# *Equality Impact Assessment of exclusive mental health legal services contracts in High Security Hospitals*

# Contents

# 1. Executive summary

The LSC has carried out this Equality Impact Assessment (EIA) of exclusive contracts in High Security Hospitals (HSHs) in order to comply with its duties under S49A of the Disability Discrimination Act (and subsequently s149 the Equality Act 2010). In particular, this work examines the impact of the need to change provider following the tender carried out in 2010

Evidence of the impact of these contracting arrangements was collected from clients, hospital clinical staff, hospital social workers, hospital advocates, providers and interest groups (including provider representative bodies and regulators) in the form of questionnaires, focus groups and meetings, and including both qualitative and quantitative data.

The key findings of this impact assessment are as follows:

- There is no evidence of direct disability discrimination
- There is no evidence of unlawful indirect disability discrimination
- There is no evidence of direct or unlawful indirect discrimination in relation to any other of the characteristics protected under the Equality Act
- However, a slightly larger proportion of clients think that the need to change solicitor, due to the tender, would have a severe negative impact on them compared with no or negligible impact
- Client individual needs are diverse, and do not appear to be linked to their type of mental health problem: they do, however, consistently value a trusting relationship with their solicitor
- A client's relationship with their individual solicitor is more important than the relationship with the provider that the solicitor works for
- Clients lack the information to make an informed choice of solicitor or provider
- Historic quality was highly variable and some questionable practices by providers have been reported that further justify the original policy aims of exclusive contracts
- Whilst there is no evidence of direct or indirect discrimination we have set out a number of options for contracting changes we could consider (see Section 13) and next steps we will take (see Section 14). However, at this stage we recommend no change to contracting arrangements in the High Security Hospitals.

# 2. Background

Exclusive contracts to deliver mental health legal advice services in the three High Security Hospitals (HSHs: Ashworth, Broadmoor and Rampton) were procured through a competitive tender in 2010. This policy was implemented on 15/11/2010 resulting in between 5 or 6 providers winning exclusive contracts in each of the 3 HSHs (see Annex A). In two hospitals the process in the contract allocation methodology designed to ensure a minimum choice of 5 providers in each hospital had to be implemented.

The purpose of a competitive tender was to further drive up quality standards, and satisfy our obligations under the Public Contracts Regulations, whilst preserving client choice. As noted above, we made provision for preserving client choice by ensuring that HSHs would have a minimum of 5 providers at each location.

We were aware from our previous liaison with stakeholders (including providers, providers' representative bodies, clients, Broadmoor, and Tribunals Service) of a number of problems with the arrangements in HSHs prior to November 2010, particularly in relation to quality and choice. Firstly administrators were often responsible for finding representatives for clients. This was often based on the relationships established between the administrator and the provider and was based on a subjective view rather than any objective criteria. Secondly, we

were also made aware of concerns that those providers who did receive direct referrals to provide services in HSHs were not necessarily those who were best able to provide quality representation before the Mental Health Tribunal (MHT) i.e. those that were providing services were not necessarily providing a satisfactory standard of representation for their clients. Also, some clients accessing services through word of mouth were unable to find their representative of first choice because the provider was unable to take additional clients at that time and, more worryingly, we have received anecdotal reports from providers of a number of firms 'touting' for business at the HSHs. Clearly those clients detained in HSHs are a particularly vulnerable client group and we would want to avoid them being exposed to this sort of practice.

As noted, the objectives for a competitive tender (both in HSHs and the other Civil categories) were to further drive up quality standards and satisfy our obligations under the Public Contracts Regulations. To do so we designed a system of essential criteria (basic entry criteria) and selection criteria (used to discriminate and order tenders on the basis of quality).

Whilst we recognised that there were only limited matter starts available to allocate and that by implementing a competitive procurement process it would mean that some providers may then be prevented from working in the hospitals where they had previously represented clients, we considered that on balance we could reassure those clients that there were alternative quality providers available who would be able to take over this work. In addition, providers were permitted to carry on working on on-going cases for their existing clients (this is called 'Remainder Work'). This preserved continuity of representation in these cases.

We decided that if we were to implement a system where a more limited number of quality-assured providers with experience of restricted cases would be able to act for clients, we needed to make provision for those providers already acting with instructions. Where a firm had previously advised a client within the last 2 years who had subsequently been transferred to a HSH, we decided to allow that client to continue to be represented by that firm, even if they did not have a contract to work in the hospital. However, this was only on the condition that they also met the stated essential quality standards. We considered that this addressed the concerns raised on consultation regarding continuity of advice for clients transferred in. Please see 'The Equality Duties' for further discussion of this issue.

An Initial Impact Assessment was carried out alongside the original consultation, 'Civil Bid Rounds for 2010 Contracts' and a Final Impact Assessment (FIA) was carried out alongside the final consultation response, including an Equalities Impact Assessment (EIA).

The EIA was based on information collected by the Legal Services Research Centre (LSRC) on both disabled providers and disabled clients (and also BAME/non-BAME clients and providers and male/female clients and providers). The first section looked at the likely impact of essential criteria requirements (including those applied to HSHs such as experience of restricted cases and all representation to be carried out by Law Society MHT Accreditation Scheme members) on clients i.e. which providers and therefore which disabled clients would be affected by being unable to meet these criteria. Since these were essential criteria (i.e. applied to all providers) and designed to improve quality, the assessment concluded there would be no negative impact on disabled clients.

It was not possible to examine the impact of competition either generally or specifically to carry out a detailed EIA. As we stated in the FIA, this is because '[the LSC] cannot predict what business decisions will be made by individual organisations, and how they will choose to bid, so we cannot make any certain predictions in terms of numbers of current providers who would or would not be awarded a new contract'.

The tender and its outcome were challenged in the Judicial Review action '*Public Interest Lawyers vs. Legal Services Commission [2010] EWHC 3277 (Admin)'.*

In the judgment it was held that:

*'Under section 49A of the Disability Discrimination Act (DDA) 1995 [described later] the Legal Services Commission must have due regard to whether they need to take steps to ameliorate that result of the contracting exercise* [that disabled clients in High Security Hospitals will be required to change advice providers].*'* [para 88].

The full wording of S49A is:

(1) Every public authority shall in carrying out its functions have due regard to—

(a) the need to eliminate discrimination that is unlawful under this Act;
(b) the need to eliminate harassment of disabled persons that is related to their disabilities;
(c) the need to promote equality of opportunity between disabled persons and other persons;
(d) the need to take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons;
(e) the need to promote positive attitudes towards disabled persons; and
(f) the need to encourage participation by disabled persons in public life.

It was the judge's view that the key requirements we should consider at this point are (a) and (d).

In accordance with this judgement we have therefore carried out further work to assess the impact of the tender with particular regard to the disability duty. In this paper we set out in full our equality impact assessment.

A number of stakeholders (especially providers) have repeatedly questioned why it has not been possible for the LSC to put in place interim arrangements either 'relaxing the contract' or putting in place arrangements allowing some clients to continue to be represented by their historic providers who did not win HSH contracts. It is not possible to implement either of these suggestions under the 2010 Standard Civil Contract without a formal contract amendment. Indeed any change to contracting arrangements in HSHs would require a formal contract amendment. This requires a formal consultation period with The Law Society, other representative bodies and indeed other stakeholders. Given the urgent timetable for carrying out this EIA, the time taken to consult would mean that any interim measure would only have been in place for just a matter of weeks. We do not believe this would have provided any further certainty for clients or providers.

## 3. The legal framework for this EIA

Since the judgment, section 49A of the Disability Discrimination Act 1995 has been replaced by the public sector equality duty under section 149 of the Equality Act 2010. This came into force on 5 April 2011. The new equality duty under the 2010 Act as it applies to disability is consistent with the former disability equality duty under the 1995 Act.

Guidance on the equality duty indicates that there is no legal duty to carry out an equality impact assessment[1]. However, having started the equality impact assessment process in

[1] Equality Act 2010: Public sector Equality Duty what do I need to know? A quick start guide for public sector organisations Government Equalities Office 2010http://www.equalities.gov.uk/pdf/110503%20GEO%20General%20EqualityDuty%20guide%20-%20FINAL.pdf

accordance with guidance relating to the disability equality duty we have proceeded on the basis that this is an effective way to have due regard to our equality duties.

In the course of the work on this EIA we have had regard to the disability duty in force when we carried out consultation work in the HSHs. We were mindful of the expectation under the former disability duty to involve and consult with disabled people.[2] We have also had regard to the equality duty under the 2010 Act. The equality duty came into force when we were analysing the information that we gathered. We have, therefore, had due regard to the new equality duty as the applicable law at the time of our assessment.

**The equality duty under the Equality Act 2010 is as follows:**

Section 149 (1) of the 2010 Act requires that in the exercise of our functions we have due regard to the need to:

a) Eliminate unlawful discrimination**,** harassment and victimisation and any conduct otherwise prohibited under the 2010 Act;

b) Advance equality of opportunity between people who share a relevant protected characteristic and those who do not; and

c) Foster good relations between people who share a relevant protected characteristic and those who do not.

Section 149(3) provides that having due regard to the need to advance equality of opportunity involves having due regard, in particular, to the need to:

(a) Remove or minimise disadvantage suffered by persons who share protected characteristic and persons who do not
(b) Take steps to meet the needs of persons who share a relevant protected characteristic that are connected to that characteristic
(c) Encourage persons who share a relevant characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low

Section 149(4) provides that the steps involved in meeting the needs of disabled persons that are different from the needs of persons who are not disabled include, in particular, steps to take account of disabled persons' disabilities.

Section 149(5) provides that having due regard to the need to foster good relations involves having due regard to the need to

(a) tackle prejudice and
(b) promote understanding

For the purpose of s 149(1) the following protected characteristics apply:

- Disability
- Gender reassignment
- Pregnancy and maternity
- Marriage and civil partnership[3]
- Race Religion or belief
- Sex
- Sexual orientation
- Age (for employment/ staff impacts;

[2] See guidance on the disability equality duty available from the website of the Equality and Human Rights Commission http://www.equalityhumanrights.com/

[3] Marriage and civil partnership apply to having due regard to s 149(1)(a) to eliminate discrimination but not to the duties to advance equality of opportunity or foster good relations under ss149(1)(b)&(c).

## 4. What has been assessed?

We have assessed the impact of introducing exclusive contracts for 5 or 6 providers in each HSH to deliver mental health legal services. In the past, all legal aid providers holding mental health contracts could, in principle[4], advise and represent clients in HSHs. In 2009/10 there were c.240 providers holding mental health contracts with between approximately 16 (Ashworth) and 36 (Rampton) providers representing clients in those hospitals. In particular, we have had due regard to the impact on some legal aid clients of changing their legal adviser as a result of the tender process.

## 5. The aims and objectives of the tender

Competitive tendering in HSHs for exclusive contracts was introduced alongside competitive tendering as part of the previous government's reforms to Legal Aid and so shares generic aims:

- Increasing minimum quality standards ('essential criteria');
- Further increasing quality by using quality criteria in competitive tenders ('selection criteria');
- Minimum contract sizes ('minimum New Matter Starts' [NMS]) increasing expertise and ensuring meaningful levels of access;
- Provision of the full range of matters in the category of law ('integrated services');
- Compliance with EU procurement law; and
- Procurement of services on a geographical basis designed around location and volume of clients rather than providers ('Procurement Areas')

Some stakeholders have asked why HSH contracts were 'singled out' for competitive tendering by comparison with mainstream mental health contracts which were procured on a non-competitive basis. As was made clear in various LSC consultation and tender documents, the competitive process in HSHs was consistent with the processes in most other Civil categories of law and in fact mainstream mental health contracts were exceptional in being singled out for a non-competitive process due to concerns about access. Briefly, the factors which justified the use of competition in HSHs are as follows:

- Historically only a small number of providers have been able to give substantial volumes of advice in this area and it has not been open to new providers to offer a service;
- Inclusion of HSH work along with mainstream work in the surrounding Strategic Health Authority procurement areas was likely to distort bids for those areas due to the demand for work in HSHs;
- We were confident that there would be a high level of interest in working in the HSHs and so HSHs provided the only opportunity in mental health to institute and test competition, driving up the quality of advice without putting access at risk; and
- Given the level of interest in working in HSHs and the limited number of matter starts (licence to start a certain number of cases) available it would be very difficult if not impossible to design a non-competitive process which would result in contracts of a viable size.

[4] In practice many providers chose not to offer services in HSHs, for example in Ashworth Hospital in 2008/09 only 16 providers reported working in the hospital. See Annex A.

## 6. The key stakeholders and beneficiaries of the tender

- Patients in HSHs (i.e. potential legal aid clients)
- Staff in HSHs, particularly those involved with the care of patients and the facilitation of access to legal advice (clinical staff, mental health act administrators (MHAAs), social workers and advocates)
- Providers of mental health services in HSHs

## 7. Information used to make our assessment

The following is a summary of the evidence we have reviewed and collected.

| **Evidence** | |
|---|---|
| • What evidence was available? | **Clients:**<br>• Volume of clients in HSHs using more than one provider 2008-2010 (see Annex B)<br><br>**Hospital staff**<br>• Record of meeting with Broadmoor discussing nature of HSHs and legal services (15/11/2007)<br><br>**Providers:**<br>• Volume of cases closed in HSHs from 09/08-08/09 carried out by a) winning providers b) losing providers and c) providers who did not tender (see Annex A)<br><br>**Interest Groups**<br>• Qualitative primary evidence on impact of changes<br><br>**Judicial Review**<br>• Some indirect evidence was provided by our opponents in the recent proceedings (e.g. letters solicited from clients) that indicated there had been a negative impact on them. |
| • What evidence we considered would help us make an assessment | **Clients:**<br>• Quantitative and qualitative primary evidence on impact of changes<br><br>**Hospital staff**<br>• Qualitative primary evidence on impact of changes<br><br>**Providers:**<br>• Quantitative and qualitative primary evidence on impact of changes<br><br>**Interest Groups**<br>• Qualitative primary evidence on impact of changes |
| How we collected this evidence[5] | **Clients:**<br>• Qualitative evidence: Focus Groups and free text sections on questionnaire<br>• Quantitative evidence: questionnaire sent to all patients |

[5] See Annex C for full details of methodology

| | |
|---|---|
| | **Hospital staff**<br>• Qualitative evidence: meetings with-<br>  • Advocates<br>  • Clinical Staff<br>  • MHAAs<br>  • Social Workers<br><br>**Providers:**<br>• Qualitative evidence: free text sections on questionnaire<br>• Quantitative evidence: questionnaire sent to all providers<br><br>**Interest Groups**<br>• Qualitative evidence: letter including questionnaire questions sent to-<br>  • Administrative Justice & Tribunals Commission<br>  • Equalities and Human Rights Commission<br>  • Mental Health Lawyers Association<br>  • Mind<br>  • Tribunal Service<br>  • The Law Society |

## 8. Involvement and engagement

Please see Annex C for full evidence collection methodology, including the tailored accessibility arrangements we used to take account of clients' disabilities and preferences.

## 9. Evidence

This section represents a summary of the themes (qualitative) and quanta collected (quantitative).

### 9.1 Provider Data on tender outcome and working in HSHs 09/08-08/09 (See Annex A)

- Many providers (most of which were small volume) have chosen not to continue working in the hospitals i.e. didn't apply for HSH contracts
- The 2010 procurement process led to a number of providers winning large contracts due to their high Selection Criteria scores and the size of their tenders
- The process also led to a number of previous HSH providers failing to win contracts due to all NMS being allocated to higher scoring providers i.e. they wish to continue doing the work but are unable to
- Some provider report data can be inaccurate (as suggested by client quantitative questionnaire data and previous LSC experience) so there may have been more providers doing more work in HSHs than the data suggests

### 9.2 Frequency of HSH clients changing provider (See Annex B)

- LSC management information collected from providers suggests that HSH clients change providers infrequently, but no more infrequently than in the other Civil Categories. Furthermore, other mental health clients change provider at around the same rate as clients in other Civil Categories and HSHs. However, this data is thought

to be unreliable due to previous experience of reporting inaccuracies, particularly with regard to client postcode.

- According to questionnaire responses, clients actually change more frequently than provider reported data suggests. However, due to the way the relevant question was phrased, and clients' understanding of it, clients may change solicitor more frequently than provider. The question posed to patients asked about 'changing solicitors' for ease of understanding so may have been interpreted as relating to either solicitor or provider.

## 9.3 Summary of Clients' evidence (see Annex D)

Focus Group discussions with clients were not recorded verbatim due to concerns about the use of recording equipment contributing to inflaming client anxieties about anonymity and the effect of their comments on their detention and care. Any illustrative quotes are therefore from questionnaire free text responses. For both the qualitative data arising from questionnaire free text responses and Focus Group discussions, responses are organised into comparable themes. It is therefore possible to compare the frequency with which these themes were raised. Themes with a 5% or greater frequency in questionnaire responses (equating to 7 patient responses) and/or mentioned in 2 or more Focus Groups are highlighted below. These are arbitrary watershed frequencies, but are required in order to make analysis of the large number of themes raised manageable. The other less common themes can be found in Annex D.

Please note there is evidence that the Focus Groups compared with questionnaires capture different personality types. The hospitals and LSRC suggested the former were more likely to be attended by more extroverted, more proactive and confident clients with the latter capturing those who are more introverted.

### *A. Qualitative*

**1.B. If you have changed solicitor's firm, what was your reason for doing so?**

The most common reason for changing provider given in response to the questionnaire was dissatisfaction with the quality of the provider (16% across all hospitals). The next most common reason was the need to change due to LSC contract changes (8%) followed by the provider being unable to continue to advise and represent (6%). None of these reasons were mentioned in any Focus Group although the more popular subjects in Focus Groups centred around the impact of being required to change and what was desirable in a provider/solicitor. Finally, 2% of questionnaire respondents and 2 Focus Groups mentioned the recommendation by other clients of a better provider as the reason for change. Please note that quantitative questionnaire responses indicated that 57% of clients had not changed provider in the last 2 years.

*"I felt firstly that my original choice were interested in legal aid rather than my situation which I consider a predicament"*

*"As I had been with the same solicitor for 10 years it was time for a change"*

*"They wasn't doing as instructed"*

*"Told my solicitor can no longer represent me because of the changes"*

*"Transfer from one special hospital to another and firm was unable to cope with the number of clients they already had at Broadmoor"*

**3.B. What kind of negative effect would being forced to change solicitor's firm have on you?**

By far the most frequent concerns were the lack of a relationship and trust with the new provider (28%, 2 Focus Groups) and the need for the new provider to get to know the client's case all over again (17%, 3 Focus Groups). Clients didn't tend to mention any negative impact on their emotions or health[6]. 2 Focus Groups (3% of questionnaire respondents) cited the lack of choice as a negative impact.

*"Having to rebuild a trusting relationship"*

*"Not knowing them and them not knowing me"*

*"My case is a longstanding, complex one. A new solicitor couldn't quickly gain sufficient knowledge of the my case to conduct it with the appropriate degree of competence"*

*"I would have my confidential case opened up to someone else, and I don't feel comfortable with that!"*

The following themes were discussed in 2 Focus Groups but were not mentioned in questionnaires:

- Client upset at first but once used to change no negative effect;
- Client recommendations of providers are now irrelevant because choice is limited;
- Limited choice is a violation of Human Rights;
- Provider with unfamiliar signing interpreter caused communication difficulties although this appears to be a one-off;
- Clients aren't listened to.

**5.B. What kind of things are important to you within your relationship with a solicitor?**

The most important factor highlighted was trust (23% of respondents, 2 Focus Groups). Less common themes were the legal proficiency of the solicitor (18%, 3 Focus Groups,), honesty from the provider (17%, no Focus Groups), being listened to and understood (15%, 1 Focus Group), commitment to the client's case (15%, 2 Focus Groups) and communication in general (11%, 2 Focus Groups). Other common responses were:

- Relationship with individual solicitor (8%, 1 Focus Group)
- Confidentiality (7%, no Focus Group)
- Good representation before MHT (6%, no Focus Groups)
- Prompt response/keeping appointments/accessibility (5%, 4 Focus Groups)
- Respect (5%, no Focus Group)
- Knowledge of case history (5%, 5 Focus Groups)
- Track record (2%, 2 Focus Groups)

[6] 4% of respondents and 1 Focus Group explicitly stated that there would be no negative impact

- Provider from home area (1%, 2 Focus Groups)
- Knowledge of therapies/hospital (1%, 3 Focus Groups)
- What other legal services can be provided (1% 2 Focus Groups)

*"Being able to express oneself fully and having a bond of trust"*

*"Trust, respect, honesty, discretion and doing a thorough job"*

*"For them to be honest even if it's not what you want to hear"*

*"To feel like they are more interested in my welfare than trying to make money"*

*"Their ability to communicate and listen to me. How much time is spent on a particular case"*

Issues raised in Focus Groups but not in questionnaires included the importance of continuity in an environment of limited choice (3 Focus Groups) and provider behaviour on wards (2 Focus Groups).

**8. Is there anything else that makes it difficult for you to get the right solicitor?**

9% of questionnaire respondents stated there were no barriers to getting the right solicitor. 5% of respondents and 1 Focus Group cited lack of choice as a barrier. The same proportion and number of Focus Groups said lack of information about who was best and lack of easy communication with the provider were also barriers. Furthermore, 3 Focus Groups (and 2% of respondents) thought that the fact that providers were a complete unknown quantity before working with them stopped them from choosing the right one. Also, 2 Focus Groups were unhappy that no BAME providers had won contracts at their hospitals (Broadmoor & Rampton).

*"Limiting the number of solicitors I am able to choose from"*

*"Due to the small amount of solicitors available the choice is not there to get the right solicitor"*

*"Not knowing much about each firm"*

*"The opportunity to try them out. Hiring a solicitor is like buying a used car: you don't know how good it is until you have run it for a while. If you hire a solicitor and find they haven't delivered the goods it's too late to change your mind. Conversely, if the solicitor is good you want to keep him or her"*

**9. Do you have anything else you would like to add?**

Many issues relating to other questions were raised in this section. 11% of respondents indicated that lack of choice was an issue and 4% of respondents and 5 Focus Groups linked this to possible collusion with the hospital and a decline in quality of services. 8% of questionnaire respondents thought their current provider was very good. A number of clients mentioned that their paranoia regarding a new provider was

an issue (2% of respondents, 5 Focus Groups). Complaints were made about the lack of notice and explanation of changes by 2% of respondents and in 2 Focus Groups. Finally 3 Focus Groups apiece thought that 10 providers was the correct level of choice and that the comparison with free choice in the Crime category was unfair.

> *"Very happy with legal rep at moment but if circumstances change would like a wider choice"*
>
> *"I am very happy with my solicitor"*
>
> *"You say firms have been chosen – how? What was asked? By whom – who had a say? What was the criteria? What about the new firms coming along? What do the solicitors have to do to be acceptable? Does the hospital have a say in the choice?*

### *B. Quantitative*

**1.B. How often have you changed solicitor over the past 2 years?**

42% of clients changed solicitor at least once in the past 2 years with 12% changing twice and 7% changing 3 times or more. This data does not agree with that recorded in Annex B (i.e. that submitted by providers in their monthly CMRF reports) which seems to further support the assumption that recording of correct postcodes by provider (and therefore the validity of any data analysis we are able to do) is very poor. It is also possible that the client data is unreliable, but it is difficult to understand why this might be. It is also the case that clients may change *solicitor* (see phrasing of question) more often than provider.

**2. Overall, how would you rate the quality of advice and representation?**

28% of clients rate providers' advice as 'average' or 'poor' with 32% rating it as 'good' and 40% as 'very good'. The majority of clients (72%) are therefore satisfied with the quality of advice and representation they receive[7].

**3.A. If you are forced to change your solicitor's firm do you feel this will have a negative effect on you?**

45% of clients think that being forced to change provider would 'very much' have a negative impact on them but 37% think it wouldn't have a negative impact 'at all' or only 'a little'. 18% thought there would be 'some/moderate' negative impact. This is not a conclusive result because opinion is so split, though more thought there would be a severe negative impact than none or only a little.

**4. Would you be happy to change solicitor's firm if they were able to give you better advice and representation?**

56% of respondents thought that they would be happy to change (35%) or happy to change with reservations (21%) whereas 44% thought they would not be (39%) or would not be with reservations (5%). This is inconclusive though more thought that they would be happy to change than not.

[7] It has been widely recognised that many clients opinion of the quality of the service provided to them is often influenced by the outcomes that are achieved rather than the actual quality of advice given

**5.A. How long does it take you to develop a good relationship with a new solicitor or firm?**

43% of clients indicated it would take greater than 6 months, with 1-6 months following closely behind (36%). Far fewer thought it would take 2-4 weeks (9%) or within 1 week (12%).

**6. Which is more important to you: the quality of advice given by a solicitor or your relationship with them?**

The majority of respondents thought that both were equally important (64%), 30% rating advice as more important and 7% rating the relationship as key.

**7.A. Do you think you would get a better service from a solicitor if you have a larger number of firms to choose from?**

46% of clients thought they would get a better service, although 34% disagreed and 20% indicated they didn't know.

**7.B. What is the minimum number of solicitor's firms you would like to be able to choose from?**

30% of respondents thought that less than 6 providers was a sufficient choice, with 22% thinking that 6-10 was the right number and 48% wanting more than 10. In Broadmoor, 70% of respondents wanted a choice of more than 10 which was far higher than the other two hospitals (both c.40%).

## 9.4 Summary of Providers' evidence: (see Annex E)

All current mental health providers (191) were sent a questionnaire, with 19 responding (c.10%). The nature and skew of this small sample is discussed in Annex E. Qualitative responses are limited to the free text sections of the questionnaire. Themes with a 10% or greater frequency in questionnaire responses (equating to 2 providers in order that singular views are not emphasised as consensus) are highlighted below. The other less common themes can be found in Annex E and are also discussed in the Analysis.

### A. Qualitative

**1.B. When clients change providers in HSHs what are their reasons for doing so?**

The most common reason given was that clients were unhappy with the individual solicitor or the relationship had irreparably broken down (37% of responses). This was closely followed by a client being unhappy with the nature of the advice given which may or may not have been caused by their mental ill health (32%). Both clients' recommendations of other providers and the desire to have a fresh look at a long case history were cited by 21% of respondents. A fairly common reason given was a patient's dissatisfaction with an MHT outcome (16%). Finally, 11% of respondents gave the following reasons:

- (Only a very small percentage of the provider's clients had changed in previous 2 years)
- Retirement/change in employer of individual solicitor
- Client's case requires specific expertise not available at current provider
- Client dissatisfaction at infrequent visits or contact

**3.B. What kind of negative effect would being forced to change solicitor's firm have on a client?**

The two most common negative impacts given were an adverse effect on the client's mental health and loss of trust with the provider (42% of respondents apiece). Linked to the latter was concern about the time it would take to build an effective relationship with a new provider (32%). Some respondents were concerned about the delay in progress to a client's case (21%). A smaller proportion (16%) indicated that the following effects would be caused:

- Additional costs to legal aid (i.e. new provider will take time to familiarise with case)
- Distress caused to the client by revisiting their entire case history
- A reluctance of the client to engage with the new provider

Finally, 11% of provider respondents thought the following negative impacts would occur:

- Loss of in-depth knowledge of case history
- Anxiety
- Paranoia
- All providers should be delivering the same high quality standards

**5.B. What kind of things are important to clients regarding their relationship with a solicitor?**

Nearly half of respondents (47%) identified trust as key to a client's relationship with slightly less (42%) highlighting the accessibility of the solicitor, including regular contact with the client. Good communication in general, continuity of advice and legal skills (including knowledge of the law) were all cited by 26% of providers. The solicitor's knowledge of a client's case history was identified as important by 21% of respondents and 16% of providers highlighted commitment and the solicitor's relationship with clinical teams (or knowledge of the particular hospital) as key. Finally, 11% of respondents thought that solicitor's experience in HSHs and standards of representation were important to clients.

**8. Is there anything else that makes it difficult for clients in HSHs to get the right provider?**

16% of respondents thought that there were no other barriers to clients getting the right provider, along with the same proportion who indicated that the limited choice of 5/6 providers was a barrier. Finally 11% of providers thought that the nature of cases (complex and requiring expertise in additional categories) and lack of access to comparative information about providers caused difficulties.

**9. Do you have anything else you would like to add?**

21% of providers thought that the questionnaire itself was either inappropriate or contained questions it was impossible to answer (largely related to the quantitative sections) with 16% suggesting it was incorrect for the LSC to imply in question 4. that those who had won HSH contracts provided a higher quality service. Lastly, 11% of respondents wanted to add the following comments:

- Forcing change of provider causes additional costs to legal aid
- Upset caused to clients
- Tender process recognised appropriate expertise
- Tender process did not recognise appropriate expertise

- Should be no difference in quality standards required in HSHs and Medium Secure Units because clients are same
- Some very good providers have been excluded
- There should be a larger choice of providers

## B. Quantitative

### 1.A. On average, how often do clients in High Security Hospitals change mental health provider in a two year period?

The response rate for this question was the lowest of all the provider quantitative questions at 80% with a number of respondents indicating that it was an impossible question to answer since clients are so diverse and providers are not privy to the frequency of changing.

69% of respondents indicated that clients never changed provider in 2 years, 31% thought that on average they changed once a year. No respondents thought clients changed more than once in a two year period.

### 2. What proportion of providers provides a satisfactory quality of advice and representation in HSHs?

50% of respondents thought more than 75% of HSH providers delivered a satisfactory quality, with 36% answering that 50-74% of providers did so and 14% indicating that 25-49% were satisfactory. No respondents thought that less than 25% were satisfactory.

### 3.A. If clients are forced to change provider is there likely to be a negative impact on them?

75% of respondents thought there would be 'very much' of a negative impact, 10% responded that there would be a moderate impact and 15% indicated that there would be a small impact. No respondents thought there would be no impact.

### 4. Do you think it is right for clients to be forced to change provider if the new provider will give them a better quality of advice and representation?

As indicated above, 16% of respondents did not agree with the implication that those providers who have won HSH contracts were going to provide higher quality services.

44% of providers answered 'no with reservations', 28% indicated an unqualified disagreement, 22% answered 'yes with reservations' and 6% provided an unqualified agreement.

### 5.A. How long does it take for you to develop a good working relationship with new clients in HSHs?

Half of respondents thought it would take more than 6 months to develop a productive relationship with clients, a quarter indicated this would happen between 1 and 6 months, 15% thought it would take a week or less and 10% indicated it would take between 2 and 4 weeks.

### 6. What kind of things are important to clients regarding their relationship with a solicitor?

79% of providers rated quality of advice and relationship with the solicitor as equally important, with only 11% rating quality of advice as most important and the same proportion rating the relationship as more important.

**7.A. Do you think clients in HSHs would get a better service from a provider if they have a larger number to choose from?**

72% thought that clients would get a better service, 22% thought that they wouldn't and 6% stated they didn't know.

**7.B. What is the minimum number of providers that clients in HSHs should be able to choose from?**

72% answered more than 10, 22% thought 6-10 was sufficient and 6% thought that less than 6 was appropriate.

## 9.5 Summary of Hospital Staff Evidence (see Annex F)

***Data considerations***

Though questionnaires were circulated to all types of hospital staff that were present at the meetings (e.g. from clinicians to advocates) and responses were requested if they did not feel any issues had been discussed, the number of responses received were sparse and inconsistent across types of staff and between hospitals[8]. Additionally, the majority were received from those who had attended meetings and already participated in discussion. This quantitative data will therefore be discounted and consideration will only be made of the qualitative evidence collected in meetings.

Additionally, the meetings emphasised how different the hospitals could be, particularly (and largely with regard to Rampton's national units for the deaf, those with learning disabilities and women) in terms of patient type. Of course, different types of staff also emphasised different concerns and viewpoints. These differences will be considered in the Analysis & Conclusion section as will those that were not raised in a large proportion of meetings but are deemed critical in understanding the impact. Here we will consider only those themes that arose in 3 or more meetings, regardless of which hospital these meetings were held.

Themes are broadly divided into Impact (of contracting changes on clients), Choice (of providers by clients), Preference (of clients for providers), Quality (of providers), LSC role (in implementing changes) and Miscellaneous.

9 meetings were held in total with 3 in each hospital.

**Impact:**

- At 5 meetings, staff indicated they thought that a forced change of provider would have a negative impact on clients.
- At 4 meetings staff qualified this by saying that the changes would have a severe impact on only a small number of clients.
- Also at 4 meetings it was identified that some clients change provider with great rapidity.

[8] Only 16 questionnaire responses were received from Hospital Staff with two each from the Clinical Staff at Broadmoor and Rampton, 9 from Ashworth Clinical staff and 3 from Broadmoor Advocacy Staff. Please see Annex C for more information on the data collection methodology.

- At 3 meetings staff identified that clients with Dangerous and Severe Personality Disorder (DSPD), Aspergers or paranoid conditions were likely to be the subset of clients upon whom a forced change might have the most profound clinical consequences.
- At Rampton, all 3 meetings emphasised that longstanding relationships with providers were most important for clients (and indeed staff) in the National Deaf Unit.
- Finally, 3 meetings opined that it was unfair to have different rules for choosing a provider for those transferring to the HSHs after 15th November 2010 and those resident in the hospitals before (i.e. those transferring could retain their existing provider if they met certain contract caveats).

**Choice:**

- At 5 meetings staff emphasised how important patient to patient recommendations were in influencing a choice of provider.
- At 4 meetings staff indicated that it was important to clients and/or their families to be able to choose a BAME provider/solicitor.

**Preference:**

- At 6 meetings (the most consistent point made) staff pointed out how important it is to clients to establish trust and or/individual understanding with solicitor in order to have a productive working relationship.
- At 4 meetings staff indicated that provider and/or individual solicitor availability and accessibility was key for clients.

**Quality:**

At 4 meetings staff thought that a longstanding relationship with a provider was the most important factor in achieving good outcomes for the client. The following points were made at 3 meetings each:

- Some providers give unrealistic expectations of the potential outcome of advice
- A good quality legal provider should be receptive to a patient's instructions
- TLS accreditation is not necessarily an indication of quality
- Some providers are applying/pushing for an MHT without the client's consent/knowledge and/or against their best interests

**LSC Role:**

3 meetings pointed out that there had been uncertainty and confusion about the contracting changes in November 2010.

**Miscellaneous:**

No point was made at more than 2 meetings. Where one of these views is deemed by the LSC to be of enough importance to be noted in this EIA (e.g. with relation to functioning of hospital or relevant to access to high quality legal advice), it will be discussed in the Analysis section.

### 9.6 Summary of evidence of Interest Groups (see Annex G)

As with the hospital staff, responses to the quantitative evidence sections of the questionnaire were inconsistent, so only the qualitative strands will be considered here. Again, in common with hospital staff we will only consider views where two or more interest groups raised them:

**Impact:**

All 5 interest groups thought there would be negative impact on clients caused by being required to change provider. 4 indicated that one of the reasons was that it takes so long to establish trust between clients and providers. Additionally, 3 emphasised that this trust would be lost as soon as the client changed provider and would not be regained easily. 3 also thought that one of the most severe impacts would be revisiting a traumatic case history with a new provider. Finally, 2 thought that cases will take longer to prepare because the new provider would not be familiar with the case history.

**Choice:**

3 bodies thought that choice of provider (and individual solicitor) was very important to clients because they have very few other choices in hospital. 2 groups thought that local links with clients' families and Local Authorities were important in both maintaining contact and when eventually released (for some clients), and also thought that greater choice of provider ensures a better service.

**Quality:**

3 interest groups thought it wasn't right to be required to change provider even if the new provider delivers higher quality service. 2 each indicated that subjective measures of quality (e.g. soft skills) are as important to clients as objective ones (e.g. knowledge) and that membership of TLS Accreditation Scheme should be used as a mark of high quality.

**Miscellaneous:**

2 bodies raised the following views:

- The questionnaire was not appropriate for stakeholders;
- Questionnaire quantitative responses were too limited to answer effectively;
- The same concerns raised here had already been raised in consultation on Civil Bid Round for 2010 Contracts.

## 10. Analysis

This analysis seeks to expand upon the themes identified in the Results by drawing out similarities and differences between different groups of consultees and considering the context of responses given.

### *10.1 Areas of agreement between stakeholders*

This exercise has collected a large amount of quantitative and qualitative evidence from a large number of groups of stakeholders. Given the different priorities, areas of interest and understanding of the different groups, this has revealed some considerable differences in views about the impact of exclusive HSH contracts on clients which are sometimes contradictory. However, there are also some areas of agreement which will be considered first.

The first area of agreement is between hospital staff and clients and this is that being required to change provider will have a varying impact on different clients. For some it will have little or no impact and for others it will have a severe and longer-lasting impact. 45% of clients indicated that being required to change would 'very much' have a negative impact upon them,

37% indicated it would have no impact (23%) or little impact (14%). Whilst this indicates that more will be severely affected, the margin is small so this is not wholly conclusive. However, there is little agreement on who it will affect most. Areas of conflicting views will be considered later on in this analysis.

The strongest area of agreement, shared by all consultees, is that the productivity of a relationship between a solicitor (rather than a provider) is highly dependent on the interpersonal skills of the solicitor. In particular development of trust and understanding have been emphasised as the most important elements. Loss of trust was also the negative impact of being required to change provider most frequently cited by clients. Consultees tended to agree that the relationship with a solicitor was equally important as the quality of advice given. This theme will be developed further later on in this analysis, but we suggest that the relationship is so important because a) clients are vulnerable and often paranoid and b) they tend to be detained for long periods of time and have very few links with the outside world. It is important to note that the LSC does not (and cannot) objectively measure this subjective skillset in providers. Not only that, but it is likely to vary between different solicitors working for the same provider.

Linked to this is agreement between providers and clients on how long it takes to develop a productive working relationship with the majority estimating more than 1 month, with a greater proportion of both estimating over 6 months rather than 1-6 months. Overall, 43% of clients indicated it would take greater than 6 months with 57% estimating less than 6 months. Therefore, it seems there is great variation in estimation of how long it would take to develop a productive relationship.

Finally, all consultees agreed to some extent that competition between a larger number of providers for clients in hospitals (rather than competition in an LSC tender process for contracts) led to higher quality. As we will see, there are other points of disagreement which conflict with this view.

### *10.2 Provider practices*

There was some agreement between clients and hospital staff about some questionable practices carried out by providers in the hospitals. These practices illustrate a very poor quality service. This has not been highlighted in the previous section because the numbers of respondents qualitatively identifying each poor practice did not reach the watershed chosen to highlight key themes. However, the serious nature of these practices and the fact that they have been identified by both hospital staff and clients mean they merit consideration here. The practices include:

- Touting for business on wards
- Failing to follow clients' instructions or even acting contrary to clients' instructions
- Asking for private payment for CPA meeting attendance
- Application for MHT without clients' permission or pressuring clients into applying
- Providing unrealistic expectations of MHT outcome in order to recruit new clients or prolong relationships with existing clients
- Lack of preparation for MHTs
- Failing to forward case files when client transfers or failing to refer when necessary
- One client had not heard from provider for more than 12 months

It is not possible to comment on how widespread these practices are and they may warrant further investigation in their own right. However, they do demonstrate exploitation of detained clients' acute vulnerability to influence their choice of provider.

### *10.3 Areas of disagreement between stakeholders*

As mentioned, there are areas of considerable disagreement and inconsistency. The first is that client respondents estimated a surprisingly large frequency of changing solicitor (42% saying once in a 2 year period) compared with information both reported by providers as part of regular contract management reporting processes and as part of this exercise. There are considerable problems with the accuracy of provider contract management data which relate to accuracy of reported location postcodes and additionally the bias of responses to this exercise. There is no reason to doubt clients estimates, particularly those received through questionnaire responses, and particularly as provider reports tend to underestimate the number of clients in HSHs. However, the questions were phrased differently for clients and providers with the former being asked about 'solicitors' for ease of understanding, and the latter being asked about providers. As discussed above, clients are particularly concerned about their relationship with a solicitor. It therefore seems that a large proportion of the client population changes solicitor regularly, although not necessarily provider.

The reasons for changing are more opaque. Clients tended to indicate quite strongly that this was due to poor quality of advice although there are issues with the subjectivity of this assessment given that clients may be unhappy with MHT outcomes and change as a consequence. It also seems reasonable to suggest that clients would change provider rather than solicitor if they were dissatisfied with the quality of advice. Then again, given the relationship with the individual solicitor is key, perhaps not. Provider and hospital staff assessment of the reasons underlying these changes may be more objective. Providers place more emphasis on the relationship having broken down and the client's condition having an influence on the decision with hospital staff emphasising how important client recommendations are in choosing a provider (but adding the caveat that recommendations may be unsuitable because they are based on different case types). Of concern were the examples given by clients and staff of poor practices by providers in the HSHs. In particular, hospital staff and clients indicated that in some cases providers ignored client instructions, acted without instructions or provided completely unrealistic expectations in order to recruit more clients. Further evidence can be found in the Annexes.

There may be other individual reasons for changing. For example, hospital staff gave differing accounts of how condition types affect a client's likelihood of changing with regularity. Some indicated that those with Personality Disorder (PD)/DSPD change regularly (with some hospital staff and clients indicating this was in order to reduce the risk of becoming a 'cash cow') whilst others indicated they tended to stay with the provider for longer. Some indicated that those with severe mental health conditions benefited most from a longstanding relationship and would be more negatively affected by the need to change provider, whereas others indicated these clients were in fact most likely to change regularly.

Quality of advice was another divisive point. 28% of clients rated standards of advice as 'average' or 'poor' (with the remainder rating it as 'good' or 'very good'), although this may be related to MHT outcomes, client conditions or relationships. Clients mentioned that they don't have any idea what the quality of service they will receive from a provider is before they are signed up. Furthermore, hospital staff indicated that quality of service had ranged from some providers (and particularly individual solicitors) who were excellent to some who were extremely poor.

Related to quality of advice, clients generally responded that they were happy to change provider if they were to receive a higher quality of advice. This view was not shared by the providers, interest groups or hospital staff's assessment of the impact of the need to change provider. There are of course problems with clients' subjective appraisal of quality (and the emphasis of interest groups, providers and hospital staff on a longstanding relationship and

'soft' skills) compared with the LSC's attempts to raise standards through objective measures. However, in principle it seems clients agree that it is right to try and raise quality standards.

Clients made a link between quality and greater choice of provider. Clients were also concerned that a reduced choice would lead to complacency on the part of providers who have won contracts and possible collusion with hospitals. However, these concerns do not accord with some other client views and the practical considerations that follow. Whilst some clients indicated lack of choice was a barrier to receiving the type of advice they wanted, the largest proportion wanted a choice of 6-10 providers rather than more than 10. Hospital staff and clients also indicated that the information available to clients to make that choice was either unavailable (e.g. information about individual firms) or misguided (e.g. recommendations by clients based on experience of different types of cases and unethical recruitment practices and unrealistic expectations raised by providers). It therefore seems that although greater choice may be a good idea in principle it does not necessarily lead to a higher quality of advice or a more stable, lengthy relationship with a provider. It was even suggested by some hospital staff that there may be beneficial clinical outcomes for clients from a reduced choice because it would force them to make more considered decisions about changing. One further consideration is that a greater choice may in fact lead to reduced specialism (and hence lower quality) due to smaller case volumes.

Whilst 45% of clients indicated that the need to change provider will 'very much' have a negative impact on them, they do not tend to identify that this will impact on their health. Whilst a few identified that change may result in stress or paranoia, most seemed to focus on practical issues like developing a trusting relationship and the provider gaining knowledge of their case. Hospital staff's views were that the need to change will have a large negative clinical impact on some clients.

In Rampton, staff raised severe concerns about the impact of the need to change provider on the National Units, but particularly upon the National Deaf Unit due to triple disabilities being deaf, having a mental condition and also having learning disabilities. However, the Focus Group in the National Deaf Unit did not reflect these concerns. Here the main issues raised reflected uncertainty on how best to choose a new provider and some concerning feedback about lack of contact from providers (and where relevant referrals) who had lost contracts.

It is worthwhile at this point to consider the differences between the hospitals and internal NHS changes that are taking place. Rampton is particularly different in terms of client population compared with the other 2 HSHs because it houses the National Units for Deaf People, the Learning Disabled and Women, in addition to the Personality Disorder (PD)/Dangerous and Severe PD (DSPD) and Mental Health patients that the other two exclusively house. Broadmoor has a greater proportion of BAME clients both due to its catchment area including London and its role housing detainees with immigration problems. Ashworth's catchment area includes Welsh clients. There is also a significant difference in ethos at each of the hospitals which have traditionally been run independently. There have been high profile public inquiries at Rampton and Ashworth. Broadmoor has a long history and might be considered the most traditional and formal. Certainly the nature of the Patient's Forum was different in each hospital. The NHS is currently reforming the governance of all 3 hospitals so that they are run broadly along the same lines through the shared 'Commissioning for Quality and Innovation' (CQUIN) targets for 2011/12. These include devising a common patient survey questionnaire, tackling obesity, improving communication and sharing a policy on meeting physical health needs. Interestingly this affects Ashworth & Broadmoor the most severely because (aside from the National Units) there are fewer changes to make at Rampton. Broadmoor is also reducing its number of beds and moving to a different clinical structure (two directorates: Mental Illness and Personality Disorder) which is shared by Ashworth & Rampton. In addition there has been a recent government consultation (ending 17th May 2011) on the treatment of DSPD patients in the NHS which recommends

progressive decommissioning of DSPD services. There is evidence from Hospital Staff and patients that these changes and consultations have caused considerable anxiety amongst both patients and staff.

The outcome of the tender had a different impact as well: for example more of the historic providers were lost at Broadmoor and Rampton where feedback concerned about a negative impact of the need to change provider has been greatest. Uncertainty and lack of information about the change in legal aid contracting at these hospitals has happened at a time when there is a large amount of other uncertainty (both for clients and staff) due to NHS changes. There is evidence that this amplified the negative feedback.

It is also true that the personalities and structures involved in administering access to legal advice in each hospital are different and have responded differently to implementing the changes (e.g. informing clients of the rationale behind them) and in their attitude to the LSC's role. It is therefore perhaps unsurprising that many of the views of hospital staff differ. At one hospital a number of clinical staff expressed the view that it was right that clients should not have unlimited choice of provider because by analogy they did not have choice of consultant (which changes regularly) which has a much more profound negative effect on their condition. This view was not raised at the other two hospitals.

Hospital staff were very concerned about the unequal treatment of those who were already resident in the hospital before 15th November 2010 and those who are transferred in after this date. The latter are able to retain their non-HSH provider as long as certain conditions are met. Clients in Focus Groups were not, in the main, concerned by this and understood the main policy justification that these clients were particularly vulnerable upon admission and had a greater requirement for continuity of advice. Client concerns were more based around the different approach (and therefore lack of choice) in HSHs compared with the Crime category and mainstream, lower security mental health services. Of course there were practical issues the LSC had to consider as well which will be considered further in the Equality Duties section which follows.

### *10.4 Summary of results and analysis*

#### LSC Process

- The LSC must ensure it communicates policy development, consultation and implementation more effectively with stakeholders in the future, where this is possible. In particular we should consider whether we are able to consult directly with HSH clients (in addition to with the hospitals) on any changes which may affect them.

#### Impact

- There will be a variable impact on clients of the need to change provider depending on the individual and not necessarily the type of condition
- Furthermore, the key relationship is between the individual solicitor (not the provider) and the individual client
- Interpersonal skills and development of trust are key to a productive working relationship between solicitors and clients: this process does not tend to happen quickly
- Clients are happy to change provider if they can be assured a higher quality of advice (although their needs in terms of quality may be difficult to measure or provide)
- The negative impact of the need to change on clients' health is estimated at a higher level by respondents other than clients

### Choice

- In principle, competition between a larger choice of providers for clients may lead to higher quality
- Clients have historically lacked (and continue to lack) access to information to make an informed, objective choice of provider
- Whilst larger choice is desired and presumed to lead to higher quality it does not do so where there is a lack of reliable information to make an informed choice or questionable practices are carried out[9]
- There is little evidence that clients are concerned that there are different rules regarding choice for those transferred in compared with those already resident
- Free choice of legal aid provider should not be a proxy for clients whose other choices have been removed due to the nature of their detention
- A large proportion of clients say they change solicitor regularly (although it is unclear whether this also means provider). Clients change solicitor for a variety of personal reasons which may or may not be influenced by their condition.

### Providers & Quality

- Quality of advice and levels of customer service delivered by providers have been variable in the past. Some poor practices have been reported.
- It seems difficult to cater for diverse client needs in a quality assured way: whilst the previous diversity of providers working in the hospitals gave clients more choice of the type of provider they wished to work with, it also allowed some questionable practices
- Quality assurance should be our priority for these acutely vulnerable clients

### Miscellaneous

- Client, staff, provider and interest groups' views on other issues vary considerably (particularly between clients and the rest)
- Patient views are the most reliable and relevant given they are the service users and must be weighted as such in this EIA
- The hospitals are very different and undergoing considerable change which may have reinforced the negative impact of changes to legal aid contracting
- Some of the provider behaviour discovered is extremely concerning: it appears that some have been taking advantage of extremely vulnerable clients
- Each hospital has historically had a very different culture (e.g. formal Patient Forum at BH, informal at AH/RH), but the NHS is moving to align them more closely
- The LSC should not make decisions based on maintaining/avoiding upsetting the status quo in other policy areas given we are engaged in reform of the legal aid system
- It is not feasible to run separate tenders/standard for each HSH when the services required in each are broadly the same

## 11 .The Equality Duties

**We have considered the finding of the consultation in relation to the equality duty under s149 of the Equality Act 2010. We have had due regard to each protected characteristic in relation to each of the three aims of the equality duty. We have found**

[9] The assumption of clients that larger choice leads to higher quality disregards the specialism that a smaller number of providers will develop, hence leading to higher quality.

**no evidence of direct discrimination or unlawful indirect discrimination or discrimination arising from disability.**

The following sections describe our conclusions, starting first with the protected characteristics of disability. Any references to duties or the 2010 Act are references to the Equality Act 2010.

## 11.1 Disability

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We have interpreted relevant unlawful discrimination for the purpose of disability as being: direct discrimination (s 13), indirect discrimination that would not be justifiable (s 15), discrimination arising from disability (s 15) and the duty to make adjustments for disabled persons (s 20). At the time of this assessment we note that the Government has chosen not to bring into force s 14 relating to dual discrimination.[10]

### *Direct discrimination*

Section 13(1) provides that direct discrimination occurs where a person (A) discriminates against another (B) if, because of a protected characteristic, A treats B less favourable than A treats or would treat others.

We have considered whether the introduction of competitive tendering in HSHs has amounted to direct discrimination. Specifically we have considered whether in awarding tender contracts to a limited number of legal aid providers following the competitive tender in 2010, we have treated potential legal aid clients in HSHs less favourably than we would treat others. The potential less favourable treatment that we have considered is the introduction of competitive tendering for legal services provision in the HSHs with consequent:

a. Restriction in choice of provider; and
b. Need to change solicitor to a new provider successful in the tender.

We have assumed that the HSH clients share the protected characteristic of disability by virtue of their detention in the HSHs for the purpose of treatment for mental health conditions. In addition we know that some clients in the HSHs also have learning disabilities, are deaf[11] and/ or have visual impairments[12].

In determining a suitable comparator to apply to the test of direct discrimination in respect to the general group of clients in HSHs with mental health-related disability, we have considered the following options:

a. Clients in HSH who do not have mental health conditions; we have discounted this group as a possible comparator because we are unable to identify members.
b. Clients who are eligible for legal aid to resolve a civil legal aid problem (other than for a mental health problems). The LSC has introduced competitive tendering for the provision of legal aid services for civil legal aid other than the

[10] http://www.equalities.gov.uk/equality_act_2010/faqs_on_the_equality_act_2010/dual_discrimination.aspx

[11] Rampton HSH includes special units for people with a learning disability and people who are deaf.

[12] Information provided to the LSC by HSH patients in response to the consultation equal opportunity survey.

mental health category of law. We think that this may be the most appropriate comparator. We consider this group as a possible comparator for the test of direct discrimination.

c. Clients who are eligible for legal aid for mental health legal problems because for this category of law we have retained non-competitive tenders in order to maintain as wide as possible access to legal aid services for mental health issues throughout England and Wales. We consider this group as an alternative possible comparator for the test of direct discrimination.
d. Clients who are detained in the criminal justice system. We consider that the criminal justice system has too many differences to provide a useful comparator for testing less favourable treatment in access to legal aid services for HSH clients. The possible comparators outlined above provide more appropriate possible comparators.

We have considered whether there is less favourable treatment of clients in HSHs where the comparator group is the set of potential clients who are eligible for legal aid for civil law categories of law other than mental health. This set of clients does contain some who have a mental health-related disability of varying severity, and this is proportional to the prevalence of clients with a mental health who are eligible for legal aid in the population at large. We assume that the majority of civil legal aid do not share this protected characteristic.

For civil legal aid clients (with the exception of the mental health category of law for non-HSH cases) the LSC has introduced competitive tendering for the provision of legal aid services. A potential civil legal aid client (in a category other than mental health law) does not have unfettered access to a legal services provider. In many Procurement Areas/Access Points they will have no choice of provider at all, there being only one that has won a contract. More generally, choice of provider is restricted to those publicly funded legal services providers who qualify and meet the criteria of the competitive tender. The introduction of competition for legal advice in HSHs does not present less favourable treatment for clients in HSHs in comparison with potential clients in other civil legal aid categories of law.

We next considered the comparative consequences of introducing competitive tendering for clients in HSHs and this comparator group. One consequence of the introduction of competition is that the actual providers with contracts to provide legal aid services have changed. We know that in HSH the consequence of competition has been that some clients may need to change their solicitor from a provider that has not won a contract in the competitive tenders to a new solicitor from a provider that has. There is no less favourable treatment for HSH clients.

Accordingly, we do not consider that the introduction of competitive tendering and the need to change solicitor is less favourable treatment in comparison with other possible civil legal aid clients.

We have considered, as an alternative comparator, whether there is less favourable treatment where the client is not detained in an HSH and is seeking legal aid for a mental health issue. In this situation, the LSC has chosen not to introduce competitive contracts for legal aid services. We have considered whether there is a difference in accessing legal services for each client group. Non-HSH clients of mental health services do not have unfettered access to publicly funded legal services. Whether or not contracts have been awarded by way of competitive tender, a client's choice of provider is restricted to those who have met LSC requirements, including quality standards, and have been awarded an LSC contract. We now have fewer providers (c.190) compared to the old contract (c.240). It is also limited by the Procurement Areas in which providers have tendered for work and the associated NMS allocation. Furthermore we know that there has been considerable movement of solicitors and other caseworkers between providers as a result of the tender outcome. The LSC does not

contract with individual solicitors, rather with providers, and as a consequence has no control over which solicitors are available to advise clients. Given that the contracts are 3 years long, that the LSC may alter providers' allocation of NMS from year to year depending on their performance, and that the providers who won HSH contracts did so partly on the basis of the volume of restricted cases they carry out, it is possible that an enforced change of solicitor would have been caused more frequently by providers under the old system. The same can assumed to be true for the comparator.

The introduction of competitive tendering in HSH was designed to give a more secure, quality assured legal service for clients in HSHs than was the status quo prior to the tender (see 'Background' section. We do not consider that the introduction of competitive tendering for HSHs treats clients in HSHs less favourably than clients seeking legal advice for mental health legal problems who are not in HSHs; in fact we consider that competitive tendering for services in HSHs improves legal services available for clients in HSHs. With the introduction of competitive tendering for HSH contracts, clients in HSHs have a choice of providers meeting higher quality standards, including for example the highest proportion of accredited solicitors.

Despite the decision to use non-competitive tendering for non-HSH mental health legal services, not all non-HSH clients may be able to access a local legal aid provider and not all providers may be able to accept him or her as a client where they do not have sufficient new matter starts. The quality standards of providers will be more variable. This does not suggest less favourable treatment of clients in HSHs.

In respect to the need to change provider, it is noted that a civil legal aid client in the comparator group may also need to change his or her solicitor for a number of reasons: there may be changes to a provider's contract with the LSC; there may be staffing changes within providers or changes to which solicitor handles a particular case. There is no difference in treatment between HSH clients and civil legal aid client mental health clients.

Finally, clients did not have true unfettered choice of either provider or solicitor under the previous system. Some providers did not offer services in the HSHs, some only offered limited services (i.e. only advising their existing clients who transferred there), some only offered services for some types of cases (e.g. MHT) and there was no requirement to ensure a client had continuity with the same solicitor/caseworker. It is also the case that since there were no HSH-specific NMS allocations, it was not clear to clients what capacity providers might have to take on new cases. The new system ensures that provider availability is clear and transparent and means it is less easy for a provider to refuse to take on a case for nebulous reasons.

**Having due regard to s149(1) there is no evidence of direct discrimination from the introduction of competitive tendering in HSHs .**

***Indirect discrimination***

We next considered the need to eliminate unlawful indirect discrimination in relation to HSH clients' protected characteristic of disability.

Section 15(1) provides that a person (A) discriminates against another (B) if A applies to B a provision, criteria or practice which is discriminatory in relation to a relevant protected characteristic of B's. For the purpose of s 15(1) a provision, criteria or practice is discriminatory in relation to the protected characteristic if A applies it to persons with whom B does not share the characteristic; it puts persons with whom B shares the characteristic at a particular disadvantage when compared with persons with whom B does not share it; it puts B at that disadvantage and A cannot show it to be a proportionate means of achieving a legitimate aim.

The provision, criteria or practice under consideration is the introduction of competitive tendering for legal services contracts in HSHs. The protected characteristic of B in the present case is the disability of clients in HSH as previously described.

As previously described, competitive tendering has been applied to other civil legal aid contracts (excluding services for non-HSHs mental health legal services). It has been applied to persons with whom HSH clients do not share the characteristic of disability as a characteristic of their generic group. Although some clients who are eligible for civil legal aid other than for issues arising while detained in HSHs may share the same or similar disabilities to those detained in HSHs, for the purpose of this assessment we assume that the comparator group of civil legal aid clients (except for mental health) where competitive tendering is in operation does not share the same protected characteristic disability as those clients in HSHs.

We considered whether competitive tendering puts clients in HSHs at a particular disadvantage compared with clients eligible for other civil legal aid services. We carried out a consultation exercise directly with stakeholders in HSHs in order to gather evidence from clients and professionals in HSHs relating to the impact of the competitive tendering exercise on clients. In particular we sought feedback about the impact on HSH clients of changing providers, and therefore, changing their solicitor. We have described elsewhere in this document the consultation exercise and a summary of findings[13].

From the consultation we have learned that some HSH clients find it more difficult to cope with changing their solicitor for reasons that may relate to their particular disability. These include difficulties forming trusting relationships due to a history of abuse and abandonment. It is not possible to say exactly what the negative impact of having to form a new relationship will be because it will vary according to individual client and the interpersonal skills of the solicitor. Some hospital staff linked particular difficulties in forming new relationships to those clients with Aspergers, DSPD or paranoid conditions. With the exception of increased paranoia, these views were not reflected by clients. In Rampton, staff also suggested that those in the National Deaf Unit, the National Womens Unit and the National Learning Disabilities Unit would experience particular difficulty. Again, this was not reflected by clients.

There is evidence that a general atmosphere of uncertainty in at least 2 of the hospitals (due to NHS changes) has compounded the uncertainty surrounding changes to legal aid contracting and may have amplified client fears, particular those relating to paranoid conditions. Certainly, some paranoia regarding the possibility of collusion between the hospital and providers has been dissipated as a result of the greater communication with hospitals and clients as a result of this exercise.

We acknowledge that some HSH clients share these experiences, which are connected with their disabilities.

We have considered whether difficulties experienced in relation to coping with a change of solicitor puts a HSH client at a disadvantage in obtaining quality legal aid services in comparison with clients in other civil categories of law for which competitive tendering had been introduced.

To assess this we have considered to what extent the ability to or the ease with which a client can establish a new relationship with a solicitor is important to allow clients to access quality legal advice. While ease of establishing a relationship with a solicitor is important, and more so for clients detained in institutions, we do not think that it is a barrier to accessing good quality legal aid services that puts clients at a disadvantage. This disadvantage does not

[13] A full account of findings is Annexed to this assessment.

prevent clients in HSHs from obtaining legal services. The need to change solicitor, if it occurs, will be a short term issue for some HSH clients. The competitive tender process has ensured that there is a pool of quality assured legal aid providers available for HSH clients. In addition, it might reasonably be assumed that all clients in the other civil categories value a longstanding trusting relationship with their solicitor and a number will experience particular difficulty in changing solicitor for that reason, but unrelated to the protected characteristics.

We next considered whether we can show that competitive tendering is a proportionate means of achieving a legitimate aim. We introduced competitive tendering for legal services in HSH in line with other civil categories in order to increase quality standards. The objectives and background to competitive tendering are set out in more detail in the 'Background' section.

Competitive tendering has been introduced across civil legal aid categories for a variety of legitimate policy reasons[14], not least to give the LSC greater control over quality. The main objective for competitive tendering was to raise quality standards and is discussed in more detail in the 'Background' section.

It should also be noted that the fundamental reason a client is detained in an HSH will vary. Whilst it is true that all can be considered disabled due to their mental health problem, some will have had their security status upgraded via mental health services only, others will have been transferred from prison having been convicted of an offence.

In the course of the consultation conducted for this assessment, we collected evidence of poor quality practices, which we describe in the Evidence section of this paper. In light of this we believe that the aim of improving quality is a legitimate aim**,**

**We consider that running a competitive tender to achieve high quality legal advice is a proportionate means to achieving a legitimate aim, and accordingly, there is no evidence that competitive tendering for legal services in HSHs amounts to unlawful indirect discrimination.**

### *Discrimination arising from disability (s 15)*

Section 15 provides that a person (A) discriminates against a disabled person (B) if A treats B unfavourably because of something arising in consequence of B's disability, and A cannot show that the treatment is a proportionate means of achieving a legitimate aim.

We do not consider that we have treated HSH clients unfavourably by introducing competitive tendering in HSHs. We refer to our reasons explained above in relation to indirect discrimination. We do not consider that by introducing competitive tendering we treat HSHs clients unfavourably for a reason relating to their disability. We reiterate that in any event, we consider that competitive tendering is a proportionate means of achieving the legitimate aim of commissioning quality legal services for eligible legal aid clients in HSHs.

### *The duty to make adjustments for disabled persons (s 20)*

Section 20 provides a duty to make reasonable adjustment for a disabled person. This includes requirements to take such steps as is reasonable to have to take to avoid the substantial disadvantage for a disabled person as a result of a provision, criterion or practice (s 20(3)); to take such steps as are reasonable to remove substantial disadvantage as a result of a physical feature (s 20(4)) and to take such reasonable steps to provide an auxiliary aid in

[14] See 'Background' section and various historic consultation documents on the LSC website

order to avoid a disabled person being put at a substantial disadvantage in comparison with persons who are not disabled (s 20(5)).

We do not consider that the introduction of competitive tendering of itself puts HSH clients at a substantial disadvantage for reasons already explained in relation to direct and indirect discrimination.

In our administration of legal aid we have in place provisions to make reasonable adjustments for disabled persons including payment for auxiliary services as required on an individual basis to assist communication between legal advisers and a disabled person, including British Sign Language interpreters (and equivalent communication professionals) to assist or in a similar way, learning disability support workers. We have undertaken to produce written documentation in EasyRead format, which is favoured by some people with learning disabilities. We have pioneered an EasyRead legal aid dictionary to aid communication with those with learning disabilities about legal aid. Indeed, we used EasyRead documentation as part of this exercise.

We will use the information that we have collected about the diverse needs of clients in HSHs to monitor and review any further reasonable adjustments that may be required in the HSHs.

***Harassment***

We have not found evidence of harassment in the operational of the provision of legal services by the LSC or by providers. We have however found that some of the behaviour of providers raises issues of poor quality of advice and questionable practices. We do not think that the outcome of the tender exercise itself is the cause of this unethical behaviour. In fact, we believe that the tighter controls will allow us to have more control over the behaviour of providers. We are reminded that one of the original aims of the tender was to address concerns about quality. The options that we will are considering have allowed us to have due regard to the need to eliminate harassment and improve safeguards for quality in general.

***Victimisation***

We have found no evidence of victimisation or other conduct that is unlawful under the Act.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

According to s 149(3), this involves having due regard to the need to remove or minimise disadvantage suffered by persons who share protected characteristic and persons who do not and, in accordance with s 149(4), to take steps to meet the needs of persons who share a relevant protected characteristic that are connected to that characteristic (including steps to take account of disabled persons' disabilities).

We acknowledge that some HSH clients suffer a disadvantage in that for reasons related to their disability, they may find it more difficult to establish new relationships as easily with new solicitors in comparison with other who do not share their disability. While we do not consider that introducing competitive tendering in HSH amounts to direct or indirect discrimination, we do consider that the disadvantage identified triggers our public sector duty to consider what we may do to remove or minimise this disadvantage.

For reasons already given, we do not consider that it would be appropriate to remove competitive tendering because we consider that this is a legitimate and proportionate means of commissioning high quality legal services in HSHs.

We note that the consequence that some clients may need to change solicitor is already mitigated to some extent by the practice that 'remainder work' started under the old contract can be completed by providers who did not win contracts. Furthermore, those transferred in to HSHs are permitted to retain their provider even if they did not win a contract, as long as that provider meets certain criteria. There is further discussion of this point following Equality Duty Aim 3.

We next considered what steps we may take in application of s 149(4) to meet the needs of HSH clients. In doing so, we have identified a number of steps that we intend to take.

We will take steps to improve how we communicate with clients in HSHs. Historically we have not directly communicated or consulted clients in relation to changes to the way that legal services contracts are commissioned. There is full consideration of the steps we will take in the 'Next Steps' section.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

According to s 149(5) this involves having due regard to the need to:

(a) tackle prejudice and
(b) promote understanding

The outcome of the tender and our consideration of the assessment suggests that it is less relevant to this aim of the equality duty. However, we have had due regard to this aim and consider that in the course of improving communication between the LSC and clients in HSHs, we will be able to incorporate steps to promote understanding amongst LSC staff about the needs of disabled clients in HSHs. Not only that, but one of the outcomes of this exercise has certainly been to promote understanding of legal aid, ensure HSH clients are participating fully in public life and promote understanding of HSH clients within the LSC.

We consider that putting in place measures to improve communication (set out in the 'Next Steps' section), will help clients to access legal services.

**11.2 Gender reassignment**

During our consultation, HSH clients were invited to tell in confidence whether they were transgender[15]. Of those completing equal opportunity monitoring forms 24% reported that they were transgender. However, hospital staff reported that the question about transgender was widely misunderstood by respondents. In light of this we treat the response rate with caution in case it is artificially high.

We have had regard to recently published information about transgender issues issued by the Government Equalities Office and information published by transgender support groups. [16] We acknowledge that people who have or have had gender identify issues may also experience

[15] A copy of the form is attached at Annex C.
[16] For example, Transgender e-bulletin no.2 June/July 2011 see Government Equalities Office http://www.equalities.gov.uk/default.aspx

related mental health issues. However respondents to the consultation raised no issues related to being transgender or gender identity.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

*Direct discrimination*

For the purpose of testing for direct discrimination[17], we consider that the appropriate comparator group for the transgender HSH clients is non-transgender clients. We are not aware of any issues that are of particular concern for transgender HSH clients in relation to consequences of the introduction of competitive tendering, which is a restriction in choice of legal aid provider and/ or a need to change solicitor. We do not consider that there is less favourable treatment of HSS clients who are transgender.

Accordingly, we do not consider that the introduction of competitive tendering in HSHs directly discriminates against HSH clients on the basis of gender reassignment.

*Indirect discrimination*

We next considered whether there may be unlawful indirect discrimination on the basis of transgender.[18] We considered whether the introduction of competitive tendering (being the provision, criteria or practice) puts HSHs clients who share the protected characteristic of being transgender at a particular disadvantage compared with HSHs clients who do are not transgender.

We have no evidence that HSH clients who are transgender experience a particular disadvantage and on that basis we consider that there is no indirect discrimination. In the event that evidence is provided to suggest otherwise, we would nevertheless consider that the introduction of competitive tendering in HSH is a proportionate means of achieving the legitimate aim of improving quality of legal services in HSHs.

*Harassment and victimisation*

Our consultation suggested neither evidence of harassment of transgender HSH clients nor evidence of victimisation in relation to transgender issues.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

We have had regard to the need to remove or minimise disadvantage suffered by persons to share the protected characteristic of transgender and those who do not. We have no evidence that transgender HSH clients suffer disadvantage in comparison with non-transgender HSH clients.

We consider that the most appropriate steps we should take to meet the needs of transgender HSH clients, is to first better understand the needs of transgender HSH clients.

[17] We refer to the definition of direct discrimination given elsewhere in this assessment.
[18] We refer to the definition of indirect discrimination given elsewhere in this assessment.

Section 149(3)(c) suggests that advancing equality of opportunity should also involve having due regard to the duty to encourage persons who share a relevant characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

According to s 149(5) the duty to foster good relations involves having due regard to the need to tackle prejudice and promote understanding. The introduction of the new equality duty is an opportunity to do this in relation to transgender.

We will consider what appropriate steps we can take to raise awareness within the LSC and among contracted providers operating in HSHs about the needs of transgender HSH clients with the aim of tackling possible prejudice and promoting understanding.

**11.3 Pregnancy and maternity**

We are not aware of any issues in relation to possible discrimination arising from pregnancy and maternity that are of particular relevance to the relationship that a woman may have with her legal aid solicitor and therefore to the introduction of competitive tendering in HSHs.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We do not consider that there is unlawful discrimination on the grounds of pregnancy and maternity in the introduction of competitive tendering in HSHs.

Our consultation suggested neither evidence of harassment of women HSH clients nor evidence of victimisation in relation to pregnancy and maternity.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

We have no evidence that women HSH clients face a disadvantage in relation to pregnancy and maternity in accessing legal aid services or if they may need to change their solicitor as a consequence of the introduction of competitive tendering.

We are unaware of relevant steps that the LSC may be able to take in relation to administering legal aid to meet the needs of women HSH clients who share the protected characteristic of pregnancy and maternity. We suggest that the needs of women in relation to pregnancy and maternity are likely to be better met by the services provided by the HSHs.

We will however maintain an open mind and have due regard to this aspect of the equality duty should it be suggested that there are steps we should consider taking.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

We are unaware of any need by the LSC to take steps to foster good relations connected to the needs of women HSH clients who share the protected characteristic of pregnancy and maternity.

We will however maintain an open mind and have due regard to this aspect of the equality duty should it be suggested that there are steps we should consider taking.

**11.4 Marriage and civil partnership**

We are not aware of any issues in relation to possible discrimination arising from marriage and civil partnership that are of particular relevance to the relationship that HSH clients may have with their legal aid solicitor and therefore to the introduction of competitive tendering in HSHs.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We do not consider that there is unlawful discrimination on the ground of marriage and civil partnership.

Our consultation suggested neither evidence of harassment of HSH clients nor evidence of victimisation in relation to marriage and civil partnership.

We note that marriage and civil partnership are not relevant protected characteristics for the purpose of s 149(b) and (c).

**11.5 Race**

During our consultation, we invited HSH clients to tell us in confidence about their ethnicity. 74% of the respondents to the equal opportunity monitoring questionnaire identified themselves as White British, 7% as Black Caribbean, 5% as Black African and 4% as White Other. There was some considerable variation across the hospitals with Broadmoor broadly having a higher proportion of respondents from Black and Asian Minority Ethnic (BAME) groups.

During the consultation some clients and hospital staff indicated they had a preference for a provider from their local area and with caseworkers with the same ethnicity as them. No respondents raised provided information to suggest that there exists any specific complaints in relation to relationships with solicitors.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We have considered whether the introduction of competitive contracts directly discriminates against BAME clients on the basis that it may have as a consequence restricted the ethnic diversity of solicitors operating in HSHs.

We do not hold sufficient information about the diversity of individual solicitors within legal aid providers[19]. However, we do not consider that BAME HSH clients receive less favourable treatment when compared with White HSH clients in relation to legal aid services provided. We do not consider that the inability to choose a solicitor from a particular ethnic group amounts to direct discrimination.

We also do not consider that the inability to choose a solicitor from a particular ethnic group amounts to a disadvantage for BAME HSH clients. We do not consider that it, thus, amounts to indirect discrimination. In the event that evidence is provided to suggest otherwise, we would nevertheless consider that the introduction of competitive tendering in HSH is a proportionate means of achieving the legitimate aim of improving quality of legal services in HSHs.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

We do not consider that that inability to choose to choose a solicitor from a particular ethnic group amounts to a disadvantage for BAME HSH clients.

The LSC has limited legal scope to influence the diversity of solicitors who work in partnership with or for publicly funded legal services providers. We cannot award procurement contracts on the basis of racial quotas. We can however encourage provider diversity within the legal profession. We have historically played an active role in doing so[20].

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

We acknowledge that fostering good relations is frequently relevant in relation to race. The introduction of the new equality duty is an opportunity to do this afresh. We will consider what appropriate steps we can take to raise awareness within the LSC and among contracted providers operating in HSHs about the needs of HSH clients from different ethnic groups with the aim of tackling possible prejudice and promoting understanding.

**11.6 Religion or belief**

During our consultation, we invited HSH clients to tell us in confidence about their religion or beliefs. The largest proportion of respondents identified themselves as Christians (42%), with 20% identifying themselves as belonging to no religion and 11% identifying themselves as Muslims. The proportion of Muslim respondents was highest in Broadmoor (18%). In Ashworth 23% of respondents identified themselves as 'other' which was responsible for supporting a 7% proportion across the three hospitals. 5% of respondents identified themselves as Buddhists, which was largely caused by a large proportion of Buddhist respondents in Ashworth (15%).

[19] This is for a number of reasons: a) this information is surveyed at office level and is not specific to categories b) the caseworker population is dynamic and the survey was last carried out over a year ago and c) the information provided is done so on a confidential basis and so with such a small sample size for the current HSH providers it would be impossible to maintain this complete confidentiality.

[20] See LSC Equalities Annual Reports on our website http://www.legalservices.gov.uk

During the consultation respondents raised no issues about specific need in relation to religion or belief.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We are aware of no issues of concern in relation to relationships between HSH clients and their legal aid solicitor or provider, and, thus, likely to be of relevance to the introduction of competitive tendering in HSHs. We are unaware of any evidence to suggest that there may be unlawful discrimination in relation to religion or belief.

Our consultation provided evidence of neither harassment nor victimisation in HSHs in relation to religion or belief.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

We have no evidence that HSH clients of any particular religion or belief suffer a disadvantage in comparison with clients who do not share that religion or belief in relation to accessing legal aid services or if they may need to change their solicitor as a consequence of the introduction of competitive tendering.

We are unaware of at the present time of relevant steps that the LSC may need to take in administering legal aid to meet the needs of HSH clients of any particular religion or belief. We will however maintain an open mind and have due regard to this aspect of the equality duty should it be suggested that there are steps we should consider taking.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

We acknowledge that fostering good relations is frequently relevant in relation to religion and belief. The introduction of the new equality duty is an opportunity to do this. We will consider what appropriate steps we can take to raise awareness within the LSC and among contracted providers operating in HSHs about the needs of clients with any particular religion or belief with the aim of tackling possible prejudice and promoting understanding.

**11.7 Sexual orientation**

During our consultation, we invited HSH clients to tell us in confidence about their sexual orientation. Most respondents identified themselves as Heterosexual (83%) with 12% identified themselves as Bisexual (12%); though this was 18% at Rampton.

During the consultation respondents raised no issues about specific need in relation to sexual orientation.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We do not consider that there is unlawful discrimination on the ground of sexual orientation in the introduction of competitive tendering in HSHs.

Our consultation provided evidence of neither harassment nor victimisation in relation to sexual orientation connected to accessing legal aid or in relationships with solicitors.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

We have no evidence that HSH clients face a disadvantage in relation to their particular sexual orientation in accessing legal aid services or if they may need to change their solicitor as a consequence of the introduction of competitive tendering.

We are unaware of relevant steps at this time that the LSC may be able to take in relation to administering legal aid to meet the different needs of HSH clients who share a particular sexual orientation.

We will however maintain an open mind and have due regard to this aspect of the equality duty should it be suggested that there are steps we should consider taking.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

We acknowledge that tackling prejudice and promoting understanding is frequently relevant in relation to advancing equality for people who have different sexual orientations, especially those who may be gay, lesbian or bisexual. We will consider what appropriate steps we can take to raise awareness within the LSC and among contracted providers operating in HSHs about the needs of gay, lesbian or bisexual HSH clients with the aim of tackling possible prejudice and promoting understanding. The introduction of the new equality duty is an opportunity to do this.

**11.8 Sex**

During our consultation we invited HSH clients to tell us in confidence whether they were male or female. 88% of respondents were male and 22% female.

Ashworth and Broadmoor HSHs cater exclusively for male clients. Rampton HSH houses the National Women's' Unit.

On reviewing the responses to the consultation we have not been able to identify any significant difference is feedback in relation to men or women HSH clients. However, we note that hospital staff at Rampton reported[21] that they perceived that the impact of having to change solicitor could be particularly severe on clients in the National Women's Unit as well as on other clients at Rampton's other special units for people with learning difficulties and who

[21] See Annex F.

are deaf. Feedback from Rampton hospital staff suggested also that clients there also have difficulty accessing family advice and that factors relating to establishing relationships and trust with a solicitor are important for Rampton clients. We have not been able to fully quantify the findings and work further with Rampton to explore the needs of clients in the National Women's Unit as our work to monitor and review this equality impact assessment.

*Equality Duty Aim 1*

*The duty to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation and any conduct otherwise prohibited under the 2010 Act: s 149(1)(a)*

We have considered whether the introduction of competitive tendering, including a possible need to change solicitor, had amounted to direct discrimination on the grounds of sex. We have considered comparators as being either male or female clients in HSHs in applying the test for direct discrimination for female and male HSH clients respectively.

We do not consider that clients at the National Women's Unit at Rampton have been treated less favourably than male HSH clients. Nor do we consider that male clients have been treated less favourably than female clients in the National Women's Unit.

Accordingly, we do not consider that the introduction of competitive tendering in HSHs amounts to direct discrimination on the ground of sex.

We next considered whether there was unlawful indirect discrimination on the ground of sex. We considered whether the introduction of competitive tendering (being the provision, criteria or practice) puts male or female HSH clients at a disadvantage in comparison with other HSH clients of the opposite sex.

We considered the evidence, summarised above, in relation to clients in the National Women's Unit. The concerns raised by Rampton hospital staff about women clients relate to the same type of concerns raised about the possible impact of a need to change solicitor on male clients. Since they are materially similar we do not feel that we do not presently have clear evidence that women have different experiences or needs in accessing legal aid advice for mental health issues in the HSH. We do not, therefore, think that women experience a particular disadvantage and accordingly, we do not think that there is unlawful indirect discrimination on the ground of sex for women HSH clients.

In the event, that evidence is provided to suggest that women do suffer a particular disadvantage we would nevertheless consider that the introduction of competitive tendering in HSHs is a proportionate means of achieving the legitimate aim of improving the quality of legal aid services in HSHs.

We have considered the position likewise for male HSHs clients in comparison with female HSH clients. We do not have evidence of any particular disadvantages as a it relates specifically to male clients. We do not, therefore, consider that there is unlawful indirect discrimination on the grounds of sex for male HSH clients. If evidence if provided to the contrary, we would again consider that the introduction of competitive tendering in HSHs is a proportionate means of achieving the legitimate aim of improving the quality of legal aid services in HSHs.

Our consultation provided evidence of neither harassment nor victimisation on the grounds of sex.

*Equality Duty Aim 2*

*Advance equality of opportunity between people who share a protected characteristic and those who do not: s 149(1)(b)*

As we have described above we have no clear evidence at this time that HSH clients face a disadvantage in relation to their sex in accessing legal aid services or if they may need to change their solicitor as a consequence of the introduction of competitive tendering.

We are unaware of relevant steps at this time that the LSC may be able to take in relation to administering legal aid to meet the different needs of male or female HSH clients. However, as noted above, we will review the needs in particular of clients in the National Women's Unit with staff at Rampton and consider what steps it may be appropriate for us to take.

*Equality Duty Aim 3*

*Foster good relations between persons who share a relevant protected characteristic and persons who do not share it: s 149(1)(c)*

We would like to discuss further with staff at Rampton and other stakeholders whether there is a need for the LSC to take action to tackle prejudice and promote understanding of the needs of women in HSHs. The evidence that we have gathered during our consultation has not been sufficient for us to identify whether there is a need for us to take positive action and if so what steps these may be. In the course of monitoring and reviewing the provision of legal aid services in HSHs we will also consider whether there is also a need for the LSC to play a role to tackle prejudice or promote understanding in relation to the needs of male HSH clients.

**11.9 Age**

The equality duty does not require us at this time to have due regard to age as a protected characteristic in relation to the procurement of legal aid services.

We did however invite consultation participants to tell us what age they were. The highest proportion of respondents came from the age brackets 25-34 (25%), 35-44 (27%) and 45-54 (23%).[22]

In the course of monitoring and reviewing the provision of legal aid services in HSHs we will consider the age profile of HSH clients and seek to establish whether different age groups suffer disadvantage or have particular needs. We will have due regard to the equality duty in relation to age in accordance with guidance that will be issued by the Equality and Human Rights Commission when this part of the duty comes into force of service provision.

**11.10 Different provisions for those transferred to HSHs and those already resident**

There has been some limited feedback that it is unfair to apply different rules to clients who have been transferred into the HSHs after 15th November 2010 and those who were transferred in before. Section 9.8 of the General Civil Contract Mental Health Specification 2010 states:

*"9.8 You may not use Matter Starts allocated for use in Strategic Health Authority Procurement Areas in High Security Hospitals, except where a Client whom you have advised in the previous two years (or where you have not advised the Client in the*

[22] See Annex C.

*previous two years you were the last Provider to advise them) is transferred to a High Security Hospital. If so you may continue to act for them and may utilise Matter Starts for this purpose only if the following criteria are satisfied:*

*(a) your Client wishes you to continue to act for them; and*

*(b) you employ an Authorised Litigator; and*

*(c) you have experience of Restricted Cases; and*

*(d) all representation before the MHT will be carried out by Law Society Mental Health Review Tribunal Accreditation Scheme members;*

*You must keep a record on the relevant case file to demonstrate compliance with these criteria. We will not pay for High Security Hospital Matters where Matter Starts allocated to Strategic Health Authority Procurement Areas are utilised outside these rules."*

This concession was introduced in relation to HSH contracts because the main concern raised on consultation was that clients who were transferred into HSHs should be allowed to retain their provider. The same concerns were not raised with regard to clients already resident in the HSHs.

We continue to believe (as originally identified through consultation) that continuity of advice is of highest importance to those who are transferred in to HSHs. For this reason, it is not inequitable to offer different rules governing provision for these clients. It is also the case that this exercise has provided strong evidence to justify the improvement of quality through competition. Compared to mainstream mental health services, the population of the HSHs is less dynamic and hence the small volume of clients transferring in who wish to retain their provider should not undermine exclusive contracts which facilitate an improvement in quality standards. On the contrary, any provision which allowed those already resident in a hospital to retain their provider, due to the potential volume of clients who might wish to do so, would undermine an improvement in quality standards.

### 11.10 Human Rights Act 1998

The Human Rights Act was mentioned by a number of clients and providers and in particular Articles 5 and 6.

This EIA is concerned with our duties under the Equality Act 2010. This is not the correct place to provide a detailed discussion of the relevance of these Articles to choice of legal advice provider. However, the LSC does not believe that clients have the right to absolute provider choice under either Article.

### 11.12 Summary of Conclusions

- ***There is no evidence of direct discrimination:***

  The most appropriate comparator for HSH clients when assessing whether discrimination has taken place are clients with other Civil legal aid problems.

  We have also considered mainstream (non-HSH) mental health clients as an

alternative comparator, despite the fact that these clients share the protected characteristic.

We do not believe that the introduction of competitive tendering and any need to change solicitor is less favourable treatment in comparison with other Civil legal aid clients due to the other competitive tenders carried out in those areas.

Mainstream mental health clients are also restricted in their ability to exercise their choice of solicitor for a variety of reasons.

- ***There is no evidence of indirect discrimination:***

  We do not believe that any need for a HSH client to establish a new relationship with a solicitor prevents a client from accessing quality legal advice or is disadvantageous, except in the short term for some clients.

  Introducing competitive tendering in HSHs was a proportionate means of achieving the legitimate aim of raising quality standards for all clients.

- ***We already make provisions for reasonable adjustments for disabled people (including HSH clients) in our administration of legal aid;***

- ***There is no evidence of harassment;***

- ***There is no evidence of victimisation;***

- ***There is no evidence of direct or indirect discrimination with respect to the other characteristics protected under the Equality Act 2010;***

- ***We have identified a number of 'Next Steps' to further advance equality of opportunity for HSH clients;***

- ***We believe it is appropriate to retain differential rules on retaining existing, non-contracted providers for those transferred into an HSH and those already resident due to the particularly acute vulnerability of the former;***

- ***We do not believe that HSH clients have the right to absolute choice of provider (or solicitor) under Articles 5 or 6 of the Human Rights Act 1998;***

## 12 .Options

The LSC now has the following options:

| Option | Strengths | Weaknesses | Recommendation and justification |
|---|---|---|---|
| No change | • As current contracting arrangements are intended to address quality issues they would continue to ensure high quality advice in HSHs<br>• Facilitates closer contract management of fewer providers to ensure that they remain independent from the HSHs and behave ethically<br>• Provides ongoing certainty for clients: other options would require development and consultation with an uncertain outcome | • Does not allow individual clients their choice of provider/solicitor which may cause a negative impact on a small number of them | **Recommended:** Given the lack of evidence of discrimination but clear evidence of questionable practices by providers it is most appropriate to focus on quality provision for all clients |
| Exceptional circumstances to allow clients to retain their provider | • Allows case-by-case approach ensuring most appropriate choice of provider for client depending on the nature of their disability<br>• Allows LSC checkpoint to approve circumstances (including meeting Essential [quality] Criteria) | • It has not been possible in this exercise to link exceptional difficulties in changing provider to a particular class or type of client therefore it is hard to conceive of a robust system which identified exactly what exceptional circumstances apply<br>• Clinical outcomes would be most effective marker for exceptional circumstances. This would pose difficulties however and a possible conflict of interest given that providers are engaged in challenging those clinicians views and decisions in the MHT<br>• It is estimated that it would take a minimum of 6 months to design a system based on clinical outcomes given the | **Not recommended:** experience shows impractical and likely to be applied inconsistently, and furthermore may introduce unfair practices |

| | | | |
|---|---|---|---|
| | | current lack of data increasing uncertainty and shortening contracts<br>• Experience of Exceptional Case assessment by the LSC (i.e. where case exceeds costs limits, escapes the Fixed Fee scheme and is paid in full) shows that it is very resource-intensive and it is hard to convince providers that consistent decisions are being made<br>• Providers have previously demonstrated inconsistent interpretation of clear guidance on Exceptional Case and Fixed Fee Scheme<br>• LSC currently lacks the resources to manage effectively and ensure consistency: Mental Health Unit is at capacity<br>• Difficult to draft and apply rules that are fair<br>• Many clients may want to retain advisor even if they do not meet exceptional circumstances and may therefore try to do so<br>• Further administrative burden on providers<br>• Uncertain how many clients this would apply to in practice<br>• Possibly open to challenge | |
| Individual arrangements at each hospital | • Takes differences in hospitals including ethos and National Units into account<br>• Could allow a different option to be taken at each hospital, for example no change at Ashworth and an expanded list of providers at Broadmoor | • Hospitals' approach being aligned<br>• This exercise has not uncovered any particular different needs for National Units, especially considering individual client variation<br>• Likely to increase client perception of unfairness | **Not recommended:** this exercise shows that client issues with changes are broadly the same in each hospital |

| | | | |
|---|---|---|---|
| | | • Would require substantial amendments to the contract the LSC holds with providers and possibly a full retender<br>• Confusion for LSC Contract Managements, further administrative burden on providers | |
| Wider choice of provider (e.g. 10) at each hospital through additional tender or extending number of 2010 contracts | • Mitigates client dissatisfaction about lack of choice and fears of collusion<br>• Reduced number of clients who need to change solicitor due to the tender | • Any attempt to amend the contract is likely to be in breach of Public Procurement Regulations 2006 since alters outcome of tender<br>• May require termination and re-tender<br>• May be open to challenge from successful providers who have lawfully won contracts<br>• May require overallocation of NMS<br>• Would require extensive consultation and development (6 months+) creating further uncertainty and shortening contracts | **Not recommended:** likely to encourage reciprocal challenge and may therefore create further uncertainty |
| Return to non competitive unlimited contracts | • Will remove potentially adverse outcome of the tender process (ie need to change legal adviser) | • Would require termination and re-tender<br>• Likely to create confusion in the hospitals<br>• Reduces baseline of quality<br>• LSC lacks resources to Contract Manage large number of providers closely so unscrupulous behaviour likely to continue | **Not recommended:** justification for termination and re-tender does not seem strong |

### *Exceptional Circumstances*

The use of exceptional circumstances, as detailed in the table above, merits further discussion since this was the solution suggested by The Law Society and a number of providers whilst the impact assessment process was being developed. The providers included some that set out 'exceptional circumstances' when requesting that they be permitted to continue representing particular clients. Despite the extensive nature of this exercise, it has not been possible to link exceptional difficulties in changing provider to a particular class of client.

In order to avoid potential disability discrimination, it would seem most appropriate to define exceptional circumstances in terms of clinical outcomes i.e. a threshold of negative clinical impact above which it would be appropriate to allow a client to retain their provider. This introduces problems of its own. Providers are not able to provide an expert clinical opinion on clients (except by recourse to expert witnesses). The only figures that would be able to do so in the HSH are the medical staff. Providers are very often engaged in challenging the clinical opinions of medical staff. There is therefore a potential for a conflict of interest for both providers and medical staff if they were to collaborate on providing evidence to support a client retaining a particular provider, not to mention a significant administrative burden. In addition, this exercise has indicated that such collaboration (and the resultant decisions) would encourage feelings of paranoia in some patients, for example those that do not meet the threshold. Furthermore, the LSC currently lacks any clinical data to base such a system on. In order to institute such a system, considerable additional work would be required, at this point estimated at 6 months or greater.

Experience of Exceptional Case assessment (i.e. cases which escape the Fixed Fee scheme due to their length) by the LSC's Mental Health Unit (MHU) suggests that an additional exceptional circumstances system would be impractical. Despite the LSC producing guidance, there has been some difficulty convincing providers of the consistency of its decision-making. This has led to a considerable number of appeals and complaints. Not only does considering circumstances on a case-by-case basis require considerable resource, but appeals and complaints add to this burden. We believe the LSC currently lacks the resources to implement and monitor such an exceptional circumstances system.

Even if we were able to develop a clear and unequivocal system and devolved powers were given to providers to run such a system themselves, past experience shows different providers would interpret the rules in different ways. This which would lead to unfairness in the way the rules are applied. For example, even the Fixed Fee scheme has been interpreted in very different ways by providers. Not only that, but clients may be encouraged by the system to try to present the clinical symptoms that may justify continuing with the same provider. The LSC believes the likelihood of introducing unjustified inequality between clients in HSHs due to the difficulties of designing an effective 'exceptional circumstances' system outweighs the potential benefits for individuals.

# 13 Next steps

Consideration of the equality duties suggests that there is no evidence of discrimination and we have taken into account all appropriate opportunities to advance equality and foster good relations. We will therefore not alter contracting arrangements immediately. However we will seek views on our conclusions and consider any feedback

We will also:

- Maintain links developed with HSHs through this exercise, in particular to identify and intervene in questionable provider practices

- Consider more carefully the practicality of directly consulting with clients on policy changes, particularly where they are disabled or members of another marginalised group

- Ensure any future contracting changes in HSHs are communicated more effectively and in good time in order to support clients and minimise paranoia and uncertainty

- We will write to those providers that have won HSH contracts asking them to provide further information about their solicitors and the services they provide to clients, potentially including provision of marketing materials or attendance at a patient group

**Monitoring and review**

As detailed above we would like to seek views of all stakeholders on this decision (and the rationale we have identified which supports it) and in particular the options detailed above. Views on how it could be possible to rapidly develop a robust, objective, efficient exceptional circumstances system or the impact of extending the number of providers available without a re-tender or full consultation would be particularly welcomed. Respondents are reminded that at this stage we can find no evidence of direct or indirect discrimination. Therefore, whilst we wish to explore the issues further there appears to be no legal imperative to take urgent mitigating action at this time.

Initial views should be sent by close of business on **Friday 29th July 2011** to:

oliver.toop@legalservices.gsi.gov.uk
zoe.farrant@legalservices.gsi.gov.uk

## Annex A – Provider Data on tender outcome and working in HSHs 09/08-08/09[23]

### 1. Tender Outcome Summary

| Hospital | No. Providers carrying out work 08/09 | No. Providers carrying out >30[24] cases 08/09 | No. Applicant organisations | Published NMS allocations | NMS tendered for | NMS allocated |
|---|---|---|---|---|---|---|
| Ashworth | 16 | 2 | 9 | 280 | 710 | 323 |
| Broadmoor | 32 | 3 | 24 | 290 | 2356 | 314 |
| Rampton | 36 | 3 | 22 | 380 | 1690 | 381 |

### 2. Ashworth Hospital

| Bidder Name | Pass/fail | Position | Selection Score | NMS Requested | NMS Capped[25] | NMS Awarded | HSH restricted cases closed 09/08-08/09[26] |
|---|---|---|---|---|---|---|---|
| Peter Edwards Law | Pass | 1 | 18 | 150 | 125 | 125 | 137 |
| JACKSON & CANTER LLP | Pass | 2 | 10 | 30 | 30 | 30 | 3 |
| Swain & Co Solicitors | Pass | 3 | 9 | 30 | 30 | 30 | 0 |
| Duncan Lewis & Co | Pass | 3 | 9 | 100 | 100 | 54 | 0 |
| Duncan Lewis & Co | Pass | 3 | 9 | 100 | 100 | 54 | 0 |
| RMNJ Solicitors | Pass | 4 | 8 | 90 | 90 | 30 | 51 |
| Provider A[27] | Fail | 7 | 6 | 30 | 30 | 0 | 12 |
| Provider B | Fail | 8 | 5 | 30 | 30 | 0 | 0 |
| Provider C | Fail | 9 | 1 | 150 | 75 | 0 | 0 |
| **Total** | | | | **710** | **610** | **323** | **203** |

[23] The accuracy of this data is dependent on correct reporting by providers according to our reporting guidance: due to provider error it is likely this data is incomplete
[24] i.e. the minimum contract size for the HSH tender
[25] At 150 NMS per Full Time Equivalent Caseworker
[26] As reported with correct HSH postcodes
[27] These names are for the sake of failed and absent bidders' anonymity and where the same provider has tendered across more than one hospital the names do not match

**Organisations not tendering**

| Name | HSH restricted cases closed 09/08-08/09 |
|---|---|
| Provider D | 5 |
| Provider E | 4 |
| Provider F | 2 |
| Provider G | 2 |
| Provider H | 2 |
| Provider I | 2 |
| Provider J | 2 |
| Provider K | 1 |
| Provider L | 1 |
| Provider M | 1 |
| Provider N | 1 |
| Provider O | 1 |
| **Total** | **24** |

## 3. Broadmoor Hospital

| Name | Pass/fail | Position | Selection Score | NMS Requested | NMS Capped | NMS Awarded | HSH restricted cases closed 09/08-08/09 |
|---|---|---|---|---|---|---|---|
| Scott-Moncrieff, Harbour & Sinclair | Pass | 1 | 18 | 120 | 120 | 120 | 0 |
| Burke Niazi Solicitors | Pass | 2 | 17 | 40 | 40 | 40 | 0 |
| Blavo & Co Solicitors | Pass | 3 | 14 | 150 | 150 | 94 | 1 |
| Gledhill Solicitors | Pass | 3 | 14 | 30 | 27 | 30 | 17 |
| Wolton and Co. | Pass | 3 | 14 | 30 | 30 | 30 | 5 |
| Provider A | Fail | 6 | 13 | 75 | 75 | 0 | 45 |
| Provider B | Fail | 6 | 13 | 50 | 50 | 0 | 1 |
| Provider C | Fail | 8 | 12 | 50 | 50 | 0 | 3 |
| Provider D | Fail | 9 | 10 | 40 | 40 | 0 | 0 |
| Provider E | Fail | 9 | 10 | 500 | 290 | 0 | 37 |
| Provider F | Fail | 11 | 9 | 30 | 30 | 0 | 8 |
| Provider G | Fail | 11 | 9 | 100 | 100 | 0 | 24 |
| Provider G | Fail | 11 | 9 | 100 | 100 | 0 | |
| Provider G | Fail | 11 | 9 | 50 | 50 | 0 | |
| Provider G | Fail | 11 | 9 | 30 | 30 | 0 | |
| Provider G | Fail | 11 | 9 | 100 | 83 | 0 | |
| Provider G | Fail | 11 | 9 | 50 | 50 | 0 | |
| Provider G | Fail | 11 | 9 | 100 | 100 | 0 | |
| Provider G | Fail | 11 | 9 | 100 | 100 | 0 | |
| Provider H | Fail | 13 | 8 | 60 | 60 | 0 | 30 |
| Provider I | Fail | 13 | 8 | 30 | 30 | 0 | 0 |
| Provider J | Fail | 15 | 7 | 30 | 30 | 0 | 1 |
| Provider K | Fail | 15 | 7 | 30 | 30 | 0 | 0 |
| Provider L | Fail | 15 | 7 | 30 | 30 | 0 | 5 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Provider M | Fail | 15 | 7 | 30 | 30 | 0 | 0 |
| Provider N | Fail | 19 | 6 | 36 | 36 | 0 | 6 |
| Provider O | Fail | 20 | 5 | 30 | 30 | 0 | 0 |
| Provider P | Fail | 21 | 3 | 60 | 60 | 0 | 0 |
| Provider Q | Fail | 21 | 3 | 75 | 75 | 0 | 0 |
| Provider R | Fail | 23 | 1 | 50 | 50 | 0 | 0 |
| Provider S | Fail | 23 | 1 | 150 | 150 | 0 | 0 |
| **Total** | | | | **2356** | **2126** | | **183** |

**Organisations not tendering**

| Name | HSH restricted cases closed 09/08-08/09 |
|---|---|
| Provider T | 8 |
| Provider U | 5 |
| Provider V | 5 |
| Provider W | 3 |
| Provider X | 3 |
| Provider Y | 3 |
| Provider Z | 2 |
| Provider AA | 2 |
| Provider AB | 2 |
| Provider AC | 2 |
| Provider AD | 2 |
| Provider AF | 2 |
| Provider AG | 2 |
| Provider AH | 2 |

| | |
|---|---|
| Provider AI | 1 |
| Provider AJ | 1 |
| Provider AK | 1 |
| Provider AL | 1 |
| Provider AM | 1 |
| **Total** | **48** |

## 4. Rampton Hospital

| Name | Pass/fail | Position | Selection Score | NMS Requested | NMS Capped | NMS Awarded | HSH restricted cases closed 09/08-08/09 |
|---|---|---|---|---|---|---|---|
| Peter Edwards Law | Pass | 1 | 18 | 30 | 30 | 30 | 18 |
| Scott-Moncrieff, Harbour & Sinclair | Pass | 1 | 18 | 110 | 110 | 110 | 0 |
| SWITALSKIS | Pass | 1 | 18 | 80 | 75 | 75 | 7 |
| Burke Niazi Solicitors | Pass | 4 | 17 | 40 | 40 | 40 | 0 |
| Cartwright King | Pass | 5 | 14 | 150 | 150 | 96 | 44 |
| Donovan Newton Solicitors | Pass | 5 | 14 | 45 | 45 | 30 | 0 |
| Provider A | Fail | 7 | 13 | 60 | 60 | 0 | 13 |
| Provider B | Fail | 8 | 12 | 60 | 60 | 0 | 0 |
| Provider C | Fail | 9 | 10 | 45 | 45 | 0 | 16 |
| Provider D | Fail | 9 | 10 | 30 | 28 | 0 | 4 |
| Provider E | Fail | 9 | 10 | 30 | 30 | 0 | 0 |
| Provider F | Fail | 12 | 9 | 80 | 80 | 0 | 43 |
| Provider G | Fail | 12 | 9 | 40 | 40 | 0 | 12 |
| Provider H | Fail | 12 | 9 | 30 | 30 | 0 | 0 |
| Provider I | Fail | 12 | 9 | 100 | 100 | 0 | 2 |
| Provider I | Fail | 12 | 9 | 50 | 50 | 0 | |
| Provider I | Fail | 12 | 9 | 80 | 80 | 0 | |
| Provider I | Fail | 12 | 9 | 100 | 83 | 0 | |
| Provider I | Fail | 12 | 9 | 80 | 80 | 0 | |
| Provider I | Fail | 12 | 9 | 100 | 96 | 0 | |
| Provider J | Fail | 16 | 8 | 30 | 30 | 0 | 0 |
| Provider K | Fail | 16 | 8 | 50 | 50 | 0 | 26 |
| Provider L | Fail | 18 | 7 | 30 | 30 | 0 | 0 |
| Provider M | Fail | 19 | 6 | 10 | 10 | 0 | 0 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Provider N | Fail | 20 | 5 | 30 | 30 | 0 | 0 |
| Provider O | Fail | 21 | 1 | 150 | 150 | 0 | 0 |
| Provider P | Fail | 21 | 1 | 50 | 50 | 0 | 0 |
| **Total** | | | | **1690** | **1662** | **381** | **185** |

**Organisations not tendering**

| Name | HSH restricted cases closed 09/08-08/09 |
|---|---|
| Kaim Todner | 30 |
| Donovan Newton | 23 |
| Hogans | 9 |
| Dale & Co | 7 |
| Bryan & Armstrong | 6 |
| Blavo & Co | 5 |
| Alistair Bateman | 3 |
| Campbell Law | 2 |
| Christian Khan | 2 |
| Bindmans LLP | 2 |
| Roebucks | 2 |
| Inyama & Co | 2 |
| Graham Stowe Bateson | 5 |
| HC Solicitors LLP | 2 |
| Best Solicitors | 2 |
| Kieran Clarke | 2 |
| Ann Mear & Co | 2 |
| Larken & Co | 2 |

| | |
|---|---|
| Miles & Partners | 1 |
| Oxford Law Group | 1 |
| Aaskells | 1 |
| Hadaway & Hadaway | 1 |
| The Ringrose Law Group | 1 |
| Pickup & Scott | 1 |
| Sills & Betteridge | 1 |
| Irwin Mitchell LLP | 1 |
| **Total** | **116** |

## Annex B – Frequency of HSH clients changing provider

**Dataset: Cases Closed in 2008/09**

| | Number of Different Providers Used in Year | Number of Clients | | | | Proportion of Clients | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only |
| 2008/09 | **1** | 594451 | 24074 | 23683 | 496 | 94.20% | 91.46% | 91.59% | 92.71% |
| | **2** | 33265 | 1983 | 1916 | 37 | 5.27% | 7.53% | 7.41% | 6.92% |
| | **3** | 2906 | 227 | 222 | 1 | 0.46% | 0.86% | 0.86% | 0.19% |
| | **4** | 345 | 32 | 32 | 0 | 0.05% | 0.12% | 0.12% | 0.00% |
| | **5** | 67 | 4 | 4 | 0 | 0.01% | 0.02% | 0.02% | 0.00% |
| | **6** | 17 | 1 | 1 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **7** | 4 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **8** | 3 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **9** | 1 | 0 | 0 | 1 | 0.00% | 0.00% | 0.00% | 0.19% |
| | **10** | 1 | 1 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **More than 10** | 2 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | | | | | | | | | |
| | **Totals** | **631062** | **26322** | **25858** | **535** | 100.00% | 100.00% | 100.00% | 100.00% |

**Dataset: Cases Closed in 2009/10**

| | Number of Different Providers Used in Year | Number of Clients | | | | Proportion of Clients | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only |
| 2009/10 | **1** | 609647 | 27086 | 26702 | 472 | 94.30% | 92.66% | 92.72% | 96.13% |
| | **2** | 33641 | 1909 | 1865 | 16 | 5.20% | 6.53% | 6.48% | 3.26% |
| | **3** | 2751 | 206 | 203 | 3 | 0.43% | 0.70% | 0.70% | 0.61% |
| | **4** | 341 | 24 | 23 | 0 | 0.05% | 0.08% | 0.08% | 0.00% |
| | **5** | 66 | 6 | 6 | 0 | 0.01% | 0.02% | 0.02% | 0.00% |
| | **6** | 20 | 1 | 1 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **7** | 13 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **8** | 6 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **9** | 4 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **10** | 0 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **More than 10** | 3 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | | | | | | | | | |
| | **Totals** | **646492** | **29232** | **28800** | **491** | 100.00% | 100.00% | 100.00% | 100.00% |

**Dataset: Cases Closed in 2008/10**

| | Number of Different Providers Used Over Both Years | Number of Clients | | | | | Proportion of Clients | | |
|---|---|---|---|---|---|---|---|---|---|
| | | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only | All Civil Cases | All MH Cases | non-HSH Cases Only | HSH Cases Only |
| 2008/10 | **1** | 1060505 | 41390 | 40968 | 717 | 90.72% | 87.19% | 87.40% | 88.41% |
| | **2** | 94364 | 5070 | 4932 | 78 | 8.07% | 10.68% | 10.52% | 9.62% |
| | **3** | 11635 | 801 | 771 | 12 | 1.00% | 1.69% | 1.64% | 1.48% |
| | **4** | 1878 | 150 | 147 | 3 | 0.16% | 0.32% | 0.31% | 0.37% |
| | **5** | 401 | 42 | 41 | 0 | 0.03% | 0.09% | 0.09% | 0.00% |
| | **6** | 124 | 13 | 12 | 0 | 0.01% | 0.03% | 0.03% | 0.00% |
| | **7** | 51 | 3 | 0 | 0 | 0.00% | 0.01% | 0.00% | 0.00% |
| | **8** | 18 | 0 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **9** | 15 | 1 | 1 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | **10** | 11 | 0 | 0 | 1 | 0.00% | 0.00% | 0.00% | 0.12% |
| | **More than 10** | 16 | 1 | 0 | 0 | 0.00% | 0.00% | 0.00% | 0.00% |
| | | | | | | | | | |
| | **Totals** | **1169018** | **47471** | **46872** | **811** | 100.00% | 100.00% | 100.00% | 100.00% |

## Annex C – Evidence Collection Methodology

The evidence collection methodology was in the first instance developed with the Legal Services Research Centre, the independent research arm of the LSC. Their expertise in qualitative and quantitative social research was used to design a methodology that was appropriate, ethical, swift and reliable. Further advice and assistance on particularly accessibility issues was sought from the Equality and Diversity Team within Service Development at the LSC. Finally, all client-facing materials were signed off by the HSHs in each instance. As the methodology was developed, feedback and agreement was sought at each stage from the clinical, management and client-engagement staff at the hospitals. Where possible, an analogous methodology was used in each hospital, but the practicalities of organising Focus Groups in distinct institutions meant that a completely identical process was impossible. Finally confirmation from the NHS National Research Ethics Service was gained that a Medical Ethics Committee was not required to oversee this work.

### Client Focus Groups

The LSC was advised early on that a central part of the evidence that should be collected should be from facilitated discussions with representative groups of clients. This is in order to gain qualitative views in a reliable way where any questions arising could be answered by LSC staff i.e. understanding was assured. It was agreed that a minimum of 3 of these groups should be carried out in each hospital. The groups were arranged with hospital staff and publicised in advance in the appropriate patient fora (e.g. via the 'Patients' Council' and ward representatives). Operational concerns such as security, availability of patients, and availability of hospital staff meant that there was some variation in attendance of meetings. A number were cancelled due to both operational restrictions and lack of interest.

Copies of the questionnaire and explanatory letter were provided to clients in advance of the meetings. LSC staff (variously Oliver Toop, Zoe Farrant and Jake Kraft) ran through the background and aims of the work briefly at the beginning of each session, answering any questions that arose. During the course of the meetings, discussions were allowed to flow freely with the emphasis on collecting evidence about the issues clients felt most strongly about. However, there were a number of specific subject areas that LSC staff encouraged clients to discuss at each meeting:

- Have you had to change provider? How has it/would it affect you?
- What do you like and dislike about your solicitor? Which is more important: your relationship with them or their legal advice and knowledge? Which is more important: a provider from your home area or one local to the HSH?
- How important is choice to you? What minimum number of providers should be available to choose from?
- What else stops you getting the advice you need?
- What do you think of the different rules for those clients transferred in to HSHs compared with those already resident?

The following table summarises the attendance at each meeting:

| Hospital | Date | Comments/composition |
|---|---|---|
| Ashworth | 09/03/2011 | Patients' Forum, c.20 minute discussion slot, c.20 clients, representing most wards in the hospital |
| | 30/03/2011 | Newsletter Group, 1 hour discussion, 5 clients |
| | 30/03/2011 | Standalone Focus Group: **cancelled due to lack of interest** |
| Broadmoor | 06/04/2011 | Patients' Forum, 10 minute introduction and collection of initial feedback, c.15 clients, representing most wards in the hospital |
| | 11/04/2011 | Standalone Focus Group, 1 hour discussion, 4 clients |
| | 11/04/2011 | Standalone Focus Group: **cancelled due to lack of interest** |
| Rampton | 05/04/2011 | Patients' Council, included PD, learning disabilities and women, 30 minute discussion, c.30 clients |
| | 14/04/2011 | Meeting with individual PD client, 1 hour discussion[28] |
| | 14/04/2011 | Standalone Focus Group, National Deaf Unit, 1.5 hour discussion, 9 clients |
| | 14/04/2011 | Meeting with individual PD client, 1 hour |
| | 14/04/2011 | Standalone Focus Group, Mental Illness: **cancelled due to hospital lockdown** |

**Client Questionnaires**

The LSRC advised that quantitative questionnaire responses should not be the primary method of data collection. However, the LSRC also advised that questionnaires and Focus Groups would encourage responses from clients with different preference for engagement method and different personality types, for example Focus Groups attracting the more vocal and extroverted clients and questionnaires allowing those who are more reticent and introverted to respond. Whilst quantitative responses were collected, the questionnaires also contained questions allowing qualitative, free text responses.

[28] Larger group in PD unit cancelled due to hospital lockdown

Questionnaires and an accompanying explanatory letter were sent to all clients in all HSHs. The questionnaire and letter were also translated into Easy Read format and made available to clients. Clients were allowed 2 weeks to return completed questionnaires to nominated hospital staff.

Response rates were as follow:

| Hospital | Total number patients | Total responses | Response rate |
|---|---|---|---|
| Ashworth | 275 | 21 | 7.6%[29] |
| Broadmoor | 260 | 39 | 15.0% |
| Rampton | 400 | 78 | 19.5% |

***Informed Consent***

It is standard practice in social research to ask for informed consent from the subject for their responses to be used in the research. In this case informed consent was asked from clients to check that they understood that their responses would be used anonymously and would also be used to provide evidence to determine whether the way mental health legal services are delivered in their HSH should be changed. Informed consent (name and signature) were given by 91% of respondents. The responses given by those who did not provide informed consent have been discounted. This was 5 respondents from Ashworth, 4 from Broadmoor and 2 from Rampton.

Interestingly, a number of respondents stated they were unhappy to give their name, particularly as the section in question stated that responses would be used anonymously. It was unfortunate that their responses had to be discounted.

The standard format questionnaire, letter text and equal opportunities monitoring form follow:

"Service User
Hospital Name
Hospital Address

3rd March 2011

**Re. Your views on the legal advice you receive**

[29] Anecdotal evidence from staff indicated that fewer clients in Ashworth had had to change provider since large, historic providers had on the whole won contracts,

The Legal Services Commission runs the legal aid system in England and Wales. This includes the free mental health legal advice you can receive in Hospital Name from solicitors.

There have recently been changes to the way the legal advice in your hospital is provided. These changes happened after 15th November 2010. In the past any mental health solicitor was able to give you advice and represent you at tribunals in the hospital. Since 15th November there are now Number of Providers solicitors' firms who can advise and represent you as a matter of course. These solicitors competed for the right to advise and represent you and other service users in your hospital. This means that they are required to meet higher standards than other solicitors. It also means that you might have to change solicitor if your old solicitor isn't able to advise and represent you anymore.

The Legal Services Commission was taken to court last year by a group of solicitors who were unhappy with these changes. As a result, we are required to talk to service users, hospital staff and solicitors about the effect of the changes. We are particularly interested in finding out about the way the changes have affected you. Depending on what people say, we might make further changes.

If you want to let us know how these changes have affected you, you can do so in two ways:

1. Attending one of 3 focus groups we will shortly be running in your hospital; and/or
2. Responding to the questionnaire that is attached to this letter.

**1. Focus Groups**

We will have a general discussion about the questions that are raised in the questionnaire. There will be food and drink provided. We would like to meet with 3 groups of 10-15 people each. These will be held on Date of Focus Groups at Time 1, Time 2 and Time 3 in Name of room. There is only limited space, so if you would like to attend one of these groups you will need to tell Contact Name. It will be first come, first served.

**2. Questionnaire**

We would also like you to complete the attached questionnaire, even if you don't want to attend a focus group. In this way we can consider the views of as many service users as possible. You can also complete the questionnaire if you want to attend a focus group as well. There is an important part of the questionnaire called 'Informed Consent' that you must complete if we are to be able to consider your views. Once you have completed the questionnaire, please give it Contact Name who will pass it on to me. Please give it to Contact Name on or before 31st March 2011 if you want your views to be considered.

I would like to reassure you that any views you would like to give us will be treated as anonymous and confidential. It will not affect your treatment or the length of your stay in hospital. If you don't feel able to come to a focus group or answer the questionnaire then this won't have any effect on your treatment or length of stay in hospital either. If you are not sure about giving us information then please talk to your advocates or doctors.

Thank you for taking the time to read this letter. I look forward to hearing your views.

Yours faithfully

Olly Toop
Mental Health Policy Developer
Legal Services Commission"

## QUESTIONNAIRE

Please return to Name of Contact by 31st March 2011 when you have completed it.

**1. A. How often have you changed solicitor's firm over the past 2 years ?**

| Never | Once | Twice | Three or more times? |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**B. If you have changed solicitor's firm what was your reason for doing so?**

_____

_____

**2. Overall, how would you rate the advice and representation you have received from the solicitor's firms you have used?**

| Poor | Average | Good | Very Good |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**3. A. If you are forced to change your solicitor's firm do you feel this will have a negative effect on you?**

| Not at all | A little | Some/Moderate | Very Much |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**B. What kind of negative effect would being forced to change solicitor's firm have on you?**

_____

_____

**4. Would you be happy to change solicitor's firm if they were able to give you better advice and representation?**

| No | No with reservations | Yes with reservations | Yes |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**5. A. How long does it take for you to develop a good relationship with a new solicitor or firm?**

| Within 1 week | Within 2-4 weeks | Within 1-6 months | >6 months |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

**B. What kind of things are important to you within your relationship with a solicitor?**

_____

_____

**6. Which is more important to you: the quality of advice given by a solicitor or your relationship with them?**

| Quality of advice | Both are equally important | Relationship with solicitor |
|---|---|---|
| ☐ | ☐ | ☐ |

**7. Do you think you would get a better service from a solicitor if you have a larger number of firms to choose from?**

| Yes | No | Don't know |
|---|---|---|
| ☐ | ☐ | ☐ |

**B. What is the minimum number of solicitors firms you would like to be able to choose from?**

| <6 | 6-10 | >10 |
|---|---|---|
| ☐ | ☐ | ☐ |

**8. Is there anything else that makes it difficult for you to get the right solicitor?**

_____

_____

**9. Do you have anything else you would like to add?**

## INFORMED CONSENT:

I, the undersigned, understand that the information I have provided here will be used to decide whether to make changes to mental health legal aid services in my hospital. I also understand that the information I provide will only used anonymously.

**Name:** .....

**Signature:**.....

**Equal Opportunities Form**

**Your answers to the following questions will help us to better understand your needs and consider ways to improve our services.**

**We will keep the information that you provide confidential and will use it only in a form whereby you will not be identified.**

**1. Are you male or female? Please tick one**

□ Male

□ Female

**2. Do you currently live or plan to live in the gender opposite to your gender at birth?**

□ Yes

□ No

**3. How old are you? Please tick one**

□ 18-24

□ 25-34

□ 35-44

□ 45-54

□ 55-64

□ 65+

□ Prefer not to say

**4. Which of the following best describes your ethnic group? Please tick one**

White

- ❑ British
- ❑ Irish
- ❑ Other White background

Asian or Asian British

- ❑ Bangladeshi
- ❑ Indian
- ❑ Pakistani
- ❑ Other Asian background

Black or Black British

- ❑ African
- ❑ Caribbean
- ❑ Other Black background

Mixed ethnic background

- ❑ Mixed White and Asian
- ❑ Mixed White and Black African
- ❑ Mixed White and Black Caribbean
- ❑ Other mixed background

- ❑ Chinese
- ❑ Other
- ❑ Prefer not to say

**5. Which of these best describes your religion or belief? Please tick one**

- □ Buddhist
- □ Christian
- □ Hindu
- □ Jewish
- □ Muslim
- □ Sikh
- □ Other
- □ Agnostic
- □ Atheist
- □ None
- □ Prefer not to say

**6. Please tick any of the following that apply to you?**

- □ Blind or Visual Impairment
- □ Deaf or Hearing Impairment
- □ Learning Difficulty
- □ Mental Health condition
- □ Mobility
- □ Other disability
- □ Prefer not to say
- □ None of these

**7. What is your preferred language or method of communication?**

- □ British Sign Language
- □ Sign Supported English

- □ Makaton
- □ English
- □ Welsh
- □ Other , please state _____
- □ Prefer not to say

**8. How would you describe your sexual orientation? Please select one**

- □ Heterosexual
- □ Gay man
- □ Lesbian
- □ Bisexual
- □ Other
- □ Prefer not to say

Thank you for completing this form.

**Provider Questionnaire**

A comparable, rephrased questionnaire along with an explanatory letter was sent via email to all current mental health providers on 28th March with 10 working days to respond. Some respondents indicated that they considered the questionnaire was inappropriate and impossible to answer: on the whole this referred to the request to estimate average frequency of changing of providers by clients (and the other quantitative questions requiring average estimation), but as with clients, free text sections were available to record any caveats or concerns about answering such questions.

Of 191 providers 19 responded to the questionnaire. Of these, 8 had failed to win HSH contracts (38%), 5 had won HSH contracts (24%) and 7 had not tendered (33%). This means the results are likely to be highly skewed because 62% of respondents have a vested interest in the outcome of the EIA.

**Hospital Staff Questionnaires**

Rephrased questionnaires were distributed in advance of and at all meetings with hospital staff. It was suggested by the LSC that if hospital staff did not feel their individual views had been reflected in discussions or that they thought of an additional point after the meetings they could return the completed questionnaire. However, this was not a requirement and in the event only 2 questionnaires were received each from the clinical staff at Rampton & Broadmoor and 2 from advocacy staff at Broadmoor. They were therefore discounted from the data analysis because the response rate was too low to draw any justifiable conclusions.

**Hospital Staff Meetings**

In a similar way to Client Focus Groups, a brief introduction to the background and aims of this exercise along with an opportunity to ask any questions were given at the start of each meeting. Briefings on the work had already been distributed alongside questionnaires. The same approach to discussions as the Client Focus Groups was taken with the following questions asked if not raised independently:

- Have clients had to change provider? How has it/would it affect them?
- What is good and bad about solicitors? Which is more important to a client: their relationship with them or their legal advice and knowledge? Which is more important: a provider from the client's home area or one local to the HSH?
- How important is choice to clients? What minimum number of providers should be available to choose from?
- What else stops clients getting the advice you need?
- What do you think of the different rules for those clients transferred in to HSHs compared with those already resident?

The following table summarises the meetings attended:

| Hospital | Date | Comments/composition |
|---|---|---|
| Ashworth | 02/03/2011 | Medical Advisory Committee: Medical Director and c.20 clinicians |
| | 02/03/2011 | Advocacy Services: Advocacy Services Manager & 1 advocate |
| | 30/03/2011 | Social Workers: Head of Forensic Social Care and 3 Social Workers |
| | N/A | Mental Health Act Administrator: did not want to participate due to inability to answer questions |
| Broadmoor | 21/02/2011 | Medical Advisory Committee: Medical |

| | | |
|---|---|---|
| | | Director, Mental Health Act Administrator and c.30 clinicians |
| | 21/02/2011 | Advocacy Services: Advocacy Services Manager & 3 advocates |
| | 06/04/2011 | Social Worker: 1 Social Worker |
| | 11/04/2011 | Social Workers: Social Work Team Manager & 4 Social Workers |
| Rampton | 21/03/2011 | Medical Advisory Committee: Medical Director & c.20 clinicians |
| | 21/03/2011 | Mental Health Act Administrator and Social Workers: Deputy Mental Health Act Administrator, Social Work Manager & 3 Social Workers |
| | 21/03/2011 | Advocacy Services: Advocacy Services Manager & 1 advocate |

**Interest Groups**

The Administrative Justice & Tribunals Council, Tribunal Service Mental Health and the Equality & Human Rights Commission were sent comparable letters and questionnaires on 29/03/2011, once again allowing 10 working days to respond. Whilst no response was received from EHRC, the AJTC forwarded the letter and questionnaire to the Care Quality Commission, who then responded.

An oversight was made at the time, and letters and questionnaires were not sent to The Law Society and Mental Health Lawyers' Association until 20/04/2011. As with other consultees, 10 working days were allowed to respond, but responses were requested as soon as possible due to pressure on the original timetable.

**Annex D – Client Evidence**

***A – Quantitative data***

1.A. How often have you changed solicitor over the past 2 years?

| | Never | | Once | | Twice | | Three times or more | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AH | 12 | 80.0% | 2 | 13.3% | 1 | 6.7% | 0 | 0.0% | 15 | 15 | 100.0% |
| BH | 22 | 55.0% | 12 | 30.0% | 5 | 12.5% | 1 | 2.5% | 40 | 40 | 100.0% |
| RH | 41 | 54.7% | 16 | 21.3% | 10 | 13.3% | 8 | 10.7% | 75 | 76 | 98.7% |
| Total | 75 | 57.7% | 30 | 23.1% | 16 | 12.3% | 9 | 6.9% | 130 | 131 | 99.2% |

2. Overall, how would you rate the quality of advice and representation you have received from the solicitor's firms you have used?

| | Poor | | Average | | Good | | Very Good | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AH | 1 | 6.7% | 4 | 26.7% | 4 | 26.7% | 6 | 40.0% | 15 | 15 | 100.0% |
| BH | 2 | 5.1% | 8 | 20.5% | 11 | 28.2% | 18 | 46.2% | 39 | 40 | 97.5% |
| RH | 7 | 9.5% | 14 | 18.9% | 26 | 35.1% | 27 | 36.5% | 74 | 76 | 97.4% |
| Total | 10 | 7.8% | 26 | 20.3% | 41 | 32.0% | 51 | 39.8% | 128 | 131 | 97.7% |

3.A. If you are forced to change your solicitor's firm do you feel this will have a negative effect on you?

| | Not at all | | A little | | Some/Moderate | | Very much | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AH | 2 | 13.3% | 3 | 20.0% | 4 | 26.7% | 6 | 40.0% | 15 | 15 | 100.0% |
| BH | 5 | 12.8% | 7 | 17.9% | 4 | 10.3% | 23 | 59.0% | 39 | 40 | 97.5% |
| RH | 21 | 29.2% | 8 | 11.1% | 15 | 20.8% | 28 | 38.9% | 72 | 76 | 94.7% |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total | 28 | 22.2% | 18 | 14.3% | 23 | 18.3% | 57 | 45.2% | 126 | 131 | 96.2% |

4. Would you be happy to change solicitor's firm if they were able to give you better advice and representation?

| | No | | No with reservations | | Yes with reservations | | Yes | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AH | 9 | 60.0% | 0 | 0.0% | 3 | 20.0% | 3 | 20.0% | 15 | 15 | 100.0% |
| BH | 12 | 31.6% | 1 | 2.6% | 11 | 28.9% | 14 | 36.8% | 38 | 40 | 95.0% |
| RH | 28 | 38.4% | 5 | 6.8% | 13 | 17.8% | 27 | 37.0% | 73 | 76 | 96.1% |
| Total | 49 | 38.9% | 6 | 4.8% | 27 | 21.4% | 44 | 34.9% | 126 | 131 | 96.2% |

5.A. How long does it take you to develop a good relationship with a new solicitor or firm?

| | Within 1 week | | Within 2-4 weeks | | Within 1-6 months | | >6 months | | Total | Total Question naires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|
| AH | 1 | 6.7% | 1 | 6.7% | 5 | 33.3% | 8 | 53.3% | 15 | 15 | 100.0% |
| BH | 5 | 13.9% | 3 | 8.3% | 14 | 38.9% | 14 | 38.9% | 36 | 40 | 90.0% |
| RH | 9 | 12.7% | 7 | 9.9% | 25 | 35.2% | 30 | 42.3% | 71 | 76 | 93.4% |
| Total | 15 | 12.3% | 11 | 9.0% | 44 | 36.1% | 52 | 42.6% | 122 | 131 | 93.1% |

6. Which is more important to you: the quality of advice given by a solicitor or your relationship with them?

| | Quality of advice | | Both are equally important | | Relationship with solicitor | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| AH | 3 | 21.4% | 9 | 64.3% | 2 | 14.3% | 14 | 15 | 93.3% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| BH | 12 | 34.3% | 20 | 57.1% | 3 | 8.6% | 35 | 40 | 87.5% |
| RH | 22 | 29.3% | 50 | 66.7% | 3 | 4.0% | 75 | 76 | 98.7% |
| Total | 37 | 29.8% | 79 | 63.7% | 8 | 6.5% | 124 | 131 | 94.7% |

7.A. Do you think you would get a better service from a solicitor if you have a larger number of firms to choose from?

| | Yes | | No | | Don't know | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| AH | 7 | 50.0% | 4 | 28.6% | 3 | 21.4% | 14 | 15 | 93.3% |
| BH | 22 | 64.7% | 7 | 20.6% | 5 | 14.7% | 34 | 40 | 85.0% |
| RH | 27 | 37.0% | 30 | 41.1% | 16 | 21.9% | 73 | 76 | 96.1% |
| Total | 56 | 46.3% | 41 | 33.9% | 24 | 19.8% | 121 | 131 | 92.4% |

7.B. What is the minimum number of solicitor's firms you would like to be able to choose from?

| | <6 | | 6-10 | | >10 | | Total | Total Q'aires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| AH | 1 | 7.7% | 7 | 53.8% | 5 | 38.5% | 13 | 15 | 86.7% |
| BH | 6 | 18.2% | 4 | 12.1% | 23 | 69.7% | 33 | 40 | 82.5% |
| RH | 26 | 39.4% | 14 | 21.2% | 26 | 39.4% | 66 | 76 | 86.8% |
| Total | 33 | 29.5% | 25 | 22.3% | 54 | 48.2% | 112 | 131 | 85.5% |

***B – Qualitative Data***

| | 1.B. If you have changed solicitor's firm, what was your reason for doing so? | | | | | | | | | | | | Patient meetings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | AH | | BH | | RH | | | |
| **Hospital** | **AH** | | | **BH** | | | **RH** | | | **Total** | | | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 3** | **Grp 4** |
| Didn't think old provider was good enough quality | 2 | 66.7% | 13.3% | 9 | 42.9% | 22.5% | 10 | 30.3% | 13.2% | 21 | 36.8% | 16.0% | | | | | | | | |
| Forced to change by introduction of exclusive contracts | | | | 6 | 28.6% | 15.0% | 5 | 15.2% | 6.6% | 11 | 19.3% | 8.4% | | | | | | | | |
| Provider/solicitor could no longer represent | 1 | 33.3% | 6.7% | 2 | 9.5% | 5.0% | 5 | 15.2% | 6.6% | 8 | 14.0% | 6.1% | | | | | | | | |
| Hospital transfer | | | | 1 | 4.8% | 2.5% | 3 | 9.1% | 3.9% | 4 | 7.0% | 3.1% | | | | | | | | |
| Recommended a better provider | | | | | | | 3 | 9.1% | 3.9% | 3 | 5.3% | 2.3% | | √ | | | | | | √ |
| Legal reasons | | | | 2 | | | 1 | 3.0% | 1.3% | 3 | 5.3% | 2.3% | | | | | | | | |
| I don't have one | | | | | 0.0% | 0.0% | 2 | 6.1% | 2.6% | 2 | 3.5% | 1.5% | | | | | | | | |
| Personal circumstances | | | | | | | 1 | 3.0% | 1.3% | 1 | 1.8% | 0.8% | | | | | | | | |
| Not sure | | | | | | | 1 | 3.0% | 1.3% | 1 | 1.8% | 0.8% | | | | | | | | |
| Provider would not do full range of work in category | | | | | | | 1 | 3.0% | 1.3% | 1 | 1.8% | 0.8% | | | | | | | | |
| Needed provider in new category | | | | | | | 1 | 3.0% | 1.3% | 1 | 1.8% | 0.8% | | | | | | | | |
| Time for a change | | | | 1 | 4.8% | 2.5% | | | | 1 | 1.8% | 0.8% | | | | | | | | |
| **Total** | **3** | **3** | **15** | **21** | **21** | **40** | **33** | **33** | **76** | **57** | **57** | **131** | | | | | | | | |
| When first transferred in unaware what services were provided by solicitors | | | | | | | | | | | | | | √ | | | | | | |

| | 3.B. What kind of negative effect would being forced to change solicitor's firm have on you? | | | | | | | | | | | | Patient meetings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | AH | | BH | | RH | | | |
| **Hospital** | **AH** | | | **BH** | | | **RH** | | | **Total** | | | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 3** | **Grp 4** |
| Don't know new provider/lack of trust | 4 | 30.8% | 26.7% | 8 | 23.5% | 20.0% | 24 | 41.4% | 31.6% | 36 | 34.3% | 27.5% | √ | | | | √ | | | |
| Getting to know case | 3 | 23.1% | 20.0% | 11 | 32.4% | 27.5% | 8 | 13.8% | 10.5% | 22 | 21.0% | 16.8% | | √ | | | √ | | | √ |
| None | 2 | 15.4% | 13.3% | | | | 3 | 5.2% | 3.9% | 5 | 4.8% | 3.8% | | | | | | √ | | |
| I don't want to change | | | | 3 | 8.8% | 7.5% | 2 | 3.4% | 2.6% | 5 | 4.8% | 3.8% | | | | | | | | √ |
| Lack of choice | | | | 4 | 11.8% | 10.0% | 1 | 1.7% | 1.3% | 5 | 4.8% | 3.8% | | | | | √ | | √ | |
| Current provider very good | 2 | 15.4% | 13.3% | | | | 3 | 5.2% | 3.9% | 5 | 4.8% | 3.8% | | | | √ | | | | |
| Paranoia | 1 | 7.7% | 6.7% | 1 | 2.9% | 2.5% | 3 | 5.2% | 3.9% | 5 | 4.8% | 3.8% | | | | | √ | | | |
| Unknown quantity | 1 | 7.7% | 6.7% | 2 | 5.9% | 5.0% | 2 | 3.4% | 2.6% | 5 | 4.8% | 3.8% | | | | | | | | |
| Stress | | | | 2 | 5.9% | 5.0% | 2 | 3.4% | 2.6% | 4 | 3.8% | 3.1% | | | | | | | | √ |
| Lack of confidence | | | | 1 | 2.9% | 2.5% | 3 | 5.2% | 3.9% | 4 | 3.8% | 3.1% | | | | | | | | |
| Abandonment issues | | | | | | | 2 | 3.4% | 2.6% | 2 | 1.9% | 1.5% | | | | | | | | |
| Failure to secure release | | | | 1 | 2.9% | 2.5% | 1 | 1.7% | 1.3% | 2 | 1.9% | 1.5% | | | | √ | | | | |
| New providers pressure clients into MHT/focused on money | | | | | | | 1 | 1.7% | 1.3% | 1 | 1.0% | 0.8% | | | | | | | √ | |
| Various | | | | | | | 1 | 1.7% | 1.3% | 1 | 1.0% | 0.8% | | | | | | | | |
| Anger | | | | | | | 1 | 1.7% | 1.3% | 1 | 1.0% | 0.8% | | | | | | | | |
| Change | | | | | | | 1 | 1.7% | 1.3% | 1 | 1.0% | 0.8% | | | | | | | | |
| All the new providers are poor | | | | 1 | 2.9% | 2.5% | | | | 1 | 1.0% | 0.8% | | | | | | | | |
| **Total** | | **13** | **15** | **34** | **34** | **40** | | **58** | **76** | | **105** | **131** | | | | | | | | |
| Upset at first but once used to change fine | | | | | | | | | | | | | √ | | | | | √ | | |
| Upset that couldn't continue to be advised by provider from home area | | | | | | | | | | | | | √ | | | | | | | |
| Patient recommendations of old providers now irrelevant | | | | | | | | | | | | | √ | | | | | | √ | |
| Limitation is violation of Human Rights | | | | | | | | | | | | | √ | | | | | | √ | |
| Resentment and bitterness on wards | | | | | | | | | | | | | | √ | | | | | | |
| Changing provider has same impact as changing ward/consultant- delays progress | | | | | | | | | | | | | | √ | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| MHT process is very stressful | | | | | √ | | | | |
| Clients using JR route to retain the same provider | | | | | √ | | | | |
| Changing provider is very difficult because they don't forward case files etc. | | | | | | | | √ | |
| New provider is very good | | | | | | | √ | | |
| Provider without familiar interpretor caused communication difficulties | | | | | | √ | √ | | |
| Clients aren't listened to | | | | | | √ | | | √ |
| Those clients that change regularly will exhaust 5/6 very quickly | | | | | | √ | | | |
| | | | | | | | | | |

| | 5.B. What kind of things are important to you within your relationship with a solicitor? | | | | | | | | | | | | Patient meetings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | AH | | BH | | RH | | | |
| **Hospital** | **AH** | | | **BH** | | | **RH** | | | **Total** | | | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 3** | **Grp 4** |
| Trust | 2 | 8.0% | 13.3% | 7 | 10.9% | 17.5% | 21 | 19.4% | 27.6% | 30 | 15.2% | 22.9% | | | √ | | √ | | | |
| Attention to detail/legal knowledge/advice | 6 | 24.0% | 40.0% | 10 | 15.6% | 25.0% | 7 | 6.5% | 9.2% | 23 | 11.7% | 17.6% | | √ | | | √ | √ | | |
| Honesty | 4 | 16.0% | 26.7% | 9 | 14.1% | 22.5% | 9 | 8.3% | 11.8% | 22 | 11.2% | 16.8% | | | | | | | | |
| Being listened to/understanding | 3 | 12.0% | 20.0% | 4 | 6.3% | 10.0% | 13 | 12.0% | 17.1% | 20 | 10.2% | 15.3% | | | | √ | | | | |
| Commitment to case | 2 | 8.0% | 13.3% | 9 | 14.1% | 22.5% | 8 | 7.4% | 10.5% | 19 | 9.6% | 14.5% | | | | | √ | | | √ |
| Communication | | | | 6 | 9.4% | 15.0% | 8 | 7.4% | 10.5% | 14 | 7.1% | 10.7% | | √ | | | | √ | | |
| Relationship with individual solicitor | 2 | 8.0% | 13.3% | 3 | 4.7% | 7.5% | 6 | 5.6% | 7.9% | 11 | 5.6% | 8.4% | | | | | √ | | | |
| Confidentiality | | | | 2 | 3.1% | 5.0% | 7 | 6.5% | 9.2% | 9 | 4.6% | 6.9% | | | | | | | | |
| Good representation | 1 | | | 2 | 3.1% | 5.0% | 5 | 4.6% | 6.6% | 8 | 4.1% | 6.1% | | | | | | | | |
| Prompt response/keeping appointments | | 0.0% | 0.0% | 1 | 1.6% | 2.5% | 5 | 4.6% | 6.6% | 6 | 3.0% | 4.6% | √ | √ | | | √ | | | √ |
| Knowledge of case history | 2 | 8.0% | 13.3% | 2 | 3.1% | 5.0% | 2 | 1.9% | 2.6% | 6 | 3.0% | 4.6% | | √ | | √ | √ | √ | | √ |
| Respect | 1 | 4.0% | 6.7% | 2 | 3.1% | 5.0% | 3 | 2.8% | 3.9% | 6 | 3.0% | 4.6% | | | | | | | | |
| Follow instructions | | | | 4 | 6.3% | 10.0% | | | | 4 | 2.0% | 3.1% | | | | | | | | √ |
| Confidence | | 0.0% | 0.0% | | | | 3 | 2.8% | 3.9% | 3 | 1.5% | 2.3% | | | | | | | | |
| Track record | | | | 1 | 1.6% | 2.5% | 2 | 1.9% | 2.6% | 3 | 1.5% | 2.3% | | √ | | √ | | | | |
| Professionalism | | | | 1 | 1.6% | 2.5% | 2 | 1.9% | 2.6% | 3 | 1.5% | 2.3% | | | | | | | | |
| Friendly | | | | | | | 2 | 1.9% | 2.6% | 2 | 1.0% | 1.5% | | | | | √ | | | |
| Reassurance | | | | | | | 2 | 1.9% | 2.6% | 2 | 1.0% | 1.5% | | | | | | | | |
| Provider from home area | | | | | | | 1 | 0.9% | 1.3% | 1 | 0.5% | 0.8% | √ | | | | √ | | | |
| Generally helpful | | | | | | | 1 | 0.9% | 1.3% | 1 | 0.5% | 0.8% | | | | | | √ | | |
| Relationship with all provider staff | | | | | | | 1 | 0.9% | 1.3% | 1 | 0.5% | 0.8% | | | | | | | | |
| Financial support for telephone costs | | | | 1 | 1.6% | 2.5% | | | | 1 | 0.5% | 0.8% | | | | | | | | |
| Knowledge of therapies/hospital | 1 | 4.0% | 6.7% | | | | | | | 1 | 0.5% | 0.8% | | √ | | | | √ | | √ |
| What other services can be provided | 1 | 4.0% | 6.7% | | | | | | | 1 | 0.5% | 0.8% | | | | | √ | | | √ |
| **Total** | | **25** | **15** | | **64** | **40** | | **108** | **76** | | **197** | **131** | | | | | | | | |
| Continuity very important when so few choices | | | | | | | | | | | | | √ | | | | √ | | | √ |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| available | | | | | | | | | |
| Important to have at least one Welsh provider | | √ | | | | | | | |
| Local provider enables quick access to advice | | √ | | | | | | | |
| All providers do same job and are equally skilful at technical issues | | √ | | | | | | | |
| Providers should be rated using a 'five star' system | | √ | | | | | | | |
| Attendance at CPA meetings | | | √ | | | | | | |
| Behaviour on wards | | | √ | | | | √ | | |
| Relationship with provider (e.g. trust, confidentiality, faith) can have clinical benefits | | | √ | | | | | | |
| Different opinions amongst clients as to quality of same provider | | | √ | | | | | | |
| Large numbers of new admissions have delayed access to legal advice | | | √ | | | | | | |
| Providers send Christmas cards and diaries to clients to encourage to change | | | √ | | | | | | |
| Providers are not carrying out referrals where necessary | | | √ | | | | | | |
| Providers are split into those with HSH experience and those with community experience: either may be more important to patient | | | √ | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

| | 8. Is there anything else that makes it difficult for you to get the right solicitor? | | | | | | | | | | | | Patient meetings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | AH | | BH | | RH | | | |
| **Hospital** | **AH** | | | **BH** | | | **RH** | | | **Total** | | | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 3** | **Grp 4** |
| None | | | | | | | 12 | 25.0% | 15.8% | 12 | 16.9% | 9.2% | | | | | | | | |
| Lack of choice | | | | 2 | 11.8% | 5.0% | 4 | 8.3% | 5.3% | 6 | 8.5% | 4.6% | | | | | √ | | | |
| Don't know who is best | 1 | 16.7% | 6.7% | 1 | 5.9% | 2.5% | 4 | 8.3% | 5.3% | 6 | 8.5% | 4.6% | | | | | | √ | | |
| Can't speak on telephone easily/in private | | | | | 0.0% | 0.0% | 6 | 12.5% | 7.9% | 6 | 8.5% | 4.6% | | | | | √ | | | |
| Lack of commitment | 1 | 16.7% | 6.7% | 1 | 5.9% | 2.5% | 3 | 6.3% | 3.9% | 5 | 7.0% | 3.8% | | | | | | | | |
| Area based in | | | | 1 | 5.9% | 2.5% | 3 | 6.3% | 3.9% | 4 | 5.6% | 3.1% | | | | | | | | |
| Trust | 3 | 50.0% | 20.0 % | | | | 1 | 2.1% | 1.3% | 4 | 5.6% | 3.1% | | | | | | | | |
| Current provider very good | | | | 1 | 5.9% | 2.5% | 2 | 4.2% | 2.6% | 3 | 4.2% | 2.3% | | | | | | √ | | |
| Don't know new provider/lack of trust | | | | 3 | 17.6% | 7.5% | | | | 3 | 4.2% | 2.3% | | | | | | | | |
| Being detained | | | | | | | 2 | 4.2% | 2.6% | 2 | 2.8% | 1.5% | | | | | | | | |
| Can't write easily | | | | | | | 2 | 4.2% | 2.6% | 2 | 2.8% | 1.5% | | | | | | | | |
| Unknown quantity | | | | 2 | 11.8% | 5.0% | | | | 2 | 2.8% | 1.5% | | | √ | √ | √ | | | |
| Being listened to/understanding | | | | 2 | 11.8% | 5.0% | | | | 2 | 2.8% | 1.5% | | | | | | | | |
| Resolving issues without provider | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Provider won't travel unless signed up as client | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Private practice best | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Translation | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| It takes time to find a good provider | | | | 1 | 5.9% | 2.5% | | | | 1 | 1.4% | 0.8% | | | | √ | | | | |
| Poor tribunal performance | 1 | 16.7% | 6.7% | | | | | | | 1 | 1.4% | 0.8% | | | | | | | | |
| Not sure | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| I don't want to change | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | √ | | |
| Providers pressure clients into MHT/focused on money | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Communication | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Reliability | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Needed provider in new category | | | | 1 | 5.9% | 2.5% | | | | 1 | 1.4% | 0.8% | | | | | | | | |
| Commitment to case | | | | 1 | 5.9% | 2.5% | | | | 1 | 1.4% | 0.8% | | | | | | | | |
| Attention to detail/legal knowledge/advice | | | | 1 | 5.9% | 2.5% | | | | 1 | 1.4% | 0.8% | | | | | | | | |
| Follow instructions | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| Should have been better notice/explanation of changes | | | | | | | 1 | 2.1% | 1.3% | 1 | 1.4% | 0.8% | | | | | | | | |
| **Total** | | **6** | **15** | | **17** | **40** | | **48** | **76** | | **71** | **131** | | | | | | | | |
| Choice is more important in HSHs than MSHs | | | | | | | | | | | | | | | | √ | | | | |
| Some providers will not travel | | | | | | | | | | | | | | | | √ | | | | |
| BAME providers have not won contract | | | | | | | | | | | | | | | | √ | √ | | | |
| Providers use HSH work as cashcow | | | | | | | | | | | | | | | | | | | √ | |
| Some patients endure very poor quality providers due to condition | | | | | | | | | | | | | | | | | | | √ | |
| Providers refuse to carry out full range of work in the category | | | | | | | | | | | | | | | | | | | √ | |
| Providers only commission independent reports at last minute before MHT | | | | | | | | | | | | | | | | | | | √ | |

| | 9. Do you have anything else you would like to add? | | | | | | | | | | | | Patient meetings | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | AH | | BH | | RH | | | |
| **Hospital** | **AH** | | | **BH** | | | **RH** | | | **Total** | | | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 1** | **Grp 2** | **Grp 3** | **Grp 4** |
| Lack of choice | 1 | 9.1% | 4.8% | 1 | 8.3% | 2.5% | 8 | 25.8% | 10.3% | 14 | 23.7% | 10.7% | | | √ | √ | | | | |
| Current provider very good | 2 | 18.2% | 9.5% | 1 | 8.3% | 2.5% | 7 | 22.6% | 9.0% | 10 | 16.9% | 7.6% | | | | | | | | |
| Limited choice means providers are too comfortable | 1 | 9.1% | 4.8% | 1 | 8.3% | 2.5% | 3 | 9.7% | 3.8% | 5 | 8.5% | 3.8% | | | √ | √ | √ | | √ | √ |
| Paranoia regarding new provider is an issue | | | | 2 | 16.7% | 5.0% | 1 | 3.2% | 1.3% | 3 | 5.1% | 2.3% | | | √ | √ | √ | | √ | √ |
| Providers pressure clients into MHT/focused on money | | | | | | | 3 | 9.7% | 3.8% | 3 | 5.1% | 2.3% | | | | | | | | |
| I don't want to change | 3 | 27.3% | 14.3% | | | | | | | 3 | 5.1% | 2.3% | | | | | | | | |
| Human Rights are being violated | 1 | 9.1% | 4.8% | | | | 1 | 3.2% | 1.3% | 2 | 3.4% | 1.5% | | | | | | | | |
| Should have been better notice/explanation of changes | | | | 1 | 8.3% | 2.5% | 1 | 3.2% | 1.3% | 2 | 3.4% | 1.5% | | | | | √ | | √ | |
| Limited choice means large caseloads | 1 | 9.1% | 4.8% | 1 | 8.3% | 2.5% | | | | 2 | 3.4% | 1.5% | | | | | | | | |
| Commitment to case is important | | | | 2 | 16.7% | 5.0% | | | | 2 | 3.4% | 1.5% | | | | | | | | |
| It takes time to find a good provider | | | | 2 | 16.7% | 5.0% | | | | 2 | 3.4% | 1.5% | | | | | | | | |
| Need better complaint system | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Should have consulted better with clients/staff | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Need information on all categories of law | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Should be 1 provider from each region | | | | | | | | | | 1 | 1.7% | 0.8% | | | | | | | | |
| Attention to detail/legal knowledge/advice is important | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Can't speak on telephone easily/in private | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Being detained stops getting best providers | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| Private practice best quality of service | | | | | | | 1 | 3.2% | 1.3% | 1 | 1.7% | 0.8% | | | | | | | | |
| New provider is an unknown quantity | | | | 1 | 8.3% | 2.5% | | | | 1 | 1.7% | 0.8% | | | | | | | | |
| Didn't think old provider was good enough quality | 1 | 9.1% | 4.8% | | | | | | | 1 | 1.7% | 0.8% | | | | | | | | |
| Knowledge of case history important | 1 | 9.1% | 4.8% | | | | | | | 1 | 1.7% | 0.8% | | | | | | | | |
| 10 providers is correct level of choice | | | | | | | | | | | | | √ | √ | | | √ | | | |
| Clinical progress is as important to outcome of MHT as quality of advice/representation | | | | | | | | | | | | | | √ | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| LSC should have delayed impact assessment until all clients had had to switch | | | | √ | | | | | |
| Unfair that in CJS clients get to choose any Crime provider | | | | | √ | | √ | √ | |
| If patient transferred to MSH and then back to HSH they can keep choice of provider | | | | | √ | | | | |
| LSC should run user satisfaction survey for every change of provider | | | | | √ | | | | |
| Providers apply to postpone/adjourn MHTs too readily | | | | | | | | √ | |
| Differental rules for those transferred in are justifiable | | | | | | √ | | | |
| All the new providers are poor | | | | | | | | √ | |

## Annex E – Provider Evidence

Of 191 providers 19 responded to the questionnaire. Of these, 8 had failed to win HSH contracts (38%), 5 had won HSH contracts (24%) and 7 had not tendered (33%). This means the results are likely to be highly skewed because 62% of respondents have a vested interest in the outcome of the EIA.

### *A. Qualitative*

| | 1.B. When clients change providers in HSHs what are there reasons for doing so? | |
|---|---|---|
| Theme | Number of responses | % of responses |
| Client unhappy with solicitor/breakdown of relationship | 7 | 36.8% |
| Due to delusions or disorder or dislike of advice | 6 | 31.6% |
| Client's desire to have fresh approach to case | 4 | 21.1% |
| Recommendation by another patient | 4 | 21.1% |
| Client's disappointment with MHT outcome | 3 | 15.8% |
| Only very small percentage of provider's clients have changed in last 2 years | 2 | 10.5% |
| Retirement of solicitor/moves to new provider | 2 | 10.5% |
| Client wishes to change to a provider with greater expertise for particular case | 2 | 10.5% |
| Client unhappy with infrequent visits/contact | 2 | 10.5% |
| MHAAs best placed to answer | 1 | 5.3% |
| Poor service from provider | 1 | 5.3% |
| Provider unable to communicate with deaf clients | 1 | 5.3% |
| Provider does not attend CPA meetings | 1 | 5.3% |
| Provider withdraws from mental health contract | 1 | 5.3% |
| PD clients who want to try all available | 1 | 5.3% |
| Changes due to paranoia necessitates larger choice | 1 | 5.3% |
| Total responses | 19 | N/A |

| | 3.B. What kind of negative effect would being forced to change solicitor's firm have on a client? | |
|---|---|---|
| Theme | Number of responses | % of responses |
| Adverse effect on mental health | 8 | 42.1% |
| Loss of trust | 8 | 42.1% |
| Takes time to build new relationship | 6 | 31.6% |
| Delay in progress | 4 | 21.1% |
| Additional costs to legal aid | 3 | 15.8% |
| Revisiting case history with new provider is distressing | 3 | 15.8% |
| Reluctance to engage with new provider | 3 | 15.8% |
| Loss of knowledge of case history | 2 | 10.5% |
| Anxiety | 2 | 10.5% |
| Paranoia | 2 | 10.5% |
| All providers should be delivering same high standards of quality | 2 | 10.5% |
| Severe dissatisfaction at being forced to change | 1 | 5.3% |
| Deterioration in quality due to restriction on competition | 1 | 5.3% |
| Administrative difficulties with statutory bodies | 1 | 5.3% |
| Failure to cooperate with clinical team | 1 | 5.3% |
| Discouraged to apply to MHT | 1 | 5.3% |
| Self harm/destructive behaviour | 1 | 5.3% |
| Loss of link with home area | 1 | 5.3% |
| Loss of consistency of advice | 1 | 5.3% |
| Unrepresented clients | 1 | 5.3% |
| Only negatively affect a small number | 1 | 5.3% |
| Little negative effect | 1 | 5.3% |

| | | |
|---|---|---|
| New provider may only be interested in high numbers of MHTs | 1 | 5.3% |
| Depends on individual | 1 | 5.3% |
| Breach of Article 6 of HRA | 1 | 5.3% |
| Unfair to treat clients in HSHs differently from other mental health clients | 1 | 5.3% |
| Total responses | 19 | N/A |

| | 5.B. What kind of things are important to clients regarding their relationship with a solicitor? | |
|---|---|---|
| Theme | Number of responses | % of responses |
| Trust | 9 | 47.4% |
| Accessibility/regular contact | 8 | 42.1% |
| Relationship with solicitor | 6 | 31.6% |
| Good communication | 5 | 26.3% |
| Continuity | 5 | 26.3% |
| Legal skills/knowledge of the law | 5 | 26.3% |
| Knowledge of case history | 4 | 21.1% |
| Commitment to case | 3 | 15.8% |
| Solicitor's relationship with clinical team/knowledge of hospital | 3 | 15.8% |
| Standard of representation | 2 | 10.5% |
| Experience of advising in HSHs | 2 | 10.5% |
| Provider local to hospital | 1 | 5.3% |
| Attendance at CPA meetings | 1 | 5.3% |
| Honesty | 1 | 5.3% |
| Understanding of mental illness | 1 | 5.3% |
| Depends on client | 1 | 5.3% |
| Total responses | 19 | N/A |

| | 8. Is there anything else that makes it difficult for clients in HSHs to get the right provider? | |
|---|---|---|
| Theme | Number of responses | % of responses |
| Limited choice | 3 | 15.8% |
| None | 3 | 15.8% |
| No access to information about providers | 2 | 10.5% |
| Cases complex and require expertise in categories other than mental health | 2 | 10.5% |
| Lack of choice means market forces do not apply | 1 | 5.3% |
| IMHAs should play role in supplying information on providers | 1 | 5.3% |
| IMHAs are not impartial and should not be supplying information on providers | 1 | 5.3% |
| MHAAs do not provide information on providers | 1 | 5.3% |
| New providers are inexperienced | 1 | 5.3% |
| Limited access to telephone | 1 | 5.3% |
| Prior authority for provider visits required | 1 | 5.3% |
| Unable to meet provider in advance of giving instructions | 1 | 5.3% |
| Providers will not facilitate link with families | 1 | 5.3% |
| Unrealistic expectations given by providers | 1 | 5.3% |
| Poaching of clients by other providers | 1 | 5.3% |
| Total responses | 19 | N/A |

| | 9. Do you have anything else you would like to add? | |
|---|---|---|
| Theme | Number of responses | % of responses |
| Questions are unanswerable/inappropriate | 4 | 21.1% |
| Implication that providers awarded contracts are higher quality is incorrect | 3 | 15.8% |
| Forcing change of provider causes additional costs to legal aid | 2 | 10.5% |
| Upset caused to clients | 2 | 10.5% |
| Tender process recognised appropriate expertise | 2 | 10.5% |
| Tender process did not recognise appropriate expertise | 2 | 10.5% |
| Should be no difference in quality standards required in HSHs and MSU because clients are same | 2 | 10.5% |
| Some very good providers have been excluded | 2 | 10.5% |
| There should be a larger choice of providers | 2 | 10.5% |
| Deterioration in quality due to restriction on competition | 1 | 5.3% |
| Upset caused to providers | 1 | 5.3% |
| Upset caused to clinicians | 1 | 5.3% |
| Not appropriate to force change of provider if increase in quality is marginal | 1 | 5.3% |
| Representation is carried out by barrister so providers' quality is immaterial in this respect | 1 | 5.3% |
| Clients rarely change providers | 1 | 5.3% |
| Provider has secured absolute discharge for 3 HSH clients | 1 | 5.3% |
| Providers should be located close to HSH | 1 | 5.3% |
| Clients in HSHs have more reliance on solicitor for emotional support due to limitations on contact with family & friends | 1 | 5.3% |
| Volume of cases is not an indication of expertise | 1 | 5.3% |
| Providers should be able to continue representing clients who are transferred to HSH | 1 | 5.3% |
| Clients' clinical staff change regularly so not unreasonable to have restrictions on available providers | 1 | 5.3% |
| Should be fewer mental health contracts to reduce costs and increase quality | 1 | 5.3% |
| Being able to offer solicitors with 5 years Post Qualification Experience should be essential criterion | 1 | 5.3% |
| Trainee solicitors and paralegals should not be allowed represent HSH clients | 1 | 5.3% |
| Some providers use solicitors and paralegals to tout for business on wards | 1 | 5.3% |
| Befriending clients is not role of solicitor | 1 | 5.3% |

| | | |
|---|---|---|
| The questionnaire was very useful to air views | 1 | 5.3% |
| LSC has created monopoly on HSH work | 1 | 5.3% |
| LSC should use Peer Review to remove lower quality providers | 1 | 5.3% |
| Clients think changes imposed by hospital | 1 | 5.3% |
| Quality of advice is impossible to measure | 1 | 5.3% |
| Clients follow individual solicitors rather than providers | 1 | 5.3% |
| Client recommendations are best way of measuring quality | 1 | 5.3% |
| Total responses | 19 | N/A |

### *B. Quantitative*

| | | Never | | Once | | Twice | | Three times or more | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1.A. | On average, how often do clients in High Security Hospitals change mental health provider in a two year period? | 11 | 68.8% | 5 | 31.3% | 0 | 0.0% | 0 | 0.0% | 16 | 20 | 80.0% |

| | | <24% | | 25-49% | | 50-74% | | >75% | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2. | What proportion of providers provides a satisfactory quality of advice and representation in HSHs? | 0 | 0.0% | 2 | 14.3% | 5 | 35.7% | 7 | 50.0% | 14 | 20 | 70.0% |

| | | Not at all | | A little | | Some/ Moderate | | Very much | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.A. | If clients are forced to change provider is there likely to be a negative effect on them? | 0 | 0.0% | 3 | 15.0% | 2 | 10.0% | 15 | 75.0% | 20 | 20 | 100.0% |

| | | No | | No with reservations | | Yes with reservations | | Yes | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4. | Do you think it is right for clients to be forced to change provider if the new provider will give them a better quality of advice and representation? | 5 | 27.8% | 8 | 44.4% | 4 | 22.2% | 1 | 5.6% | 18 | 20 | 90.0% |

| | | Within 1 week | | Within 2-4 weeks | | Within 1-6 months | | >6 months | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5.A. | How long does it take for you to develop a good working relationship with new clients in HSHs? | 3 | 15.0% | 2 | 10.0% | 5 | 25.0% | 10 | 50.0% | 20 | 20 | 100.0% |

| | | Quality of advice | | Both are equally important | | Relationship with solicitor | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 6. | What kind of things are important to clients regarding their relationship with a solicitor? | 2 | 10.5% | 15 | 78.9% | 2 | 10.5% | 19 | 20 | 95.0% |

| | | Yes | | No | | Don't know | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 7.A. | Do you think clients in HSHs would get a better service from a provider if they have a larger number to choose from | 13 | 72.2% | 4 | 22.2% | 1 | 5.6% | 18 | 20 | 90.0% |

| | | <6 | | 6-10 | | >10 | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 7.B. | What is the minimum number of providers that clients in HSHs should be able to choose from? | 1 | 5.6% | 4 | 22.2% | 13 | 72.2% | 18 | 20 | 90.0% |

## Annex F – Hospital Staff Evidence

| | | AH | | | BH | | | RH | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Theme | Comment | Advocates | Clinical Staff | Social Workers | Advocates | Clinical Staff and MHAAs | Social Workers | Advocates | Clinical Staff | Social Workers and MHAAs | Count of fora |
| Impact | Severing link/forcing change will have a negative impact on clients | √ | | | √ | | √ | √ | | √ | 5 |
| | Severing link/forcing change will have a profound negative impact on a small number of clients | | √ | | | | √ | √ | √ | | 4 |
| | Some clients change providers rapidly (often due to dissatisfaction with the service) | | | | √ | √ | | √ | | √ | 4 |
| | For those with DSPD/paranoid/Aspergers change could have very difficult clinical consequences | | √ | | √ | | | | | √ | 3 |
| | Longstanding relationships between clients/staff/providers are important in the NDU | | | | | | | √ | √ | √ | 3 |
| | Unfair to have different providers for those transferred in | | √ | | | √ | √ | | | | 3 |
| | Uncertainty has a negative impact on clients | √ | | | | | √ | | | | 2 |
| | Going over case history when changing provider has negative impact on clients | √ | | | | | √ | | | | 2 |
| | Few clients change solicitor regularly | | | √ | | | | | √ | | 2 |
| | Particular skills required in the National Deaf Unit and National Learning Disabilities Unit | | | | | | | √ | | √ | 2 |
| | Impact is particularly severe on clients in the NDU, NLU and National Women's Unit | | | | | | | | √ | √ | 2 |
| | Particular skills required to work with an intepreter | | | | | | | √ | √ | | 2 |
| | Majority of clients have a provider on the list | | √ | √ | | | | | | | 2 |
| | Culture in RH based around longstanding, less adverserial relationships has been undermined | | | | | | | √ | √ | | 2 |
| | Advocates/social workers have received/dealt with an increased number of legal queries | | | | | | | √ | | √ | 2 |
| | New providers will take time to determining what clients' information is delusional and what is true | √ | | | | | | | | | 1 |
| | Sometimes changing solicitor is positive since it allows a fresh look at a case | | | | | | √ | | | | 1 |
| | Some providers will get a better solicitor than they had before | | | | | | √ | | | | 1 |
| | As soon as a patient changes provider the trust established with the old provider is lost | √ | | | | | | | | | 1 |
| | DSPD clients do not tend to change provider often | | | | | | √ | | | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | PD clients asking for case to be taken to Upper Tribunal to stay with the same provider | | | | | | √ | | | | 1 |
| | Mental Illness clients more likely to be less vocal than PD ones about change | | | | | | √ | | | | 1 |
| | Those on the High Dependency Unit change providers regularly | | | | √ | | | | | | 1 |
| | Clients who are acutely unwell are likely to change provider more often | | | | √ | | | | | | 1 |
| | Many clients have abandonment issues and may feel rejected if solicitor can no longer act | | | | | | √ | | | | 1 |
| | Many clients have additional barriers to accessing advice (stammer, poor english etc.) | | | | | | √ | | | | 1 |
| | Unfair to have different standards for same work (e.g. MSH vs. HSH) | | √ | | | | | | | | 1 |
| | Differential treatment of clients transferring in will not cause problems | | | | | | √ | | | | 1 |
| | Where clients have had to change provider the process has been chaotic | | | √ | | | | | | | 1 |
| | Transfer of clients and handover is generally handled well by providers | | | | √ | | | | | | 1 |
| | Word of mouth recommendations will mean that the work will be concentrated among a few providers only | | | | √ | | | | | | 1 |
| | Most clients will not have a provider from the list | | | | | | √ | | | | 1 |
| | There has been an erosion of trust between the hospital and clients | | | | | | √ | | | | 1 |
| | Some clients think that reduction of providers is due to collusion between solicitors and hospital | | | | | | √ | | | | 1 |
| | There is increased anxiety in the hospital generally | | | | | | | √ | | | 1 |
| | New providers are applying for a lot of MHTs which is creating additional work | | | | | | | | | √ | 1 |
| | Improved quality may not mitigate the drawbacks of having to change provider | | | | √ | | | | | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Choice | Patient recommendations are an important way of choosing | √ | | | | | √ | √ | √ | √ | 5 |
| | Families and/or clients often want a specialist BAME provider and this is important | | | √ | √ | √ | √ | | | | 4 |
| | Some clients panicked when new list was published | √ | | | | | √ | | | | 2 |
| | Shorter list makes it easier for clients to choose | √ | | | | | | | | | 1 |
| | Shorter list makes clients think more carefully about changing provider | √ | | | | | | | | | 1 |
| | 6-10 providers is reasonable choice | √ | | | | | | | | | 1 |
| | 5 providers is acceptable in terms of choice | | | √ | | | | | | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Choice of provider/individual solicitor very important to clients | | | | √ | | | | | | 1 |
| | Only new clients should need to choose from one of the contracted providers | | | | | √ | | | | | 1 |
| | Restricting choice likely to be detrimental to black clients | | | | | | √ | | | | 1 |
| | Conflict of interest as some clients will not want to be represented by the same solicitor as a patient with whom they do not get along | | | | | | | | | √ | 1 |
| | Choice will be reduced further when providers run out of NMS | | | | | | | √ | | | 1 |
| | Clients will no longer be able to choose local solicitors | | | | | | | | | √ | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Preferences | Establishing trust/relationship/individual understanding with solicitor is very important | √ | | | √ | √ | √ | √ | | √ | 6 |
| | Provider availability is very important to clients | | √ | | √ | √ | | √ | | | 4 |
| | Clients tend to like to use a solicitor from their home area | √ | | | | | | √ | | | 2 |
| | Long term clients tend to stay with the same provider and this is important to them | √ | | | √ | | | | | | 2 |
| | Frequency of meeting with solicitor will determine how quickly trust is established | √ | | | √ | | | | | | 2 |
| | Solicitors must match their communication to the individual patient and their state of health | √ | | | | | | | | √ | 2 |
| | Clients are diverse: their type of illness and state of health are important to their relationship with solicitors | √ | | | | | | | | √ | 2 |
| | Many clients have been with the same provider for more than 20 years | | | | √ | | √ | | | | 2 |
| | Some clients have multiple providers at the same time | | | | √ | √ | | | | | 2 |
| | Relationship with solicitor is very important because no other link with outside world | √ | | | | | | | | | 1 |
| | Clients tend to follow individual solicitor if they change provider | √ | | | | | | | | | 1 |
| | Clients with PD are better able to express themselves | √ | | | | | | | | | 1 |
| | Those who are severely unwell with a mental illness will not be able to express themselves | √ | | | | | | | | | 1 |
| | Some clients often want to change individual adviser if they see a new solicitor on ward, particularly if they are female | | | √ | | | | | | | 1 |
| | Clients are attracted to a particular provider if there is an unexpected positive result at MHT | | | √ | | | | | | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Quality | The best outcomes are achieved where a long stranding relationship has developed | | | √ | | | √ | √ | √ | | 4 |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Some providers give unrealistic expectations of the potential outcome of advice | | | √ | | | √ | √ | | | 3 |
| A good quality legal provider should be receptive to a patient's intructions | | | √ | √ | | √ | | | | 3 |
| TLS accreditiation is not necessarily an indication of quality | | | | | √ | | | √ | √ | 3 |
| Some providers are applying/pushing for an MHT without the client's consent/knowledge and/or against their best interests | | | | | | √ | √ | | √ | 3 |
| Clients tend to be satisfied with the quality of advice they receive | √ | | | | | | √ | | | 2 |
| It is difficult to measure quality of advice objectively | √ | | | | | | | √ | | 2 |
| A good quality legal provider should explain realistically what will happen in a case | | | √ | | | √ | | | | 2 |
| Providers operating at a distance do not offer as good a service as those closer by | | | | | | | √ | √ | | 2 |
| Many clients are borderline learning disabled so communication important | √ | | | | | | | | √ | 2 |
| Subjective measures of quality (e.g. soft skills) are as important to clients as objective ones (e.g. knowledge) | √ | | | | | | | | | 1 |
| Providers are not providing referrals to clients where necessary | √ | | | | | | | | | 1 |
| Some providers refuse to advise the most challenging clients | √ | | | | | | | | | 1 |
| Very vulnerable clients are more likely to need a high quality solicitor | | | √ | | | | | | | 1 |
| A good quality legal provider should be able to argue a strong position in an MHT | | | √ | | | | | | | 1 |
| Providers refer clients where they are not able to deal with that area of law themselves | | | √ | | | | | | | 1 |
| If patient is happy with provider the quality of that provider does not matter | | | | √ | | | | | | 1 |
| More than 50% of providers deliver an acceptable level of service | | | | √ | | | | | | 1 |
| Longstanding providers better at MHT as they have accumulated knowledge of past MHTs | | | | | | √ | | | | 1 |
| A good quality legal provider should be aware of a patient's best interest | | | | | | √ | | | | 1 |
| Some solicitors do not prepare adequately for a MHT | | | | | | √ | | | | 1 |
| Some providers overstep the boundaries of a professional relationship | | | | | | √ | | | | 1 |
| Some providers will understand key issues immediately but othersl take a lot longer | | | | | | √ | | | | 1 |
| Some providers have a large caseload which means they are often inaccessible | | | | | | | √ | | | 1 |
| Criticising the clinical staff can disturb a client's treatment | | | | | | | | √ | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Experienced solicitors are better able to manage realistic expectations of outcomes for clients | | √ | | | | | | | | 1 |
| LSC role | Large degree of uncertainty/confusion in November 2010 | | √ | | √ | | | | | √ | 3 |
| | Change not in line with the Government's general direction on Mental Health | | | | | | | | √ | | 1 |
| | Current situation is also difficult because clients are in limbo | | | | | | | | √ | | 1 |
| Misc | Some clients do not realise that they should have MH provider rather than Crime | √ | | | | | √ | | | | 2 |
| | There are a myriad of problems with independent expert reports, including cost, lack of research and vested interests | | | √ | | √ | | | | | 2 |
| | Recent reduction in solicitor attendance at CPAs attributed to introduction of Fixed Fees | | | √ | | | | √ | | | 2 |
| | Patients have been distressed by a hospital restructure | | | | √ | | √ | | | | 2 |
| | The locality of some successful providers seems unusual | | | √ | | √ | | | | | 2 |
| | Some providers send paralegals/legal executives to see clients | | | | √ | | √ | | | | 2 |
| | Average age of clients is falling fast | √ | | | | | | | | | 1 |
| | Fewer patients detained under S3 and more under S37/41, S47/49 and S49a (forensic) | √ | | | | | | | | | 1 |
| | LSC should consult with the nursing staff and patient families | | | √ | | | | | | | 1 |
| | There is evidence of potential touting on wards | | | √ | | | | | | | 1 |
| | The remit of the MHTs increasingly goes beyond matters of detention | | | √ | | | | | | | 1 |
| | Requests for independent social worker reports are rare | | | √ | | | | | | | 1 |
| | Many providers give clients their mobile phone numbers which makes them more accessible | | | √ | | | | | | | 1 |
| | Many providers will often apply for an MHT right at the end of the Period of Eligibility | | | √ | | | | | | | 1 |
| | The MHT should ideally concentrate on MHA legislation and allow wider issues to be dealt with elsewhere | | | √ | | | | | | | 1 |
| | Very unusual for patients to be released directly into the community | | | | √ | | | | | | 1 |
| | PD clients often believe that the provider has a vested interest in their prolonged detention due to the potential for continued income stream and may change provider accordingly | | | | √ | | | | | | 1 |
| | Clients are not happy that providers are no longer attending CPAs | | | | √ | | | | | | 1 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Those on DSPD/PD Units have a good awareness of legal issues | | | | √ | | | | | | 1 |
| | There is no internet access in the hospitals | | | | √ | | | | | | 1 |
| | Clients on s37/41 and s47/49 tend to be well informed about their rights | | | | √ | | | | | | 1 |
| | Patients must have an approved telephone list before they can call and often run out of money for paid services | | | | √ | | | | | | 1 |
| | The rate of turnover between new and old patients is about 40-50 a year with some only resident for a short period of time | | | | | √ | | | | | 1 |
| | At least one provider is working pro bono having not got a contract | | | | | √ | | | | | 1 |
| | Other common legal work in BH includes wills, public law cases, criminal cases and complaints | | | | | √ | | | | | 1 |
| | MHTs can often result in small gains for a patient | | | | | | √ | | | | 1 |
| | No one has explained to clients that different rules apply to other areas of law | | | | | | √ | | | | 1 |
| | Fairer to have a pool of solicitors able to work at all HSHs | | | | | | √ | | | | 1 |
| | Clients who transfer in are vulnerable and need a familiar provider | | | | | | √ | | | | 1 |
| | Provider who conducts initial interview may not always be the one to see the patient | | | | | | √ | | | | 1 |
| | Some providers have droppped out of Mental Health work recently | | | | | | √ | | | | 1 |
| | 48 women in RH who can't mix with the men | | | | | | | √ | | | 1 |
| | Very difficult to access Family advice | | | | | | | | √ | | 1 |
| | Some providers have asked to be paid to attend a CPA | | | | | | | | √ | | 1 |
| | Older clients usually have a wider set of legal requirements | | | | | | | | | √ | 1 |
| | Anecdotal evidence of increased adjournments | | | | | | | | | √ | 1 |
| | RH increasing have to use Trust solicitors as the MHTs become more adversarial | | | | | | | | | √ | 1 |
| | Increasing use of barristers at MHTs | | | | | | | | | √ | 1 |
| | Capacity issues are more likely in the National Learning Disabilities Unit | | | | | | | | | √ | 1 |

## Annex G – Evidence of Interest Groups

| | | AJTC | CQC | MHLA | TLS | TSMH | Count of responses |
|---|---|---|---|---|---|---|---|
| Impact | Severing link/forcing change will have a negative impact on clients | √ | √ | √ | √ | √ | 5 |
| | It takes time to establish trust | √ | √ | √ | √ | | 4 |
| | As soon as a patient changes provider the trust established with the old provider is lost | √ | √ | | | √ | 3 |
| | Traumatic for patient to revisit earlier case history when changing provider | | | √ | √ | √ | 3 |
| | Cases will take longer to prepare because new provider will be unfamilar with case history | √ | | | | √ | 2 |
| | Forcibly severing link amounts to discrimination under DDA | | √ | | | | 1 |
| Choice | Choice of provider/individual solicitor very important to clients who have little other choice in hospital | √ | √ | | | √ | 3 |
| | Local links with family and Local Authorities are important in maintaining contact and eventually being released | √ | | √ | | | 2 |
| | Greater choice ensures better service from provider | | | | √ | √ | 2 |
| | Clients do not have access to the appropriate information to make an informed choice | √ | | | | | 1 |
| | IMHAs should facilitate informed choice | √ | | | | | 1 |
| | Limited choice means difficult for providers to demonstrate independence from hospital | √ | | | | | 1 |
| | Going over case history when changing provider has negative impact on clients | √ | | | | | 1 |
| | There should be a choice of >10 providers | | | | | √ | 1 |
| Preference | Reasonable accommodation' should be used to allow continued relationships with established providers | √ | | | | | 1 |
| Quality | Not right to be forced to change provider even if new provider delivers higher quality service | √ | | √ | | √ | 3 |
| | Subjective measures of quality (e.g. soft skills) are as important to clients as objective ones (e.g. knowledge) | √ | | | | √ | 2 |
| | Use of Panel as a mark of quality positive | | | √ | √ | | 2 |
| | LSC selection criteria and essential criteria for HSH contracts do not necessarily ensure higher quality of advice | √ | | | | | 1 |
| | Higher quality standards required in other settings in addition to HSHs | √ | | | | | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Provider plays wider role (including only link with outside world) than just legal advice | | | | | √ | 1 |
| | Important that provider familiar with case in order to facilitate efficient and untraumatic MHT | | | | | √ | 1 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Misc. | Questionnaire not appropriate for stakeholders | √ | | | √ | | 2 |
| | Questionnaire quantitative responses too limited to answer effectively | √ | | | | √ | 2 |
| | Concerns already raised in consultation on Civil Bid Round for 2010 contracts | √ | | √ | | | 2 |
| | Not given enough time to respond | √ | | | | | 1 |
| | CQC should have been included in original list of consultees | √ | | | | | 1 |
| | UN Convention on the Rights of People with Disabilities is relevant | | √ | | | | 1 |
| | Being forced to change will result in increased costs to Legal Aid | | | | | √ | 1 |
| | Current exceptions in relation to transferred clients should be extended to those already in HSH's | | | | √ | | 1 |
| | Does no believe in competition for HSH's | | | √ | | | 1 |

## Annex H – Non-disability Equality Strands

Please note that due to the pressing need to answer the central question in this Impact Assessment relating to Disability Discrimination it has not been possible to carry out a full analysis of the responses given by the other equalities groups at this stage. This will be carried out by the LSC in due course as resources and priorities allow. This is an initial analysis that looks at the responses to the Equal Opportunities Monitoring section of the Client Questionnaire.

| | | | Male | | Female | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Are you male or female? | AH | 14 | 100.0% | 0 | 0.0% | 14 | 15 | 93.3% |
| | | BH | 33 | 100.0% | 0 | 0.0% | 33 | 40 | 82.5% |
| | | RH | 60 | 81.1% | 14 | 18.9% | 74 | 76 | 97.4% |
| | | Total | 107 | 88.4% | 14 | 11.6% | 121 | 131 | 92.4% |

| | | | Yes | | No | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| 2 | Do you currently live or have plans to live in the gender opposite to your gender at birth?[30] | AH | 2 | 15.4% | 11 | 84.6% | 13 | 15 | 86.7% |
| | | BH | 7 | 22.6% | 24 | 77.4% | 31 | 40 | 77.5% |
| | | RH | 16 | 23.9% | 51 | 76.1% | 67 | 76 | 88.2% |
| | | Total | 25 | 22.5% | 86 | 77.5% | 111 | 131 | 84.7% |

| | | | 18-24 | | 25-34 | | 35-44 | | 45-54 | | 55-64 | | 65+ | | Prefer not to say | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3 | How old are you? | AH | 0 | 0.0% | 2 | 14.3% | 2 | 14.3% | 6 | 42.9% | 4 | 28.6% | 0 | 0.0% | 0 | 0.0% | 14 | 15 | 93.3% |
| | | BH | 1 | 2.5% | 7 | 17.5% | 16 | 40.0% | 6 | 15.0% | 4 | 10.0% | 0 | 0.0% | 0 | 0.0% | 40 | 44 | 90.9% |
| | | RH | 4 | 5.4% | 23 | 31.1% | 17 | 23.0% | 17 | 23.0% | 12 | 16.2% | 0 | 0.0% | 1 | 1.4% | 74 | 76 | 97.4% |

[30] Please note, this question was widely misunderstood by clients, according to anecdotal evidence from hospital staff. This appears to be born out with 23% of respondents indicating they were transgendered. The results must therefore be considered with care.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | 5 | 3.9% | 32 | 25.0% | 35 | 27.3% | 29 | 22.7% | 20 | 15.6% | 0 | 0.0% | 1 | 5.0% | 128 | 135 | 94.8% | | | | |

| | | | White (British) | | White (Irish) | | Other White Background | | Black (African) | | Black (Caribbean) | | Black (Other) | | Asian (Bangladeshi) | | Asian (Indian) | | Asian (Pakistani) | | Asian (Other) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | AH | 9 | 64.3 % | 0 | 0.0% | 1 | 7.1% | 1 | 7.1% | 2 | 14.3% | 1 | 7.1% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| | | BH | 19 | 55.9 % | 1 | 2.9% | 3 | 8.8% | 3 | 8.8% | 5 | 14.7% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% |
| | Which of the following best describe your | RH | 62 | 83.8 % | 3 | 4.1% | 1 | 1.4% | 2 | 2.7% | 1 | 1.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 3 | 4.1% | 0 | 0.0% |
| 4 | ethnic group? | Total | 90 | 73.8 % | 4 | 3.3% | 5 | 4.1% | 6 | 4.9% | 8 | 6.6% | 1 | 0.8% | 0 | 0.0% | 0 | 0.0% | 3 | 2.5% | 0 | 0.0% |

| | | | Mixed (White & Asian) | | Mixed (White & Black African) | | Mixed (White & Black Caribbean) | | Mixed (Other) | | Chinese | | Other | | Prefer not to say | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | AH | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 14 | 15 | 93.3% |
| | | BH | 0 | 0.0% | 0 | 0.0% | 1 | 2.9% | 0 | 0.0% | 0 | 0.0% | 1 | 2.9% | 1 | 2.9% | 34 | 40 | 85.0% |
| | Which of the following best describe your | RH | 0 | 0.0% | 0 | 0.0% | 1 | 1.4% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 1.4% | 74 | 76 | 97.4% |
| 4 | ethnic group? | Total | 0 | 0.0% | 0 | 0.0% | 2 | 1.6% | 0 | 0.0% | 0 | 0.0% | 1 | 0.8% | 2 | 1.6% | 122 | 131 | 93.1% |

| | | | Buddhist | | Christian | | Hindu | | Jewish | | Muslim | | Sikh | | Other | | Agnostic | | Atheist | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | AH | 2 | 15.4% | 4 | 30.8% | 0 | 0.0% | 0 | 0.0% | 1 | 7.7% | 0 | 0.0% | 3 | 23.1% | 0 | 0.0% | 0 | 0.0% |
| | | BH | 0 | 0.0% | 11 | 39.3% | 1 | 3.6% | 1 | 3.6% | 5 | 17.9% | 0 | 0.0% | 2 | 7.1% | 0 | 0.0% | 0 | 0.0% |
| | Which of these best describes your religion or | RH | 3 | 4.4% | 31 | 45.6% | 0 | 0.0% | 1 | 1.5% | 6 | 8.8% | 0 | 0.0% | 3 | 4.4% | 1 | 1.5% | 4 | 5.9% |
| 5 | belief? | Total | 5 | 4.6% | 46 | 42.2% | 1 | 0.9% | 2 | 1.8% | 12 | 11.0% | 0 | 0.0% | 8 | 7.3% | 1 | 0.9% | 4 | 3.7% |

| | | | None | | Prefer not to say | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|
| | Which of these best describes | AH | 3 | 23.1% | 0 | 0.0% | 13 | 15 | 86.7% |
| 5 | your religion or | BH | 6 | 21.4% | 2 | 7.1% | 28 | 40 | 70.0% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | belief? | RH | 13 | 19.1% | 6 | 8.8% | 68 | 76 | 89.5% |
| | | Total | 22 | 20.2% | 8 | 7.3% | 109 | 131 | 83.2% |

| | | | Blind or Visual Impairment | | Deaf or Hearing Impairment | | Learning Difficulty | | Mental Health condition | | Mobility | | Other disability | | Prefer not to say | | None of these | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 | Please tick any of the following that apply to you? | AH | 0 | 0.0% | 2 | 28.6% | 0 | 0.0% | 1 | 14.3% | 1 | 14.3% | 0 | 0.0% | 0 | 0.0% | 3 | 42.9% | 7 | 15 | 46.7% |
| | | BH | 2 | 13.3% | 1 | 6.7% | 1 | 6.7% | 3 | 20.0% | 0 | 0.0% | 0 | 0.0% | 3 | 20.0% | 5 | 33.3% | 15 | 40 | 37.5% |
| | | RH | 3 | 7.7% | 6 | 15.4% | 14 | 35.9% | 4 | 10.3% | 1 | 2.6% | 1 | 2.6% | 5 | 12.8% | 5 | 12.8% | 39 | 76 | 51.3% |
| | | Total | 5 | 8.2% | 9 | 14.8% | 15 | 24.6% | 8 | 13.1% | 2 | 3.3% | 1 | 1.6% | 8 | 13.1% | 13 | 21.3% | 61 | 131 | 46.6% |

| | | | British Sign Language | | Sign Supported English | | Makaton | | English | | Welsh | | Other | | Prefer not to say | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 7 | What is your preferred language or method of communication? | AH | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 13 | 100.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 13 | 15 | 86.7% |
| | | BH | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 26 | 92.9% | 0 | 0.0% | 0 | 0.0% | 2 | 7.1% | 28 | 40 | 70.0% |
| | | RH | 6 | 8.6% | 1 | 1.4% | 0 | 0.0% | 62 | 88.6% | 1 | 1.4% | 0 | 0.0% | 0 | 0.0% | 70 | 76 | 92.1% |
| | | Total | 6 | 5.4% | 1 | 0.9% | 0 | 0.0% | 101 | 91.0% | 1 | 0.9% | 0 | 0.0% | 2 | 1.8% | 111 | 131 | 84.7% |

| | | | Heterosexual | | Gay man | | Lesbian | | Bisexual | | Total | Total Questionnaires | Response rate |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | How would you describe your sexual orientation? | AH | 12 | 85.7% | 1 | 7.1% | 1 | 7.1% | 0 | 0.0% | 14 | 15 | 93.3% |
| | | BH | 27 | 90.0% | 0 | 0.0% | 0 | 0.0% | 3 | 10.0% | 30 | 40 | 75.0% |
| | | RH | 43 | 78.2% | 1 | 1.8% | 1 | 1.8% | 10 | 18.2% | 55 | 76 | 72.4% |
| | | Total | 82 | 82.8% | 2 | 2.0% | 2 | 2.0% | 13 | 13.1% | 99 | 131 | 75.6% |

## Annex I – Glossary

| Term | Explanation |
|---|---|
| BAME | Black and Asian minority ethnic |
| Clients | HSH mental health legal aid clients |
| CMRF | Controlled Matter Reporting Form, this is how provider report mental health closed cases and contains a range of management information |
| Competitive tender | Use of selection criteria scores to award contracts to as many bidders as NMS availability allows, as applied to HSHs |
| CPA Meeting | Care Plan Approach Meeting, being a multi-party discussion in hospital of treatment plans. There is no formal requirement for providers to attend these meetings but they should where the discussions are relevant to a case. |
| DSPD | Dangerous and severe personality disorder |
| EIA | Equality Impact Assessment |
| Exceptional Cases | Where a case exceeds certain cost limits, it escapes payment under the Fixed Fee scheme and may be paid on a full costs basis. However, first the claim must be validated by the LSC's Mental Health Unit. |
| Focus Group | Guided discussion with a one or more consultees, collecting qualitative evidence |
| Hospital staff | All staff consulted, being clinical staff, advocacy staff, social workers and MHAAs |
| HSH | High Security Hospitals, being Ashworth, Broadmoor & |
| Interest groups | non-hospital, non-provider, non-client stakeholders consulted, being Mental Health Lawyers Association, The Law Society, Tribunals Service, Administrative Justice & Tribunals Council, Care Quality Commission and the Equality & Human Rights Commission |
| LSC | Legal Services Commission, responsible for the administration of the legal aid scheme |
| LSRC | Legal Services Research Centre, independent research arm of the LSC |
| Mainstream mental health contracts | All non-HSH mental health contracts |
| MHAA | Mental Health Act Administrator |
| MHT | Mental Health Tribunal |
| MSU | Medium Secure Unit, being the level of security immediately below an HSH |
| NDU | National Deaf Unit, Rampton Hospital |
| NLDU | National Learning Disabilities Unit, Rampton Hospital |

| | |
|---|---|
| NMS | New matter starts, or licence to start a particular number of cases |
| Non-competitive tender | Use of essential criteria only to award contracts to all bidders meeting them |
| NWU | National Women's Unit, Rampton Hospital |
| Patients | All HSH patients |
| PD | Personality disorder |
| Qualitative evidence | Evidence not measurable by quantity i.e. free text/meeting responses |
| Quantitative evidence | Evidence measurable by quantity, i.e. tick box responses |