

# Deprivation of Liberty Safeguards

Best practice guidance for ADASS/DH Form 3

## **Acknowledgements**

The following guidance has been written by Lorraine Currie and developed collectively with contributions by numerous Best Interests Assessors (BIAs) from across the country, the regional Deprivation of Liberty Safeguards (DoLS) leads and with support from Neil Allen Barrister and lecturer. Others have contributed examples of aide-memoires, in particular Mick Stanley from the Association of Directors of Adult Social Services (ADASS) Yorkshire and Humberside region. The Local Government Association (LGA) are also grateful to Kate Lees and Ani Murr from the University of Wolverhampton in assisting with focus groups.

# Contents

Background	4
Guidance	6
FAQs	22
Burdens and benefits suggested template	23

# Background

## General comments:

Since April 2015, the BIA should be using the national ADASS/Department of Health (DH) forms. Please note ADASS/DH Form 3a is **only** for a situation where the BIA finds that there is no objective evidence of a deprivation of liberty occurring. In other words the acid test is not met. In all other cases a BIA should complete their assessments on Form 3 even if the person has been found to have capacity, as there may be other issues to address. Since the Supreme Court judgement in 2014 there are now more variables than there are forms due to the acid test applying to many more people.

It has been suggested during focus groups that the BIA may want to use a different font to the rest of the ADASS/DH form in order to make their words clear. Supervisory bodies may have their own requirements in relation to this.

BIAs will have their own style and supervisory bodies may have their own specific requirements beyond this guidance document. Therefore, this guidance is intended to assist BIAs with content rather than style.

Any best interests assessment being completed using ADASS/DH Form 3, whether this is completed by an employed BIA or an independent BIA, should follow the best practice guidance in this checklist and should adhere to the following general principles:

## General principles:

- It should be a professional report based on factual information and professional judgement.
- All information contained in the report should be related to the deprivation of liberty.
- There should be professional ownership of the report by the BIA and all detail should be contained in one report with no subsidiary reports or evidence recorded elsewhere. Ensure that documents relied on during the assessment are clearly identified within the report.
- The BIA is expected to write in the 'first person'.
- The BIA should articulate their reasons as well as their conclusions.
- The BIA should check with the person how they prefer to be referred to throughout their assessment but many supervisory bodies prefer the person's title and surname (eg 'Mrs Bloggs') to be used in the assessment.
- The assessment should be **objective, concise and unambiguous**. Where opinions, assumptions or 'hearsay' are recorded they should be clearly framed as such.
- Where information is being taken from previous assessments the source should be referenced (particularly relevant for reviews / renewals).

- The assessment should be spell-checked and proof read. It is a legal document. Try to avoid abbreviations and jargon. The BIA should remember that this assessment will be read by people who may not have had prior knowledge of the Deprivation of Liberty Safeguards.
- The ADASS/DH Form 3 stands as a whole and information does not need to be repeated.
- Most importantly of all, remember that **the assessment is about a person and they should be evident throughout the assessment.**

# Guidance

## Mental Capacity Assessment

### Practicable steps to support the person to make the decision

Bear in mind the assumption of capacity; that an unwise decision is not necessarily an incapacitated decision; that the burden of proof lies on the person asserting a lack of capacity; and that the standard of proof is the balance of probabilities. Do not judge capacity by reference to whether the person's decision is a 'good' or 'bad' one. Rather, your assessment is focusing on the mental process being followed by the person to arrive at their decision.

Remember that the person must be given the concrete options that are available now and in the reasonably foreseeable. The BIA must not assess capacity with a blank canvass.

The assessment begins with a clear requirement to state the practicable steps which have been taken to enable, support and improve the ability of the person to participate in the decision making process. Remember these steps are to enable the person to make the decision and should go beyond stating that the BIA considered the time, location and setting for the assessment.

One such step may be to carry out a reassessment or to return to the assessment at a better time. Other steps may include the use of assistive technology, support from another specialism, and communication tools.

It may be useful to discuss with the managing authority, social worker, care manager, and NHS staff what steps have already been taken to support the person to make the decision.

Even where communication is difficult, there are usually practicable steps the assessor can attempt to facilitate communication and involvement. Describe what these are and the extent to which they were successful. It is essential that the voice of the person is heard wherever possible.

### What is the evidence of impairment or disturbance in the functioning of mind or brain?

The impairment/disturbance will usually be diagnosed by a clinician, although a formal diagnosis is not necessarily required. It can be temporary or permanent. The BIA should highlight where the mental impairment is likely to be temporary.

### The functional test

An inability to undertake any one or more of these four aspects of the decision making process because of the impairment/disturbance will be sufficient for a finding of incapacity. Thus, a person lacking capacity may be able to understand and retain relevant information and communicate the decision but be unable, because of the impairment/disturbance, to use or weigh the relevant information.

Each of these functional areas (understand, retain, use/weigh, communicate) should be tested and evidence recorded. **Avoid using phrases which suggest the person has failed to prove something to you: s/he need not prove anything as the burden is on you.** It would be wholly inadequate to simply state their diagnosis as evidence of their inability in any of these areas. Neither is it adequate to make generalised statements about the particular impairment. This assessment must be entirely person centred.

If the circumstances permit, give some examples of the key questions you asked and the answers that were given that led you to believe that the person was unable to make the decision.

### Understand

Before 'understanding' can be tested it is necessary to identify what someone would need to understand in order to make the specific decision. It is good practice to identify some of the salient points in this section. For example you might say "In order to make this decision Mrs Smith would need to understand where she lives, what kind of establishment it is, what care she needs and receives and why she is there."

It is also important to ask the specific question that you are assessing the person's capacity to make. The level of understanding must not be set too high. The test is looking at their understanding of the salient points which you will need to have identified first.

If the person is unable to understand salient information please be sure to explain why you believe this is the case. Give some examples of how you provided the relevant information, and the individual's responses to this information that has led you to believe that the person was unable to make the decision.

The rationale for your conclusions in this box are very important as they may also justify why there is less detail recorded in the other functional areas. For some people their impairment may be so complex and their understanding so limited that the evidence that you record here, also provides evidence as to why the other functional areas of "retaining" and "using or weighing" do not meet the functional test.

## Retain

Be aware that there is a subtle distinction between 'retain' and 'remember'. To 'retain' something means that the person is able to hold onto it long enough to be able use it at the material time. Whereas to 'remember' is the ability to pull information back from their memory banks. A person may need aids to support their retention. This does not mean they will not meet this element of the functional test.

If the person is unable to retain salient information be sure to explain why you believe this is the case. Give examples. Some BIAs will tell the person their name in order to test this element and later ask them to remember it. If the person fails to do so they will refer to this as evidence the person is unable to retain information. This is not advised as the information is not relevant to the decision.

For this functional element it is important to remember that the test is based on the person retaining information in order to make a decision at the material time. If a further visit is necessary the BIA may consider leaving material behind that can support the person's retention of the relevant information.

## Use or weigh

Be clear about what the relevant information is and consider how the person can engage with the decision-making process. Consider their ability to see various sides of the issue and to understand the reasonably foreseeable consequences of making a decision or failing to do so.

It is important here not to consider someone as unable to make a decision because they are making an unwise or irrational choice. Equally bear in mind that the person may have applied his or her own values or outlook to the relevant information in making the decision and chosen to attach no weight to that information. That does not mean that s/he is unable to use or weigh it.

If the person is unable to use or weigh salient information be sure to explain why you believe this is the case. Please give examples.

## Communicate

If a person is able to understand, retain, and use/weigh, it would be rare for them to lack capacity on the sole basis that they cannot communicate their decision. This category exists only to pick up those people where communication is completely lacking. There is no requirement to describe at length the person's communication abilities here unless they fail to meet this requirement due to them.

## Conclusion/causative nexus

The person can only be proven to lack capacity if their inability to do one or more of the functional elements is 'because of' the impairment/disturbance (as opposed to something else). There must be a causal connection to prove incapacity. An inability 'related to' the impairment/disturbance would not, for example, be adequate to prove incapacity. The question is **not** whether the person's ability to make the decision is merely affected by their mental impairment/disturbance: rather, it is whether they are rendered 'unable' to make the decision 'because of it'.

## No Refusals assessment

This assessment is short and to the point and does not need much explanation. Note, however, that it is the view of any **welfare** Lasting Power of Attorney (LPA) or **welfare** deputy that counts. So if a property and affairs LPA/deputy objects, that does not necessarily prevent the use of DoLS (although it may give rise to funding issues). BIAs will need to make the Supervisory Body aware of any objection so that a decision can be made on the way forward. BIAs will need to check the type of LPA or deputy and if necessary can verify this with the Office of the Public Guardian (using form OPG100).

### Documents which have been considered as part of the assessment with dates

Please record all the documents used in the assessment. This will include the care plans. It may also include IMCA s39A reports, paid RPR reports, risk assessments, daily activity logs, daily record sheets, MCA documentation, health and social needs assessments, mental health records, Care Quality Commission inspection reports, records of restrictive practices, and past and present DoLS assessments.

It is important to identify any deficits in recording and comment on them later. The BIA can utilise the box with actions for others or can, if appropriate, set a condition relating to care records. It is useful to record both the date of documents you are relying on and the date that they were seen.

### Background information

The background and historical information relating to the current or potential deprivation of liberty provides the context to the assessment. It explains why the person is in that particular care home, for example, why they are considered to require residential care, what else has been tried, and what else has failed. This section should give the reader a sense of the person being assessed. It should result in a pen portrait which is person centred. It is useful to note here for example whether the person arranged their own admission and chose the care home when they had capacity to do so.

The following issues may be useful to document:

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

If carrying out a review, or a renewal of a previous authorisation, it is essential to consider previous conditions set and whether they have been met. It is useful to summarise the person's care and support needs on the ADASS/DH Form in order to determine the purpose of the authorisation. They can be recorded here or in the 'views of others' section.

# Best Interests Assessment

## Views of the relevant person

BIAs should use this section to record the person's views on the placement. Using their own words wherever possible. These views may be gathered from the person themselves, the observations of the assessor, or may come from what others are able to provide.

There should be emphasis on the person's past and present wishes, feelings, values and beliefs and matters which they would consider if they could. Did the person actually choose this care home for themselves for example? Whether the person is expressing an objection by any means, or whether they would do so if they could, may usefully be recorded here to assist with the issue of best interests. Objection may also be relevant to selection of a representative later.

The person may not be able to give their views but there may be information that gives an indication of what their views were in the past or would be likely to be now. It can be helpful to get information from others which provides evidence of the person's beliefs and values, however the BIA may need to distinguish historical evidence about the person's past wishes, feelings, beliefs and values from current information based on recent knowledge of the person. It would be useful to state that this is another person's reflection of the relevant person's views.

Bear in mind that sometimes wishes, for example, can be determined from the person's behaviour where they are unable to communicate. Also, there may be information from care notes and staff which will support their views. In such circumstances the BIA should also show what they did to observe how the person appeared to respond to their environment.

Some case law has attached greater weight to a person's views if they are closer to having capacity as well as the strength and consistency of their view. It is useful to record exactly what the person says in this section. Please avoid correcting any inaccurate information the person may give you as this is a reflection of their views.

It is good practice to read at least the past month of daily records to gauge how consistent the person's views are.

If there is an LPA or Deputy for Health and Welfare, the BIA should remember to ask them about the person's wishes, feelings, beliefs and values.

## Views of others

In this section you are recording the views of others in relation to the care restrictions which amount to a deprivation of liberty, and in order to gather information about the person's wishes, feelings, beliefs and values to assist with the best interest's decision.

The views of all those consulted should be recorded in the ADASS/DH Form 3. Record the views of the MH assessor in terms of the impact of the deprivation. Show how you have considered these. You will already have recorded the documents you have considered so it is not necessary to repeat it here.

Record all views, especially where they are conflicting and particularly those who may be objecting to the deprivation of liberty.

If not all family members were consulted, please record whether one of them speaks for all the family. It is also important not to omit consultation with someone who may have a dissenting view. If a family member or significant other is objecting, an application to the Court of Protection may need to be considered, so BIAs should make a clear note of this for the Supervisory Body's consideration. Please note that the DoLS do not cover breaches of Article 8 ECHR (eg monitoring or prohibiting contact with family members), even where the family are abusive; these matters would have to be adjudicated by the Court.

## **The objective and subjective elements should be evidenced with a brief statement of why the deprivation is imputable to the state.**

There should be ownership of the assessment by the BIA as an Independent Practitioner; for example "In my professional opinion, the measures in place amount to a deprivation of the person's liberty".

The assessor will provide evidence of all three critical conditions namely the objective and subjective elements of deprivation and whether the deprivation is imputable to the State in order to evidence the acid test is met.

## Objective element

This focuses upon the evidence of confinement in a particular restricted space for a not negligible period of time. Please consider the concrete situation of the person including type, duration, effects and manner of implementation of the measures in question in order to determine whether they meet the acid test of (1) complete or continuous supervision and control and (2) not free to leave.

It is not adequate to simply state that the acid test is met: this must be supported by evidence. Reference to the following factors and the descriptors in the Code of Practice (read in the light of the acid test) are still useful. Please provide details of the number of hours of supervision and under what situations and details of the type of control exercised by staff/carers. Factors will include but are not limited to:

- Descriptions of all personal care and how this is provided.
- A description of choices which the person is able to exercise.
- The environment around the person and in which they receive care.
- Medication and in particular any sedative or antipsychotic medication: describe the type being administered and the method of administration; does it affect mood, alertness, behaviour?
- Use of behaviour methods, charts and monitoring.
- Use of physical restraint: describe the situations when physical restraint is used; the type of restraint, the frequency and duration.
- Whether staff ratios vary by day and night.
- Any limits on movement or contacts.
- Particular risk management plans.

In relation to freedom to leave, this does not relate to the ability of the person to express a desire to leave but on what those with control over their care arrangements would do if they attempted to leave.

Use this evidence to determine whether the acid test is met. Demonstrate how you have reached your decision not just the decision you have made.

### **Subjective element**

This considers whether there is a lack of valid consent to be in the accommodation to receive care and/or treatment. This should have been evidenced in the mental capacity assessment. It is not necessary to repeat the reasoning here but it is adequate to refer to the earlier conclusions.

If the BIA has not carried out the mental capacity assessment they must have a copy of it and refer to it in this section. The BIA should notify the supervisory Body if there are significant concerns regarding the quality of the capacity assessment.

There may be possible instances of an unlawful deprivation of liberty if the individual has capacity but is not consenting to their accommodation for care or treatment

### **Imputable to the state**

Please explain whether the State is responsible for the deprivation of liberty. This will usually be straightforward even for those who fund their own care. The following may be useful:

- the local authority was involved in the care planning process which led to the person's placement
- the care home is registered under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010
- the care home/hospital is inspected by a public authority, the Care Quality Commission.

## Why is the deprivation of liberty necessary to prevent harm to the person?

Please describe the harm the person would otherwise experience which makes the deprivation of liberty necessary.

This is a key part of the overall decision making. The question you are asking is “Why can this harm not be avoided in any other way than by depriving the person of their liberty?”

It is important to distinguish harm from hazards (ie things which have the potential to cause harm).

Include particulars of the harm that will be avoided by depriving the person of their liberty (that will be mitigated / avoided by the proposed care arrangements).

Document evidence, examples and dates where possible. This should include severity of any actual harm and corroboration of any anecdotal evidence. The harm should be specific to the person and not to a particular client group.

It could include (but is not limited to) physical, psychological, emotional, financial forms of harm.

It should only include the specific harm which requires the person to be deprived of their liberty, not other types of harm which could be managed in less restrictive ways.

The assessor should consider why the deprivation of liberty is **necessary** to prevent harm to the person.

Include evidence in this section even if it has already been mentioned elsewhere in the form; this is the place where the evidence of harm should be consolidated in order to justify a measure which is so extreme it deprives a person of their liberty.

The BIA will consider why the current care and treatment is the least restrictive option in arriving at a conclusion that a deprivation of liberty is necessary to prevent harm.

Many BIAs provide a list of harms; this is acceptable as long as the above principles are followed.

### **Why is deprivation of liberty a proportionate response to the likelihood and seriousness of harm?**

Relate this response specifically to the risks of harm identified above; do not repeat the list or descriptions of harm.

Detail the severity of harm that is likely to be avoided by the authorisation.

Describe why the seriousness of the harm means that the deprivation of liberty is a proportionate response.

Comment on the likelihood of the harm occurring if the person is not deprived of their liberty.

In deciding whether the deprivation of liberty itself is a proportionate response to the harm consider:

- Should the person be here in the first place? But bear in mind the reality of only being able to consider available options.
- What else has been explored and why have other options been discounted? It is important to explain why options are not available in order to evidence that they have been considered.
- Make it clear what alternatives have been considered in terms of placement as well as adjustments to the care plan.
- If the BIA feels that there are less restrictive options available now or in the reasonably foreseeable future, they may still need time to facilitate and may also need actions to be carried out by others such as the care manager. These can be recorded on the Form 3.

Do not forget to consider the impact on the person of their wishes not being adhered to.

## MCA section 4 best interests checklist should be evidenced

You should consider the provisions of section 4 of the Mental Capacity Act 2005, the additional factors referred to in paragraph 4.61 of the deprivation of liberty safeguards Code of Practice and all other relevant circumstances. Remember that the purpose of the person's deprivation of liberty must be to give them care or treatment.

You must consider best interests from the incapacitated person's point of view. Crucially, consider whether any care or treatment the person needs can be provided effectively in a way that is less restrictive of their rights and freedom of action. This should include which options have been tried and considered. You should provide evidence of the options considered. What else has been explored and why have they been ruled out? Make it clear what alternatives have been considered in terms of placement as well as adjustments to the care plan. You can refer to your reasoning under the sections discussing harm.

The statutory checklist should be referenced or be apparent in the text. This can be summarised as

1. Equal consideration and non-discrimination.
2. Consider all relevant circumstances.
3. Consider P regaining capacity.
4. Permitting and encouraging participation of P.
5. P's past and present wishes, feelings, beliefs and values (the BIA should consider all four).
6. Views of other people.
7. Life sustaining treatment decisions should not be motivated by the desire to bring about P's death.
8. Other factors the person would be likely to consider if s/he were able to do so.

This is not an exhaustive list; it is just a minimum. Please bear in mind that you are looking at best interests in the widest sense from P's point of view and not, for example, best 'medical' interests. You must therefore consider not just health related matters but also emotional, social and psychological wellbeing also. Consider what the person might have decided if they had had capacity to do so.

All too often the risk of emotional harm is not given the consideration / weight that it merits. Specific issues of culture need to be considered throughout.

The assessor should consider the degree of weight and importance to be attached to the person's wishes and feelings - the strength and consistency of their views. Are the wishes realistic ie do they really have a home/spouse to return to?

Consider the possible impact on the person of their wishes and feelings not being adhered to. This may be a useful place to refer to the Mental Health Assessor's conclusions regarding the likely effect of being deprived of liberty.

Consider whether the person's wishes and feelings can be accommodated within the overall assessment of what is in their best interests.

There should be evidence of your decision making and not just your decision. It is important to show that you have used the checklist to gather evidence and then you have weighed that evidence.

There should be evidence of your decision making and not just your decision. It is important to show that you have used the checklist to gather evidence and then you have weighed that evidence.

To determine best interests, there should be a burden and benefits analysis (pros and cons) of **each available option** with additional weight given to different factors as appropriate (there is a table to assist with this at the end of this document). This will be in the form of a balance sheet. These options must be realistically available which is likely to mean that there must be funding available or reasonably foreseeable for an option if you are to consider it. You are not looking at unavailable possibilities.

In many situations there will only be one placement for the BIA to consider. You will have evidenced elsewhere in the Form why other placements are not available. Even within that one placement, however, there may be less restrictive ways of providing the necessary care or treatment.

Remember the best interests process is quite separate from the duty of the local authority to assess and meet care and support needs. This process should have been carried out before your assessment which means that you should know what the available options are.

Once you have analysed the benefits and burdens you need to draw a conclusion.

## Length of time for the deprivation

When setting a time limit, explain why you have chosen that maximum and what, if anything, needs to be achieved within that time frame. Give your rationale. In determining the duration, you should take into account any prior period of unlawful detention. If you are setting conditions remember to allow time for those conditions to be met.

If the person is settled with very little possibility of any change either in them or in the regime then a longer authorisation will probably be appropriate.

In an acute hospital setting it is likely that a short authorisation will be needed.

The following may suggest a longer authorisation:

- the situation will not change
- the persons mental and physical health is unlikely to improve
- the person is settled
- all those concerned are in agreement.

The following may suggest a shorter authorisation:

- issues/concerns/objections been raised by others
- conditions to be set or not previously met
- expectation that something will change
- person may recover physically/mentally
- there are alternatives to place of care
- placement is not meeting their needs.

Also think about the setting which can link to the length of the authorisation eg general hospital is likely to be a shorter stay, placement in a care home likely to be a longer stay.

### Only recommend appropriate conditions

When recommending conditions ensure they are not care planning issues. Consider whether the condition(s) would be needed even if the person was not deprived of their liberty. If the answer is 'yes', then it is likely to be a care planning issue. If the answer is 'no', it is likely to be a legitimate condition related to the deprivation of liberty.

If possible, please request the managing authority to submit evidence to demonstrate adherence with the conditions recommended. Remember to tick the box to be consulted again if conditions are changed. Any conditions should be negotiated with and achievable by the managing authority as they 'must. comply with them according to the legislation.

Conditions should be SMART:

**Specific** – clear to and negotiated with staff of care home or hospital.

**Measurable** – how will you know if they are met?

**Achievable** – the care home or hospital is responsible for them.

**Relevant** – directly related to the DoLS itself (see code of practice).

**Time specific** – when do they need to be achieved?

If you are completing a review or renewal assessment check if the conditions were followed/achieved. If not, then consider 'why?'. Depending on the answer you should look at other options such as making a 'recommendation' in writing to the supervisory body.

Conditions must be negotiated with the managing authority and be within their remit to adhere to. It is the BIA's responsibility to check with the managing authority that they can meet the recommended conditions.

Remember that conditions cannot be used to compel other organisations such as the commissioners to act. You can only recommend a condition that would have been available to the person had they been able to make the decision for themselves.

However, conditions may be used to require the managing authority to refer to other bodies, for example to refer to the local authority for a necessary assessment.

Recommendations or actions for care managers, social workers, commissioners or health professionals can be provided later in the ADASS/ DH Form.

Please use this section to highlight issues from your report which are care management issues. Things which need to be done or observations which may impact on the care planning process. This may include consideration of options which appear to be available to the person. The BIA may feel that the best interests decision making process has not been followed and want to suggest further considerations or the person may need a referral to another type of service such as for a seating assessment.

### **Throughout the report there should be evidence of the BIA's awareness of current case law principles**

A BIA needs to keep up to date with relevant case law. Up to date knowledge of relevant case law should be apparent from the Form 3 and the BIA should be applying the overarching principles of the case law to the particular facts before them. It is unnecessary to cite case law in the report.

### **Selection and recommendation of Representative**

It is important to note that there are two stages to this process for the BIA. The first is to select; the second is to recommend. You must recommend the representative no matter who has selected them. By recommending them to the Supervisory Body you are confirming that the person selected is eligible and would:

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

You must refer to the guidance notes (and it is advisable to read the AJ case in full) ([AJ Case](#))

It is essential that you identify any potential conflicts of interest. This will involve evidence as to whether the representative was involved in a best interests decision about the placement. However, this does not necessarily mean a possible representative is automatically discounted. They could still be suitable if they will challenge the authorisation if the relevant person objects.

It is also good practice to ensure that the representative is fully informed about the role, that non-means tested legal aid is available, and that they know what action to take in the event of a future objection by the person or a future conflict of interest.

### Completion of Form 3/3a following negative eligibility assessment

In line with good practice, in the event of a **negative eligibility assessment**, the mental health assessor should refer for the MHA assessment as detailed on ADASS/DH Form 4. The BIA should still address the question of whether the regime amounts to a deprivation of liberty. Supervisory Bodies will vary in approach as to when they require this information on ADASS/DH Form 3 (or ADASS/DH Form 3a if it is not a deprivation of liberty). The BIA should provide the assessing Mental Health Act team with their opinion about deprivation of liberty and promote discussion with the eligibility assessor/make the eligibility assessment available to the team.

If the MHA assessment does not result in detention under the MHA the reasons why should be conveyed to the Supervisory Body so that they can review their position on eligibility.

The BIA may be asked to complete Form 3, giving their opinion about deprivation of liberty. If the person is deprived, the BIA should indicate that this is an unauthorised deprivation on ADASS/DH Form 3 and if necessary generate an associated safeguarding referral. The BIA should provide clear directions about how the unauthorised deprivation of liberty can be resolved, which may include releasing the person or seeking authorisation from the Court.

# FAQs

Question	Answer
Does a BIA have to consult every single family member eg there are three adult children, do you speak to all of them or just one?	Where it is practicable and appropriate to consult them, you should speak to all those interested in the person's welfare. It will not always be practicable or appropriate however.
Can a health and welfare LPA or deputy authorise a deprivation of liberty without the need to use DoLS?	No
If there is only one available option do I still need to consider others?	If there is only one option say there is only one option. Note, however, that there may be less restrictive ways of providing the necessary care or treatment within the placement.  Authorisation conditions and a shorter duration may then be used to pursue that care regime which is less restrictive of the person's rights and freedom of action.
If the person chose the care home themselves when they had capacity does that still count as consent?	No DoLS is still needed at the stage when the person has lost capacity to make the relevant decision.
If there are no options available now but the BIA feels that there could realistically be options available in the future what should they do	The BIA needs to reflect in their report their own findings and if these have highlighted options which the funding body would be prepared to fund and which it seems may become available they should say so and raise it as a recommendation for the care manager and or commissioners of the care.

# Burdens and benefits suggested template

## Benefits and burdens, best interests balance sheet

### Example 1

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

Benefits of own home (A)	Benefits of care home (B)
<p><b>1. Continues to remain in a familiar place.</b></p> <p>2. She does not feel unsafe.</p> <p>3. She wants to be independent.</p> <p>4. She wonders why she is in a hotel and not at home.</p> <p><b>5. More family contact and maintaining community contacts.</b></p> <p>6. Increased care package.</p> <p><b>7. This is where she is happiest.</b></p>	<p><b>1. Regular meals/hydration.</b></p> <p>2. Prompting with medication.</p> <p>3. Prompting with personal care/hygiene.</p> <p>4. Pressure/skin area support/treatment.</p> <p>5. Physical safety improved.</p> <p>6. Staff available 24/7 to deal with crisis.</p> <p>7. Ongoing reassurance for her anxieties.</p> <p><b>8. Improved dignity.</b></p> <p>9. Release strain on family members.</p> <p>10. Anti-depressants and anti-psychotics can be administered.</p> <p><b>11. She enjoys the company of others.</b></p> <p>12. TLC and treatment may slow her decline.</p> <p>13. Less need for her to contact emergency services.</p> <p>14. Reduced possibility of exploitation/cold callers.</p>

Plus burdens of own home (A)	Plus burdens of care home (B)
<p><b>8. Not eating or drinking enough.</b></p> <p>9. Insufficient/irregular medication. Deteriorating personal hygiene.</p> <p>11. Deteriorating pressures areas. Risks of wandering/falls. Increased psychological distress. Community/family support has failed</p>	<p>15. Likely to be affected by not being in own home.</p> <p><b>16. Loss of independence.</b></p> <p>17. Inevitable short term anger/distress.</p> <p>18. Stronger possibility of depression.</p> <p>19. She may just give up.</p> <p>20. Problems with contact and community activities.</p>

## Example 2

This hypothetical involves a woman in her 70s with bipolar affective disorder, vascular dementia and personality disorder who was being required to reside by her guardian in a nursing home, which she was also subject to a DOLS authorisation, but wanted to return to her own home.

Benefits of care home (A)	Benefits of returning home (B)
<ol style="list-style-type: none"> <li>1. Staff are able to facilitate regular contact with her son.</li> <li>2. Encouraged to engage in leisure and social activities routinely with support.</li> <li>3. Is able to attend local church, go shopping and see friends.</li> <li>4. <b>Familiar environment where she has mostly resided for more than 1 year.</b></li> <li>5. <b>Mental health and associated symptoms can be effectively monitored and deterioration minimised.</b></li> <li>6. Accurate standardised and functional assessments can be offered and more effectively completed.</li> <li>7. Readily available support to maintain self-care and activities of daily living. P will accept help with self-care in the nursing home, and in fact will demand it, whereas will refuse it at home.</li> <li>8. Nursing home staff are able to manage her emotional responses to promote positive mental health and wellbeing.</li> <li>9. <b>Staff are able to manage her diet, fluid intake and prescribed medication in respect of her physical ill health.</b></li> <li>10. Encouraged to use walking frame to maintain mobility and to minimise risk of falls.</li> <li>11. Minimises risk of financial exploitation.</li> <li>12. Friend now believes that she requires 24 hour support.</li> </ol>	<ol style="list-style-type: none"> <li>1. <b>Recognises her Article 8 right to respect for her home, private and family life.</b></li> <li>2. <b>This is where she feels most content and where she probably feels as though she belongs.</b></li> <li>3. During trial was observed as being able to use her mobility scooter safely.</li> <li>4. She believes that she can cope at home.</li> <li>5. Accepted breakfast being prepared by care team during trial. Friend indicates that she will eat if not eating alone.</li> <li>6. Able to use local shops independently during trial to purchase fast food. Was supported by shop staff to put her purse away safely and to carry items to her scooter.</li> <li>7. Was mostly able to manage her medication during trial.</li> <li>8. During trial was able to wash her own clothes and attend to self-care, although care staff observed that personal care was not attended to.</li> </ol>

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





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