Submission of the

NEW SOUTH WALES COUNCIL FOR CIVIL LIBERTIES

to the

NSW Department of Health

Exposure Draft of the Mental Health Bill 2006

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1. Executive Summary

1. The NSW Council for Civil Liberties ('CCL') has major concerns about sections of the Mental Health Bill 2006 (NSW) ('the Bill') dealing with the membership and appointment of members of the NSW Mental Health Review Tribunal ('the Tribunal'). In particular, we recommend that the multi-disciplinary composition of the Tribunal should not be weakened.
2. CCL recommends that:

- important due process rights in relation to Tribunal proceedings should continue to be expressly provided for by Parliament in the Act–they should not be governed by regulations as dictated by the Bill;
- provision for the participation of victims in Tribunal proceedings should not be made in the Act or the regulations *at this stage* because this issue warrants comprehensive consideration in the pending review of the forensic provisions of the *Mental Health Act 1990* (NSW), where it can be considered in its proper context.

3. CCL supports the introduction of a single community treatment order ('CTO') as opposed to the previous dual system of community orders, but is opposed to the extension of the maximum length of a CTO to 12 months and recommends introducing more effective review mechanisms after an individual has been detained under the 'breach' procedures.
4. CCL recommends allowing appeals at first instance to be made to the Administrative Decisions Tribunal against decisions of the Tribunal to ensure appeal rights are not just a theoretical possibility.
5. CCL encourages the Government to enhance the provision of legal representation, advocacy and support to ensure that individuals falling within the jurisdiction of the Act are better able to protect both their civil rights and rights regarding treatment.
6. CCL recommends changing the provisions dealing with the limited detention of 'mentally disordered persons' to avoid unjustified and prolonged detention of people in this category.
7. CCL recommends that the provisions relating to disclosure of information, in particular to 'primary carers', need to be more carefully drafted to avoid confusion and better protect the privacy of mental health service users.

2. promoting quality care not pure control

8. CCL is concerned at the limited availability of appropriate treatment facilities and accommodation in the community to cater for the needs of individuals at different stages of treatment and recovery, and also the lack of beds to deal with acute cases of mental illness. We wish to see quality care provided for mental health service users while ensuring that their civil liberties are interfered with to the absolute minimum. We recognise that attaining this goal may warrant subjecting individuals to compulsory treatment–as either an inpatient in hospital or under a CTO–in limited circumstances.
9. As the Department of Health ('the Department') states, improving the quality of mental health care is largely dependent on 'a range of non-legislative and resources issues'.[1] CCL commends the Government's new funding package and initiatives aimed at delivering better quality care and services. We would like to emphasise, however, that better resourcing and strategies for the provision of mental health care is as much about protecting civil liberties as it is about providing quality care. Where health services are struggling to manage heavy workloads with insufficient resources, compulsory treatment may be a quick and easy way to keep tabs on people who could be effectively treated on a voluntary basis if only there were better resources, facilities and systems in place in hospitals and the community to make this goal a reality. In light of this risk, these new policy initiatives should be an urgent and ongoing priority.
10. While mental health legislation plays a limited role in assuring access to quality care, the Act should make it clear that using involuntary treatment for purely custodial purposes, or as a control measure alone, is unacceptable. This principle has been highlighted in the recently released World Health Organisation publication, *WHO Resource Book on Mental Health, Human Rights and Legislation*:

    > Persons should be admitted involuntarily only if there is a therapeutic purpose to the admission. This does not necessarily mean that medication must be provided, as a wide range of rehabilitative and psychotherapeutic approaches may be implemented. A lack of therapeutic success does not imply a lack of therapeutic purpose, and involuntary admission can be justified if the person is receiving therapeutic care, even if the available treatments are not able to completely cure the person's condition. *A person requiring purely custodial care should not be kept in a psychiatric facility as an involuntary patient.*[2]

11. By extension, a person subject to a CTO who is required to comply with a treatment plan in the community should be provided with *effective*

[1] NSW Health, *Review of the Mental Health Act 1990, Report*, Department of Health of NSW, Sydney, 2006, p 1.
[2] World Health Organisation, Geneva, 2005, p 49. Emphasis added.

care. Otherwise, the order amounts to an arbitrary restriction of freedom.

12. CCL is in general satisfied that the objects of the Act sufficiently protect against the arbitrary use of involuntary treatment as a control measure alone, a position which will be buttressed by the more extensive principles for care and treatment contained in s 68 of the Bill. The Act also emphasises in a number of places that people with mental illnesses should receive the best available care in the least restrictive environment.

13. CCL joins with stakeholders, however, in recommending that the word 'control' in the object 'to provide for the care, treatment and control of persons who are mentally ill or mentally disordered' should be replaced with a more appropriate word like 'support'.[3] While treatment approximating pure control may be necessary to prevent imminent threats to health and safety, such treatment should not be used for any more than very limited periods of time. The objects of the Act should not, as they currently do, suggest otherwise.

3. the mental health review tribunal

3.1 composition of the Tribunal

14. CCL does not support the provisions of the Bill which potentially allow for substantial watering down of the multi-disciplinary approach to Tribunal decision-making.[4] CCL believes that this approach is one of the great strengths and contributions of the Tribunal, distinguishing it from the past medically driven and controlled provision of mental health care in a largely closed and unscrutinised setting. The multi-disciplinary composition of the Tribunal ensures that its members have the breadth of skills, experience and competence needed to determine matters falling within its jurisdiction. The Tribunal's multi-disciplinary composition is thus an important protector of the civil liberties of its clients and prospective clients, ensuring their right to freedom from arbitrary detention.

15. Psychiatric expertise is essential to ensure that the Tribunal accurately applies the criteria for involuntary treatment to the facts of a case, especially those relating to the person's mental condition and its likely effects. The 'other suitably qualified members' of the Tribunal have a wide range of experience in service provision, or use, in hospitals and the community which is also crucial in the proper application of these criteria, including the important requirement that the Tribunal consider whether a less restrictive form of treatment is appropriate and available.

16. CCL recommends retaining the current provisions of the Act regarding the composition of the Tribunal for the exercise of its functions, while

[3] NCOSS, *NCOSS Submission to the Review of the Mental Health Act, Discussion Paper 2*, Council of Social Service of NSW, Surry Hills, 2004, p 3.
[4] Section 150 (2)-(3).

acknowledging that it may be appropriate for a single lawyer member on occasions to exercise a limited number of procedural functions, such as making a ruling on a formal request for an adjournment of a hearing, or making directions concerning the hearing process to be followed.

17. It should be noted, however, that 'procedural questions' in Tribunal proceedings are often bound up in substantive issues regarding the mental condition of, and care and treatment provided to, the subjects of proceedings. The decision whether or not to adjourn proceedings, for example, is often closely connected to broader treatment planning and therefore greatly benefits from the input of a psychiatrist member.

18. CCL notes with disapproval that regulations, which are subject to change by the Executive without proper public scrutiny, are to make provision for the composition of the Tribunal. If the Act is to be amended to allow for less than 3 members to exercise certain functions, these functions should be listed in the Act itself.

CCL recommends that there should be a strong presumption in the Act that all substantive decisions of the Tribunal should always be made by a multi-disciplinary 3 member panel.

If at any time the Tribunal is constituted by less than 3 members the subject of the proceedings, or someone on their behalf, should be entitled to request a full 3 member panel instead.

3.2 appointment of members

19. Judges have security of tenure to ensure they make independent decisions, a feature which is especially important when it comes to the uniquely judicial function of deciding to detain an individual and restrict their freedom. The Tribunal makes decisions affecting people's freedom and is for practical purposes the final decision maker for many people subject to involuntary treatment under the Act. Its functions therefore have a distinctly judicial character in comparison to some other administrative tribunals. The Tribunal also makes decisions which impact on the care and treatment people receive when they are acutely unwell.

20. Because of the critical nature of its functions, CCL recommends that the Tribunal's members have security of tenure within a minimum term, such as 3 years, as is the case for the Guardianship Tribunal.

21. The appointment of Tribunal members by the Minister for Health creates a risk of actual or perceived bias in both the appointment process and the Tribunal's decision-making processes. This appointment process gives rise to a strong conflict of interest, because the Minister appointing members is at the head of the department whose decisions the Tribunal is reviewing.

CCL recommends that members of the Tribunal be appointed for a minimum term, such as 3 years, by the Attorney-General.

3.3 tribunal procedure and fundamental safeguards

22. CCL notes with disapproval that s 154(2) of the Bill effectively removes from the Act fundamental safeguards such as an individual's right to appear and be legally represented at Tribunal hearings, and instead provides for numerous aspects of so-called 'Tribunal procedure' to be governed by regulations.[5] Regulations are not an appropriate place for such major powers because they are subject to change by the Executive without proper public scrutiny. Provision for a number of the matters referred to in this section of the Bill should therefore be made by Parliament expressly in the Act.

23. Specifically, CCL is strongly opposed to removing the following sections from the Act: s 272 (open proceedings); s 274 (rights of appearance and representation), s 275 (assistance of interpreters); s 276 (access to medical records; s 279 (records of proceedings); and s 280 (record of determinations). These provisions are critical to ensuring that due process rights are realised. CCL notes that Part 6, Division 2 of the Guardianship Act (rather than regulations) provides for these aspects of Guardianship Tribunal 'procedure'.

24. Regulations may be an appropriate place to set out more detailed rules regarding Tribunal procedure. Provisions which protect due process rights and lay out the broad framework within which such procedure operates, however, should be in the Act.

CCL recommends that basic provision for aspects of 'Tribunal procedure' referred to in s 154(2) of the Bill be made in the Act rather than regulations. Sections 272, 274, 275, 276, 279 and 280 of the Act should be retained.

3.4 participation of victims

25. CCL notes that s 154(2) of the Bill also allows for the participation of victims in Tribunal proceedings to be governed by regulations. Victims are generally involved in Tribunal proceedings dealing with forensic patients found not guilty by reason of mental illness in a criminal trial. As the participation of victims in Tribunal proceedings is only an issue in the Tribunal's forensic jurisdiction, we recommend against making provision for the participation of victims in the new Act or regulations *at this stage*. The decision about appropriate legislative provisions dealing with this issue is more properly left to be determined in the course of the separate review on the forensic proceedings of the Act, where it can be considered in its proper context.

26. CCL notes that victims' rights principles were originally developed *without* forensic mental health proceedings in mind. There are important differences between criminal trials and Tribunal proceedings

[5] The Bill, s 154(2).

which indicate that great care is needed when developing procedures for the participation of victims which are appropriate in this unique jurisdiction.

27. The participation of victims in a criminal trial traditionally occurs at the point of sentencing and serves punitive purposes. In contrast, victims become involved in forensic proceedings under the Act after a person has been found not guilty by reason of mental illness, at a stage of the process which is not meant to achieve punitive purposes. Although analogies with the criminal justice system are not entirely appropriate, victim involvement at this stage is comparable to victim involvement in Executive decisions relating to parole. As such, it may effectively subject a person to double punishment for a crime of which they have been acquitted.

CCL recommends that the issue of victim participation in Tribunal proceedings warrants comprehensive consideration in the pending review of the forensic provisions of the Act–it should not be provided for in the Act or regulations at this stage.

4. community treatment orders

4.1 length of community treatment orders

28. CCL recommends including a provision in the Act which states that the length of a CTO must be the minimum necessary to ensure the person receives the best possible care in the least restrictive environment. This requirement would reduce the risk that applicants and decision-makers will default to the maximum length months without adequate justification.

29. The extension of the maximum duration of a CTO from 6 to 12 months proposed in the Bill is problematic for a number of reasons.[6] Firstly, *regular* periodic review of involuntary treatment is crucial to prevent arbitrary deprivation of freedom and ensure that involuntary treatment is not continued unless it serves a therapeutic purpose. CCL believes that a maximum period of 6 months strikes the best balance, which protects an individual's civil rights while at the same time allowing sufficient time to provide treatment in line with the treatment plan and assess whether a further order might be necessary.

30. Even though CTOs are a less restrictive form of involuntary treatment in that they allow a person to live in a community setting, they are highly intrusive on individual freedom. The conditions of a CTO are often very strict: the person may be required to receive medication at a place which is far from their home at a time which may interfere with other commitments; they may have had to agree to live at a certain place; they can be readmitted to hospital as an involuntary patient for 'breaching' an order.

[6] The Bill, s 56(2).

31. CCL notes that mental health legislation in a majority of Australian jurisdictions currently sets a maximum period of 6 months for a CTO.[7] Although Victorian CTOs can last for up to 12 months, individuals subject to a CTO can appeal to the Mental Health Review Board against the order *at any time*.[8] Comparable appeal and review mechanisms in NSW are much more onerous.

32. A further argument against extending the maximum length of a CTO as proposed in the Bill relates to the way in which the Act is currently being implemented. CTO hearings are often characterised by: brevity; conduct via telephone; non-attendance by prospective 'affected persons'; and no legal representation. In other words, they are far from an ideal means of either: (1) ensuring the Tribunal can reach an informed decision; or (2) allowing individuals to effectively challenge an order.

33. The Department's assertion that legal representation is currently available for CTO applications is only true in a very abstract sense.[9] Legal Aid does not automatically offer representation for CTO applications to the Tribunal and the vast majority of prospective 'affected persons' are unrepresented at these hearings.

34. CCL encourages the Government to enhance advocacy and support services available for people on CTOs–and for whom a CTO application has been made–to better assist them to protect both their civil rights and their rights regarding treatment. Such an initiative would be essential, however, for prospective CTO candidates if the maximum length of a CTO is to be extended to 12 months.

CCL recommends against extending the maximum length of a CTO to 12 months.

CCL recommends including in the Act the statement that the length of a CTO must be the minimum needed to ensure that the 'affected person' receives the best possible care in the least restrictive environment.

4.2 review following non-compliance with a community treatment order

35. After a person has been detained in hospital following alleged non-compliance with a CTO, mandatory review by the Tribunal must take place within 3 months.[10] The Bill does not change this position.[11]

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[7] *Mental Health Act 1990* (NSW), s 135(1)(b); *Mental Health (Treatment and Care) Act (ACT)*, s 36J; *Mental Health and Related Services Act (NT)*, s 123; *Mental Health Act 2000* (Qld), s 118(2); CTOs last for only 3 months in Western Australia*: Mental Health Act 1996(WA)*, s 68(1)(d).
[8] Section 29(1).
[9] NSW Health, *Review of the Mental Health Act 1990, Report*, Department of Health of NSW, Sydney, 2006, p 6.
[10] The Act, s 143A.
[11] The Bill, s 63.

36. The only avenue for review is for an individual to be brought before the Supreme Court if the Court receives information on oath that the person is wrongly detained in hospital.[12] This avenue is going to be practically ineffective in the vast majority of cases, especially considering the vulnerable position that 'affected persons' will be in following their readmission to hospital and the obstacles they are likely to face in initiating such an action.

37. CCL therefore recommends that the Act provide for mandatory review by the Tribunal within a week of detention in these circumstances. At a minimum, there should be an amendment to include an option to apply to the Tribunal for an early review. Articles 9(1), 9(4) and 2(3) of the *International Covenant on Civil and Political Rights*,[13] to which Australia is a party, indicate that this approach would best protect civil rights:

> **Article 9(1)**
> Everyone has the right to liberty and security of person. No one shall be subjected to arbitrary arrest or detention. No one shall be deprived of his liberty except on such grounds and in accordance with such procedure as are established by law.
>
> **Article 9(4)**
> Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.
>
> **Article 2(3)**
> Each State Party to the present Covenant undertakes:
> (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity;
> (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy;
> (c) To ensure that the competent authorities shall enforce such remedies when granted.

5. appeal rights

38. Appeal rights from Tribunal decisions are at present far too restrictive. Almost no appeals are made against decisions of the Tribunal–almost certainly because of the cost and formalities involved. A much more ready access to appeal would come from the Administrative Decisions Tribunal, which already has a role in hearing appeals against Protected Estates Orders made by the Tribunal. However, if this new appeal process were to be adopted, the Administrative Decisions Tribunal would itself need to have suitably qualified members, such as psychiatrist members, adjudicating on appeals.

39. Similarly, if the maximum length of a CTO is extended to 12 months (CCL recommends against this, see section 4.1 above), the affected

[12] The Act, s 285; the Bill, s 159.
[13] [1980] ATS 23 (entry into force: 13 November 1980).

person should be able to appeal at first instance to the Administrative Decisions Tribunal instead of the Supreme Court.

CCL recommends that decisions of the Tribunal should be appellable, initially, to the Administrative Decisions Tribunal and, in the second instance, to the Supreme Court.

6. legal representation and advocacy

40. The UN *Principles for the protection of persons with mental illness and the improvement of mental health care* ('UN Principles') state:[14]

> **Principle 1(6)**
> If the person whose capacity is at issue does not himself or herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it.

CCL recommends that the government increase funding to Legal Aid so that free legal representation is offered to the subjects of all Magistrates inquiries and Tribunal hearings, including for CTO applications to the Tribunal.

41. CCL also recommends including a provision in the Act to ensure that mental health service users can choose to be assisted or represented by a non-legal representative, such as a consumer advocate, throughout their contact with the mental health system, including at Magistrates inquiries and Tribunal hearings.

7. limited detention of 'mentally disordered persons'

42. The Act and the Bill state that a 'mentally disordered person' 'must not be detained in a hospital for a continuous period of more than 3 days (not including weekends and public holidays)' and that a person cannot be detained for this limited period 'on more than 3 occasions in any 1 month'.[15] This wording may be interpreted as allowing 'mentally disordered persons' to be detained for up to 13 or 14 days without review by a Magistrate or the Tribunal, and the Act is sometimes used to this effect.

CCL recommends amending the Act to make it clear that there must be a break between each 3 day period in any 1 month for which an individual is detained as a 'mentally disordered person', including if a new month has started.

CCL also recommends amending the Act so that weekends and public holidays are *not* included when counting each 3 day period of detention as a 'mentally disordered person'.

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[14] UNGA Resolution 46/119 (17 Dec 1991), see <http://www.unhchr.ch/html/menu3/b/68.htm>.
[15] The Act, s 35; the Bill, s 31.

43. If the Act *is* intended to be used as outlined above in para 42, CCL recommends including a provision in the Act to require a person to be brought before a Magistrate or the Tribunal as soon as practicable after they have been detained on the grounds that they are a 'mentally disordered person', or at a minimum to allow a person to apply to the Tribunal for an optional review of such detention.

8. primary carers

44. The proposed reforms to the Act have included enhanced recognition of the important part that carers play in supporting people with mental illnesses. The Bill specifically provides that primary carers will be able to request confidential information about a patient's medication.[16] Primary carers will now be notified of the initial detention of a patient, and other listed events.[17]

45. This area involves competing interests and complex issues. CCL has reservations about these aspects of the Bill, which may impinge on the rights of patients to confidentiality. These rights should not be abrogated simply because an individual has a mental illness or is subject to involuntary treatment under the Act.

46. CCL views the broad nature of ss 71 and 72 in its definition of a 'primary carer' and process for nominating this person as a problematic feature of the Bill. These sections are overly vague, considering that the right to privacy is an important civil right.[18] Furthermore, there is too little emphasis on possible detriment to the patient through any repercussions upon giving out their personal information.

47. CCL recommends that Divisions 1 and 2, specifically the provisions relating to primary carers, be more carefully framed with tighter definitions and procedures. Firstly, the Act should establish a clear right for the patient themselves to nominate the primary carer. Only if the patient lacks the capacity to make this nomination, should health service staff be required to make the decision. Another suggestion would be to more clearly assign possible candidates in a hierarchical manner, prioritising who should fall within this category, and to establish higher threshold requirements.

48. The Act could adopt similar drafting to ss 341 and 342 of the *Mental Health Act 2000* (Qld). The Queensland provision better protects the right to privacy by acknowledging that an individual should be entitled to decide who will be their 'allied person' unless they do not have the capacity to make this decision and providing more stringent criteria to determine who is to be a patient's 'allied person'. Higher threshold requirements apply in that the 'allied person' must be someone who is 'capable, readily, available and willing' to take on this role.

[16] Section 73.
[17] Sections 75, 76 and 78.
[18] International Covenant on Civil and Political Rights, Article 18(1).

49. Section 342(4) of the Queensland Act provides a 'listed order' to be followed by the treating health service when determining who is the 'allied person' if the patient lacks the requisite capacity:

> **s 342 Who is allied person if patient does not have capacity to choose allied person …**
> (2) If the patient, by an advance health directive under the *Powers of Attorney Act 1998*,115 has directed that a stated person be the patient's allied person, the stated person is the patient's
> allied person.
> (3) If subsection (2) does not apply, the administrator must choose a person, other than a health service employee at the patient's treating health service, to be the patient's allied Person.
> (4) The person chosen must be—
> (a) the first person in listed order of the persons mentioned in section 341 who is willing, readily available, capable and culturally appropriate to be the patient's allied person; or
> (b) if no-one in the list is willing, readily available, capable and culturally appropriate to be the patient's allied person—
> (i) if the patient is an adult—the adult guardian; or (ii) if the patient is a minor—the Commissioner for Children and Young People and Child Guardian under the *Commission for Children and Young People and Child Guardian Act 2000*.

50. The Queensland Act also recognises that it may not be appropriate for a patient to have anyone acting as an 'allied person'.[19] CCL recommends that the Act should recognise that a person should be able to choose to have no-one fulfilling the role of primary carer under the Act, and that this decision should be overridden only if they lack the capacity to make it.

51. CCL believes that the issue of consent is not adequately dealt with in the provisions of the Bill relating to primary carers. Disclosure of someone's personal information without their consent, even to a person involved in providing care to them, may have serious consequences that a health service employee may not foresee, including exacerbation of the person's mental health condition. An individual may have valid reasons for not wanting a carer to be told certain information about their care and treatment, but may find it difficult to put them forward.

CCL recommends that patients be granted a clear right in the Act to nominate a 'primary carer' unless they lack the capacity to do so.

Patients should have the right to be informed that their personal information will be disclosed to their primary carer wherever practicable, with the proviso that they may request this not be done. If it is decided that they lack the capacity to make this decision and/or information is released without their knowledge, then a record should be kept of the transaction so that they may be provided with the details when judged competent.

The Act should contain a definition of capacity for the purposes of applying these provisions.

[19] Section 343(b).

9. disclosure of information

52. Section 182 of the Bill dealing with disclosure of information makes no mention of overlap with the *Health Records and Information Privacy Act 2002* (NSW), an Act which could conceivably better deal with access to information in this area.

53. The Act should specify whether personal information collected in the exercise of functions under the Act is meant to be subject to the *Health Records and Information Privacy Act*, if at all and to what extent. The current wording of the Act and the Bill are likely to lead to inconsistent dealings with personal information collected under the Act, as health services may be uncertain whether their obligations under the Act or those under the *Health Records and Information Privacy Act* take precedence. Section 182(2) of the Bill is not conclusive on this point.

54. Section 182 of the Bill introduces a new exception to the non-disclosure requirement, which allows information to be disclosed 'to a primary carer of a person, in connection with the provision of care or treatment to the person under this Act'. CCL believes that a stronger justification for the release of personal information to a carer is found in the confidentiality provision of the *Mental Health Act 1986* (Vic), s 120A(3)(CA). This section provides that information can be disclosed to a guardian, family member or primary carer if:

> (i) the information is reasonably required for the on-going care of the person to whom it relates; and
> (ii) the guardian, family member or primary carer will be involved in providing that care …

55. By requiring: (1) a 'reasonable' threshold as to when information may be given; and (2) that the primary carer will actually be involved in providing the relevant care, the confidentiality provision of the Victorian Act is better suited to the case by case basis that is the reality of the provision of care in the mental health arena. This provision also minimises the risk that confidential information will be disclosed to people who are not genuinely acting in care giving roles at the relevant time.

CCL recommends that the Act be amended to clarify its intersection with the *Health Records and Information Privacy Act*.

There should be a higher threshold requirement for when information can be disclosed to a patient's primary carer in the disclosure of information provision, such as the test in s 120A(3)(CA) of the Victorian *Mental Health Act 1986*.

10. 5 year review and monitoring

56. CCL notes with approval that the new Act is to be reviewed by the Minister in 5 years.[20] We also note, however, that such a review would be hollow unless the Government sets in motion independent and ongoing monitoring of the implementation of the Act in the interim.

57. Three aspects in particular warranting further consideration could be illuminated by such evaluation:

- the dual system of review involving both Magistrates and the Tribunal;
- the issue of consent to specific medical treatments, which is currently dealt with in an inconsistent way;
- the new role of the 'primary carer' contained in the Bill, which may create unforeseen problems in its implementation.

[20] Section 192.