MENTAL CAPACITY ACT 2016

WHAT DOES DEPRIVATION OF LIBERTY MEAN FOLLOWING THE UK SUPREME COURT JUDGMENT ON 2ND JUNE 2026?

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1. THE NORTHERN IRELAND ATTORNEY GENERAL REFERENCE ON DOLS / VALID CONSENT (UKSC/2025/0042, [2026] UKSC 16)

1.1 The Court was asked to determine whether the Minister of Health had the legal authority to amend the Deprivation of Liberty Safeguards (DoLS) Code of Practice (issued under section 288 of the Mental Capacity Act (Northern Ireland) 2016) so as to allow individuals aged 16 and over who lack capacity to make decisions about their care and treatment to be regarded as giving valid consent through the expression of their wishes and feelings, and whether such amendments would be compliant with Article 5 of the European Convention of Human Rights (ECHR).

1.2 The Court held that these changes were ECHR Article 5 compliant and as such the Minister of Health would be acting within his powers in making the proposed changes, and that the Code of Practice can therefore be revised accordingly ("the 2nd June judgment").

1.3 In doing so, the Supreme Court also established a new approach for determining whether a person (P) is deprived of their liberty for the purposes of Article 5.

Before the decision:

P was considered deprived of their liberty if they were subject to continuous supervision and control and were not free to leave (the Cheshire West "acid test"), even where they appeared content and the arrangements were normalised or the least restrictive option (commonly referred to as 'the Cheshire West Acid Test').

Now:

The Cheshire West "acid test" is no longer sufficient on its own. Determining whether P is deprived of their liberty now requires a multi-factorial/holistic, context-specific assessment of all of the person's circumstances.

The 2nd June Judgment

1.4 Whilst the 2nd June judgment has changed the considerations required with regard to whether a person is subject to a Deprivation of Liberty (DoL), it remains the case that P must lack capacity in relation to the decision. There must be a reasonable belief that P lacks capacity, or this must be formally established through a capacity assessment. If there is a belief that P has capacity, then they should not be deprived of their liberty and the Mental Capacity Act (MCA) does not apply.

1.5 Prior to the 2nd June judgment, if a person was under continuous supervision and control and not free to leave (the "acid test" established through Cheshire West), they were deemed to be under a DoL and, as such, the appropriate safeguards had to be put in place in order to provide protection from liability and to ensure that the detention was lawful.

1.6 The 2nd June judgment means that the acid test of being "under continuous supervision and control and not free to leave" is no longer sufficient on its own to assess if a person is subject to a DoL. Instead, it must now be considered as part of a multi-factorial, context-specific assessment of all the relevant factors.

1.7 Further to this, the Court has ruled that a lack of capacity under the MCA no longer automatically prevents a person from giving valid consent for the purposes of determining whether there is a DoL under Article 5. P may be assessed as lacking capacity in relation to decisions about their care and residence, but may still, in Article 5 terms, be capable of giving or withholding valid consent through the expression of their wishes and feelings. This will depend on whether P has sufficient awareness to indicate that they are content or unhappy with their living arrangements.

1.8 Importantly, valid consent is an autonomous concept under Article 5. It is not the same as, nor dependent on, the MCA test of capacity to decide on care and residence arrangements.

1.9 In the same manner as prior to the 2nd June judgment, and throughout the process outlined in this guidance, practitioners should remain person-centred in their approach. Whilst the 2nd June judgment reviewed if these changes would be compliant with Article 5, practitioners should remain mindful of Article 8 of the ECHR and consider any infringement on the individual's right to a private and family life.

1.10 Practitioners should:

- Remain person-centred at all times.
- Focus on P's individual circumstances, experiences, and perspective.
- Avoid assumptions based on diagnosis, setting or level of support.

1.11 In relation to P's best interests and their rights under Article 8, consideration should be given to:

- **Appropriateness of care and treatment**
  Consider whether P is receiving the care and treatment that meets their needs and supports a life that is as close as possible to normal for them.

- **Proportionality and restriction**
  Assess whether the level of restriction is proportionate and in P's best interests, taking into account their Article 8 rights. Consider whether restrictions are justified in light of what would be relatively normal for a person in P's circumstances.

- **Least restrictive option**
  Determine whether the arrangements represent the least restrictive way of delivering care, including respect for:
  - family life
  - privacy
  - the ability to enjoy their home environment.

  Do the arrangements enable a life that approximates ordinary living and avoid unnecessary or excessive control beyond what is relatively normal?

- **Additional safeguards**
  Confirm that appropriate safeguards are in place to protect P's rights, wellbeing, and dignity.

1.12 The principles of the MCA remain applicable, including the offer of all practicable help and support to P and ensuring their best interests are considered throughout.

2. MULTI-FACTORIAL/HOLISTIC ASSESSMENT

2.1 In the 2nd June judgment the Court ruled that a multi-factorial assessment is required when considering whether the objective element of a DoL has been met. The judgment identified a number of relevant factors to consider, although this list is not exhaustive:

1	**The type of restrictions involved** Identify and describe any restrictions in place, such as: • physical restraint • locked doors or restricted exits • isolation or limited movement • controlled or limited contact with others (including family).
2	**The duration and frequency of the restrictions**
3	**The effect of the restrictions on the individual**
4	**The presence or absence of objection** if the person is capable of objecting or giving tacit agreement. This includes consideration of force, coercion and sedative medication.

	The absence of objection may make it difficult to conclude that there is a deprivation of liberty; however, this must be considered alongside all other relevant factors.
5	**The manner of implementation of the restrictions** (how they are applied in practice). Evaluate the degree of supervision and control over the person's movements, the possibility for them to leave the restricted area, the extent of isolation and the availability of social contacts.
6	**The 'relative normality' of the placement** • Consider whether P's day-to-day life reflects relative normality, including: o freedom of movement within and beyond the home o meaningful activities and choices o social interaction and relationships. • Consider what would be 'relatively normal' for a person in P's position, recognising that restrictions arising from disability or care needs may form part of ordinary life.
7	**The level and combination of the restrictions** Consider whether the intensity and overall combination of restrictions go beyond what would be relatively normal for someone living in a similar care setting.
8	**The purpose of the measures** (in "borderline cases" where the measures are far from the 'paradigm' case of detention in a prison cell): the extent to which the measures are therapeutic, and their proportionality to that purpose. Consider whether the arrangements are genuinely for care, protection, and enabling as normal a life as possible, or whether, in reality, they amount to detention from P's perspective.
9	**Whether the situation amounts to confinement** Consider whether the person's situation amounts to actual confinement, or whether it is closer to ordinary living arrangements with care and support.
10	**Whether other relevant rights are engaged** Consider whether other relevant human rights, including Articles 2, 3 and 8, are engaged, particularly in light of the potentially intrusive nature of the assessments required to determine whether there is a DoL.

2.2 If, following this assessment, it is decided that the objective element of a DoL is met, the next step is to consider the subjective element, including whether P is demonstrating valid consent

3. VALID CONSENT

Valid Consent

3.1 The issue of valid consent arises when considering the subjective element of a DoL. In its 2nd June judgment, the Court made clear that even if a person lacks legal capacity to make decisions about their care and treatment, their views should still be considered. If they are able to show an understanding of the arrangements and express agreement to them, this may amount to valid consent and should be respected.

3.2 If the objective element of a DoL is established, so that the arrangements amount to a deprivation of liberty, the subjective element should then be considered, including the issue of valid consent.

3.3 Do not assume that a lack of capacity under the MCA automatically equates to a lack of valid consent regarding those care and treatment arrangements, these are assessed separately. Each must be considered independently and clearly evidenced.

What counts as 'Valid Consent'?

- **Core test: sufficient awareness**
  The key question is whether P has: "*sufficient awareness of the circumstances in which they are maintained in confinement as to be able to register whether they are happy or unhappy with those circumstances and to enter protest against their treatment if they are unhappy with them*" (para 135 of the 2nd June judgment).

- **Ability to express wishes and feelings**
  Where P has a basic level of awareness of their living arrangements and can:

    - recognise their situation, and
    - communicate whether they are happy or unhappy,

  they may be treated as able to give or withhold valid consent.

- **Contentment is not the same as consent**
  Do not treat apparent happiness, compliance or lack of objection as automatic evidence of valid consent. There must be a clearer indication of P's wishes and feelings. Current wishes and feelings can matter, but mere silence, passivity or lack of objection is not enough. The evidence must show more than acquiescence.

- **Impact of medication**
  The administration of medication may be highly relevant where it suppresses P's ability or freedom to express wishes and feelings.

- **Practical and realistic approach**
  The assessment should be 'practical and realistic'. Where there is serious doubt about P's true attitude, no inference of consent should be drawn.

Assessing P's Ability to Give Valid Consent

- **P's expressed views**
  Consider whether P appears actively happy, resistant, distressed, ambivalent, inconsistent, or unable to express a clear view. Consider whether there is objection to the care arrangements.

- **Presence of coercion or influence**
  Assess whether there is any coercion, pressure, undue influence or conflict within relationships affecting P's apparent agreement or behaviour.

- **Quality and reliability of consent**
  Assess whether any factors may undermine genuine consent, such as:

  - learned compliance or habitual acquiescence
  - trauma responses
  - lack of meaningful alternatives
  - fear of consequences
  - institutional or relational pressure
  - effects of medication
  - distress masked as cooperation
  - fluctuating or inconsistent presentation.

- **Evidence and safeguards**
  Ensure that:

  - there is clear evidence demonstrating valid consent, where relied upon
  - appropriate review mechanisms are in place to monitor changes
  - changes in P's wishes and feelings are actively identified and responded to.

Recording and Evidencing Decision-Making

- **Documentation**
  Maintain clear, comprehensive, and contemporaneous records of decision-making and all relevant factors considered.

  Explicitly record which factors has been considered, including such things as, but not limited to:

- what comparison has been used to relatively normality (e.g. similar needs, setting, age group)
- why the arrangements are or are not considered beyond that norm.
- the type of restrictions and why they are needed as opposed to other possible alternatives
- the duration of these and why
- how any condition may impact on P's "liberty" regardless of care and treatment arrangements as set out in parts 2 and 3 above.

- **Supporting evidence**
  Reference care records, professional assessments, risk assessments and any legal or safeguarding input to support conclusions reached.

- **Capture P's voice and presentation**
  - what P has said verbally
  - observations of behaviour, presentation and emotional responses.

- **Wider perspectives**
  Include, if relevant, information from:
  - care providers
  - family members
  - advocates or others involved in P's life.
  - document why this information is relevant to the matter.

- **Outcome**
  Clearly state whether P is or is not considered to be deprived of their liberty, and if so whether they are demonstrating valid consent, and the rationale for this conclusion.

- **Review and monitoring arrangements**
  Specify how:
  - P's valid consent will be reviewed over time
  - any changes in P's wishes and feelings will be identified and addressed.

4. SOURCES AND CLICKABLE AUTHORITIES

Main source:
UK Supreme Court judgment: A Reference by the Attorney General for Northern Ireland, [2026] UKSC 16
Judgment given 2nd June 2026. Key points used: paras 183-186, 200-208 and Annex 1.

Case page:
UKSC/2025/0042 case page
Includes issue, parties, written arguments, judgment date and neutral citation.