale. As far as practical, they should communicate to managing authorities the procedure and give them the relevant contact details for making an application.

3.11 Upon receipt of an application for authorisation of deprivation of liberty, the supervisory body should 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.

Advance applications for authorisation

3.12 A standard authorisation may come into force at a specific time after it is given, for example when authorisation is sought as part of care planning (such as discharge planning from hospital). But an authorisation cannot be given too far in advance as this might mean that an assessor cannot make an accurate assessment of what the person's circumstances will be by the time the authorisation comes into force.

3.13 There may be cases in which the supervisory body considers that an application for an authorisation has been made too far in advance. This might mean that an assessor could not make an accurate assessment of what the person's circumstances will be by the time the authorisation comes into force. In such a case, the supervisory body may agree with the managing authority that the application should be withdrawn, to be resubmitted at a more appropriate time.

Obtaining assessments

3.14 As soon as the supervisory body has confirmed that the request should be pursued, it must obtain the relevant assessments to ascertain whether the qualifying requirements of the deprivation of liberty safeguards are met. Assessments must be completed within 21 days, or seven days if an urgent authorisation has been granted. The assessments (described in paragraphs 3.31 to 3.74 below) are:

- age assessment (paragraphs 3.32 to 3.33)
- mental health assessment (paragraphs 3.34 to 3.38)
- mental capacity assessment (paragraphs 3.39 to 3.42)
- best interests assessment (paragraphs 3.43 to 3.58)
- eligibility assessment (paragraphs 3.59 to 3.70), and
- no refusals assessment (paragraphs 3.71 to 3.74).

If the supervisory body is not in the same place as the care home or hospital, they should arrange to use assessors based in the person's area.

3.15 If an 'equivalent assessment' to any of these assessments has already been obtained, it may be relied upon instead of obtaining a fresh assessment. An example could be a recent assessment carried out for the Mental Health Act 1983.

An equivalent assessment is an assessment that:

- has been carried out in the preceding 12 months, not necessarily for the purpose of a deprivation of liberty authorisation
- meets all the requirements of the deprivation of liberty assessment (it is unlikely that all the requirements could be met for a best interests assessment), and
- the supervisory body accepts and sees no reason why it should no longer be accurate.

Great care should be taken in deciding to use an equivalent assessment and this should not be done routinely. Supervisory bodies are advised to record the reasons if a decision is taken to use an equivalent assessment. Where the required assessment is an age assessment, there is no time limit on the use of an equivalent assessment.

3.16 The regulations for England 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.

3.17 However, if an urgent authorisation is already in force, the assessments must be completed before the expiry of that authorisation. Urgent authorisations may be given for an initial seven-day period, and may, in exceptional circumstances, be extended by the supervisory body for up to a further seven days.

Minimum number, independence and suitability of assessors

3.18 It is expected that it will be unusual for there to be six separate assessors and, while assessors must make their own individual decisions, there may be opportunities for them to work together in a way that minimises the burden on the person being assessed. However, in the interests of ensuring that an appropriate degree of objectivity is brought to the assessment process, and to avoid the risk that arbitrary decisions will be taken about deprivation of liberty:

- There **must** be a minimum of two assessors.
- The mental health and best interests assessors **must** be different people.

- The best interests assessor can be an employee of the supervisory body or managing authority but **must not** be involved in either the care of the person they are assessing or in decisions about their care. Nor may they be on the staff of the care home concerned where the assessment relates to a care home placement, or, in the case of a hospital placement, on the staff of the hospital concerned. Where it is unclear whether the proposed assessor is employed at the hospital concerned, for example if the person is based elsewhere but contracted for some sessions at the hospital, the supervisory body should aim to avoid any possible conflict of interests.
- A potential best interests assessor **should not** be used if they provide treatment or care to the relevant person or are in a line management relationship with the professional proposing the deprivation of liberty or the mental health assessor. (See also paragraph 3.24 below, which covers cases where the supervisory body and managing authority are the same body.)
- None of the assessors may have a personal financial interest in the care of the person they are assessing.
- The assessor **must not** be a close relative of the person being assessed or a close relative of a person with a personal financial interest in the person's care. For this purpose, a 'close relative' is:
    - a spouse, civil partner or partner, or their children
    - a parent or child
    - a brother or sister, or their children
    - a grandparent or grandchild
    - a stepfather or stepmother, or
    - a half-brother or half-sister.

3.19 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 experience of working with older people if the person being assessed is an older person, and
- whether the potential assessor has experience of working with people from the cultural background of the person being assessed.

3.20 Supervisory bodies will need to ensure that sufficient assessors are available to meet the needs of those in their area and that they have the skills, qualifications and training required by regulations to perform the function. Consideration of their experience will be essential in order to have available suitable assessors for the range of cases that can be anticipated. It will be useful to keep a record of qualified assessors and their experience and availability. Supervisory bodies

should consider what arrangements need to be put in place in order to afford assessors the necessary opportunities to maintain their skills and knowledge (of legal developments, for example) and share, audit and review their practice.

3.21 Assessors act as individual professionals and are personally accountable as such for their decisions. Managing authorities and supervisory bodies must not dictate or seek to influence their decisions.

3.22 There is no reason in principle why assessments cannot (where relevant) cover more than the particular qualification requirement. For example, if an assessment can usefully be combined with an interview or examination for a potential application under the Mental Health Act 1983, or for service provision, then it should be combined to avoid unnecessary burdens on both the person being assessed and on staff.

Protection against liability

3.23 Nobody can or should carry out an assessment, other than an age assessment, unless they covered by indemnity in respect of any liabilities that might arise in connection with carrying out the assessment.

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

3.24 The fact that a single body is 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 – 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. For example, in a case involving a local authority care home, the best interests assessor could be an NHS employee or an independent practitioner.

When should an IMCA be instructed?

3.25 If there is nobody appropriate to consult, other than people engaged in providing care or treatment for the relevant person in a professional capacity[8] 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 issued.

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[8] 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.

3.26 Chapter 10 (What is the new Independent Mental Advocacy Service and how does it work?) of the main Code describes the wider rights and role of an IMCA. However, 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:

- give information or make submissions to assessors, which assessors must take into account in carrying out their assessments
- receive from the supervisory body copies of any deprivation of liberty assessments that the supervisory body are given
- receive a copy of a standard authorisation, if granted, from the supervisory body
- be notified by the supervisory body if they are unable to give a standard authorisation because all the deprivation of liberty assessments did not come to a positive conclusion
- receive a copy of any urgent authorisation from the managing authority
- receive from the supervisory body a copy of a notice declining to extend the duration of an urgent authorisation
- receive from the supervisory body a copy of a notice that an urgent authorisation has ceased to be in force, and
- 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).

The assessment and authorisation process is described later in this chapter.

3.27 An IMCA will need to familiarise themselves with the circumstances of the person to whom the deprivation of liberty safeguards are being applied, 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.

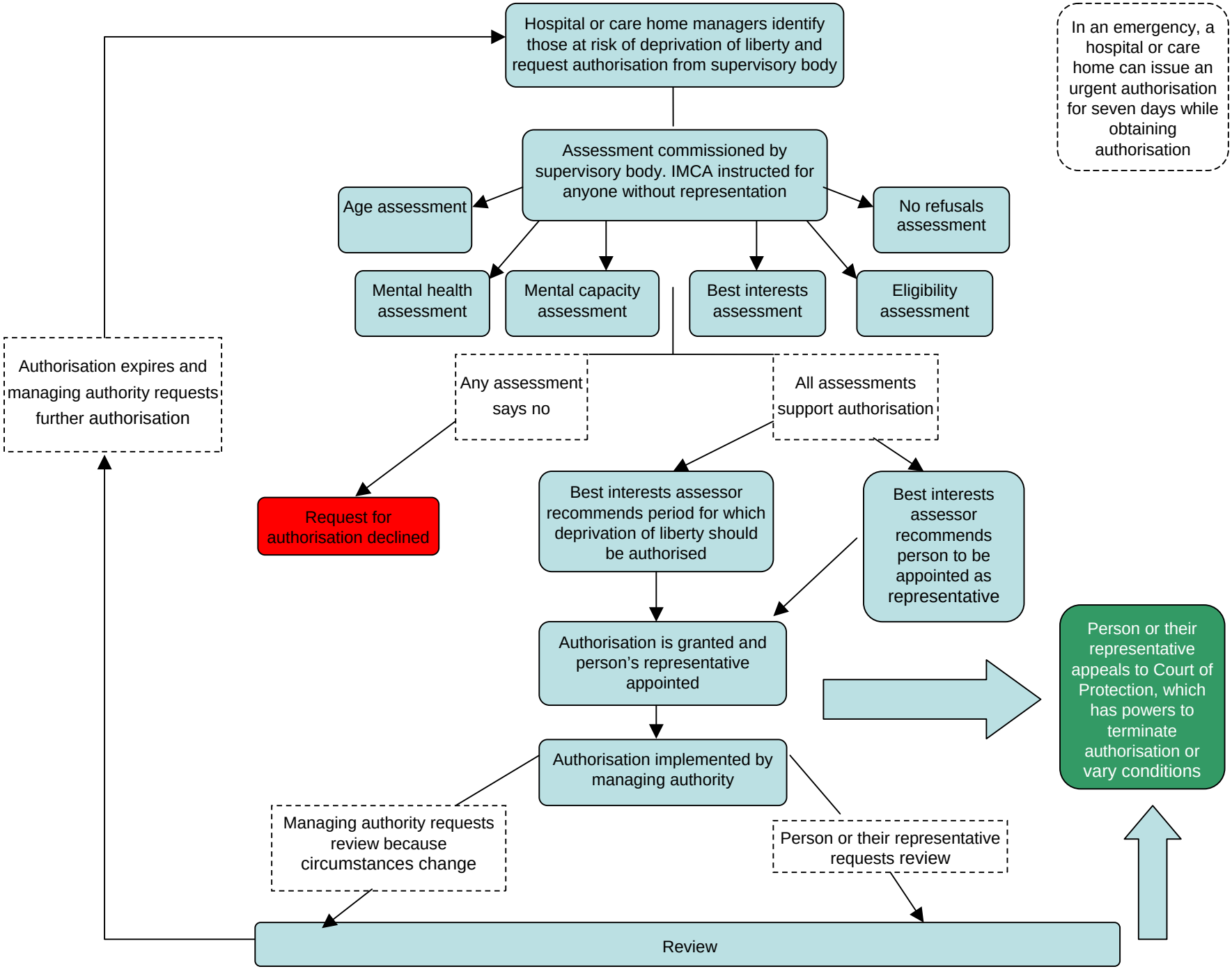
3.28 Differences of opinion between an IMCA and an assessor should ideally be resolved while the assessment is still in progress. Where there are significant disagreements between an IMCA and one or more of the assessors that cannot be resolved between them, the supervisory body should be informed before the assessment is finalised. The supervisory body could then consider what action might be appropriate, including perhaps convening a meeting to discuss the matter. The objective should be, wherever possible, to resolve differences of opinion informally in order to minimise the occasions on which it is necessary for an IMCA to make application to the Court of Protection.

3.29 An IMCA will also need to consider whether they have any concerns about the giving of an urgent authorisation, and whether it would be appropriate to challenge the giving of such an authorisation via the Court of Protection.

3.30 Once a relevant person's representative is appointed (see chapter 4), the role of the IMCA falls away. However, the IMCA may 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 the views of the relevant person's representative on the matter into account. An IMCA may 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 4.33 to 4.36). An IMCA can also be instructed to assist the relevant person and their representative either on their request or if a supervisory body believes that appointing an IMCA will help to ensure that the person's rights are protected (see paragraphs 4.37 to 4.41).

Summary: Flowchart of processes

The following flowchart gives an overview of how the deprivation of liberty safeguards should operate. The subsequent paragraphs explain the assessments in detail.


Hospital or care home managers identify those at risk of deprivation of liberty and request authorisation from supervisory body
In an emergency, a hospital or care home can issue an urgent authorisation for seven days while obtaining authorisation
Assessment commissioned by supervisory body. IMCA instructed for anyone without representation
Age assessment
No refusals assessment
Mental health assessment
Mental capacity assessment
Best interests assessment
Eligibility assessment
Authorisation expires and managing authority requests further authorisation
Any assessment says no
All assessments support authorisation
Request for authorisation declined
Best interests assessor recommends period for which deprivation of liberty should be authorised
Best interests assessor recommends person to be appointed as representative
Authorisation is granted and person's representative appointed
Person or their representative appeals to Court of Protection, which has powers to terminate authorisation or vary conditions
Authorisation implemented by managing authority
Managing authority requests review because circumstances change
Person or their representative requests review
Review

What is the assessment process?

3.31 As indicated in paragraph 3.14, there are six assessments that must be conducted before a supervisory body can grant an authorisation. The assessments are age, mental health, mental capacity, best interests, eligibility and no refusals. This section explains the assessment process.

Age assessment

3.32 The purpose of the age assessment is simply to confirm whether the relevant person is aged 18 or over. This is because, as paragraph 1.15 explained, the deprivation of liberty safeguards only apply to people aged 18 or over. For people under the age of 18, a different safeguards process applies. In cases of doubt, age should be established by a birth certificate or other evidence of age which the assessor considers reliable.

3.33 This assessment can be undertaken by anybody whom the supervisory body thinks is suitable to undertake it. This includes a person who is conducting one or more of the other assessments.

Mental health assessment

3.34 The purpose of the mental health assessment is to establish whether the relevant person is suffering from a mental disorder within the meaning of the Mental Health Act 1983. However, the assessment disregards the special provision in that Act in relation to persons with a learning disability. This means that a person with a learning disability can receive deprivation of liberty safeguards, if appropriate and the other assessments are positive, whether or not their disability is associated with abnormally aggressive or seriously irresponsible conduct. This is not an assessment to determine whether the person requires mental health treatment.

3.35 For supervisory bodies in England, the regulations specify that:

- this assessment must be carried out by a doctor, and
- the assessing doctor either has to be approved under section 12 of the Mental Health Act 1983 or be a registered medical practitioner who has special experience in the diagnosis and treatment of mental disorder.

Whether or not the assessor is section 12 approved, they must have completed the appropriate Mental Capacity Act 2005 mental health assessor training.

3.36 Supervisory bodies must be satisfied that the assessor has the required skills for the role and should take account of guidance produced on the necessary competences. Supervisory bodies must consider the suitability of the

assessor appointed to the particular case, for example whether they have experience relevant to the person's condition.

3.37 Supervisory bodies should consider using a doctor who is eligible to carry out the assessment and who already knows the relevant person to undertake this assessment if they think it would be of benefit. This would primarily arise if a professional 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 are assessed by somebody they do not know.

3.38 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.

Mental capacity assessment

3.39 The purpose of the mental capacity assessment is to establish whether the relevant person lacks capacity to consent to the arrangements proposed for their care.

3.40 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.

3.41 The regulations for England specify that the mental capacity assessment can be undertaken by anyone who is eligible to act as 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.

3.42 As with the mental health assessment, supervisory bodies should consider using an eligible professional who already knows the relevant person to undertake this assessment if they think it would be of benefit.

Best interests assessment

3.43 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
- such deprivation of liberty is a proportionate response to the likelihood of the relevant person suffering harm and the seriousness of that harm.

3.44 In England, the deprivation of liberty best interests assessment must be undertaken by an approved mental health professional or a social worker, nurse, occupational therapist or psychologist with the skills and experience required by the regulations. The supervisory body must also be satisfied that the assessor:

- has the required skills for the role, taking account of guidance produced on the necessary competences and skills listed in regulations
- has completed specific deprivation of liberty best interests assessor training, and
- is suitable considering the circumstances of the case. Relevant factors might include experience relevant to the person's condition, cultural factors and skills in addressing particular communication needs.

3.45 Section 4 of the Act sets out the general 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?) is also relevant and in particular paragraph 5.13 of the main Code includes a checklist of factors that need to be taken into account in determining 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:

- the nature of the possible harm that may arise if the deprivation of liberty does not take place
- the likelihood of that harm arising (i.e. is the level of risk sufficient to justify a step as serious as depriving a person of liberty?)
- evaluation of other care options to avoid deprivation of liberty, and
- if deprivation of liberty is currently unavoidable, identifying what action could be taken to avoid it in future.

The role of the best interests assessor

3.46 The best interests assessor is the person who is responsible for assessing the best interests of a relevant person for whom a managing authority has applied for authorisation to deprive them of their liberty.

Establishing whether deprivation of liberty is occurring

3.47 The first task of a best interests assessor is to establish whether deprivation of liberty is occurring, or is going 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 inform 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 assessor must inform the supervisory body that the best interests requirement is not met.

3.48 The best interests assessor must consult the managing authority of the relevant hospital or care home and examine any relevant needs assessments and care plans prepared in connection with the relevant person being accommodated in the hospital or care home. The best interests assessor must consider whether the proposed care plan and the manner in which it will be implemented would constitute a deprivation of liberty. If it would not, then no deprivation of liberty authorisation would be required for that care plan.

3.49 The managing authority and supervisory body must provide the best interests assessor with any needs assessment or care plan that they have undertaken or which has been undertaken on their behalf.

The best interests assessment process

3.50 If the best interests assessor considers that deprivation of liberty is or will be occurring, they should start a full best interests assessment. In line with section 4(7) of the Act, this involves seeking the views of the following about whether they believe that depriving the relevant person of their liberty is, or would be, in the person's best interests to prevent them from harm or to enable them to follow the care plan proposed:

- anyone engaged in caring for the person
- anyone interested in the person's welfare
- any IMCA who has been instructed, and
- staff involved in the person's care.

Clearly, 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 views received should be taken into account as far as practical and appropriate.

3.51 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. Family and friends may not be confident about expressing their views and 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 Smith is 60 and suffers from Korsakoff's syndrome, an alcohol-induced dementia. After initial treatment in hospital, he was admitted to a registered care home, and he had sufficient capacity to consent to this.

However, he has no insight into his dementia and 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.

Although he had no access to alcohol in hospital, there is a pub within walking distance of the home which Mr Smith visits and drinks in. When he returns to the home intoxicated, his behaviour can be very distressing and potentially dangerous to other residents, many of whom are much older and physically frail, and if this continues there may be no other option than to consider his return to hospital under the Mental Health Act 1983.

The home staff have failed in their attempts to persuade him to drink only in moderation, and the landlord has been asked not to serve him more than one drink but has refused to do so. The manager, on behalf of the home, has therefore applied for a standard authorisation to prevent Mr Smith from leaving the home without an escort and to prevent visits from friends from the pub who bring Mr Smith alcohol.

As the pub is open all day, if the authorisation were granted, Mr Smith would be prohibited 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.

The best interests assessor first speaks to his consultant psychiatrist who will be acting as mental health assessor. The consultant confirms that Mr Smith lacks capacity in relation to this particular issue, and advises that if he continues to drink to excess his dementia is likely to advance very rapidly and his life expectancy will be much reduced. However, small amounts of alcohol will not be significantly harmful.

The best interests assessor next phones Mr Smith's daughter who is his closest relative. She says that having a drink and socialising in the pub is her father's 'only remaining pleasure' and that if he still had capacity she is sure he would have chosen to carry on drinking, regardless of the health risks. The best interests assessor arranges a meeting at the home with the daughter, the home manager and Mr Smith's key worker.

At the meeting, the best interests assessor concludes that the restrictions would severely limit Mr Smith'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 would not be in Mr Smith's best interests to prevent him from having any alcohol at all, but in view of the health risks and the likelihood that he would otherwise have to be detained in hospital, it would be in Mr Smith'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, and in particular on ensuring that he is still able to visit the pub and drink in moderation. The key worker says that when she has gone to the pub with Mr Smith he has been fully co-operative, and has just had 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 per week, and the shops and the park at other times, and that his daughter (who agrees to be appointed as his representative) will be able to take him out at any time. All of this will be stipulated in conditions attached to the authorisation.

3.52 The best interests assessor must also involve the person they are assessing 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 (paragraph 3.10 of the main Code) or the support of speech and language therapists. It may also help to involve others who the relevant person already trusts and who are used to communicating with the relevant person.

Scenario: Non-verbal communication

Leroy has been living in a small care home for people with learning disabilities and challenging behaviour. The manager of the home considers that the restrictions necessary to provide care to Leroy in this setting may deprive him of his liberty and applies for an authorisation.

Leroy's best interests assessor sets out to assess whether Leroy would prefer to stay in this care home or move into a less restrictive setting. The best interests assessor looks through Leroy's notes and lists the relatives and friends who had been involved in Leroy's life in the last five years as well as any previous care workers and social workers who had written reports. There were two relatives who visited infrequently, one advocate who had been involved a year ago and a care worker who had taken Leroy on a group holiday.

The best interests assessor then contacts as many of these as she can to discuss Leroy's situation and what he may want were he allowed to choose. The relatives feel strongly that Leroy could be supported to live more independently, and the care worker agrees.

The best interests assessor creates two picture books, one with pictures of Leroy in the care home and one with pictures of Leroy in an independent flat. Leroy is very drawn to the latter and stands by the front door, indicating that he wants to leave.

The best interests assessor concludes that Leroy has communicated through his behaviour that if he were offered the choice he would like to try living in a less institutional setting.

The assessor therefore decides that the authorisation should be granted but for three months, and recommends that conditions are attached that rehabilitation support be given to help Leroy to acquire the skills needed to live in a more independent setting. The assessor recommends that Leroy should be taken to visit other possible care settings and supported to express his views.

3.53 The best interests assessor will also 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.

3.54 If the best interests assessment supports deprivation of liberty in the care home or hospital in question, the assessor should state for how long any authorisation should be given, with a maximum period of 12 months. This recommendation should be based on the information obtained during the consultation process – but particularly on the information within the care plan about how long any treatment will last, and any details about how likely it is that the relevant person's circumstances will change. 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 which would affect the authorisation within that timescale.

The report of the best interests assessor

3.55 The best interests assessor will need to give reasons for their conclusion in the report of their assessment. 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 how deprivation of liberty could be avoided. In such a case, it may also be helpful for the best interests assessor to discuss the matter with the providers of care **during the assessment process**.

3.56 The best interests assessor may recommend that conditions should be attached to the authorisation. For example, they might want to deal with contact issues, issues relevant to the person's culture or other major issues related to the deprivation of liberty, without which deprivation of liberty would cease to be in the patient's best interests. Conditions may also be recommended 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.

3.57 Conditions should not be a substitute for a properly constructed care plan and the application of other relevant processes, for example the Care Programme Approach and care management. 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 assessor to discuss any proposed conditions with the relevant personnel at the home or hospital before finalising the assessment.

3.58 Where possible, the best interests assessor should also recommend someone to be appointed as the 'relevant person's representative' (see chapter 4). The

assessor should be well placed, as a result of the consultation process, to identify whether there is anybody who could suitably act as a relevant person's representative. The appointment of the relevant person's representative cannot take place unless and until the 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.

Eligibility assessment

3.59 This assessment relates specifically to the relevant person's status, or potential status, under the Mental Health Act 1983 and aims to confirm whether the relevant person should be covered by that Act rather than the deprivation of liberty safeguards under the Mental Capacity Act 2005.

3.60 For most authorisations sought by care homes, the eligibility assessment will effectively be irrelevant.

3.61 A person is not eligible for a deprivation of liberty authorisation if:

- they are, at the time of the authorisation, detained as a hospital in-patient under the Mental Health Act 1983, or
- the authorisation, if granted, 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.

3.62 In addition, 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 not be eligible if:

- they are currently on leave of absence from detention under the Mental Health Act 1983, or subject to Supervised Community Treatment or conditional discharge in which case powers of recall under the Mental Health Act 1983 should be used, or
- 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.

3.63 In many cases, a patient will be perfectly able to state such an objection. However, where the patient is unable to communicate, or can only communicate to a limited extent, assessors will need to consider the patient's behaviour, wishes, feelings, views, beliefs and values, both present and past,

so far as they can be ascertained (see paragraphs 5.37 to 5.48 of the main Code for guidance on how to do this). If there is reason to think that a patient would object if able to do so, then the patient should be assumed to be objecting. Occasionally, it may be that the patient's behaviour initially suggests an objection, but that this objection is in fact not directed at the treatment at all. In that case, the patient would **not** be taken to be objecting. Assessors should always bear in mind that their job is simply to establish whether the patient objects to treatment – the reasonableness of that objection is not the issue.

3.64 The eligibility assessment will often be carried out by the best interests assessor but, where this is not the case, the eligibility assessor must seek and take account of the views of the best interests assessor in deciding whether the person objects to being in hospital or to treatment for mental disorder.

3.65 Even where a patient 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).

When patients are assessed as ineligible

3.66 If the eligibility assessor believes that the patient is not eligible, but (based on the report of the best interests assessor) that they nevertheless should be deprived of liberty in their best interests, the eligibility assessor should immediately take steps to arrange for appropriate action to be taken under the Mental Health Act 1983. The same applies if, for any other reason, the eligibility assessor considers that the use of the Mental Health Act 1983 should be considered.

3.67 In the case of someone already subject to the Mental Health Act 1983, the eligibility assessor should contact the relevant responsible clinician (i.e. the clinician in overall charge of the patient's treatment) or, if the person is subject to guardianship, the relevant local social services authority. Otherwise, the assessor should take steps to arrange for the patient to be assessed further so that an application can be made for admission to hospital under the Mental Health Act 1983. Assessors will need to be familiar with local arrangements for doing that.

3.68 In some cases, even before the assessment is made, it might well be known that the person may have to be assessed with a view to an application under

the Mental Health Act 1983 rather than being made subject to 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 have.

Who can conduct an eligibility assessment?

3.69 The regulations for England specify that anybody that the supervisory body considers to be appropriate, by virtue of possessing the necessary experience and meeting the training and skills specifications, may undertake the eligibility assessment. In most cases, it should be carried out by a person conducting one or more of the other assessments. It is important that the eligibility assessor is familiar with the Mental Health Act 1983, particularly in cases in which it appears that there might be the potential for the use of the Mental Health Act 1983 rather than the deprivation of liberty safeguards.

3.70 Where the eligibility assessor and best interests assessor are different people, the eligibility assessor, in undertaking the assessment, must seek information from the best interests assessor about the person's attitude to the arrangements being made for their care and treatment. This will be appropriate in a case where a person is receiving, or is to receive, treatment for a mental disorder in a hospital setting and where, if they can be said to be objecting to the treatment, it would be appropriate to consider using the provisions of the Mental Health Act 1983 rather than the deprivation of liberty safeguards.

No refusals assessment

3.71 The purpose of the no refusals assessment is to establish whether an authorisation to deprive a person who lacks capacity to consent of their liberty would conflict with other existing authority for decision-making for that person.

3.72 The following examples show instances of a conflict which would mean that a standard authorisation could not be given.

- If the relevant person has made an advance decision that remains valid and is applicable to some or all of the treatment that the person would receive if authorisation were granted, then a standard authorisation cannot be granted. See sections 24 to 26 of the Act and chapter 9 of the main Code (What does the Act say about advance decision to refuse treatment?) for more information about advance decisions and when they are valid and applicable.
- 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 of a Lasting Power of Attorney (an 'attorney') or a deputy appointed by the court (a 'deputy'), then a standard authorisation cannot be granted. For example, if an attorney or deputy decided that a person should not be

in a particular care home, and that decision was within their authority, then the care plan would need to be reviewed with the attorney or deputy.

3.73 If there is a conflict, the no refusals assessment qualifying requirement will not be met and a standard authorisation for deprivation of liberty may not be given.

3.74 The no refusals assessment can be undertaken by anybody that the supervisory body considers has the skills and experience to perform the role, including a person conducting one or more of the other assessments.

What other provisions are there relating to the work of assessors?

Access to records

3.75 Assessors may examine and take copies of records which they consider may be relevant to their assessment. Assessors should list in their assessment report what records they examined.

Recording and reporting assessments

3.76 As soon as possible after carrying out their assessments, assessors must give copies of their assessment report(s) to the supervisory body. The supervisory body must give copies of these to:

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

Standard forms will be produced for use by assessors.[9]

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

3.77 If all the assessments conclude that the person meets the criteria for authorisation, and the supervisory body has written copies of all the assessments, it must give a standard authorisation. The supervisory body cannot give a standard authorisation if all the criteria are not fulfilled. The supervisory body may attach conditions to the authorisation, taking account of the best interests assessor's recommendations (see paragraph 3.56). 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

[9] Titles of forms for England and for Wales to be inserted in final document.

3.54). It is the responsibility of the supervisory body to appoint a representative for the person (see chapter 4).

3.78 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 (as recommended by the best interests assessor), and
- the reason why each qualifying requirement is met.

3.79 After granting 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 IMCA involved and every interested person consulted by the best interests assessor as soon as is possible.

How long can an authorisation last?

3.80 A person should be deprived of liberty for the shortest period possible. The best interests assessor should only recommend authorisation for as long as the person is likely to meet all of the qualifying requirements. The authorisation may be for quite a short period. A short period might, 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).

3.81 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 which would affect the authorisation within that timescale.

What restrictions exist on authorisations?

3.82 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 Act.

3.83 This means that any treatment can only be given to a person who has not given their consent if:

- it is confirmed that the person lacks capacity to make the decision concerned
- it is determined 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
- the treatment does not conflict with a decision made by an attorney or a deputy.

3.84 In deciding what is in 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. Chapter 5 of the main Code gives guidance on assessing best interests. The provisions of sections 24 to 26 of the Act regarding advance decisions are also relevant.

3.85 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?

3.86 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.

3.87 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 issue an urgent authorisation (see paragraphs 3.98 to 3.116).

3.88 The only exception is if the care regime in the new facility will not involve deprivation of liberty.

3.89 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 criteria is not met?

3.90 If any of the assessments conclude that one of the criteria 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 granted, and
- provide the managing authority, the relevant person and any IMCA involved with copies of those assessments that have been carried out. This should be done as soon as possible because in some cases different arrangements will need to be made for the person's care.

3.91 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?

3.92 The managing authority is responsible for ensuring that it does not deprive a person of their liberty without an authorisation.

3.93 The commissioners of care are responsible for ensuring that any care package is commissioned in compliance with the deprivation of liberty safeguards.

3.94 If the supervisory body is commissioning the care, it will need to do so in such a way that makes it possible for the managing authority to provide the care in accordance with the outcome of the deprivation of liberty assessment process.

3.95 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 person was not in fact being, or going to be, deprived of liberty, no action is likely to be necessary.
- If the best interests assessor concluded that the proposed deprivation of liberty was not in the 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. 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.
- If the mental capacity assessor concluded that the 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 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 person does not have a mental disorder, the care plan will need to be modified to avoid a deprivation of liberty.
- Where there is a valid refusal by an attorney or deputy or an applicable and valid advance decision, 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.

3.96 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 will need to liaise with the managing authority in order to ensure that an unauthorised deprivation of liberty is not permitted to continue in these circumstances. The person's care plan and the provision of care must be reviewed immediately and the changes made as soon as possible. The steps taken to end the deprivation of liberty should be recorded in the care plan. Where possible it will be important to involve family, friends and carers in deciding how to prevent the unauthorised deprivation of liberty from continuing.

3.97 It is the responsibility of the managing authority to comply with the law in this situation and it will need to keep the person's care under review to ensure that

unauthorised deprivation of liberty does not arise in future. Should the supervisory body have continuing doubts about the matter, it should alert the inspection body (see chapter 8).

Under what circumstances can an urgent authorisation be given?

3.98 The 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 a person to be deprived of liberty is so urgent that it is appropriate to begin the deprivation before the request is made, or
- 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 it is appropriate to begin the deprivation before the request is dealt with by the supervisory body.

This means that an urgent authorisation can never be issued without a request for a standard authorisation being made.

3.99 Urgent authorisations should normally only be used in response to sudden unforeseen needs but may 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).

3.100 Any decision to issue 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 Act and, where restraint is involved, must comply with the additional conditions in section 6 of the Act (see chapter 6 of the main Code).

3.101 The managing authority must decide the period for which the urgent authorisation is given, but this must not exceed seven days (see paragraphs 3.111 to 3.116 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.

3.102 Supervisory bodies and managing authorities should have a procedure/protocol in place that identifies:

- what action should be taken when it is necessary to make use of the urgent authorisation process
- by whom the action should be taken, and

- within what timescale.

The processes surrounding the giving of urgent authorisations should be clearly recorded, and regularly monitored and audited, as part of an organisation's governance structure.

Recording urgent authorisations

3.103 The managing authority must keep a written record of any urgent authorisations given, and must give a copy of the authorisation to the relevant person and any IMCA involved. 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.

3.104 The managing authority should notify the person's family, friends and carers in order to enable them to offer informed support to the person.

Consulting about urgent authorisations

3.105 If the managing authority is considering depriving a person of liberty in an emergency and issuing an urgent authorisation, they must, as far as is appropriate, take account of the views of anyone engaged in caring for the relevant person or interested in their welfare (section 4(7)(b) of the Act).

3.106 The steps taken to involve family, friends and carers, and others with an interest, should be recorded in the person's records, along with their views and the reasons why it was decided to issue an urgent authorisation. 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.

3.107 The ultimate decision, though, will need to be based on a judgement of what is in the person's best interests. The person from the managing authority who is making the decision 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.

Terminating an urgent authorisation

3.108 An urgent authorisation will terminate at the end of the period for which it is given (up to seven days, which may in exceptional circumstances be extended to a maximum of 14 days by the supervisory body.) It will terminate before this time if the standard authorisation applied for is granted. An urgent

authorisation will also terminate if a managing authority receives notice from the supervisory body that the standard authorisation will not be granted. It will not then be lawful to continue to deprive the person of their liberty. The supervisory body must inform the relevant person and any IMCA appointed that the urgent authorisation has ended, and this can be combined with the notification to them of the outcome of the application for standard authorisation.

Moving a person into care under an urgent authorisation

3.109 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 might 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 the need for admission is considered to be so urgent that there is not time to follow the standard authorisation process.

3.110 For some people, such a change of location would 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 would 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.

Scenario: Considering an urgent authorisation

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

John has an accident at home. His parents think he may have broken his arm and take 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, and that John can return home to recover.

However, because of the pain he is in and the crowded environment, John has become very agitated, to the extent that hospital security personnel feel a need to restrain him. The A&E doctor who has been dealing with John has very little experience of this type of situation and thinks it would be unsafe to

let John leave the hospital, so considers admission and whether an urgent authorisation might be needed.

As part of the decision-making process, the A&E doctor discusses the matter with John's parents. They say that they have experienced similar situations many times, that they are confident that John will calm down once he is back in his home environment and that any more detailed assessment of his mental state should take place there.

At the request of John's parents, the doctor phones a community nurse who knows John and is reassured that John does not present a danger to himself, his parents or the general public. The doctor decides that it will be in John's best interests to return home with his parents.

Shortly after John and his parents return home, the community nurse visits them. By this time, John has calmed down. The community nurse decides that it is best that he remains in his home environment and that further consideration of admission to hospital is not necessary.

How and when can an urgent authorisation be extended?

3.111 The managing authority may, if necessary, 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.

3.112 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 authorise the deprivation of liberty, and
- it is essential for the deprivation of liberty to continue while the supervisory body makes its decision.

3.113 Extensions will only be granted in exceptional circumstances. An example of when an extension would be justified might be where the supervisory body was satisfied that:

- it was not possible to contact a person 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.

3.114 An urgent authorisation can only be extended once.

3.115 The supervisory body should 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.

3.116 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.

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

Once a standard authorisation has been granted, supervisory bodies must appoint a relevant person's representative as soon as possible 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 to supervisory bodies and managing authorities on how to select a representative and when to consult them.

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

4.1 The supervisory body must appoint a relevant person's representative for every person that they issue a standard authorisation for deprivation of liberty for. It is important that the representative is appointed at the time the authorisation is granted or very shortly thereafter.

4.2 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 operation of 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.

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

4.3 As soon as possible after an authorisation is issued, the managing authority must take all practical and appropriate steps to ensure that the relevant person and their representative understand:

- the effect of the authorisation
- their right to request a review
- 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, and
- their right to request the support of an IMCA.

4.4 In 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 a relevant person's representative?[10]

4.5 To be eligible to be a relevant person's representative, a person must be:

- 18 years of age or over
- willing to be appointed, and
- able to keep in contact with the relevant person.

The person must not be:

- prevented by ill health from carrying out the role of representative
- financially interested in the relevant person's managing authority
- a close relative of a person who is financially interested in the managing authority (paragraph 3.18 explains what is meant by 'close relative')
- if the person is deprived of liberty in a care home, employed by, or providing services to, that care home
- if the person is deprived of liberty in hospital, employed to work at that hospital in a role that is or could be related to the relevant person's case, 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.

4.6 The appointment of a relevant person's representative is in addition to, and does not affect, any appointment of an attorney or deputy. The functions of the representative are in addition to, and do not affect, the authority of any attorney, the powers of any deputy or any powers of the court.

4.7 There is no presumption that a relevant person's representative should be the same as the person who would be their nearest relative for the purposes of the Mental Health Act 1983, even where the person is likely to be subject simultaneously to an authorisation under these safeguards and a provision of the Mental Health Act 1983.

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[10] Requirements relating to the eligibility, selection and appointment of relevant person's representatives in England are covered in regulations. The draft regulations for England are the Mental Capacity (Deprivation of Liberty: Appointment of Relevant Person's Representative) Regulations 2008. Welsh ministers are currently considering how they will use their regulation-making powers for Wales; details will be inserted once finalised.

When should a relevant person's representative be identified?

4.8 The process of identifying a representative should begin as soon as possible.

4.9 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.

4.10 This does leave a risk that the process to identify a representative might begin in cases where authorisation is not granted. Nevertheless, it is important that the process is commenced so that the representative can be in place within an appropriate timescale.

How should the relevant person's representative be selected?

4.11 The best interests assessor should firstly establish whether the person potentially being deprived of liberty 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 rules set out in paragraph 4.5 above), the best interests assessor must recommend that person to the supervisory body for appointment.

4.12 If there is an attorney or deputy with the appropriate authority, they may select the person to be recommended as the relevant person's representative, again subject to the rules set out in paragraph 4.5, where the relevant person lacks capacity to do so. If an attorney or deputy selects an eligible person then the best interests assessor must recommend that person to the supervisory body for appointment.

4.13 It is up to the best interests assessor to confirm whether any representative proposed by the person, an attorney or 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.

4.14 If neither the person concerned, nor an attorney 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.

4.15 In making a recommendation, the assessor will wish to consider, and balance, factors such as:

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

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

4.16 It should not be assumed that the representative needs to be someone who supports the deprivation of liberty.

4.17 The best interests assessor must not select a representative where the relevant person, an attorney or a deputy objects to that selection.

4.18 If the best interests assessor is unable to recommend anybody to be the relevant person's representative, the assessor must notify the supervisory body accordingly. The supervisory body must then itself identify an eligible person to be appointed as the representative, following the conditions set out in paragraph 4.5 above. The supervisory body cannot select a person from among family, friends and informal carers who has not been recommended by the best interests assessor.

4.19 The supervisory body may pay the person that they select to provide this service. The service could be commissioned through an advocacy services provider, ensuring that the service provides effective independent representation for the person deprived of liberty.

4.20 When selecting a suitable representative for a person, the 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?

4.21 The supervisory body must invite the person recommended by the best interests assessor to become the relevant person's representative. If the best interests assessor does not recommend someone, then the supervisory body should invite the person it has identified. If the person is willing to become the

representative, the supervisory body must 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.

4.22 The appointment of a relevant person's representative by the supervisory body must be in writing, stating the date of expiry, which must be for the period of the standard authorisation that has been issued. The supervisory body must send copies of the written appointment to:

- the appointed person
- the relevant person
- any attorney or deputy of the relevant person
- any IMCA involved
- every interested person consulted by the best interests assessor, and
- the managing authority of the relevant hospital or care home.

4.23 The person appointed must confirm in writing that they are willing to take on the role.

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

4.24 It is important that the person should be in ongoing contact with their representative. In order to fulfil their role, the representative will need to be able to have face-to-face contact with the person. That means that the care home or hospital should accommodate visits by the representative at reasonable times. Details about who the person's representative is should be recorded in the person's health and social care records.

4.25 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.

4.26 If the representative ceases to maintain contact with the relevant person, for whatever reason, the person may effectively be unable to access their review and appeal rights. For this reason, the managing authority will need to consider informing the supervisory body if the representative does not maintain contact with the person. When the managing authority is reviewing the person's care plan, it should consider whether the representative is in sufficient contact to be effective. Records kept of frequency of contact will support this consideration.

4.27 This is a matter about which the managing authority will need to exercise discretion. The managing authority might consider it appropriate to raise the matter with the representative initially, before notifying the supervisory body if the representative still does not maintain regular contact with the relevant person.

Under what circumstances can the appointment of a relevant person's representative be terminated?

4.28 The appointment of a 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 granted.
- The relevant person, if they have capacity to do so, selects a different person to be their representative, and that person is eligible and willing to take on the role.
- An attorney or deputy, if it is within their authority to do so and the relevant person lacks the capacity to decide, selects a different person to be the representative, and that person is eligible and willing to take on the role.
- The representative informs the supervisory body in writing that they are 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.
- The supervisory body becomes aware that the relevant person's representative is no longer eligible.
- The relevant person's representative dies.

4.29 If the supervisory body considers that the representative may not be keeping in touch, or is no longer eligible, it should contact the representative to clarify the position before deciding whether to terminate the appointment.

4.30 When the appointment of a relevant person's representative ends, the supervisory body must give notice to the representative, and should also inform the relevant person, every interested person consulted by the best interests assessor and the managing authority of the relevant hospital or care home. This notice should be given as soon as possible, stating when the appointment ended and the reason why.

4.31 When the appointment of a relevant person's representative ends but the lawful deprivation of liberty continues, the supervisory body must identify

a suitable replacement as the relevant person's representative as soon as possible. When selecting a new representative, the supervisory body should take account of any recommendations made by the best interests assessor. If the reason for the termination of the former representative's appointment is that they were 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 appointment. This process should continue until an eligible person is willing to accept appointment.

4.32 If a replacement representative is being selected because the appointment of the current representative is to end, then a person qualified to be a best interests assessor will need to be appointed to make the selection.

Instructing an IMCA to act during a standard authorisation when there is no relevant person's representative available

4.33 A person who is being deprived of their liberty will be in a particularly vulnerable position during any gaps in the appointment of a 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.

4.34 The role of the IMCA during their period of appointment is essentially the same as that of the relevant person's representative. Once a relevant person's representative is appointed, the role of the IMCA falls away.

4.35 However, after the representative has been appointed, the IMCA may 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 the views of the relevant person's representative on the matter into account. As in other cases, IMCAs may want to approach the Official Solicitor (OS) with the facts of any case if they wish to challenge it legally. The OS can decide to apply to the court as a litigation friend. Alternatively, the local authority or the NHS body may decide with the IMCA that they want to seek the court's views on appropriate action to be taken in serious cases.

4.36 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.

Instructing an IMCA to act during a standard authorisation to support the person or their representative

4.37 Both a person who is deprived of liberty under a standard authorisation and their representative have the statutory right of access to an IMCA. It is the responsibility of the supervisory body to instruct an IMCA if the person or their representative requests one. The intention is to provide extra support to the person or a family member or friend acting as their representative if they need it, to make use of the review or court of protection safeguards. If the person already has a paid 'professional' representative, the need does not arise and so an IMCA would not be provided.

4.38 The role of the IMCA is to explain the authorisation to them: what it means, why it has been granted, why it is considered that the person meets the criteria for authorisation, how long it will last and how to trigger a review or challenge in the Court of Protection. The IMCA can provide support with a review or with an application to the Court, for example to help the person to communicate their views.

4.39 The IMCA will have the right to make submissions to the supervisory body on the question of whether a qualifying requirement is reviewable 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.

4.40 An IMCA must be instructed if this is requested by the person or their representative. A request may be made more than once during the period of the authorisation. For example, help may be asked for at the start of the authorisation and then again later in order to request a review.

4.41 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.

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

In all cases where 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 might 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 around reviewing cases, and what happens when an authorisation ends.

When should a standard authorisation be reviewed?

5.1 The supervisory body must carry out a review if requested to do so by the person concerned, their representative or the managing authority, and may also carry out a review at any other time. There are no restrictions on when a review can be requested. The supervisory body must tell the relevant person, their representative and the managing authority if they are going to carry out a review.

5.2 In general, the grounds for requesting a review are that:

- The relevant person no longer meets all of the six qualifying requirements.
- The person is ineligible because they now object to receiving mental health treatment in hospital (see paragraphs 3.62 to 3.63 above).
- The reason why the relevant person meets a qualifying requirement is not the reason stated in the authorisation.
- There has been a change in the relevant person's situation and, because of the change, it would be appropriate to vary the conditions to which the authorisation is subject.

5.3 Each person's records should include information about any formal reviews that have been requested, when they were considered, and the outcome.

5.4 An authorisation only **permits** deprivation of liberty: it does not mean that a person **has to be** deprived of liberty. If a care home or hospital decides that deprivation of liberty is no longer necessary then they must end it immediately, by adjustment of the care regime or whatever other change is appropriate. The managing authority should then apply to the supervisory body to review the authorisation. While this review is happening, the person concerned should no longer be subject to deprivation of liberty.

How should standard authorisations be reviewed?

5.5 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.

- If the supervisory body concludes that none of the qualifying requirements need to be reviewed, it need take no further action. For example, if there has been a very recent assessment or review and no new evidence that the person does not meet the criteria, or of a change, is submitted, there will be no need for a review.
- If one or more of the qualifying requirements appear to be reviewable, the supervisory body must arrange for a separate review assessment to be carried out in relation to each reviewable requirement. In terms of the eligibility requirement, this only applies where the relevant person is objecting to being a patient or to some or all of the mental health treatment they are being given.

The supervisory body should record the reasons for decisions taken.

5.6 In general, review processes should follow the standard authorisation processes – so supervisory bodies should conduct the assessment processes outlined in chapter 3 of this addendum for any issue that needs to be reviewed.

5.7 Where the supervisory body decides that the best interests requirement should be reviewed solely because details of the conditions attached to the authorisation need to be changed, and the review request does not include evidence that there is a significant change in the person's case, there is no need for a full reassessment. 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 contested in the review request.

Scenario: Deciding whether a review is needed

Louise is 28 and has autism and a learning disability. Louise's residential home has been granted authorisation to deprive her of her liberty. One of the conditions of the authorisation was that Louise goes back to stay with her family once a week.

For a couple of months this arrangement worked well, but then Louise started to become very upset when she returned to her care home. The distress lasted for a few days each time, and neither the care home nor Louise's family were able to identify the reason. The home became concerned about her behaviour and decided that the contact with her family was causing distress to Louise.

The care home requested a review from the supervisory body, suggesting a change to the conditions attached to the authorisation, so that Louise would go home every week but for a day visit rather than an overnight stay, to reduce the disruption to her routine. The supervisory body decided that this was a significant enough change to the conditions to require a best interests assessment.

The best interests assessor consulted the appointed representative – Louise's mother, Francine – and other people who knew Louise. Francine believed that Louise should still sleep at home every weekend. Louise has always been close to her family and it was clear from the original best interests assessment that she enjoys spending time with them. Staying in the family home was seen as important to reinforce the bond with the family.

The best interests assessor wanted to communicate with Louise to see if she could find out what was upsetting her. She spoke to Francine and the care home, and considered the written information that the care home had submitted during the initial request for authorisation, which included Louise's communication and language needs. Because Louise doesn't communicate using speech, she had in the past worked with a speech and language therapist. The best interests assessor arranged for this therapist to meet with Louise and use a visual communication system with her, to which Louise had previously responded well. Using this system, and her experience that Louise was more comfortable communicating where she felt relaxed, for example in the garden of the care home, the therapist was able to find out the reasons for the increase in Louise's anxiety.

It became clear that Louise was upset because her brother normally drove her home at the end of the visit, but had not been doing so for the past three weeks. Following consultation with Francine, the best interests assessor

discovered that the reason for this was that Louise's brother had hurt his ankle. It was this change in routine at the end of the weekend that had been upsetting Louise, so it was explained to Louise why her brother wasn't driving the car and the family agreed that Louise's brother would accompany her back to the care home until he was able to drive again.

The outcome of the best interests review assessment was that the authorisation and the conditions originally attached should remain unchanged.

5.8 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.

5.9 If the assessment shows that the requirement is still met, then the supervisory body must consider whether the reason that it is met has changed from the reason originally stated on the authorisation and make any appropriate amendments. In addition, if the review relates to the best interests requirement, the supervisory body must consider whether any conditions should be varied in view of the outcome of the assessment.

5.10 If any of the criteria are not fulfilled, then the authorisation must be terminated immediately.

5.11 The supervisory body must give written notice of the outcome of a review to the care home or hospital, the relevant person, the representative and the IMCA, if an IMCA is involved.

Scenario: The review process

Jo is 29 and sustained severe brain damage in a road traffic collision that killed her parents. As well as the brain injury, Jo now has profound hearing loss, suffers from epilepsy, and has great difficulty in communicating. Jo can get very frustrated and has been known to lash out at other people in the independent nursing care home where she now lives. Jo's placement is jointly funded by the NHS and the local social services authority, following an assessment of her needs. However, she regularly attempted to leave the home and expressed a consistent wish to live on her own again. The view of the organisation providing Jo's current care was that such a move would place her at serious risk and that she should be prevented from leaving the home.

Arrangements were established for Jo to be 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, such has been the nature of Jo's progress at the home that she has now been assisted to request a review. The review request is in the form of a letter with pictures, prepared by Jo, with assistance from staff based at the care home. The pictures describe Jo's frustration with the legal processes that prevent her from moving. The organisation providing Jo's current care is of the view that her needs now could be better served if she could move. A suitable rehabilitation placement has been identified and discussed with her.

The supervisory body allocates a social worker to bring forward the review. The social worker contacts the advocate who has been appointed as Jo's representative and checks which of the qualifying requirements needs to be reviewed and by whom. The social worker then co-ordinates the overall review process, before formally recommending back to the supervisory body that the authorisation should end.

Subsequently a copy of a revised and agreed care plan to support Jo to live more independently is provided for Jo.

Short-term suspension of authorisation

5.12 There are separate review arrangements in 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 being a patient or to some or all of the mental health treatment they are being given. For example, if the relevant person is detained as a hospital in-patient under the Mental Health Act 1983, then the managing authority must notify the supervisory body, who will suspend the authorisation. Then:

- if the person 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, at the expiry of the 28-day period the authorisation will cease to have effect.

5.13 If the patient ceases to meet the eligibility requirement because they begin to object to being in hospital for the purposes of treatment for mental disorder, review procedures should be started immediately (see paragraph 5.2 above).

What happens when an authorisation ends?

5.14 When an authorisation ends, the managing authority cannot lawfully continue to deprive a person of their liberty.

5.15 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.

5.16 There is no specified time limit on how far in advance of the expiry of one authorisation the application for a renewal authorisation may be made. It will need to be far enough in advance for the renewal authorisation to be given before the existing authorisation ends.

5.17 Managing authorities should bear in mind that requests for assessments of qualifying requirements made too far in advance might mean that an assessor could not make an accurate assessment of what the person's circumstances will be by the time the renewal authorisation is due to come into force.

5.18 Once under way, the process for renewing a standard authorisation is basically the same as for obtaining an original authorisation, with the same assessment processes needing to take place. However, the need to instruct an IMCA will not usually arise because most people at this stage will already have a person appointed to represent their interests.

5.19 When a standard authorisation ends, the supervisory body must inform in writing the person and their representative, the care home or hospital and every interested person consulted by the best interests assessor.

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

Depriving someone who lacks capacity to consent of their liberty without authorisation is a serious issue. If anyone believes that a person is being deprived of their liberty without authorisation, they should raise this with the relevant authorities as described more fully below.

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 investigations.

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

6.1 If a 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, asking them to apply for an authorisation. Given the seriousness of deprivation of liberty, a managing authority would normally be expected to respond within 24 hours.

6.2 If the concerned person has done this, but the managing authority has not applied for an authorisation within a reasonable period, the concerned person has a right to 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.

6.3 In such circumstances, the supervisory body must select and appoint a person who would be suitable and eligible to carry out a best interests assessment to investigate whether the person is deprived of liberty.

6.4 The exception to this is if the supervisory body believes that:

- the concern 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 decided again.

The supervisory body should record the reasons for their decisions.

6.5 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 appointed IMCA:

- that it has been to 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.

How will the assessment be conducted?

6.6 Where an assessment of whether an unlawful deprivation of liberty is occurring is necessary, it must be carried out within seven days.

6.7 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 will 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.

What happens once the assessment is conducted?

6.8 There are three possible outcomes of an 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.)
- the person is being deprived of their liberty unlawfully.

6.9 The supervisory body must notify the third party who made the request, the relevant person, the managing authority of the relevant hospital or care home and any appointed IMCA of the outcome of the assessment.

6.10 If the outcome of the investigation 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.

6.11 If the managing authority considers that the care regime should continue while the assessments are carried out, it will be required to issue an urgent authorisation and to obtain a standard authorisation within seven days. The managing authority must supply the supervisory body with the information that the managing authority would have had to include in a request for a standard authorisation.

6.12 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 7 for more details of the role of the Court of Protection.

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

In order to comply with Article 5(4) of the ECHR, it is necessary to provide anybody deprived of their liberty in accordance with the safeguards described in this Code with the right of speedy access to a court for a review of 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?

7.1 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. Such an application to the court might seek a declaration as to 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. Every attempt should be made to resolve concerns about the assessment process informally or through the supervisory body's complaints procedure.

7.2 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
- the period during which the standard authorisation is to be in force
- the purpose for which the standard authorisation is given
- the conditions subject to which the standard authorisation is given.

7.3 Where an urgent authorisation has been given, the relevant person or any other person acting on his or her behalf has the right to apply to the Court of Protection to determine any question relating to the following matters:

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

7.4 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 the Court to decide whether the authorisation should have been given. However, it is up to the Court of Protection to decide whether or not to consider an application from these other people. As stated above, the relevant person and their representative have the right to apply to the Court of Protection and do not need to apply for permission.

What orders can the Court of Protection make?

7.5 The Court may make an order:

- varying or terminating a standard or urgent authorisation
- 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.

As explained in paragraph 1.23, it will only be lawful to deprive somebody of their liberty in places other than a hospital or registered care home when following an order of the Court of Protection in a personal welfare matter.

8. How will the safeguards be monitored?

8.1 Regulations[11] will confer the responsibility for the inspection process of the operation of the deprivation of liberty safeguards in England on the new regulator created by merging the existing inspectorates, the 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 legislation, and the new health and adult social care regulator is expected to be fully operational by 2009/10.

8.2 In summary, the inspection body for care homes and hospitals in England will be expected to:

- monitor the manner in which the deprivation of liberty safeguards are being operated by managing authorities and supervisory bodies by
    - visiting hospitals and care homes in accordance with their existing visiting programme
    - 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
- report annually to the Secretary of State summarising their activity and their findings about the operation of the deprivation of liberty safeguards.

8.3 The inspection body will have the power to require supervisory bodies and managing authorities of hospitals or care homes to disclose information to them.

8.4 The inspection process will address whether:

- the end-to-end process of the safeguards is working properly, to highlight where it is not and to recommend remedial action. Subsequently, it will check that remedial action has been taken and is effective
- the deprivation of liberty provisions have been applied correctly and in line with guidance in this Code of Practice in cases where authorisation has been requested

[11] Draft regulations for England will be consulted upon later. Welsh ministers are currently considering how they will use their regulation-making powers for Wales; details will be inserted once finalised.

- guidance in this Code of Practice on identifying those at risk of deprivation of liberty, and on avoiding deprivation of liberty, is being complied with
- conditions attached to authorisations, and requirements to request reviews if circumstances change, are complied with
- appropriate steps are being taken in cases where authorisation has been refused.

8.5 The inspection process will not cover:

- treatment and care other than as it relates to the deprivation of liberty
- the revisiting of individual assessments (other than by way of a limited amount of sampling).

8.6 The inspection process will not constitute an alternative review or appeal process. But should an inspection body come across a case where they believe deprivation of liberty may be occurring without an authorisation, they may initiate a third party application with the supervisory body in the same way that any other third party may.

8.7 The inspection body will look at the protocols and procedures in place. The aim is to use a small amount of sampling to evaluate the effect of these protocols and procedures on individual cases. The expectation is that this monitoring will 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.

8.8 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 granting in light of their local population. This information may be relevant to policy decisions about commissioning care and support services.

Checklists

Key points for care homes and hospitals (managing authorities)

In implementing the deprivation of liberty safeguards, managing authorities should be particularly aware of the following key points;

- Managing authorities need 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 into their care planning processes.

- A managing authority must not, except in an urgent situation, deprive a person of liberty unless a standard authorisation relating to the person's residence in that hospital or care home has been given by the supervisory body, 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 where it is considered to be urgent that the deprivation of liberty begins immediately. In such cases, authorisation must be obtained within seven days of the start of the deprivation of liberty.

- A managing authority must ensure that any conditions attached to the authorisation are complied with.

- 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)

In implementing the deprivation of liberty safeguards, supervisory bodies should be aware of the following key points:

- They will receive applications from managing authorities for standard authorisations of deprivation of liberty.
- Supervisory bodies will need to ensure that sufficient assessors are available to meet the needs of those in their area and that they have the skills, qualifications and training to perform the function.
- 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 required criteria (including that the deprivation of liberty is necessary to protect them from harm and will be in their best interests).
- Authorisation may not be given unless the assessors recommend it.
- 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 in writing to specified people and notify specified people of its decision.
- The supervisory body must appoint a relevant person's representative to represent the interests of every person that they issue a standard authorisation for deprivation of liberty for.
- At any time when an authorisation is in force, the relevant person, the relevant person's representative or any IMCA representing the individual has a right to require the authorisation to be reviewed by the supervisory body.

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.

- Prior to the expiry of the current period of authorisation, 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 relevant criteria 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 and appropriate.

- A decision to deprive a person of liberty may be challenged by the relevant person, or by the relevant person's representative, by means of an application to the Court of Protection, without requiring permission. 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.

- In a case where there is a question about whether or not a managing authority is authorised to deprive a person of their liberty, the deprivation will be lawful where it is necessary:
    - for the purpose of giving the person life-sustaining treatment, or
    - to prevent a serious deterioration in their condition

  while a decision as respects any relevant issue is sought from the court.

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

See flowchart below.

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.

1. Does the person lack capacity to consent to remain in the registered care home or hospital in order to receive the care or treatment that is necessary to prevent harm to them?

No – an application cannot be made as they have the capacity to agree to or refuse the proposed care. The person should be supported to make their own decision, and the care plan amended accordingly. If the person appears to require mental health treatment to which they do not consent and meets the criteria for detention under the Mental Health Act 1983, an application under that Act may be considered.

Yes – an application may be required.

2. Is the person who lacks capacity at risk of deprivation of liberty now or within the next 28 days?

No – an application is not required. This question should be reconsidered when changes are made to the person's care.

Yes – an application may be required.

3. Can the person receive the planned care or treatment via a less restrictive but still effective alternative than depriving them of their liberty?

No – an application may be required.

Yes – an application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue and that the care or treatment **is** provided via a less restrictive alternative, which may include a move or transfer to another facility.

4. Is the person 18 years of age or older (or going to turn 18 in the next 28 days)?

No – an application cannot be made but you may need to consider the use of the Children Act 1989, or if the person requires mental health treatment and appears to meet the criteria for detention under the Mental Health Act 1983, an application under that Act may be considered when appropriate.

Yes – an application may be required.

5. Is the person subject to any of the powers of the Mental Health Act 1983 in a way that would mean they are ineligible for a deprivation of liberty under the Mental Capacity Act 2005?

Yes – an application cannot be made. The relevant Mental Health Act 1983 powers should be used in these circumstances.

No – an application may be required.

6. Is the proposed deprivation of liberty at least in part in order to provide treatment and has the person made a valid and applicable advance decision to refuse that treatment?

No – an application may be required.

Yes – an application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue. If the person appears to meet the criteria for detention under the Mental Health Act 1983, an application under that Act could be initiated.

7. Is the proposed deprivation of liberty at least in part for the purpose of mental health treatment in hospital and does the person object to going to (or staying in) hospital or the proposed treatment? Does the person meet the criteria to be detained under section 2 or 3 of the Mental Health Act 1983 instead?

Yes (to both questions) – an application cannot be made (unless an attorney or deputy has consented on the person's behalf to the things to which the person objects.)

No (to either question) – an application may be required.

8. Has the person's attorney or deputy, who has the authority to do so, indicated that they will object to the person entering (or staying) in the hospital or care home or that they will refuse any or all of the proposed treatment or care on their behalf?

Yes – an application cannot be made. The care plan will need to be speedily reviewed and where necessary alternative arrangements made to ensure that an unauthorised deprivation of liberty does not commence or continue. If the person appears to meet the criteria for detention under the Mental Health Act 1983, an application under that Act may be considered.

9. Is it necessary in the person's best interests for the deprivation of liberty to begin immediately?

No – the managing authority needs to apply to the supervisory body for a standard authorisation – in the case of a registered care home to a local authority and in the case of a hospital to a PCT.

Yes – the managing authority should grant an urgent authorisation itself and apply to the supervisory body for a standard authorisation – in the case of a registered care home to a local authority and in the case of a hospital to a PCT.

No – an application **is** required.

Definition of capacity: the ability to make a decision about a particular matter at the time the decision needs to be made.

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