Deprivation of Liberty in Practice: Article 5, DoLS and the 2026 Supreme Court Ruling

THE TALKING THERAPIES UK PRACTITIONER SERIES

Deprivation of Liberty in Practice: Article 5, DoLS and the 2026 Supreme Court Ruling

A premium, in-depth programme on liberty, the Deprivation of Liberty Safeguards and the Court of Protection after the Supreme Court's June 2026 judgment

Advanced level · 30 hours of continuing professional development

TALKING THERAPIES UK

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First edition, 2026.

This manual accompanies the Deprivation of Liberty in Practice: Article 5, DoLS and the 2026 Supreme Court Ruling course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

Revision 3. This printing was set on 2 November 2026 from the course as it stood that day.

A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

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How to use this manual

This premium programme is a comprehensive, practice-focused course on deprivation of liberty for therapists, best interests assessors, social workers, nurses and other practitioners in England and Wales who work with people whose care may restrict their liberty. It is written for practitioners who need to decide whether a person is deprived of their liberty, how any deprivation should be authorised and reviewed, how the person's voice can be heard and how restrictions can be reduced.

The course is current to October 2026. It is built around the Supreme Court's judgment of 2 June 2026 in the reference by the Attorney General for Northern Ireland, which departed from the Cheshire West acid test, restored a multifactorial assessment of the objective element and recognised valid consent as a distinct concept, so that some people who lack capacity may nonetheless consent to their arrangements. It teaches the Department of Health and Social Care's guidance of June 2026, updated in September 2026, including the two-stage assessment, the advice to continue using the safeguards where there is doubt, and the recording of decisions to let authorisations lapse. It uses the official statistics for 2024 to 2025 and states clearly that the Liberty Protection Safeguards have not been implemented.

Across six modules and thirty lessons you will study why the law protects liberty and the structure of Article 5; the path from Guzzardi to Cheshire West and the 2026 judgment; the scope, processes, assessments, eligibility rules and representatives of the Deprivation of Liberty Safeguards; how to assess the objective element and valid consent, including serious doubt and medication; how the framework applies across settings; reviews, section 21A challenges, community authorisation by the Court of Protection, children and young people, and state responsibility; least restriction, the person's voice, families and psychological practice in restrictive settings; and reform, other United Kingdom jurisdictions, governance, ethics and supervision-level practice.

Every lesson contains a worked clinical example, the common pitfalls in

practice and a reflective question, together with key points, a practice task for the week, study activities and further reading. The course includes an extended case study, a glossary and a 25-question assessment with a pass mark of 80 per cent. Every reference has been checked against its publisher, legislation.gov.uk, the National Archives, the European Court of Human Rights or the issuing body.

The course treats liberty as a matter of people's lives as well as of law. It is clear about what the law requires, who decides and what remains uncertain after the 2026 judgment, and it emphasises the contribution therapists and other practitioners make by hearing the person's voice and reducing restriction. It asks you at each stage to check the current position, because guidance and case law continue to develop.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 30 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Explain why the law protects liberty, the structure of Article 5 and the three components of a deprivation of liberty.
- Trace the development of the law from Guzzardi to Cheshire West and explain what the Supreme Court decided on 2 June 2026.
- Apply the multifactorial assessment of the objective element to people in different settings.
- Assess valid consent, recognising serious doubt, the effects of medication and the position of people who cannot express a view.
- Describe the scope, processes, assessments, eligibility rules, representatives and advocacy of the Deprivation of Liberty Safeguards.
- Explain reviews, suspension, termination and section 21A challenges, and make sure that a person's objection reaches the court.
- Identify when the Court of Protection must authorise a deprivation of liberty, including for 16 and 17-year-olds, and the routes for younger children.
- Apply the principles of state responsibility to private and family arrangements.
- Reduce restriction and elicit the person's voice, working with families and contributing psychological understanding.
- Record defensible decisions, contribute to governance and explain the status of reform, including the unimplemented Liberty Protection Safeguards.

PART 1

Liberty, Article 5 and the 2026 reset

Why the law protects liberty, the structure of Article 5, the development of the definition from Engel and Guzzardi to Cheshire West, and the Supreme Court's 2026 judgment that replaced the acid test.

CHAPTER 1

Liberty, confinement and why the law cares

A therapist visiting a client on a hospital ward or in a care home will sometimes meet a locked door, a person asking to go home and a member of staff who explains that the person is informal, or not detained, or there for their own good. The practical questions are simple. Is this person confined? If so, what gives anyone the authority to confine them, and who checks that it is justified? The law on deprivation of liberty answers those questions for people who cannot answer them for themselves, usually because dementia, a learning disability, autism, a brain injury or a mental illness affects their ability to decide where to live and what care to accept. This lesson explains how English law came to protect the liberty of people who do not, or cannot, object, and why both unauthorised confinement and indiscriminate authorisation carry real costs for the people concerned.

For most of the twentieth century, many people in England with learning disabilities or long-term mental illness lived for years, often decades, in large long-stay hospitals. As those hospitals closed, care moved into care homes, staffed houses, family homes and, later, supported living. The buildings changed faster than the practices: locked doors, fixed routines, restricted visiting and staff decisions about where a person may go did not end when care left the institution. Series (2022) reads the modern safeguards against that history, in which the forms of institutional care have outlasted the institutions themselves. Mental health law, meanwhile, has for more than sixty years allowed a person to enter psychiatric hospital informally, without compulsory powers or formalities, and section 131 of the Mental Health Act 1983 preserves that route. Informality works well for people who choose to be admitted and can choose to leave. It works badly for people who can do neither but do not resist.

The Bournewood case, R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458, concerned a man known in the English courts as L and at Strasbourg as HL. He was autistic, could not speak and had limited understanding of his situation. He had lived for many years in a

long-stay hospital before moving, in the 1990s, to live with paid carers in their family home, where he was settled. In July 1997 he became severely agitated at his day centre, was taken to hospital and was admitted to a psychiatric unit. Because he did not resist, he was admitted informally and the Mental Health Act was not used. His carers wanted him home. The hospital did not release him, did not allow his carers to visit for a period, and made clear that if he tried to leave, formal detention would be considered. On paper he was an informal patient. In practice the professionals around him decided where he lived, whom he saw and whether he could go.

Proceedings were brought on his behalf. The Court of Appeal held that he had been unlawfully detained, but the House of Lords reversed that decision. Their Lordships did not agree on whether L had been detained at all, but they held that what had been done was justified by the common law doctrine of necessity, which permits care and treatment of a person who cannot consent where it is in their best interests. The practical effect was that compliant patients who lacked capacity could continue to be admitted and kept in hospital informally, without any of the protections the Mental Health Act gives detained patients: no formal application supported by medical recommendations, no time limit, no role for the nearest relative and no right to apply to a tribunal.

The European Court of Human Rights disagreed in HL v United Kingdom (2005) 40 EHRR 32, and held that HL had been deprived of his liberty. The decisive point was not whether the unit was locked but the control actually exercised over him. The professionals treating him had taken full control of his assessment, treatment, contact and residence; he was under continuous supervision and control and was not free to leave. That he had not tried to leave did not change the analysis, because the right to liberty is too important to be lost simply because a person submits to confinement. The court then asked whether the deprivation was lawful, and the doctrine of necessity failed: it offered no fixed procedure, and no one had standing to object on HL's behalf. The court found a breach of Article 5(1) and, because the remedies then available did not allow a court to examine whether the conditions for detaining him were actually met, a breach of Article 5(4) as well. Lesson 1.2 examines those procedural requirements.

The Bournewood gap describes the position of people who lack capacity to consent to their care arrangements, do not resist them and are confined

without any procedure prescribed by law. Parliament responded through the Mental Health Act 2007, which inserted the Deprivation of Liberty Safeguards (DoLS) into the Mental Capacity Act 2005 as Schedules A1 and 1A, and they came into force in April 2009 with their own Code of Practice (Ministry of Justice, 2008). The DoLS apply to people aged 18 and over who lack capacity to consent to being accommodated in a hospital or care home for care or treatment. The hospital or care home, as managing authority, must ask a supervisory body (in England the local authority; in Wales the local authority or the local health board) for authorisation. A best interests assessor, who must not be involved in the person's care, and a doctor acting as mental health assessor test the case against six requirements. Any authorisation is time-limited, reviewable, accompanied by a representative and open to challenge in the Court of Protection, and each of those features answers something HL lacked. Outside hospitals and care homes, and for 16 and 17-year-olds, authorisation comes from the Court of Protection instead. Module 2 sets out the scheme in detail.

It helps to be precise about what the safeguards protect. They do not stop people who lack capacity from receiving care in restrictive settings; many people need such care and are better off for it. They exist so that confining a person who cannot consent is never simply a matter of professional habit or convenience: someone independent of the care team checks that the confinement is necessary and proportionate, the authority runs out unless it is renewed, the person has someone to speak for them, and a court can decide any dispute. These protections matter most to the people least able to secure them. A person who has never been asked, who cannot say, or who has learned that objecting changes nothing will not appear in any complaints log, which is why the law's concern has always reached people who do not object. How much weight their apparent contentment should carry is the question the Supreme Court reopened in 2026.

The cost of unauthorised confinement is clearest in individual cases. For months HL was kept from his home and the people he knew by decisions that no one outside the hospital had examined. Unauthorised confinement also tends to drift: an admission for assessment becomes a stay of indefinite length, a door locked during a crisis stays locked, and restrictions on visitors introduced to help someone settle are never revisited. Without an assessment, no one has to ask whether a less restrictive arrangement would do, and without a time limit nothing forces a review. The person's distress,

meanwhile, is interpreted by the people imposing the restrictions. For the organisation, a deprivation of liberty without authority is unlawful and may lead to a claim for damages. For the person, the loss is counted in time away from home and in relationships and skills that become harder to rebuild the longer it lasts.

Over-authorisation has costs too, although they are less visible. After the Supreme Court adopted a broad test in P v Cheshire West and Chester Council; P and Q v Surrey County Council [2014] UKSC 19, the number of people needing authorisation rose far beyond what the scheme had been designed for (lesson 1.3 sets out the consequences). Many people waited months for assessment, so the procedure meant to make their confinement lawful arrived late or not at all. Assessments became shorter and more formulaic, authorisations were granted that changed nothing in a person's day, and families were told that a parent who seemed content in a care home was deprived of liberty, which some found confusing or distressing. People who objected or were restrained competed for assessors' attention with everyone else. Once an authorisation is in place, the restrictions it covers can also look settled and legitimate, so the question of whether they could be reduced is asked less often. Assessors can attach conditions and recommend changes, but those tools work only if the care team acts on them.

The evidence on how well the safeguards have worked is largely critical. The House of Lords Select Committee that scrutinised the Mental Capacity Act found that its empowering ethos had not been embedded in practice and that the DoLS were poorly understood and often not used when they should have been, and recommended their replacement (House of Lords Select Committee, 2014). As applications multiplied, the Law Commission concluded that the scheme could not cope and proposed a new one, which in modified form became the Liberty Protection Safeguards in the Mental Capacity (Amendment) Act 2019 (Law Commission, 2017); that scheme has not been implemented. Series (2022) prompts a further question: whether any procedural safeguard can change the institutional features of care, or whether it mainly regulates them. Before 2009, people like HL could be confined with no procedure at all; after 2014, so many people needed authorisation that the procedure often arrived late. On 2 June 2026 the Supreme Court departed from the 2014 test in A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of

Schedule 10 to the Northern Ireland Act 1998 [2026] UKSC 16 (AGNI). Fewer people are likely to be found deprived of liberty, which may let assessors concentrate on those who object, but a person whose apparent contentment is really resignation or fear could again fall outside any safeguard, as HL did.

Many practitioners taking this course will never authorise or assess a deprivation of liberty. A counsellor, psychologist or therapist is nevertheless often the professional who knows how a person communicates, what distresses them and what they say about where they live when they feel safe enough to say it. That knowledge is evidence. The law places the duty to recognise a possible deprivation of liberty, and to seek authorisation, on the managing authority. Assessors must consult people who know the person, and the representative must act on the person's objections. The therapist contributes by noticing confinement, recording the person's words and behaviour accurately, raising concerns through the organisation's Mental Capacity Act or safeguarding lead, and giving assessors an honest account when asked. The therapist does not decide whether someone is deprived of liberty and should not advise families on their legal position; where the position is unclear, the route is the organisation's policy and, where necessary, legal advice.

Worked clinical example. Joel Asante, aged 36, is autistic, has a learning disability and communicates with a few spoken words, some signs and a book of photographs. For nine years he has lived with Bev and Martin Hale under a shared lives arrangement. After his day service closed and a familiar support worker left, his distress grew over several weeks until one evening the Hales could not settle him and he was taken to an emergency department. He was admitted to an adult mental health assessment unit with a locked entrance. Because he did not resist, he was recorded as an informal patient; no one assessed his capacity to decide about the admission. On his fourth day the Hales came to take him home. Joel fetched his coat and stood at the door, and the nurse in charge told them he could not leave and that a Mental Health Act assessment would be requested if they insisted.

Dr Priya Raman, the unit's clinical psychologist, asked the consultant psychiatrist, Dr Siobhan Kerr, to review Joel before anything else was done, and set out her reasoning. The informal label assumed a choice Joel might not be able to make, so his capacity to decide about staying needed

assessment; Dr Kerr assessed it that afternoon, using his photographs and with Bev present, and concluded that he could not understand or weigh the relevant information. His compliance could not be read as agreement: he had gone to the door twice before and been redirected, he kept saying “home”, and he now had his coat on. The unit controlled where he lived, whom he saw and whether he could go, and staff were about to stop him leaving with the people he lived with. The facts pointed strongly to a deprivation of liberty without authority, the situation Bournewood exposed. The trust’s Mental Capacity Act lead advised that, as this was a psychiatric unit and Joel appeared to object, DoLS was unlikely to be available (Module 2 explains why), so the lawful options were a Mental Health Act assessment or discharge. There was no evidence of a mental illness needing in-patient treatment; Dr Raman’s formulation linked Joel’s distress to losing his day service and support worker, and the Hales were confident they could manage with daily visits from the community learning disability team. Dr Kerr concluded that formal powers were neither justified nor needed, and Joel went home that evening with a crisis plan and a visual timetable. Dr Raman recorded Joel’s words and behaviour, the capacity assessment and who was present, the Hales’ account, the advice given and the reasons for discharge. She also reported through the incident system that the Hales had been told Joel could not leave before anyone had identified a legal basis. The ward manager added two prompts to the admission checklist: assess capacity to consent to informal admission, and refer any proposal to stop an informal patient leaving to the doctor or approved clinician in charge, who can consider the holding power in section 5(2) of the Mental Health Act 1983 where its criteria are met.

Common pitfalls. The first is treating compliance as consent. A person who does not resist may be unable to object, may not know that objecting is possible, or may have learned that it achieves nothing; record what the person does and says, including at the door, rather than writing that they are settled or happy to stay. The second is equating an unlocked door or an informal label with freedom to leave. The Strasbourg court in HL v United Kingdom looked at the control actually exercised, so notes should describe that control concretely: who decides when the person goes out, with whom, and what happens if they try. The third runs the other way: assuming that once an authorisation exists, every restriction in the care plan is justified. An authorisation permits a deprivation of liberty that meets the legal

requirements; it does not make each restriction necessary, and practitioners should keep asking whether a restriction could be reduced and raise it with the care team and the person's representative. The fourth is a therapist deciding that liberty is someone else's business. A therapist who sees a person being stopped from leaving with no apparent authority should raise it with the person in charge and, if necessary, with the organisation's Mental Capacity Act or safeguarding lead, and record having done so, without advising the family on the legal position.

Reflective question. Think of a person you have worked with whose daily life was organised around other people's decisions about where they could go and whom they could see. If an independent assessor had asked you what that person wanted about where they lived, how much of your answer would have rested on things you had observed and recorded, and how much on assumptions about what someone in their position would want?

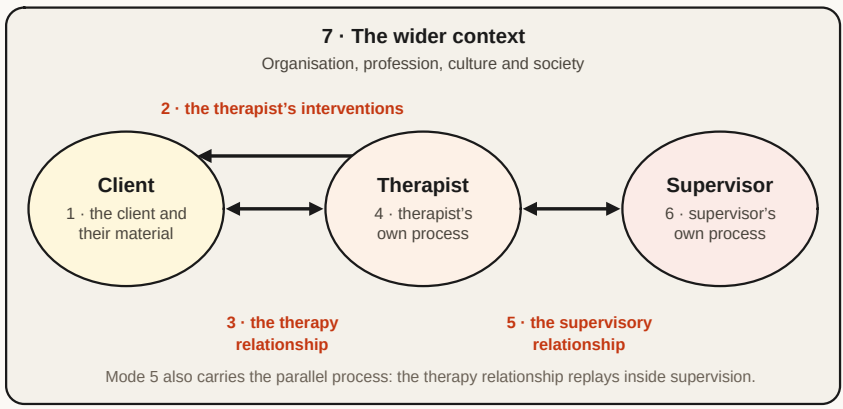


FIGURE 1.1 The seven-eyed model of supervision
Hawkins and Shohet's seven modes give supervision its lenses: the client and their material, the therapist's interventions, the therapy relationship, the therapist's own process, the supervisory relationship itself (including parallel process), the supervisor's process, and the wider organisational and social context around all of it.

Points worth keeping

- Informal admission assumes a person has chosen hospital, yet it gives compliant people who lack capacity none of the Mental Health Act's safeguards.
- In Bournewood the House of Lords upheld an autistic man's informal admission under the common law doctrine of necessity, although its members disagreed on whether he was detained.
- HL v United Kingdom held that he was deprived of liberty because professionals controlled his treatment, contact and residence, and that necessity lacked the procedure Article 5 requires.
- The Mental Health Act 2007 inserted the Deprivation of Liberty Safeguards into the Mental Capacity Act 2005, and they came into force in April 2009.
- The safeguards give adults in hospitals and care homes independent assessment, time-limited authorisation, a representative and access to the Court of Protection, all of which HL lacked.
- Unauthorised confinement tends to drift without scrutiny, while mass authorisation after 2014 brought long delays and authorisations that often changed little in daily life.
- Therapists rarely make these decisions, but their records of a person's words, behaviour and communication are evidence that assessors and representatives rely on.
- After the 2026 Supreme Court judgment fewer people are likely to need authorisation, so apparent contentment that is really resignation or fear needs particular attention.

PRACTICE TASK

This week: Choose one person you currently work with who lives in a hospital, care home, supported living service or family home where other people control when they go out. Without identifying them, write a short factual note covering where they live, who decides when they go out and with whom, what happens if they try to leave, whether anyone has assessed their capacity to decide about these arrangements, and whether any authorisation or court order is in place. Add what the person has said or shown about living there, in their own words or as described behaviour. Where you cannot answer a question, record it as a gap and discuss it with your supervisor or your organisation's Mental Capacity Act lead.

Study activities: The first is a reflective-practice activity, intended to connect the Bournewood history with your own setting. Reread the account of HL's admission in this lesson, then write a page comparing it with the way people are admitted to, or kept in, the place where you work. Identify one point at which a person's compliance could be mistaken for agreement, and note what you would need to see or hear to tell the difference. Allow 25 minutes. The second is a skills-practice activity, intended to build the habit of describing confinement in neutral, evidential language. Take a recent care or clinical note that uses words such as settled, wandering, refusing or absconding, and rewrite one paragraph so that it records what the person did and said, when, and how staff responded, without interpretation. Compare the two versions with a colleague or supervisor and agree which details a best interests assessor would need to see. Allow 30 minutes.

Further reading:

Series, L. (2022) Deprivation of Liberty in the Shadows of the Institution. Bristol: Bristol University Press.
House of Lords Select Committee on the Mental Capacity Act 2005 (2014) Mental Capacity Act 2005: post-legislative scrutiny. HL Paper 139. London: TSO.
R v Bournewood Community and Mental Health NHS Trust, ex parte L [1999] 1 AC 458.

CHAPTER 2

Article 5: structure, safeguards and lawful procedure

When a care home locks its front door and a resident who lacks capacity repeatedly tries to leave, the team's first question is usually whether she is deprived of her liberty. The second question matters as much: if she is, what makes it lawful, and what is she entitled to while it continues? Article 5 of the European Convention on Human Rights answers both through a deliberate structure: a right, a closed list of exceptions, a requirement of lawful procedure, and rights to reasons, to court review and to compensation. Each component of the Deprivation of Liberty Safeguards (DoLS) exists because Article 5 demands it. A practitioner who understands that structure can see why a missing assessment, an expired authorisation or an objection that nobody passed on leaves the person without protection the law requires.

Article 5(1) of the Convention (Council of Europe, 1950) gives everyone the right to liberty and security of person and permits deprivation of liberty only in the cases it lists and in accordance with a procedure prescribed by law. The list in sub-paragraphs (a) to (f) is exhaustive and the Strasbourg court reads it narrowly. It includes detention after conviction, lawful arrest, the detention of minors for educational supervision and, in Article 5(1)(e), the lawful detention of "persons of unsound mind", alongside people detained to prevent the spread of infectious diseases, alcoholics, drug addicts and vagrants. The remaining paragraphs supply the safeguards. Article 5(2) concerns being told the reasons for an arrest and 5(3) protects people arrested on suspicion of an offence. Article 5(4) entitles anyone deprived of liberty to take proceedings in which a court decides speedily whether the detention is lawful and orders release if it is not, and Article 5(5) gives an enforceable right to compensation for detention in breach of the Article. For adults who lack capacity in hospitals and care homes, 5(1)(e) supplies the ground and the rest of the Article determines what the state must provide.

The leading Strasbourg authority on Article 5(1)(e) is Winterwerp v Netherlands (1979) 2 EHRR 387. The court declined to give "unsound mind" a fixed definition, because psychiatric understanding develops, but held that

nobody may be detained simply because their views or behaviour depart from the norms of their society. It then set three minimum conditions. The first is that the person must be reliably shown, by objective medical expertise, to be of unsound mind, save in an emergency. The second is that the disorder must be of a kind or degree warranting compulsory confinement. The third is that continued confinement is valid only while that disorder persists. The DoLS mirror each condition. The mental health requirement, assessed by a registered medical practitioner with the required training, supplies the medical evidence and covers any mental disorder within the meaning of the Mental Health Act 1983, with the learning disability qualification disregarded. The best interests requirement, which asks whether deprivation of liberty is necessary to prevent harm to the person and proportionate to the likelihood and seriousness of that harm, answers the question of kind or degree. Authorisations of up to one year, with reviews in between, answer the question of persistence, and the urgent authorisation can be understood as the scheme's counterpart to Winterwerp's allowance for emergencies.

Lawfulness under Article 5(1) means more than the existence of some legal power. The deprivation must follow a procedure set out in domestic law that is accessible and precise enough to be foreseeable, and that law must protect the person against arbitrariness. HL v United Kingdom (2005) 40 EHRR 32, shows what this requires by describing what the common law doctrine of necessity lacked: no formal procedure stating who could propose admission and on what assessment, no requirement to fix the purpose of the admission, no limit on its length, no continuing clinical check that a disorder warranting detention persisted, and no representative able to object or apply on the person's behalf. The DoLS answer each point with a request by the managing authority, assessments by people whose eligibility and training are set by regulations, an authorisation tied to a specified hospital or care home and purpose, a maximum duration, review under Part 8 of Schedule A1, and a representative for every standard authorisation. Section 4A of the Mental Capacity Act 2005 makes the requirement explicit. A deprivation of liberty is permitted only where it gives effect to a welfare order of the Court of Protection under section 16(2)(a), is authorised under Schedule A1, or falls within the narrow section 4B power to provide life-sustaining treatment or do a vital act while a court decision is sought. Anything else is unauthorised, however benign.

Article 5(4) adds the right to have a court examine the lawfulness of the detention speedily, including whether its substantive conditions are met, with power to order release. In HL's case the remedies then available could not examine those conditions, which was a separate breach. The DoLS answer is section 21A of the Mental Capacity Act 2005, under which the Court of Protection can decide whether the qualifying requirements are met and can vary or end an authorisation, with non-means-tested legal aid available. A right to go to court is of little use to someone who cannot organise an application, so the scheme gives the practical burden to others. The relevant person's representative, appointed by the supervisory body for each standard authorisation, must keep in contact with the person, represent and support them, and help them request a review or apply to court, and a section 39D independent mental capacity advocate (IMCA) can support the person and an unpaid representative. In AJ v A Local Authority [2015] EWCOP 5 the court made clear that where a person objects, the representative and the IMCA must ensure that the right to challenge is put into effect. A therapist who hears a person say they want to leave may hold the information that triggers that duty.

None of this machinery applies unless there is a deprivation of liberty. Storck v Germany (2006) 43 EHRR 6, concerned a young woman held for a long period on a locked ward of a private psychiatric clinic, who had tried to escape and been brought back by the police. The court identified three components that must all be present. The objective component is confinement in a particular restricted space for a not negligible length of time. The subjective component is the absence of valid consent to that confinement. The third component is that the deprivation is imputable to the state. English law now assesses the objective component through the multifactorial approach set out by the Supreme Court in A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998 [2026] UKSC 16 (AGNI), and the same judgment treats valid consent as an autonomous Convention concept, distinct from mental capacity under domestic law. Lesson 1.4 examines both. The structural point is that a capacity assessment answers a domestic question about a person's ability to make a decision; it does not by itself answer any of Storck's three questions.

The Convention reaches English courts through the Human Rights Act 1998. Section 6 makes it unlawful for a public authority to act incompatibly with a

Convention right, section 7 lets a victim bring proceedings, and section 8 allows a court to award damages where that is necessary to afford just satisfaction. Section 3 requires legislation to be read compatibly with Convention rights so far as possible, and section 2 requires courts to take Strasbourg case law into account. Section 64(5) of the Mental Capacity Act 2005 provides that references in that Act to deprivation of liberty have the same meaning as in Article 5(1). That is why AGNI changed the reach of the DoLS immediately, without any amendment to the statute. Local authorities and NHS bodies are public authorities, and private providers may be treated as exercising public functions in some arrangements. Since 6 April 2026 a new section 142C of the Mental Health Act 1983 treats a registered private care provider as exercising a function of a public nature, for the purposes of section 6(3)(b) of the 1998 Act, when providing after-care arranged under section 117, or in-patient assessment or treatment for mental disorder that an NHS body has arranged or funded. The DoLS duties themselves apply to every hospital and care home, whoever owns it.

Imputability does not require a public body to impose the confinement itself. Article 5 also places positive obligations on the state to take reasonable steps to protect people from deprivations of liberty by private persons that the authorities know or ought to know about. In Storck, Germany's responsibility rested on, among other things, the police involvement and the state's failure to supervise the private clinic effectively. In Secretary of State for Justice v Staffordshire County Council [2016] EWCA Civ 1317 (the SRK case), a private care regime funded by a damages award amounted to a deprivation of liberty that was imputable to the state, because the state knew or ought to have known of it, so authorisation by the court was required. A deprivation of liberty in a privately arranged setting is therefore not outside the law merely because no public body arranged or pays for it.

Article 5's structure attracts serious criticism. Its text, agreed in 1950, places people with mental disorders in the same sub-paragraph as vagrants and alcoholics, and Winterwerp made medical evidence of disorder the gateway to lawful detention. The committee that monitors the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) takes the position, in its guidelines on article 14, that detention on the basis of impairment is incompatible with that Convention (CRPD Committee, 2015). That is a critique of the European framework, not English law, which continues to permit detention under Article 5(1)(e) with safeguards. A second criticism

concerns practice. Procedural rights work only when someone uses them, and the people most often deprived of liberty are the least able to start proceedings, find a lawyer or complain. Delays in assessment also mean that many people spend weeks or months confined while a request is pending, after any urgent authorisation has ended and without the authorisation Article 5 requires; Module 2 sets out the figures. A further limitation is that Article 5 asks whether and how liberty is taken but says little about the quality of life within the arrangements, which is why practitioners also need Article 8 and the best interests framework of the Mental Capacity Act 2005.

For therapists, the structure shows where their evidence fits. What a person says and does about where they live bears on valid consent and on any objection. Distress, withdrawal or loss of skills bear on the effects of the measures, which form part of the objective assessment and of the best interests decision, and knowledge of how the person communicates helps everyone else hear them. None of this makes the therapist a decision maker, and therapists should not advise people or families on challenging an authorisation. They should know who the representative is, pass on objections in the person's own words, and follow their organisation's policy when unsure whether a deprivation of liberty is authorised.

Worked clinical example. Ifeanyi Okeke, aged 77, a retired accountant with vascular dementia and Parkinson's disease, moved into a nursing home in Croydon ten days ago. His daughter, Chioma, chose the home, and he pays the fees from the sale of his house; the local authority has had no involvement. The front door has a keypad, he walks with a frame, staff accompany him in the garden because he falls, and a pressure mat alerts them when he gets out of bed at night. Most mornings he puts on his jacket and says he must get to the office; when staff tell him he lives here he becomes agitated, and they steer him away from the door. By the afternoon he is usually settled and joins activities. The manager, Grace Mensah, a registered nurse, wondered whether an application was needed when the family had arranged everything and nobody was objecting. She worked through Storck's three components with the home's visiting clinical psychologist, Dr Aled Morgan.

On the objective component they described the measures rather than labelling them: a locked door, accompaniment whenever he goes outside,

night monitoring and redirection each morning, with no physical restraint and no medication given to calm him. The arrangements were intended to be permanent. Their effects were real but uneven: he could not leave or go out alone, and his mornings ended in distress. The setting was a nursing home rather than a ward, and the purpose was to protect a frail man from falls and from getting lost. They could not be confident that the objective component was absent, and guidance from the Department of Health and Social Care says that doubt should be resolved by using the DoLS process (DHSC, 2026a). On the subjective component, Mr Okeke was aware of his surroundings, but each morning he believed he was due at work and did not accept being stopped, so they could not identify valid consent. On imputability, Grace had assumed that a self-funded placement was a private family matter. Dr Morgan explained that the DoLS apply to every care home whoever pays, that the home as managing authority has a statutory duty to request authorisation, and that the state's positive obligations extend to arrangements it knows or ought to know about. Grace gave an urgent authorisation and requested a standard authorisation the same day, recording that the request should have been made on admission. Her record set out the evidence under each component, Mr Okeke's own words, and the times of day his distress occurred. She notified the Care Quality Commission (CQC) of the application, told Chioma that a best interests assessor would consult her, and asked Dr Morgan to write up his observations of the mornings so that the assessor could consider whether a different morning routine would reduce the need to stop him.

Common pitfalls. The first is assuming that Article 5 has nothing to say about privately arranged care. A self-funded care home placement, or a care package at home paid for by the family or a damages award, can still be a deprivation of liberty for which the state is responsible; care homes must apply whoever pays, and practitioners who learn of restrictive private arrangements in the community should raise them with the local authority. The second is treating a pending request as if it were an authorisation. An urgent authorisation lasts for up to seven days unless the supervisory body extends it by up to seven more, and once it ends without a standard authorisation in place the deprivation is unauthorised; the managing authority should chase the supervisory body, record the position and keep the person's situation under review. The third is treating the right to challenge as theoretical. Where a person objects, the representative and any

IMCA must ensure the objection can be tested in court, as AJ requires, and a therapist who hears the objection should pass it on in the person's own words. The fourth is letting the capacity assessment stand in for the Article 5 analysis. A finding that a person lacks capacity to decide whether to be accommodated in the care home is necessary for DoLS, but it says nothing about whether they are confined, whether they validly consent or whether the state is responsible.

Reflective question. Think of someone you have known who was subject to a DoLS authorisation or a Court of Protection order. What would it have taken, from you and from the people around them, for their right to challenge the arrangements to be something they could actually use rather than a sentence in a letter they could not read?

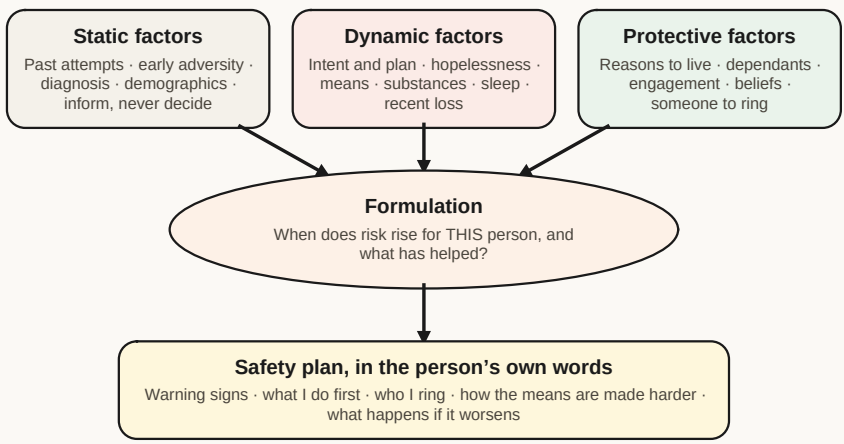


FIGURE 2.1 From risk assessment to risk formulation

A defensible approach to risk does not predict, it formulates: it separates the factors that cannot change from those that can, names what protects, and converts the picture into a plan somebody could actually follow at three in the morning. A checklist score recorded without a formulation and a plan is a record of an assessment, not the management of a risk.

Points worth keeping

- Article 5(1) permits deprivation of liberty only on the listed grounds, including persons of unsound mind under 5(1)(e), and only through a procedure prescribed by law.
- Winterwerp requires objective medical evidence of mental disorder, a disorder of a kind or degree warranting confinement, and continued confinement only while that disorder persists.
- HL v United Kingdom showed that lawful confinement requires fixed rules on who proposes it, on what assessment, for what purpose, for how long and with what representation.
- Section 4A of the Mental Capacity Act 2005 permits deprivation of liberty only under a Court of Protection welfare order, Schedule A1 or the narrow section 4B power.
- Article 5(4) requires speedy court review, which DoLS provides through section 21A, non-means-tested legal aid and the duties of representatives and IMCAs described in AJ.
- Storck v Germany identifies three components of a deprivation of liberty: objective confinement, the absence of valid consent, and responsibility that is imputable to the state.
- Section 64(5) of the Mental Capacity Act 2005 gives deprivation of liberty its Article 5 meaning, so the AGNI judgment changed the reach of DoLS immediately.
- Positive obligations mean the state must act on private deprivations of liberty that it knows or ought to know about, as SRK confirmed for a damages-funded care regime.

PRACTICE TASK

This week: Take one person you work with who is subject to a DoLS authorisation or a Court of Protection order, or ask your organisation's Mental Capacity Act lead to talk you through an anonymised example. Map the situation against Article 5: the ground relied on, the medical evidence, the dates and any conditions of the authorisation or order, who the representative is, whether an IMCA is involved, and whether the person has expressed any objection. Note any gap you find, such as an urgent authorisation that has expired, a representative who has not visited or an objection that has not been passed on, and agree with your supervisor or the relevant manager who will act on it and by when.

Study activities: The first is a reflective-practice activity, intended to help you examine your own position on the disability rights critique of Article 5. Reread the paragraph on criticism in this lesson, then write a page setting out where you agree and disagree with the view that detention on the basis of impairment is incompatible with the rights of disabled people, using one person you have worked with, anonymised, to test your view. Allow 20 minutes. The second is a skills-practice activity, intended to build your ability to explain rights accessibly. Draft no more than six short sentences explaining to a person with moderate dementia what a DoLS authorisation means for them and that they can ask for it to be looked at again by a judge. Read it aloud to a colleague playing the person, revise it for clarity, and note what pictures, objects or repetition would help the person understand and remember it. Allow 30 minutes.

Further reading:
Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe, 1950), Article 5.
AJ v A Local Authority [2015] EWCOP 5.
Secretary of State for Justice v Staffordshire County Council [2016] EWCA Civ 1317 (the SRK case).
Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities (CRPD Committee, 2015).