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| Case ID Number: | | | | | | | | |
| **DEPRIVATION OF LIBERTY SAFEGUARDS FORM 4**  **MENTAL CAPACITY, MENTAL HEALTH, and ELIGIBILITY ASSESSMENTS** | | | | | | | | |
| This combined form contains 3 separate assessments; if any assessment is negative there is no need to complete the others unless specifically commissioned to do so by the Supervisory Body. | | | | | | | | |
| **Please indicate which assessments have been completed**  *(\*Supervisory Bodies will vary in practice as to who completes the Mental Capacity assessment)* | | | | | | | | |
| Mental Capacity**\*** |  | Mental Health | |  | Eligibility | | |  |
| This form is being completed in relation to a request for a standard authorisation. | | | | | | | |  |
| This form is being completed in relation to a review of an existing Standard Authorisation under Part 8 of Schedule A1 to the Mental Capacity Act 2005. | | | | | | | |  |
| Full name of the person being assessed | | |  | | | | | |
| Date of birth  *(or estimated age if unknown)* | | |  | | | Est. Age |  | |
| Name of the care home or hospital where the person is, or may become, deprived of liberty | | |  | | | | | |
| Name and address of the Assessor | | |  | | | | | |
| Profession of the Assessor | | |  | | | | | |
| Name of the Supervisory Body | | |  | | | | | |
| The present address of the person being assessed if different from the care home or hospital stated above. | | |  | | | | | |

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| **MENTAL CAPACITY ASSESSMENT** *Place a cross in ONE of the following boxes* | |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process. ***Please describe these steps:*** | |
| In my opinion the person **LACKS** capacity to make their own decision about whether they should be accommodated in this hospital or care home for the purpose of being given the proposed care and / or treatment because of an impairment of, or a disturbance in the functioning of the mind or brain |  |
| In my opinion the person **HAS** capacity to make their own decision about whether they should be accommodated in this care home or hospital for the purpose of being given the proposed care and / or treatment |  |
| **Stage One:** What is the impairment of, or disturbance in the functioning of the mind or brain? | |
|  | |
| **Stage Two:** | |
| 1. **The person is unable to understand the information relevant to the decision:**   *Record how you have tested whether the person can understand the information, the questions used, how you presented the information and your findings.* |  |
| b**. The person is unable to retain the information relevant to the decision:**  *Record how you tested whether the person could retain the information and your findings.* |  |
| c. **The person is unable to use or weigh that information as part of the process of**  **making the decision:**  *Record how you tested whether the person could use and weigh the information and your findings.* |  |
| d. **The person is unable to communicate their decision (whether by talking,**  **using sign language or any other means:**  *Record your findings about whether the person can communicate the decision.* |  |
| e. **Conclusion** (including any further input needed). *Record the conclusion of the assessment stating clearly whether the person is unable to make the specific decision as a result of the impairment or disturbance in the functioning of their mind or brain. Explain why the person’s inability to decide the matter is because of their impairment of, or disturbance in the functioning of the mind or brain:* | |

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| **MENTAL HEALTH ASSESSMENT** | | |
| In carrying out this assessment, I have taken into account any information given to me, and any submissions made by any of the following:   1. The relevant person’s representative 2. Any IMCA instructed for the person in relation to their deprivation of liberty 3. I have consulted the Best Interests Assessor for any relevant information about possible objections to treatment, including whether any donee or Deputy has made a valid decision to consent to any mental health treatment. | | |
| **Place a cross in EITHER box below** | | |
| In my opinion the person **IS NOT** suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).  ***Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour*** | |  |
|  | | |
| In my opinion the person **IS** suffering from a mental disorder within the meaning of the Mental Health Act 1983 (disregarding any exclusion for persons with learning disability).  ***Provide a rationale for your opinion, including details of their symptoms, diagnosis and behaviour*** |  | |
|  | | |
| In my opinion, the person’s mental health and wellbeing is likely to be affected by being deprived of liberty in the following ways: | | |

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| **ELIGIBILITY ASSESSMENT**  *Reference to Cases A to E refers to the cases of ineligibility for DoLS described in* ***MCA Schedule 1A*** | | | | | | |
| **Answer ALL of the following questions Yes or No, by placing a cross in the relevant box.** | | | | | | |
| The person is detained under section 2, 3, 4, 35-38, 44, 45A, 47, 48 or 51 of the Mental Health Act 1983(*Case A*). | | | | | Yes |  |
| No |  |
| The person is subject to s17 leave or conditional discharge (*Case B*), or Community Treatment Order (*Case C*), or Guardianship (*Case D*), and a Standard Authorisation would be incompatible with a Mental Health Act requirement (e.g. as to residence) | | | | | Yes |  |
| No |  |
| If you have answered “Yes” to either of the above, the person is ineligible for DoLS.  *Please give reasons/explanation for your answer:* | | | | | | |
| **Hospital Cases Only (*Case E*)** | | | | | | |
| The purpose of detention is to receive medical treatment for mental disorder  ***Please explain further:*** | | | | | Yes |  |
| No |  |
| In my opinion this person could be detained under the Mental Health Act (on the assumption that the person cannot be assessed and treated under the Mental Capacity Act 2005  ***Please explain further:*** | | | | | Yes |  |
| No |  |
| **If the answer to both of the above statements is YES please consider the next two statements**  **If either of the below are ticked the person is ineligible for DoLS** | | | | | | |
| The person objects, or would object if able to do so, to some or all of the medical treatment for a mental disorder  ***Please explain further:*** | | | | | Yes |  |
| Are the deprivation of liberty safeguards the least restrictive way of best achieving the proposed care and treatment?  ***Describe the least restrictive way of best achieving the proposed care and treatment:*** | | | | | No |  |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | |
| Signed |  | Date | |  | | |
| Print Name |  | Time | |  | | |
| ***In order to safeguard their rights please request that the person is assessed under the Mental Health Act and confirm this below:*** | | | | | | |
| **CONFIRMATION OF REQUEST FOR MENTAL HEALTH ACT ASSESSMENT** | | | | | | |
| Date and Time of request for Mental Health Act Assessment | | |  | | | |
| Name of Person to which the request was made | | |  | | | |