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| Case ID Number: Click here to enter text. | | | | | | | | |
| **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 | | | Click here to enter text. | | | | | |
| Date of birth  *(or estimated age if unknown)* | | | Click here to enter text. | | | Est. Age | Click here to enter text. | |
| Name of the care home or hospital where the person is, or may become, deprived of liberty | | | Click here to enter text. | | | | | |
| Name and address of the Assessor | | | Click here to enter text. | | | | | |
| Profession of the Assessor | | | Click here to enter text. | | | | | |
| Name of the Supervisory Body | | | Click here to enter text. | | | | | |
| The present address of the person being assessed if different from the care home or hospital stated above. | | | Click here to enter text. | | | | | |

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| **MENTAL CAPACITY ASSESSMENT** | |
| The following practicable steps have been taken to enable and support the person to participate in the decision making process:  Click here to enter text. | |
| In my opinion the person **LACKS** capacity to decide whether or not they should be accommodated in this hospital or care home for the purpose of being given the proposed care and/or treatment, and the person is unable to make this decision because of an impairment of, or a disturbance in the functioning of, the mind or brain. |  |
| In my opinion the person **HAS** capacity to decide whether or not they should be accommodated in this hospital or care home 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? | |
| Click here to enter text. | |
| **Stage Two:** Functional test | |
| 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.*  Click here to enter text. |  |
| 1. **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. Note that a person’s ability to retain the information for only a short period does not prevent them from being able to make the decision.*  Click here to enter text. |  |
| 1. **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.*  Click here to enter text. |  |
| 1. **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.*  Click here to enter text. |  |
| **Stage Three:** *Explain why the person is unable to make the specific decision because of the impairment of, or disturbance in the functioning of, the mind or brain.* | |
| Click here to enter text. | |

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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*** | |  |
| Click here to enter text. | | |
| 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*** |  | |
| Click here to enter text. | | |
| In my opinion, the person’s mental health and wellbeing is likely to be affected by being deprived of liberty in the following ways:  Click here to enter text. | | |

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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:*  Click here to enter text. | | | | | | |
| **Hospital Cases Only (*Case E*)** | | | | | | |
| The purpose of detention is to receive medical treatment for mental disorder  ***Please explain further:***  Click here to enter text. | | | | | 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:***  Click here to enter text. | | | | | 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:***  Click here to enter text. | | | | | 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:***  Click here to enter text. | | | | | No |  |
| **PLEASE NOW SIGN AND DATE THIS FORM** | | | | | | |
| Signed | Click here to enter text. | Date | | Click here to enter a date. | | |
| Print Name | Click here to enter text. | Time | | Click here to enter text. | | |
| ***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 | | | Click here to enter text. | | | |
| Name of Person to which the request was made | | | Click here to enter text. | | | |