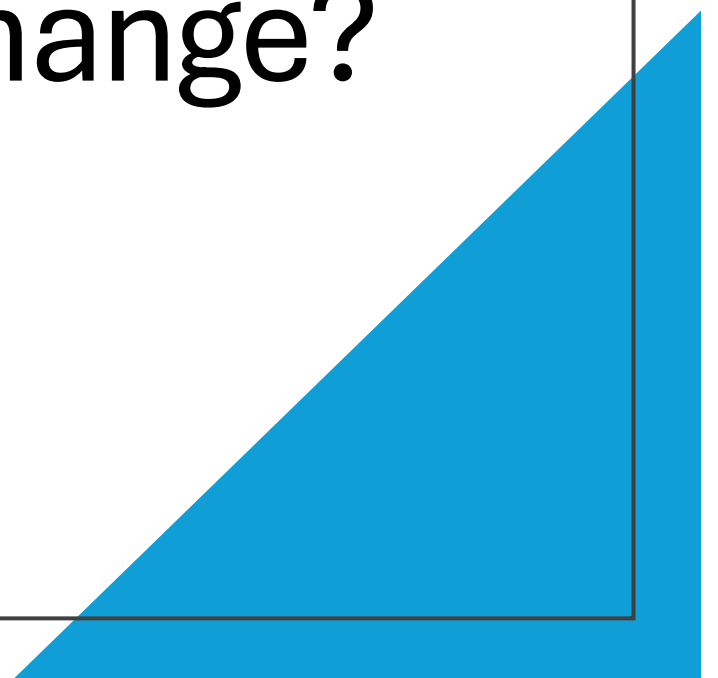


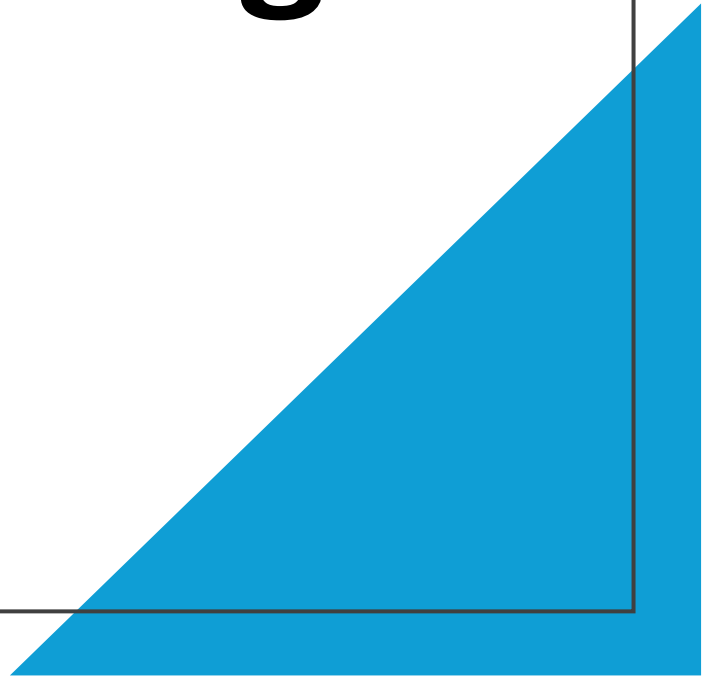
# **After the AGNI Judgment: Will Forensic Learning Disability and Mental Health Practice Change?**

Dr Phil Temple,  
Locum Consultant Psychiatrist



*a.k.a.*

**Is a gilded cage still a cage?**





# Case Vignette – Patient A

- 35 year old man
  - Mild Learning Disability, Autism Spectrum Disorder, Schizophrenia, Anxiety Disorder
  - Detained under s37 in MSU for past 15 years
  - Prior to this, history of notable violence across multiple supervised placements
  - Has made significant progress in hospital and has progressed to extended periods of s17 leave at single occupancy provider
  - Likely suitable for discharge, but only if tight package of care remains in place – including medication monitoring, support with finances, no access to illicit substances, supervised contact with family
  - No legal for conditional discharge, but needs some framework for the above if successful case to be made to MoJ
  - Previously plan for DOLS, but changes in law raise questions about validity of this...
-



# Case Vignette – Patient B

- 50 year old man.
  - Diagnoses of Mild Learning Disability, Autism, ADHD, ETOH dependence.
  - Index offence of arson.
  - Lengthy, but fairly unremarkable, period of admission to MSU, then LSU.
  - Significant concerns about ability of cope independently, tendency to relapse into drinking if unsupervised, and escalating risk of arson in that setting,
  - Assessed as lacking capacity to understand these risks due to degree of LD and other difficulties.
  - This lead to very restrictive planned package of care in community – with DOLS application made prior to conditional discharge.
  - Despite significant restrictions, he presents as happy with living arrangements (superficially at least) and has no objection to these.
-

# Outline

- Explore the AGNI judgement and implications for mental health practice, especially from a forensic LD perspective.
- **The history** – how did we get to where we are today?
- **The implications** – what are the positives and negatives of these changes?
- **The implementation** – how do we apply this?
- **Forensic considerations** – how does this affect forensic cases specifically and what guidance is there for what we do?
- **The cases** – how does this impact on the patients we've just met?
- **The discussion** – where do we go from here?



# The legal situation in a single sentence...

AGNI (Attorney General for Northern Ireland — handed down by the Supreme Court on 2 June 2026) overturns Cheshire West (2014) and replaces the "acid test" for deprivation of liberty with a broader, multifactorial assessment.

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The history – how did we  
get here?



# The starting problem: Bournemouth / HL v UK (ECtHR, 2004)

- HL - an autistic man with significant learning disabilities - informally admitted to Bournemouth Hospital - he wasn't objecting, so no formal detention was thought necessary).
- His carers challenged this. The House of Lords found he wasn't detained.
- The European Court of Human Rights disagreed: clinicians had taken "complete and effective control over his care and movements" and he was not "free to leave" — so he had been deprived of his liberty, and because he had no formal status, he'd had no way to challenge it.
- The “**Bournemouth gap**” - informal, compliant patients lacking capacity, with no legal route to review.

# The legislative fix: DOLS (2007–2009)

- Parliament's answer was the Deprivation of Liberty Safeguards, inserted into the Mental Capacity Act 2005 as Schedule A1 (via the Mental Health Act 2007 amendments, in force April 2009).
- This created the standard authorisation process for anyone in a hospital or care home who lacks capacity and meets the criteria.
- But "**deprivation of liberty**" itself was left undefined in statute.

# Cheshire West (Supreme Court, 2014)

- Lady Hale, giving a majority judgment, held **a person is deprived of their liberty if subject to continuous supervision and control, and not free to leave** — the so-called "***acid test***."
- Critically, she held this applied regardless of the person's compliance, the comparative normality of the setting, or the benevolent purpose behind it.
- **"A gilded cage is still a cage."**
- The vote was narrow: three justices concurred with Lady Hale's analysis, and three dissented. The dissenting justices warned this went further than Strasbourg required and that *"nobody using ordinary language would describe people living happily in a domestic setting as being deprived of their liberty."*

# The fallout (2014–2026)

- Cheshire West hugely increased the number of people who might be considered to be deprived of their liberty and whose care required additional legal authorisation.
- DoLS referrals surged well beyond what the system was built to process.
- This drove the Law Commission review and the Mental Capacity (Amendment) Act 2019, which created the Liberty Protection Safeguards (LPS) as a streamlined replacement.
- These were legislated but never brought fully into force - with LPS implementation effectively shelved.

# AGNI (Supreme Court, 2 June 2026)

- The case reached the Court via a formal Northern Ireland devolution reference, but its effect is UK-wide.
- The Supreme Court handed down its judgment on 2 June 2026 and concluded that:
  - The Cheshire West 2014 judgment was incorrect
  - Instead of relying on the single 'acid test', an assessment of whether someone is deprived of their liberty must now consider multiple factors.
  - The starting point is to look at the specific situation of the individual and take into account the type, duration, effects and manner of implementation of restrictions on the person - crucially, no single factor is determinative

# AGNI (Supreme Court, 2 June 2026)

## **The Court identified six errors in the majority reasoning in Cheshire West:**

1. The acid test is insufficient: meeting it does not automatically establish deprivation of liberty; a full multifactorial analysis is still required.
2. Compliance and lack of objection were wrongly excluded: they are relevant features for considering the effect of restrictions, which forms part of the objective element.
3. The acid test ignores the setting: it treats a person in a Category A prison identically to a person living in their own home.
4. It ignores innate limitations: it does not distinguish between restrictions imposed upon a person and limitations arising from that person's own condition.
5. It wrongly excludes the purpose of the measure in borderline cases.
6. It equates lack of domestic legal capacity with lack of valid Convention consent: this is the most fundamental error

# AGNI (Supreme Court, 2 June 2026)

- The Cheshire West 2014 judgment wrongly assumed that if someone lacks legal capacity under the MCA 2005, they cannot give valid consent to the arrangements.
- The 2026 judgment clarifies that a person's expression of their wishes and feelings carries significant weight. **A person can give valid consent if they are conscious of their environment, have a basic level of understanding and are capable of expressing a view that they accept and/or are happy with the situation.**
- However, if there is serious doubt, no conclusion of valid consent can be drawn.
- The effect of the restrictions on the person may differ based on whether or not the person is content with their arrangements - Cheshire West 2014 was wrong to conclude that a person's lack of objection is never legally relevant to the question of objective confinement.
- These changes to the definition of a deprivation of liberty apply with immediate effect and extend across the UK.



# In summary...

- Bournemouth gap → DOLS created to fill it → Cheshire West widened who counted as deprived of liberty and strained the system → LPS attempted a procedural fix but stalled →
  - AGNI now narrows the substantive test itself, sending it back roughly toward the pre-Cheshire West, more fact-sensitive approach...
  - ... but with the same underlying tension (protecting people vs. respecting expressed contentment) unresolved and now sitting with the new "multifactorial" standard.
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The implications – what are the  
positives and negatives of these  
changes?

# Initial Reaction

*“This judgement sets us back decades and removes safeguards that history shows us are vital for disabled people. By removing independent checks, advocacy, and automatic access to legal aid, the Court has closed the gateway to justice and support for many who need it most. Stripping away these safeguards makes it easier for abuse and neglect to go unnoticed behind closed doors. A litany of previous wrongdoings demonstrate how closed cultures, lack of independent oversight and restrictive care can lead to abuse scandals and decisions like this fly in the face of everything we've learnt.”*

**Joint statement Mencap, Mind and National Autistic Society**



# Buckinghamshire Disability Service (BuDS) response:

“The Supreme Court has made a legal decision based on a legal interpretation of the European Convention on Human Rights. This cannot be characterised as an attack on disabled people or disability rights.

The best way of understanding this situation is that the Supreme Court took the wrong view in 2014, and that mistaken interpretation has now been corrected. The ‘rights and safeguards’ which the big charities say have been ‘taken away’ were at least partly based on the wrong law.”

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# Buckinghamshire Disability Service (BuDS) response:

“The Supreme Court has now said that the Cheshire West decision was wrong, and that a different test, the Guzzardi test, should apply. The Guzzardi test was set out by the European Court of Human Rights in 1981 and has applied in other ECHR countries for many years. The Supreme Court was not therefore abolishing safeguards for vulnerable people but replacing them with a different and well-tested model.

This test is not concerned with how the person living under restrictions thinks about those restrictions – that is covered by the ‘subjective’ test mentioned above. The Guzzardi test is about whether, objectively, the person is really deprived of their liberty, or not. It is therefore known as the ‘objective’ test.”

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# Buckinghamshire Disability Service (BuDS) response:

“The Supreme Court’s reading of the Guzzardi judgement is that a prisoner in a prison cell is the starting point for any thinking about whether a person has been deprived of their liberty. The closer a person’s everyday experience is to that of a prisoner in a prison cell, the more likely it is that they have been deprived of their liberty. On the other hand, the further a person’s everyday experience is from that of a prisoner in a prison cell, the less likely it is that they have been deprived of their liberty. Professionals need to look at the individual facts and circumstances of each case to decide, objectively, if there is a deprivation of liberty. This is a very different approach to the ‘hard edged’ test set out in Cheshire West, which simply refers to people being ‘not free to leave’.”

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# Buckinghamshire Disability Service (BuDS) response:

“BuDS view now is that it is too early to tell whether this decision will be positive or negative for disabled people’s rights. We do not agree with the rather kneejerk reaction of the big charities, who are already saying that this Court decision is an attack on disabled people or an erosion of our rights. Until the decision is fully studied, and we know the Government’s reaction to it, it is far too early to be making bleak or cataclysmic predictions like that. It will be a long time before the implications of the Court decision are fully understood and implemented.”

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# Potential benefits

## **Reduced administrative burden and better-targeted safeguards.**

- The volume of DoLS referrals since Cheshire West overwhelmed supervisory bodies; a narrower test should shrink the pool of people requiring formal authorisation, freeing BIA and mental health assessor capacity for cases that genuinely warrant scrutiny.
- The judgment itself includes this directly - the administrative burdens of DoLS and applications to the court interfere with the adult's Article 8 rights by requiring confidential documents to be produced and shared with administrators, lawyers, judges and family members.
- Fewer unnecessary authorisations means less exposure of private care information for people who were never meaningfully "detained" in any ordinary sense.

# Potential benefits

## **Less intrusion for people who are genuinely content.**

- For patients and families who found the DoLS process bureaucratic and stigmatising for someone plainly safe, well cared for, and happy, the multifactorial test removes a label that felt mismatched with lived reality.
- For people who consider their loved ones well cared for, safe, and happy, the pre-AGNI processes were nonsensical and often intrusive, so the ruling brings a sense of relief to many.

# Potential benefits

## **A more clinically intuitive framework.**

- The multifactorial approach – which weighs purpose, intensity, and the person's own wishes and feelings rather than a binary supervision/control test - arguably better matches how you would assess someone's situation clinically, rather than forcing an acid-test answer in mixed circumstances.

# Potential risks

## **Loss of procedural protection for people who can't reliably communicate objection.**

- This is the central worry in the commentary.
- The judgment inevitably means a loss of procedural protections for some for whom DOLS or the Re X process provided safeguards, but who are no longer counted as deprived of liberty under the new test.
- For patients where communication, insight or capacity to express sustained objection may be impaired, this is a concern.
- The people least able to object are also least able to trigger review under a test that leans on apparent wishes and feelings.

# Potential risks

## **Vagueness in what counts as valid "consent" or contentment.**

- The subjective interpretation of what may or may not equate to happiness or unhappiness - how this is judged and who judges that - is vague
- This may pose a disadvantages to a cohort who previously benefited from judicial and statutory oversight.
- Without settled guidance, individual assessors are left making a judgment call that used to be structured by statute.

# Potential risks

## **Uneven application in practice.**

- Early case commentary suggests even extensive supervision, monitoring and 24-hour support may fail to qualify as deprivation of liberty under certain circumstances post-AGNI.
- As in one case involving a young woman under constant supervision including CCTV.
- That's a long way from the clarity of the acid test's
- It suggests scope for an unpredictable approach, especially (but perhaps not exclusively) as practice beds in.

# Potential risks

## **Thin practical guidance so far.**

- Position statements and judgments applying AGNI are short on detail from the perspective of anyone trying to understand how decisions are actually being made.
- Local authorities seem to be leaning heavily on supervision, monitoring, and 24-hour support as still constituting deprivation, which may or may not survive scrutiny.
- Updated Codes of Practice and DoLS e-learning are still pending.

# Potential risks

## **Advocacy gap.**

- At least one commentator is pressing for wider advocacy mechanisms to safeguard Article 8 rights, beyond time-limited, issue-specific roles like IMCAs and Care Act advocacy.
- The concern is that as fewer cases trigger DoLS, fewer people get any independent scrutiny of their arrangements at all, formal or informal.

# Potential risks

## **Retrospective/transitional uncertainty.**

- Existing DoLS authorisations don't automatically lapse, but services need Part 8 reviews to work out who now falls outside the framework.
- This process risks being applied unevenly across organisations pending clearer national guidance, with providers currently told to keep referring as before in the meantime.

# In summary...



The judgment trades a blunt but predictable and universally-applied test for a more clinically sensible but currently under-specified one



And the population most likely to fall through the resulting gap is the one least equipped to highlight that they have.

The implementation –  
how do we apply this?

# Department of Health & Social Care Guidance

- Organisations should begin aligning their practice with this new legal position
- Providers and local authorities should use their professional experience and take a proportionate and considered approach in how they respond to the Supreme Court judgment, before further government guidance is published.
- In the long term, these changes are likely to reduce significantly the number of deprivation of liberty authorisations.
- In the short term, we recognise that a more cautious approach will be needed, with borderline cases referred for review.

# Department of Health & Social Care Guidance



Local authorities should also ensure that essential safeguards such as independent advocacy and access to an appointed relevant person's representative (RPR) continue where applicable.



This ruling will not remove the need to comply with ECHR article 5 where it is engaged. Where there is reason to believe that a person is deprived of their liberty, the DoLS process still applies in hospitals and care homes, and the court process still applies in other settings.



# Assessing deprivation of liberty

The starting point is a multifactorial assessment of the proposed arrangements before considering whether a person could be said to validly consent, through an expression of their wishes and feelings, to those arrangements.

There is no “acid test”.

# Assessing deprivation of liberty

- The multifactorial assessment considers:
  - the type of restrictions (for example, locked doors, physical control, supervision, sedating medication social isolation and so on)
  - the duration of those restrictions
  - the effects of the restrictions on the person
  - the manner of implementation of the restrictions
  - whether the person objects
  - how far removed the case is from the situation of detention in a prison cell
  - the relative normality of the arrangements (for example, greater restrictions would be required at home in order for deprivation of liberty to arise)
  - the purpose of the arrangement, for example whether the arrangements are for care and protection, rather than punishment or coercion

# Assessing deprivation of liberty

- For there to be a deprivation of liberty, there must be an element of restriction being imposed on a person against their will.
- This means that it is unlikely to be a deprivation of liberty if a person's liberty is constrained by their own illness, condition or impairment.
- *For example, if someone's physical disabilities prevent them from leaving a particular setting and they are unable to form any desire to leave, this will likely not be considered a deprivation of liberty.*

# Determining objection

- Whether a person is objecting to the confinement is relevant to the question of objective deprivation of liberty.
- Where a person is objecting, then it follows that valid consent is unlikely to be present. If there is an absence of objection when the person is capable of objecting, then it is more likely that the person is not being confined.
- Any objection would point towards a deprivation of liberty. Objection could take a number of forms and could include:
  - attempts to leave the setting where the arrangements take place, such as a care home, hospital or supported living
  - refusing care or treatment and/or physical rejection of care (for example, pushing staff away when care is being provided)
  - physical restraint or one-to-one care to manage behaviour
  - covert medication if objecting to medication
  - sedating medication to manage behaviour if it impacts on an individual's ability to object

# Determining someone's wishes and feelings

- A person may be able to give valid consent in relation to a deprivation of liberty even if they lack legal capacity to consent to their care and residence under the MCA 2005.
- Compliance does not automatically mean someone is consenting. A critical question to consider could be ***‘how do we know what this individual actually understands and wants?’*** rather than ‘are they compliant?’.
- When assessing wishes and feelings, consideration should be given to what the person is communicating both verbally (if they are able) and through their actions and behaviour. For example:
  - **do they appear happy or unhappy?**
  - **are they trying to leave or are they distressed in any way?**
  - **are they able to express a view?**



# Determining someone's wishes and feelings

- Consideration should also be given to the individual's previously expressed wishes and feelings or previously observed behaviour that could indicate an objection to the current arrangements.
  - People should be given all support necessary to enable communication of their wishes and feelings. Assessment should also require a thorough review of care and/or medical notes and speaking to family and staff. It may require multiple visits.
  - All practitioners assessing wishes and feelings should be alert to circumstances that may impact someone's ability to express their wishes and feelings, for example:
    - sedating medication
    - fear of consequences
    - perceived pressure
    - feeling that they do not want to be a burden
-



# Seeking further advice

- Where practitioners are in doubt about whether someone is objecting to their confinement or, in instances where people fluctuate between appearing content and appearing to object to their confinement, a referral should be made to the local authority for consideration of a DoLS authorisation, or the Court of Protection.
  - Practitioners should continue to use DoLS processes and court applications where there is any doubt as to whether arrangements constitute a deprivation of liberty.
  - This includes where there are any doubts about valid consent, where restrictions are significant or where it appears ECHR article 5 may be engaged.
  - Hospital trusts and local authorities may want to contact their own legal teams for advice where necessary.
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# Existing DoLS authorisations



It is likely that there will be many people currently subject to DoLS authorisations who no longer fall in scope of DoLS. This could be because the restrictions are no longer seen to amount to a deprivation of liberty following a multifactorial assessment and/or because the person is able to give valid consent to them.



Where the person is no longer deprived of their liberty but has a DoLS authorisation in place, their cases should be reviewed as soon as is practicable. However, leaving the authorisation in place in the meantime does not mean the person is being unlawfully deprived of their liberty.



Local authorities should document their approach for responding to the change in definition in terms of their caseloads, referrals and current authorisations, and clear decision making should be recorded, particularly where authorisations are left to lapse if they no longer fall in scope of DoLS.

# Existing DoLS authorisations

- It is worth noting that within existing DoLS authorisations, if someone's circumstances change and they no longer require the level of restrictions imposed on them, restrictions can be reduced without the need for a review or a new authorisation.
- The Department of Health and Social Care (DHSC) continues to stress the importance of an MCA 2005-centred approach following this judgment. Plans for responding to the judgment should reflect the paramount importance of the wellbeing of people who have health and care needs.

Forensic considerations – how does this affect forensic cases specifically and what guidance is there for what to do?

# Background considerations

- Until recently, neither the Secretary of State for Justice nor the Mental Health Tribunal could impose conditions on a conditional discharge that amounted to a deprivation of liberty - that was *SSJ v MM* [2018] UKSC 60.
- Workarounds developed (coordinating a Court of Protection welfare order alongside the tribunal decision, or deferring/adjourning discharge until a DOLS authorisation was in place) but the position was legally awkward.
- The Mental Health Act 2025 reversed *MM*: since 18 February 2026, the SSJ (and the Tribunal, on stricter conditions) can impose discharge conditions amounting to a deprivation of liberty, provided it's necessary for protection of the public from serious harm
- **“Supervised Discharge.”**
- When *AGNI* judgement was made in June 2026, MHCS had barely finished introducing this new statutory framework built around DoL conditions — and *AGNI* immediately reopened what "deprivation of liberty" means.
- MoJ issued guidance in July '26 that sets out how the Mental Health Casework Section will deal with these issues.



# MoJ guidance – July ‘26

- “Many of you have been in touch with MHCS to ask how the Judgment affects your patients. Our current position is set out below and is informed by the recently published Department for Health and Social Care ‘interim’ guidance”
  - “ In due course we intend to update our published guidance on discharge under s42 of the Mental Health Act 1983 and our guidance on supervised discharge. We will notify our stakeholders when those changes are made.”
  - “DHSC have published an initial high-level guidance document in respect of what constitutes a deprivation of liberty. This note applies that interim guidance to restricted patients. Until further guidance is issued stakeholders are advised to follow the MHCS operational interpretations in this note along with the DHSC guidance”
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# MoJ guidance – approach for existing cases

- **(a): where patient was previously assessed as lacking capacity and a deprivation of liberty (DoLS) in the community has previously been authorised through the Court of Protection or Local Authority and their conditional discharge relied upon the DoLS.**
  - For restricted patients cases where a DoL has been in place, those responsible for the patients' care, following DHCS's guidance on the multifactorial assessment with the patient's ability to indicate consent to conditions of constant supervision, may consider that the DoLS is no longer required.
-

# MoJ guidance – approach for existing cases

- In such cases we ask that the treating team take the following steps in relation to the patient:
- Does the multifactorial assessment, with an assessment of the patient's views and whether they validly consent, suggest a deprivation of liberty is taking place?
  - **If no** it is likely that renewing the DoLS is inappropriate; the community team must inform MHCS in advance of the order lapsing.
  - The team must set out how they have established that there is no restriction / confinement against the patient's will, detailing the multifactorial circumstances of the confinement including what can be ascertained about the patient's views.
  - MHCS will deal with this via a change of conditions, and an updated conditional discharge warrant will be issued with the revised conditions listed.
- If yes, it is likely a DoLS will require renewal
- The team should advise MHCS of their proposed approach prior to the DoLS lapsing.

# MoJ guidance – approach for existing cases

- **(b) Previously agreed SD:** Warrants remain valid and the patients continue to be lawfully discharged with a continuous supervision condition.
- These cases should also be reviewed by care teams and consideration given to DHSC's guidance of the multifactorial assessment with an assessment of the patient's views / consent.
- Does the multifactorial assessment, with an assessment of the patient's views and whether they validly consent, suggest a deprivation of liberty is taking place?
- If no, clinicians should contact MHCS before the first referral to the MH Tribunal is due
- Before approaching MHCS the care team and community RC should also consider if the criteria for a conditional discharge amounting to a DoL continues to be met – ... “that those conditions are necessary for the protection of the public from serious harm.”
- Where the serious harm aspect is in question, it may be appropriate to move the patient to a conditional discharge under s42(2) of the MHA 1983 with an appropriate supervision condition..

# MoJ guidance – approach for existing cases

- **(c) Future Cases (i.e. those not yet discharged)**
- Future discharges where a constant supervision requirement is considered necessary for the safe management of the patient in the community will still be via conditional discharge (either s 42(2) or section 42(2A) MHA83).
- The Secretary of State will continue to consider the nature of the appropriate arrangements for the patient, including whether constant supervision is necessary, and for what purpose. This will inform MHCS decision making in terms of which subset of conditional discharge will be most appropriate.
- For decisions made from this point onwards, the multifactorial assessment must take place, with an assessment of whether the patient's views can be ascertained and what they are.

# MoJ guidance – approach for existing cases

- **(c) Future Cases (i.e. those not yet discharged)**
- Where the proposed conditions of care and treatment in the community amount to confinement and the patient does not consent to the proposed conditions, Supervised Discharge may still be used to enable the patient's safe discharge from hospital, where this is necessary to protect the public from serious harm.
- Where the patient does give valid consent to discharge with strict supervisory conditions, conditional discharge under s 42(2) may be appropriate.
- For all cases of this nature the SoS will want to clearly document the decision and how the patient's consent (or lack of) was understood. Additional scrutiny to determine that a patient continues to consent will also need to be considered and similarly documented throughout the discharge of consenting patients, in line with DHSC policy.

# MoJ guidance – approach for existing cases

- **(c) Future Cases (i.e. those not yet discharged)**
- The Secretary of State notes the DHSCs position that following the judgment it is anticipated that fewer people will fall in scope of the DoLS.
- Notwithstanding that the part III MHA 1983 context differs (including that it may sometimes be closer to ‘the paradigm case of confinement in a cell’ as described in the AGNI judgment) a similar expectation is anticipated for Supervised Discharge where it has always been the presumption it will be used infrequently and for small numbers of patients.
- We note the intention of DHSC to publish further guidance in September, and we will consider our approach in line with future publications.



Two further  
considerations  
from a forensic  
perspective

# The evidential problem in a forensic setting

- The first detailed first-instance application of AGNI demonstrated a difficulty that relates directly to forensic risk assessment:
- The court had to determine whether someone who lacked *de jure* capacity was nonetheless *de facto* able to understand their situation, and judge valid consent by reference to that.
- This raises questions such as:
  - *Is evidence required as to agreement and disagreement, and can it be challenged?*
  - *What happens where a patient's position shifts over time? (fluctuating insight, ambivalence about treatment, or a history of superficial compliance masking risk-relevant concerns)*
  - *Who decides, and on what evidential basis?*
- These questions were unresolved even in a straightforward civil DoL case - they get harder in a forensic setting.

# The structural risk in a forensic setting

- The concern raised elsewhere - that people who struggle to express their views, or who have no one to speak up for them, will remain invisible under the new test - has forensic implications.
- Forensic patients are a group whose compliance is closely monitored and whose apparent "settledness" within a restrictive regime can be difficult to disentangle from institutionalisation, learned compliance, or fear of jeopardising progression through the system.
- A multifactorial test that gives weight to compliance and lack of objection risks equating institutional compliance as something closer to consent.
- This is of particular concern in populations where the underlying purpose of the restriction is risk management as well as patient welfare.

The cases – how does this impact on the patients we met previously?



# Case Vignette – Patient A

- 35 year old man
  - Mild Learning Disability, Autism Spectrum Disorder, Schizophrenia, Anxiety Disorder
  - Detained under s37 in MSU for past 15 years
  - Prior to this, history of notable violence across multiple supervised placements
  - Has made significant progress in hospital and has progressed to extended periods of s17 leave at single occupancy provider
  - Likely suitable for discharge, but only if tight package of care remains in place – including medication monitoring, support with finances, no access to illicit substances, supervised contact with family
  - No legal for conditional discharge, but needs some framework for the above if successful case to be made to MoJ
  - Previously plan for DOLS, but changes in law raise questions about validity of this...
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# Case Vignette – Patient B

- 50 year old man.
  - Diagnoses of Mild Learning Disability, Autism, ADHD, ETOH dependence.
  - Index offence of arson.
  - Lengthy, but fairly unremarkable, period of admission to MSU, then LSU.
  - Significant concerns about ability of cope independently, tendency to relapse into drinking if unsupervised, and escalating risk of arson in that setting,
  - Assessed as lacking capacity to understand these risks due to degree of LD and other difficulties.
  - This lead to very restrictive planned package of care in community – with DOLS application made prior to conditional discharge.
  - Despite significant restrictions, he presents as happy with living arrangements (superficially at least) and has no objection to these.
-



Discussion - where do we  
go from here?





Thank you.