Casenotes

Deferred Conditional Discharges – The New Regime

*David Mylan**

R (on the application of IH) v Secretary of State for the Home Department (1)
Secretary of State for Health (2)
-and-
Mental Health Review Tribunal (1) Nottinghamshire Healthcare NHS Trust (2) Appellant C (3) (Interested Parties)
[2002] EWCA Civ 646
Court of Appeal (15th May 2002) Lord Phillips MR, Dyson LJ, and Jonathan Parker LJ

The Facts

On the 21st. July 1995 IH was found not guilty by reason of insanity of a serious assault on his young son, and the Court made an order under Section 5 of the Criminal Procedure (Insanity) Act 1964 [as substituted by section 3 of the Criminal Procedure (Insanity and Unfitness to Plead) Act 1991] ("CPIA"). The effect of this disposal is for all relevant purposes to confer the same status as a patient detained under Section 37 of the Mental Health Act 1983 ("the Act") together with a restriction without limit of time under Section 41.[1]

He was detained at Rampton High Security Hospital, and because his detention was pursuant to Section 5 CPIA, his case was referred by the Secretary of State[2] to the Mental Health Review Tribunal ("MHRT") (the first tribunal) after the first six months of his detention. This Tribunal met on the 18th. July 1996, and although requested to support a move to IH's local Regional Secure Unit (RSU), it declined to do so stating:

> "In the tribunal's view, the resources at Rampton Hospital may well make it preferable that he remain there. No doubt this is ultimately a clinical decision, but we do not think we should make a recommendation either way."

IH's case was next considered by the MHRT following his application on the 11th. September 1998. At this time he was asymptomatic. During his detention he had never been treated with medication at a therapeutic level although he had been provided with trial doses of medication to which he experienced severe side effects.

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1 *Section 79(1)(b) of the Act.*
2 *Section 71(5) of the Act.*

At the second tribunal, IH's Responsible Medical Officer ("RMO") opined that IH no longer suffered from a mental illness but he considered that he should be transferred to a RSU for rehabilitation. The Tribunal decision was not to grant a discharge but it stated:

> "The Tribunal endorse the view that the Patient should be transferred to a suitable RSU for further observation and treatment."

IH was subsequently assessed by the clinical team at the appropriate RSU, and was granted leave by the Secretary of State to visit the RSU for an orientation visit which was subsequently successfully undertaken. IH was assessed by the RSU as suitable for transfer, and since 1998 both his clinical team at Rampton Hospital and the relevant psychiatrist from the RSU have consistently stated their views that IH does not require the special security of Rampton Hospital but does require ongoing treatment which should take place within the setting of the RSU.

The transfer of a restricted patient from one hospital to another cannot take place without the permission of the Secretary of State[3]. Since 1998 the Secretary of State has refused to grant permission for the transfer.

On the 7th. June 1999 a third Tribunal considered IH's detention. It adjourned the hearing on the following terms:–

> "Having considered all the medical evidence we have come to the conclusion that IH is not now suffering from mental illness of a nature or degree which necessitates his detention in hospital for medical treatment but having regard to the serious nature of the condition he suffered and the possibility of recurrence we do consider it appropriate for the patient to remain liable to be recalled to hospital for treatment. We adjourn the hearing until 1st. December 1999 at the latest for a full Care Plan to be drawn up. The terms which we consider should probably be attached to the Conditional Discharge are
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> 1. Supervision by a named social worker.
> 2. Supervision by a named forensic psychiatrist; Mr. IH to be subject to the directions of the psychiatrist including any relating to drug monitoring.
> 3. Residence at a suitable hostel preferably staffed 24 hours a day.
>
> If it is considered that he should be excluded from any area because of the presence there of the victim we should be given full details of the area proposed.
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> We require [X] Council to provide full details of a suitable plan at the adjourned hearing."

In the event the third Tribunal did not resume until the 3rd. February 2000 and, although it had the benefit of further reports, it was not presented with the name of a psychiatrist who would supervise in the community, the address of a suitable hostel or a care plan. The Tribunal was positively satisfied that IH was not suffering from a mental disorder of a nature or degree which makes it appropriate for him to be liable to be detained in hospital and was also positively satisfied that it was not necessary for his health, safety or for the protection of other persons that he should receive such treatment.[4] A deferred conditional discharge was directed in accordance with the Tribunal's statutory power under section 73(7) MHA 1983.

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3 Section 41(3)(c)(ii) MHA.

4 The hearing took place prior to The Mental Health Act 1983 (Remedial) Order of 18th. November 2001 and in consequence the onus was on IH to prove on a balance of probabilities that he did not possess a disorder of the necessary nature or degree and that his treatment within hospital was not necessary for his health, safety or the protection other persons.

The reasons for the decision were:

> "Having considered the reports and correspondence from [X] Social Services and the [Y] Health Authority, and having heard the evidence of Miss M of the [X] Social Services we are very concerned that no supervising psychiatrist has yet been identified and as a result no care plan has been put in place. For the reasons given on the 7th. June 1999, we make a Conditional Discharge order in the following terms:
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> 1. There shall be supervision by a named social worker;
> 2. There shall be supervision by a named psychiatrist, preferably by a Forensic Psychiatrist;
> 3. IH shall be subject to the directions of the psychiatrist including any relating to drug monitoring;
> 4. IH shall reside at a suitable hostel, preferably a hostel staffed 24 hours a day;
> 5. IH shall be excluded from [Z] save for the purpose only of visiting his relatives in their homes. In the event that his psychiatrist or supervising social worker wishes to vary the exclusion zone for the purpose of implementing the conditions of this order as to treatment and/or residence application may be made for that purpose.
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> IH's discharge shall be deferred until the arrangements listed have been made."

The crucial factor in arranging the aftercare plan was the identification of a psychiatrist willing to supervise IH in the community. The psychiatrists at the catchment area RSU were willing to offer a bed and supervise within the RSU, but were not willing to provide supervision in the community as they disagreed with the decision of the Tribunal and considered it clinically inappropriate.

The Health Authority used its best endeavours to secure a psychiatrist outside the catchment area without success. The Secretary of State maintained his refusal to consent to a transfer to the RSU.

In order to seek to ameliorate IH's position, a request was made to his RMO to seek the consent of the Secretary of State[5] to the grant of unescorted leave on the basis that IH's detention after a reasonable time from the decision of the Tribunal of the 3rd. February 2000 was unlawful. The request was refused on the basis that the RMO did not consider it clinically appropriate. IH sought leave to seek judicial review;–

a) Against the RMO's decision not to seek the consent of the Secretary of State for Section 17 leave;

b) Against the Secretary of State for not consenting to the request (in the event that the RMO subsequently made such a request);

c) Damages;

d) A declaration of incompatibility, namely between sections 73(2) and/or (7) MHA 1983 and Articles 5(1)(e) and/or (4) of the European Convention on Human Rights.

The paper application was refused by Mr. Justice Silber on the 1st. March 2001 and, after hearing oral argument, by Mr. Justice Ouseley on the 25th. April 2001.

5 Section 41(3)(c)(i) MHA.

Leave was sought from the Court of Appeal, and on the 3rd. July 2001 Lord Justice Sedley on a paper application ordered the application to be renewed as soon as possible in open court. His reasons were:

> "I agree at present with Ouseley J that it is not possible to extract from the MHRT's order an obligation to grant unescorted day leave.
>
> But this itself has major implications for the operation of the Human Rights Act 1998. Either MHA s.73(7) is incompatible with the Convention rights , in which case government needs to address the conflict ; or – what seems likelier to me – there is a lacuna for which the UK may be answerable in Strasbourg because the State (its courts included) is unable to secure the implementation of the MHRT's order.
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> In either event it may be necessary for this court to say – if it be the case – that the end of the domestic legal road has been reached and why."

On the 23rd. July 2001 the application for leave was renewed before Lord Justice Simon Brown (Vice President of the Court of Appeal, Civil Division), Lord Justice Tuckey and Lord Justice Laws. Leave was refused against the RMO, and granted against the Secretary of State for the Home Department. It was further ordered that the Secretary of State for Health, and Nottingham Healthcare NHS Trust (Rampton Hospital) be joined as Respondents and that the MHRT be joined as an interested party.

The Judicial Review application was heard in the Administrative Court before Mr. Justice Bell, and Judgment was delivered on the 5th. December 2001. The claim had been refined by abandoning the damages claim, and the only matter before the Court was the request for the declaration of incompatibility.

Mr. Justice Bell found that:

> "It is at least arguable that the claimant has been detained unlawfully from a period a few months after February 2000"[6]

He went on to say:–

> "In summary, I cannot therefore conclude that in this case where there was a clear medical issue as to whether the claimant suffered from mental illness at all, the effect of the Tribunal's February 2000 order was that they found that Mr. H would continue to be lawfully detained in compliance with the 1983 Act and the Convention until such time as conditions including psychiatric supervision could be satisfied."[7]
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> "I am more confident that in breach of Article 5(1)(e) and (4), the claimant has been left in limbo, as Mr. Owen put it, for some twenty-one months."[8]

Mr. Justice Bell went on to find that there was no incompatibility, as it was possible to interpret Section 73(7) of the Act in a way that produced compatibility. He did however grant leave to appeal on the basis that the question of incompatibility was at least arguable.

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6 *Paragraph 52 of the Judgment of the Administrative Court.*

7 *Paragraph 53 ibid.*

8 *Paragraph 54 ibid.*

The Issue before the Court of Appeal

The central issue before the Court of Appeal was whether in circumstances such as those pertaining to IH (i.e. where a Restricted Patient applies to the MHRT and is successful in obtaining an order that he should be discharged subject to conditions, but where it has not proved possible to assemble the resources that will enable him to comply with the conditions, and in consequence he remains detained), it is possible to interpret the Act in such a way that it does not infringe the patient's rights under Article 5(1)(e) or 5(4) of the Convention.

Article 5(1)(e) states:

> "Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:
>
> the lawful detention ..... of persons of unsound mind."

Article 5(4) states:

> "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be speedily decided by a court and his release ordered if the detention is not lawful."

IH's case was that it was not possible to interpret the present legislation in a way that produced compatibility. It was the Respondents' case (with which the Court subsequently agreed) that compatibility could be produced by revisiting the decision in the case of *Campbell*[9] (for details of which see below).

The Decision

The Court of Appeal's approach to the problem is to introduce a clear distinction between a patient who:–

> "is suffering from a mental disorder of a nature or degree which makes it essential for his safety or that of others that he be detained in hospital for treatment"[10]

and other patients who may be one of three types:–

> "i) The patient is clearly no longer suffering from mental disorder and there is no risk of a relapse or renewed outbreak of illness such as to make it appropriate for him to be subject to any further treatment or supervision.
>
> ii) The patient is probably no longer suffering from mental disorder, but there is a risk that this diagnosis may be wrong and that the patient is merely in remission. Supervision or treatment is appropriate to guard against this risk.
>
> iii) The patient is still suffering from mental disorder which requires treatment or supervision for his own health and safety or the protection of others. This can be provided satisfactorily either in hospital or in the community."[11]

Having introduced these three categories of patients who do not fall within the category of the clearly detainable, the Judgment goes on to reverse the House of Lords decision in *Campbell*.

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9 Campbell -v- Secretary of State for the Home Department [1988] 1 AC 120

10 Paragraph 76 of the Judgment

11 Paragraph 76 of the Judgment.

Campbell was clear authority that the decision of a Tribunal that a patient should be conditionally discharged, and that the discharge should be deferred[12], was a final and not a provisional decision[13]. The sole judgment in *Campbell* was given by Lord Bridge. It is summarised in IH as follows:

> "Section 73 provides for a two stage process in relation to a conditional discharge. At the first stage the Tribunal decides that it will direct the patient's discharge subject to conditions, but defers giving the direction so that arrangements may be made to enable the patient to comply with the conditions. The second stage is reached if and when the Tribunal is satisfied that those arrangements have been made, whereupon it directs the conditional discharge. The Tribunal is not obliged, or even entitled, to reconsider its earlier decision in order to accommodate any new facts that might cause it to alter that decision."[14]

The Court of Appeal in the light of the Human Rights Act 1998 has now reversed the *Campbell* situation,[15] and the Judgment has highlighted this by including a cross heading:–

> "The New Regime
>
> Tribunals should no longer proceed on the basis that they cannot reconsider a decision to direct a conditional discharge on specified conditions where, after deferral and before directing discharge, there is a material change of circumstances. Such a change may be demonstrated by fresh material placed before or obtained by the Tribunal. Such material may, for instance, show that the patient's condition has relapsed. It may show that the patient's condition has improved. It may demonstrate that it is not possible to put in place the arrangements necessary to enable the conditions that the Tribunal proposed to impose on the patient to be satisfied. The original decision should be treated as a provisional decision, and the Tribunal should monitor progress towards implementing it so as to ensure that the patient is not left "in limbo" for an unreasonable length of time."

The Critical Impasse

The Judgment proceeds to offer a way in which the "critical impasse" can be resolved. The critical impasse arises when the MHRT considers that it is reasonable for the patient to continue treatment in the community rather than in hospital and that the treatment is necessary but the psychiatrists who have to provide such treatment refuse because they disagree with the MHRT's view.[16]

The way in which the Court of Appeal summarises the position of a MHRT considering a conditional discharge accords with the submissions made on behalf of the Secretaries of State as follows:–

> "i) The Tribunal can at the outset, adjourn the hearing to investigate the possibility of imposing conditions.

12 *Pursuant to the power under Section 73(7) MHA.*

13 *This was despite the fact that rule 2 of the Mental Health Review Tribunal Rules 1983 (S.I. 1983 No. 942) states that "provisional decision" includes a deferred direction for conditional discharge in accordance with section 73(7) of the Act and a notification to the Secretary of State in accordance with section 74(1) of the Act."*

14 *Paragraph 53 of the Judgment.*

15 *It may seem surprising that the Court of Appeal can reverse a House of Lords decision in a precedent-based system. However this is due to the interaction of sections 2 and 3 of the Human Rights Act 1998, and the consequent duty on the Courts to interpret legislation compatibly with the ECHR.*

16 *Paragraph 92 of the Judgment.*

ii) The Tribunal can make a provisional decision to make a conditional discharge on specified conditions, including submitting to psychiatric supervision, but defer directing a conditional discharge while the authorities responsible for after-care under s. 117 of the Act make the necessary arrangements to enable the patient to meet those conditions.

iii) The Tribunal should meet after an appropriate interval to monitor progress in making these arrangements if they have not by then been put in place.

iv) Once the arrangements have been made, the Tribunal can direct a conditional discharge without holding a further hearing.

v) If problems arise with making arrangements to meet the conditions, the Tribunal has a number of options, depending upon the circumstances.

a) It can defer for a further period, perhaps with suggestions as to how any problems can be overcome.

b) It can amend or vary the proposed conditions to seek to overcome the difficulties that have been encountered.

c) It can order a conditional discharge without specific conditions, thereby making the patient subject to recall.

d) It can decide that the patient must remain detained in hospital for treatment.

vi) It will not normally be appropriate for a Tribunal to direct a conditional discharge on conditions with which the patient will be unable to comply because it has not proved possible to make the necessary arrangements."[17]

Was IH unlawfully detained?

The Judgment makes it clear that the Court considered that after a reasonable period from the decision of the MHRT to discharge him, IH was unlawfully detained:–

" ..... under the Convention and the principles to be derived from *Johnson*[18] this uncertainty could not justify the continued detention of IH for more than a reasonable period to enable arrangements to be put in place for his discharge. His prolonged detention in these circumstances, was in violation of Article 5(1)."[19]

Discussion

The case establishes a totally new framework for the MHRT when considering the case of a restricted patient. It is impossible to predict exactly how the changes will operate in practice and the resource implications.

17 *Paragraph 98 of the Judgment.*

18 *Stanley Johnson -v- United Kingdom [1997] 27 EHRR 296.*

19 *Paragraph 100 of the Judgment.*

Consideration of the Discharge Criteria under the New Regime

The first issue that the MHRT should address when considering an application or reference concerning a restricted patient is whether both the criteria for continuation of the detention are satisfied.[20] Before the clarification provided in *IH*, the first task of the MHRT was to direct itself to answering yes or no to each of the tests set out in Section 72(1)(b)(i) and (ii) of the Act. Following *IH*, the MHRT should consider into which of the four types of 'mental state' set out at paragraph 76 of the Judgment, the patient falls. These are set out above and may be paraphrased as:

1. A mental state such that it is essential for the patient's safety or that of others that s/he be detained in hospital for treatment.
2. A mental state that is asymptomatic and there is no risk of relapse.
3. A mental state that is asymptomatic where there may or may not be a risk of relapse.
4. A mental state that continues to require treatment that can be provided satisfactorily in the community provided clinicians to provide the treatment can be found, and, in the absence of such clinical resources in the community, can be provided in hospital.

Type 1 will contain patients whose presentation whether as a consequence of active psychosis or severe personality disorder makes them easy to identify as requiring hospital treatment.

It is unlikely there will be many, and possibly no, patients who fall into type 2. The use of the term "*no risk of relapse*" is rarely heard in forensic psychiatry. Should any patient be considered to fall into this category they would be prime candidates for an absolute discharge, and indeed it would be difficult to justify how a MHRT could find that a patient did fall into this category and then make them liable to recall by granting a conditional discharge.

The MHRT will be need to be astute to differentiate between types 3 and 4 but that is what it must do in order to know how to proceed, if it is necessary to reconsider the case following the granting of a deferred conditional discharge (DCD), should the resources required to meet the proposed conditions not have been identified within a reasonable time.

In deciding *IH*, the Court had to resolve what was referred to as "*the critical impasse*". This is the position that can arise when the MHRT decides that the patient no longer satisfies the criteria for continued detention, and the clinicians with community responsibility disagree. The clinicians rely on the concept of clinical judgment to refuse to treat the patient when they consider that the treatment cannot be safely provided in the community. Quite simply they disagree with the finding of the MHRT, and in consequence they refuse to co-operate in the implementation of the decision. On behalf of IH, it was argued that unless the MHRT had the necessary power to ensure implementation of its own decision it lacked an essential requirement of an Article 5 judicial body.

In order to resolve this impasse, the Court of Appeal devised the types set out above. There can be little doubt that the impasse has been resolved for a patient falling into type 4. The MHRT when considering such a patient will have satisfied itself firstly that the risks can be safely managed in the community provided there is sufficient support, and secondly that in the absence of sufficient support, such risks cannot be safely managed. In consequence it can grant a DCD, and in the event that the resources are not available, can rescind at a future hearing the original decision, which was both provisional and contingent on resource provision.

20 Section 72(1)(b)(i) and (ii) as applied by section 73(1)(a) and 73(2) MHA.

The possible effect of the introduction of this type of situation is that advocates could find it easier to obtain a DCD firstly because the MHRT would be aware that it is not a final decision, and secondly because the balancing factor in deciding the detainability of many patients is the availability or otherwise of risk minimisation resources in the community. The granting of the DCD would be a way for the MHRT to explore this availability.

The court in identifying the type four situation makes it explicit that the treatment or supervision the patient requires " ..... *can be provided satisfactorily either in hospital or in the community.*"

The apparent distinction between type 4 and type 3 is that for type 3, the MHRT must in any event discharge the patient following the grant of the DCD even if the resources necessary to meet the original proposed conditions have not been assembled. That is not to say that at the following hearing it must discharge, for there are no restrictions on the number of subsequent hearings that the MHRT may have, subject only to determining the application within a reasonable time. The position is clearly set out in the judgment:

> " ..... In order to comply with *Winterwerp* and *Johnson* a conditional discharge must not be deferred under section 73(7) beyond a reasonable limited period. After that the tribunal must discharge the patient whether or not it has proved possible to put in place arrangements to accommodate the conditions that the Tribunal wished to impose. If it has not, the Tribunal should make appropriate modification to the conditions so that it will be possible for the patient to comply with them…"
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> " ..... If, however, the preferred arrangements prove impossible, the Tribunal must make appropriate modifications to the conditions and direct the discharge of the patient. Such a course is necessary because in this situation the second and third requirement in *Winterwerp* will not be satisfied."[21]

There is in consequence a fundamental distinction between a type 3 and a type 4 patient. Should a MHRT when granting a DCD fail to indicate either expressly or implicitly in the reasons for their decision into which category the patient falls, the MHRT may be vulnerable to subsequent judicial challenge not only because of inadequacy of reasons but also in respect of any further decision they may take. The type 4 patient should be aware that if it is not possible to find the resources to meet the conditions, he or she will remain in hospital, whereas the type 3 patient should be aware that if the resources to meet the conditions cannot be found, the MHRT is required to either modify the conditions so that they can be met or impose no conditions in order that discharge can be implemented. He or she will then be granted a conditional discharge, free of conditions other than the statutory provision that he or she remains liable to be recalled to hospital.

Although the introduction of the distinctions between different types of DCD situations will undoubtedly resolve many cases where otherwise the impasse might arise, it is difficult to conclude that there is under the new regime no possibility of an impasse.

For example, a MHRT may conclude that a patient clearly falls within type 3 but requires a supported hostel, and it indicates such when setting proposed conditions on a DCD. If it then

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21 Paragraphs 90 and 91 of the judgment. In Winterwerp v Netherlands [1979] 3 EHRR 387, the European Court ruled that the essential requirements for detention on grounds of 'unsoundness of mind' to be compliant with Article 5(1)(e) ECHR are that (i) the patient is shown on reliable objective medical expertise to have a true mental disorder; (ii) the disorder is of a nature or degree warranting compulsory confinement; and (iii) the disorder must be persistent throughout the period of detention.

reconvenes and no such hostel is available, it may be unwilling to withdraw the condition and is precluded from deciding that the patient should remain in hospital.

The MHRT has the power to direct the attendance of witnesses[22] by the use of summonses if necessary. The attendance of the Chief Officers of service providers may resolve some problems. The theoretical chance of an impasse appears possible and only time will tell whether in practice an impasse will occur.

Hearings following the making of a Provisional Decision to Discharge

There is within the judgment nothing to indicate the procedure for ensuring that the case returns to the MHRT for a final decision. Following the making of the provisional decision to make a DCD, the MHRT may fix a new date when it will review the case if it has not previously been notified that the resources necessary to meet the conditions have been assembled. It may simultaneously give directions to the authorities with section 117 responsibility to provide reports, and to request or direct the attendance at the resumed hearing of those individuals within those authorities with the responsibility for the service provision[23].

Alternatively the MHRT may elect not to fix a new date. Should it adopt this course then presumably any party or the Secretary of State may request a new hearing in the event that there has been a material change in circumstance or there has been an unreasonable delay. The Court of Appeal do not set out any timetable and presumably it depends on the particular circumstances of the case. Although a delay in assembling resources is permissible[24] the delays must be reasonable if the detention is not to become unlawful.

Resource Implications

The MHRT was an interested party in IH, and adduced evidence to show that the new regime would be unlikely to have major resource implications in view of the relatively small number of DCDs that are made. This view may be optimistic.

The resources of the MHRT are currently stretched to meet the current caseload. Although DCDs are a relatively small proportion of the total workload, under the new regime they may create a disproportionate amount of additional work as they are more likely than other cases to require the MHRT secretariat to ensure the attendance of witnesses who are not parties to the case, and to follow up the directions of the MHRT when making a DCD.

Practical difficulties may arise in ensuring the attendance of the legal member who will usually be a circuit judge. He or she is allocated by the circuit to sit on MHRTs for one or more periods a year, but will not necessarily be available when it becomes appropriate and necessary to re-consider the provisional decision.

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22 Rule 14(1) op.cit.

23 ibid. Rules 14 & 15.

24 Johnson op. cit.

Conclusion

IH failed to obtain the declaration under section 4(2) of the Human Rights Act 1998 which he sought. It was submitted on his behalf that sections 73(2) and/or (7) of the Mental Health Act 1983 are incompatible with Articles 5(1)(e) and/or (4) of the Convention, in that MHRTs lack the power to guarantee that such conditions as they may attach to a deferred conditional discharge will be implemented within a reasonable period from the making of the order. The Court of Appeal did however accept that the existing regime was incompatible, and only by reversing the decision of the House of Lords in *Campbell* and setting out a new regime, was it able to interpret section 73(2) and (7) in a Convention-compliant way.

The effect of the new regime will have a major impact on the way in which MHRTs consider applications and references of restricted patients, both in respect of the initial finding of the detainability of the patient and, in the event that discharge could be appropriate, in the way in which the MHRT proceeds to its final decision.

A likely consequence of the *IH* case is that for some patients there may be several hearings as the MHRT attempts to influence the authorities with responsibility for providing necessary community resources to fulfill their obligations. Ultimately some patients may not then be discharged because it has proved impossible to assemble the resources, and others will be discharged with less stringent conditions than might otherwise have been the case.

It remains to be seen how easily the MHRT will be able to cope with this new regime and whether it will require further resources. Most significantly it remains to be seen whether the impasse has truly been resolved or whether there will be cases in which a MHRT refuses to alter its provisional decision that a patient should be discharged subject to the provision of the resources necessary to enable him to comply with the conditions it considers appropriate, and the service providers remain unable or unwilling to provide the resources that will enable the patient to comply.

So far as IH is concerned, the Court of Appeal was satisfied that he had been unlawfully detained for a lengthy period of time. The consequence of such a detention is an entitlement to damages under Article 5(5)[25] of the Convention. It remains to be determined which public authority is liable for such damages.

25 *Article 5(5) ECHR states: 'Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation'.*