Non-adversarial Justice Conference: Implications for the Legal System and Society  
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Non-adversarial justice & mental health review tribunals: a reflexive turn

Introduction

Mental health law and practice has been instrumental in developing non-adversarial justice, especially the field of therapeutic jurisprudence which emerged from insights gathered in the mental health context in 1970s and 1980s. The ongoing development of non adversarial perspectives beyond mental health is, in turn, shaping critical debate about current mental health review tribunal (MHRT) practice. Considering MHRT practice in light of non-adversarial approaches intersects with current debate about MHRT compliance with human rights obligations, particularly the recognition of the people with mental illness as an equal subject before law. This highlights the importance of participation and representation before MHRTs, and raise new questions about the appropriate scope of the tribunal powers.

This paper considers the intersection of human rights and non-adversarial justice perspectives in the context of MHRTs. It argues that human rights and non-adversarial justice are compatible perspectives that create a coherent theoretical basis for the reform of mental health tribunal law and practice. Part 1 of the paper discusses the foundations of non-adversarial justice, the role of MHRTs in rights based mental health laws, and

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2 MHRT refers generally to all mental review tribunals or boards.
4 Convention on the Rights of Person with Disabilities (CRPD), Article 5 & 12.

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current research concerning mental health tribunal practice. Part 2 considers the related questions of early review of psychiatric detention, participation in MHRT proceedings and representation before MHRTs. It concludes that a person centred approach recognised by both non-adversarial justice and human rights should inform revised tribunal practices that enhance participation, and an expansion of tribunal powers.

**Part 1: The genesis of tribunal powers**

**The foundations of non-adversarial justice**

‘Non-adversarial justice’ refers broadly to a collection of theoretical and practical responses to the perceived limitations of adversarial, court based adjudication, including therapeutic jurisprudence, restorative justice, preventative law, holistic law, and appropriate dispute resolution. These approaches seek to affirm the principles and values of justice through holistic perspectives, and share a common concern for proactive multidisciplinary responses which attend to process, pursue collaboration and encourage creative problem-solving. They allow for recognition of the human and social context in which legal problems arise.

Non-adversarial justice builds on the legacy of the alternative dispute resolution movement of the 1970s and 1980s which founded new legal forums including neighbourhood justice centres, tribunals, ombudsmen and commissioners. These approaches lay the foundation for the establishment of ‘second generation’ alternative legal forums such as drug courts, mental health courts, indigenous sentencing courts and other problem-solving courts, all of which draw upon the principles of non-adversarial justice. Non adversarial justice therefore encompasses a diverse range of processes and forums that seek to be more comprehensive, inclusive, holistic and psychologically attuned than the earlier forms of alternative dispute resolution.

**The role of MHRTs**

Mental Health Review Tribunals (MHRTs) do not sit neatly within a progressive narrative of non adversarial justice because they are firmly rooted in the earlier tribunal paradigm. MHRTs were established by sweeping rights based law reform in mental health laws in developed western jurisdictions in the 1980s at the height of the influence of the alternative dispute resolution movement. Like other tribunals, they were intended to provide informal accessible, cost effective justice, but they were created to fit the mental health context, being tailored to address human rights concerns and the sensitive task of reviewing the medical decisions to detain and treat...

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people with mental illness involuntarily.\textsuperscript{11} Rights based mental health law reform sought to address the human rights abuses by setting a ‘gatekeeper’ role for law, that closely regulated entry into the medical domain and grafted criminal law processes and safeguards onto the civil commitment process. Prior to these reforms, the civil commitment was governed by the broad discretionary powers of psychiatrists with the (theoretical) opportunity for formal judicial oversight of civil detention being rarely exercised.

Rights based mental health laws establish threshold statutory criteria for civil commitment. Some commentators describe the rights based law reform of the 1970s and 1980s as the triumph of law and lawyers over medicine.\textsuperscript{12} However, the gatekeeper approach is more aptly described as a careful delineation between the complementary spheres of medical and legal power.\textsuperscript{13} By defining who is, and who is not, legitimately subject to medical power, non voluntary medical intervention was permitted when a person was mentally ill and in addition, was in need of medical treatment for their own safety or for the safety of others. Once the legally defined threshold criteria were met, medical determinations governed clinical decision making. MHRTs were designed to review the determination that a person met the threshold criteria.

MHRTs were typically established as multidisciplinary panels comprising legal, medical and lay expertise. This formation was intended to balance purely diagnostic assessments with the broader social wisdom of a lay perspective, and the expertise of the lawyers. Subsequent reviews of MHRT practice have consistently affirmed the strength of the multidisciplinary model. For example, Leggatt affirmed that

\begin{quote}
…decisions are made jointly by a panel of people who pool legal and other expert knowledge and are the better for that range of skills\textsuperscript{14}
\end{quote}

Nevertheless, there is ongoing debate about the benefits, limitations and cost burden of the multidisciplinary panels, and about the respective roles and contributions of the different members. These debates overlay broader considerations concerning the role of MHRTs, their scope of statutory powers, and the ongoing struggle of MHRT to interpret and apply them effectively.\textsuperscript{15}

Despite the deferent division of power between legal and medical expertise in rights based mental health laws, current studies of MHRTs show that medical opinion dominates the determinations. Whether a person has a mental illness, and whether the illness is in need of treatment are fundamentally medical determinations.

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\textsuperscript{11} Franks Committee, Report of the Committee on Administrative Tribunals and Enquiries 1957, Cmdn, 218.

\textsuperscript{12} Jones, Kathleen, Asylums and After. A revised history of the Mental Health Services: from the early 18th Century to the 1990s (The Athlone Press, London & Atlantic Highlands, N.J 1993)


Coupled with the expectation that medical knowledge is able to accurately assess risk and danger further entrenches medical influence upon the decision making process.

Medical influence in MHRTs is countered by the requirement to provided intervention in the least restrictive manner. The insertion of the ‘least restrictive’ principle in mental health legislation provides a statutory basis for global movement toward institutionalisation, including in some jurisdictions the imposition of compulsory treatment in the community.16 The principle provides more scope for MHRTs to become engaged with some aspects of the clinical decision making, particularly in the context of reintegration into the community.17 As the discussion below will illustrates, whether MHRTs should have wider authority to engage with treatment decisions is the critical question. This paper argues that non-adversarial and human rights principles support the expansion of tribunal powers.

Assessing MHRT practice
Research into MHRTs has been concerned with the ability of MHRT processes to satisfy the principles of fairness or natural justice, on the one hand, and provided innovative adjudication on the other. In Australia, Rees (2009)18 has criticised the tendency for MHRTs to adopt unnecessary formality.

Regrettably, the imprecision of these rules (natural justice) tends to stifle innovation. The inviolability of the right to be heard by an impartial decision-maker, the right to be informed of the evidence, and submissions that are contrary to one’s own interests, and the right to lead evidence and present submissions in support of one’s own interests are not in question.

In contrast, Freckelton et al observe a surfeit of innovation expressed as the tendency of tribunal members to substitute their own criteria in the absence of any clear and consistent guidance for the discharge of a treatment order. These were

‘...the presence — or absence — of symptoms, of insight, of compliance and cooperation, and of risk and danger to the patient and other people.’19

The tension between formality, justice and innovation is also encapsulated in research conducted in the United Kingdom. In 1994, Blumenthal et al found that tribunal members were dissatisfaction with MHRT practice.20 All reported that the adversarial attitude of the legal representatives was stressful, all express concern that adversarialism was potentially detrimental to the doctor–patient relationship, all expressed frustration at the limited powers of the MHRT. The lay and legal members also felt that they had insufficient training in mental health issues. In 2003, Perkins noted less concern about inappropriate adversarialism, but highlighted the lack of rigour in the MHRT processes, fundamental flaws in collaborative practices, generally conflicting interpretations of the legislation, and particularly, an inability to interpret legislative references to the ‘nature’ or ‘degree’ of a mental disorder or risks associated with it. These problems contributed to extreme variability in

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17 Bartlett.
19 Freckelton 2003.
tribunal practice.21 The reported difficulties mirror Sarkar’s 2005 findings that show that medical opinion is seldom challenged in question or cross examination by the MHRT, that subjective opinion disguised as medical facts is not uncommonly introduced, and hearsay and unsubstantiated evidence may be presented that leads to detention on grounds of risk.22

Ultimately the test of tribunal processes support effective decision making. One way to evaluate practice is to examine the outcome of MHRT hearings. In the United Kingdom, Taylor et al found that in 90% of cases brought to MHRTs there was no change to the patient’s status, although younger patients, women, and patients with a psychopathic disorder were more likely to be discharged.23 Discharge is also more likely if the application is supported by the person’s treating clinician, and if the person is legally represented.24

As the foregoing illustrates, existing research on tribunals canvasses a broad range of general issues and problems involving MHRT. In Australia, the particular development of law and practice has raised four current issues which echo international concerns. These are the question of early review of psychiatric detention, participation of the person in the hearing, representation before the tribunal and the content of the tribunal hearing. These are discussed in the following section.

Part 2: Non adversarial and human rights perspectives

Early review of the detention
Liberty and security of the person are fundamental human right. Furthermore, human rights principles require review of all instances of deprivation of liberty, even those undertaken for public health purposes.25 In mental health, involuntary detention is often imposed as crisis intervention for the protection of the person. Evaluation of the human rights content of psychiatric detention therefore requires an assessment of the potential limitation of both civil and political and economic social and cultural rights.

Australia is party to the International Covenant on Civil and Political Rights (ICCPR). Article 9(1) of the (ICCPR) requires review of all detentions ‘without delay’. In considering the meaning of this phrase, the Human Rights Committee, which monitors the implementation of the ICCPR, considers that any delay ‘must not exceed a few

21 Perkins, E 2003 p116
24 Ibid at168.
Despite this early authoritative statement, there has been considerable debate about the timing of the initial review of psychiatric detention. The Principles for the Protection of People with Mental Illness and the Improvement of Mental Health Care (MI Principles), which are the only United Nations statement specifically concerned with the rights of people with mental disabilities in mental health care, permit a ‘short’ period of detention for observation and preliminary treatment, following by a review that must take place ‘as soon as possible.’ 27 Expert reviews in international jurisdictions have recommended a maximum period of five to seven days. 28 These shorter periods contrast with the jurisprudence the European Court of Human Rights which has recognised a period of ‘less than 24 days’. 29 The Convention on Rights of Persons with Disabilities (CRPD) requires that review takes place in accordance with international human rights law.

In Australian there is considerable variation in practices relating to the initial review of psychiatric detention. Three of the eight Australian jurisdictions have legislation which requires, either expressly or impliedly, that external review take place within the 14-day period, while the remaining jurisdictions conduct reviews between 4 and 8 weeks after involuntary admission. In NSW, where the initial psychiatric detention must be authorized by a magistrate, review of the decision usually occurs in less than seven days. 30 In Victoria reviews are not scheduled until a person has been an involuntary patient for at least six weeks. Given the short duration of most acute admissions, review of the detention is likely to occur, if at all, after the person has been released into the community on a community treatment order. At this time the review is likely to be concerned with issues of prospective management and care. For the person who is the subject of the order, six weeks of compulsory detention and treatment without review represents a significant infringement of liberty, and the freedom of bodily integrity. Prof Neil Rees argues that human rights standards require that

Any initial and short-term interference with the entitlement of a person with a mental illness to exercise the civil rights of freedom of movement and freedom of bodily integrity, in order to treat that person’s mental illness, should occur only following the use of transparent procedures laid down by law and assessment criteria which have been developed and applied in compliance with internationally accepted medical standards. 31

He warns that that

‘...we pay lip service to the notion that wherever possible people with a mental illness should enjoy the same rights as other members of the community, if most people who become involuntary patients are not reviewed.’ 32

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26 General Comment 8 (1982)
29 L v France (2002) re Article 5(4) of the ECHR.
30 Rees 2003above note 26 at 83.
31 ibid
32 ibid
One argument put in defence of delayed initial review in Australia is that the principle of participation (discussed in more detail below), which is sometimes interpreted as merely requiring the presence of the person at a hearing, may be unproductive or have damaging anti-therapeutic consequences for the person. If it is accepted that participation can occur in a variety of ways, human rights considerations are reconciled with non-adversarial or therapeutic perspectives. Early review may provide an opportunity to ensure that clinical decision have taken into account available evidence about the particular circumstances of the person, for example, when these pertinent information is contained in a psychiatric advance directive thereby enhancing both human rights and therapeutic objectives.

In addition it can be argued that it may be anti-therapeutic to delay the initial review. The experience of psychiatric detention is profoundly confronting. Like other detentions, it is an event where uncertainty heightens inevitable feelings of fear and anxiety, particularly when a person is suffering from acute illness. Prompt review has the potential to reduce stress, particularly if it is taken as opportunity to engage with the person’s social circumstance. For example, people with mental illness who are subject to crisis intervention may be carers who are responsible for dependent children or animals. Human rights and non-adversarial justice principles requires that the intervention takes account of this broader context, ensuring that appropriate alternative care is provided for dependents. 33

**Participation in the legal process**

Both non-adversarial justice and contemporary human rights perspectives emphasise the importance of autonomy, and self determination which is expressed in a preference for the active participation of the person in the resolution of legal problems. From a human rights perspective, participation of the person in all matters and decisions concerning them flows from the recognition that the principles of equality and non-discrimination are universally applicable. People with mental illness of other mental disabilities, are therefore entitled to be recognised before the law on the same basis as other people, and are entitled to receive such support and assistance a is necessary to enable them to do so. From a human rights perspective legal decisions that proceeds without the participation of the person are suspect.

Non-adversarial justice literature also emphasises the importance of participation as matter of fairness, legitimacy and efficacy. Tyler reports that people are more likely to accept and follow the directions of legal authorities where they feel that the authorities' processes are fair and their motives legitimate. 34 When people are enabled to present their case, and the case is taken into account by a respectful legal authority, people are

more likely to follow the legal authority's decision based on an internal commitment to the decisions. In the mental health context, Winick attests to the critical importance of respect autonomy particularly the understanding that coercion and paternalism in legal processes are likely to promote non compliance and resistance to change. While it is trite to observe that fairness is in the eye of the beholder, research has shown that patients are consistently less likely to agree that the MHRT was independent or fair compared to MHRT members. This observation indicates the importance of conducting consumer focussed research to gauge the effect of MHRT procedures.

What then are the implications of the principle of participation for tribunal practice? First, the principle of participation suggests that should be present at all tribunal hearings. While the presence of person at the tribunal hearing in clearly important, mere presence does not equate with participation. People with mental illness who participated in the MHLC study commented on the difficulties they experienced in attending tribunal hearings, particularly when they were unwell. While they wished to attend the hearings, they indicated that it would have been helpful if the conduct of the hearing was modified to take account of their illness. The difficulties of attending a hearing were also exacerbated when the clinical routine failed to take account of the tribunal hearing. People reported that they had received ECT treatments, additional sedation, or a change in medication on the day of the hearing. Taking participation seriously requires that the person be actively assisted to engage with the process.

Second, the principle of participation requires that the person is provided with information about the process, when the hearing will take place, about their rights and entitlements including that they are entitled to view the documentation that will be put before the tribunal. Research in the UK has shown that there is a low level of awareness of rights among compulsorily detained patients, that few patients who are compulsorily detained in hospital know about their rights, that more than half a group of detained patients who were provided with booklet explaining their rights could not understand it, that there was a serious lack of knowledge

38 MHLC (2008) above note 35.
and understanding of tribunal processes and powers among patients, 42 but that higher level of awareness of tribunal processes are identified amongst those who had been detained before. 43 People with higher education qualifications or previous experience of compulsory hospital admission were more likely to appeal against their detention. 44 Shah et al found that 35% of people appealed, but young people, and older people, especially with dementia were least likely to appeal, suggesting profound inequalities amongst detained patients. 45 46 These studies show that, at a minimum effective method of communication about rights and entitlement must be developed for all psychiatric patients.

Finally, the principle of participation recognises that a people may be too unwell to do so. In that case, human rights principles require that provision must be made for proxy representation. This observation raises a broader question about the entitlement to legal representation.

**Legal representation and MHRTs**

Consistent with its preference for empowerment of the individual and mindful of the cost burdens associated with compulsory legal representation in adversarial forums, the alternative dispute resolution movement sought to create legal forums that could function without the parties being legally represented. Tribunal experience has shown that legal representation is sometimes essential to counter the power imbalance between the parties. This was particularly so in tribunals where the respondent was experienced corporation of government department with access to sophisticated legal advice. MHRT tended usually permit legal representation if the person so chooses. In the mental health context rates of representation before MHRTs are likely to reflect, in the first instance, the public funding arrangements for representation.

Whether or not people should be represented in MHR hearing is matter of ongoing debate. 47 As the research in the United Kingdom indicates, in the earlier years of MHRT practice lawyers were perceived as bringing an inappropriate adversarialism to tribunal hearings. Concern was expressed by that the adversarial approach of lawyers was distressing, counterproductive and damaging to the doctor patient relationship. Those findings are consistent with Winick’s observation that lawyers who act paternalistically and perfunctorily may be a direct

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43 above note 42.


cause of psychological dysfunction in their clients. Some commentators argue that the involvement lawyers inevitably and always draws the tribunal toward damaging adversarial practices. Therapeutic and non-adversarial justice principles would suggest therefore that legal representation at MHRT hearings should not be encouraged.

In contrast, Pekins research in the UK, which raises concern about the lack of rigour in tribunal hearings, whether tribunals are adversarial enough. In this view lawyers are seen as bringing a welcome intellectual rigour to the tribunal proceedings, as they are skilled in assessing the relevance and probative value of the material put before the tribunal. This particularly so if practitioners bring sensitivity and maturity to the process and are skilled in mediation and other non-adversarial approaches. It is accepted that professional legal representation will ensure that the patient's views were put to the MHRT, and that legally represented patients are more informed, and less intimidated by the proceedings. Professional legal representation may also bring to the surface disagreements between participants that cannot be easily resolved. This does not indicate a lack of profession skill or the adoption of adversarial stances, but underscores the complexity of mental health decision making. This view of legal advocacy assumes a compatibly between non-adversarial justice and human rights perspectives by turning attention to the quality, rather the fact, of legal advocacy in the MHTR context. It raises implications for the training and education of lawyers who may choose to practice in the jurisdiction.

A third response to the question of representation in tribunals is to argue for the inclusion of community, lay or peer advocates. There are many variations of this general approach ranging from allowing a support to be present at the proceedings to the full and active participation of a legally trained peer advocates as envisaged by the Mental Health Legal Centre (MHLC) in Victoria. The NSW New South Wales Legal Aid Commission’s Mental Health Advocacy Service envisages the involvement of advocates to link the person with community

51 Beaupert, F ‘Mental Health Tribunals From Crisis To Quality Care?’ Alternative Law Journal Vol 32:4 December 2007 at 219
53 The Victorian Auditor General Crisis Report 2002 :111.
based services. A continuing advocacy model has also been trialled in the ACT. The advocacy approach seeks to avoid the worst aspects of adversarial legalism and harness the benefits of supportive advocacy. Issues raised by these schemes include whether or not the person is independent, appointed by the Tribunal, attached to the health services, and chosen by the person. There is also a range of views what level of training the person should have, including formal legal training, and whether they should be bound by the wishes of the person they are representing or answerable to the tribunal. The NSW scheme addresses some of the limitation of tribunal powers by providing a bridge between tribunal decision and the community based services.

International human rights standards expressed in the MI Principles require the representation of people with mental disabilities before all tribunal hearings that determine questions about a person’s capacity. Although widely criticised, particularly around its consent provision, they are a non binding statement that remains persuasive to the extent that it does not contradict the CRPD.

The MI Principles requires that determinations of a person’s capacity must be made by a fair and independent tribunal established in domestic law. The person whose capacity is at issue is entitled to be represented by a counsel who will be paid for by the state if the person is unable to do so, and that a person who is deemed to lack capacity be allocated a personal representative. The MI Principles are problematic in this regard because they suggest a finite determination of capacity, which is out of step with the CRPD notion of mental capacity as fluid, fluctuating or intermittent, amenable to support and only displaced by substitute decision making processes for a limited time and to the minim extent necessary. Accordingly the CRPD embraces the notion of supported decision making, which is as yet undefined, but accords with ‘best practice’ models of legal advocacy.

Rates of representation before MHRT vary considerably across the jurisdictions. For example, in Northern Ireland, Coates reports that nearly all Mental Health Review Tribunals have legal representation for both the patient and the detaining Trust. She argues that that in her experience legal representation allows a fuller, more considered, more expert, appraisal of the evidence.

In Australia, although there is a statutory right to be represented in nearly all Australian jurisdictions, not necessarily be a lawyer, few individuals are in fact represented before MHRTs. Williams reports that in 2002 only 9.2% of hearing in Victoria, 10% in Western Australia, and 18.3% in NSW were represented. Beaufort

57 J Feneley, Review of the New South Wales Legal Aid Commission’s Mental Health Advocacy Service (Legal Aid, Sydney, 2006, pp 7,10.
59 CRPD, Article 12(4)
60 Mental Health Act 1983 (Mental Health (Northern Ireland) Order 1986, Coats 2004
61 Williams 2009. PPL.
reports that in 2006 the rates had dropped to 5.6% of hearings in Victorian and 16.2% in NSW. In the Northern Territory, where representation was compulsory in 2002, people were represented in 90.7% of hearings. In Tasmania, the Tasmanian Mental Health Tribunal Representation Scheme (MHTRS) provided law student representation in 65% of matters. The low figures in the larger jurisdictions are thought to reflect inadequate funding for legal representation for mental health patients. They may also reflect the general lack of knowledge about rights and entitlements consistently reported in the research literature, even amongst mental health patients those who have been informed of their rights.

Paradoxically, when patients are represented they report a high level of dissatisfaction with their legal representatives. This may reflect the fact that while legal representation improves the chances of being discharged from involuntary status, discharge rates remain low. It may also reflect a frustration with the limited powers of MHRT to review the content of the clinical decisions, and the failure of the mental health laws to provide for the discharge of patients from compulsory orders.

Conclusion

As discussed above MHRTs struggle to interpret and apply their story powers in consistent and coherent way, but ultimately adopt an approach to the decision making task that seeks to find the most appropriate solution. For example, Peay with Perkins, Freckelton, and Sarkar, found that MHRT members interpret the law in a way that reaches the 'right answer'. Most commonly the right answer expresses a preference for sanctioning the proposed treatment on the grounds that the decision promotes good health and wellbeing for the individual and minimises risk of harm to the public interest. This outcome may be construed as one that seeks to honours non adversarial practice and attends to an implicit recognition of the emerging human rights obligation to protect physical and mental integrity and the right to health. If so, it indicates an urgent need for legislative reform of tribunal powers to ensure that MHRT practice is grounded in legislative authority.

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62 Beaufort 2009
63 Williams 2009 above note 59
65 Patients with legal representation were discharged from their involuntary status 15.1 per cent of the time, while patients without representation were discharged on 4.5 per cent of occasions. Mental Health Services for People in Crisis Report Auditor-General Victoria Mental Health Services for People in Crisis, October 2002, p. 7. <www.audit.vic.gov.au/reports_par/mhs_report.pdf>
70 Terry Carney and Fleur Beaufort, ‘Mental health tribunals: rights drowning in un-‘Chartered’ health waters?’ AJHR 13.2 (2) 2008: 181-207
Another view of the ‘right answer’ approach is that it expresses a form of mild paternalism that is contrary to both non adversarial and human rights principles because the determination are regarded as overly deferent to medical opinion and avoid a real engagement with either the clinical or social circumstances of the person. Non adversarial and human rights are both animated by an understanding that the essence of their disciplines rests with a person centred approach. A person centred approach, as described by the Leggat Review of MHRT in England and Wales, requires MHRTs to be independent, to be composed of an active multidisciplinary panel and to boast arrangements that are sufficient to enable the person appearing before the tribunal to challenge the medical information that it put before it. Bearing in mind the statutory exclusion of MHRTs from clinical determinations in rights based mental health laws, and the poorly developed processes for active participation discussed above, achieving a person centred approach requires a considerable expansion of tribunal powers and considerate development of supporting process to enable a robust process to occur. People with mental illness argue that this is essential to provide them with a forum in which medical decisions and treatment plans can be challenged and modified.

The three issues canvassed in this paper are discrete aspects examples dynamic MHRT model that adopts a person centred approach and in therefore enlivened the principle that people must be able to probe and test the information put before the tribunal, at the same time as they are protection by non adversarial paradigms. Understanding the compatibility of non-adversarial justice and human rights points to the importance of creating MHRTs that are engaged with a holistic account of the experience of each person’s who appears before them. More importantly, it provides a solid theoretical grounding for an expansion of tribunal powers.

72 Leggatt, Tribunals for users: One system, one service. Report of the Review of Tribunals, 16 August 2001;