The Fifth Year of the Independent Mental Capacity Advocacy (IMCA) Service - 2011 /2012

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Description	This is the annual report on the Fifth Year of the Independent Mental Capacity Advocacy (IMCA) service. It provides statistical information on the continued increase in referrals to this statutory advocacy service and makes recommends to CCGs and LAs about its use for those who lack capacity.
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Contents

Executive Summary

Introduction

This report is the fifth annual report on the Independent Mental Capacity Service. It also provides an overview of the last five years.

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service to empower and safeguard people who do not have the capacity to make certain important decisions. The Act also introduced a legal duty on NHS bodies and local authorities to refer eligible people to the IMCA service and to consider their views. The IMCA service covers both the period April 2011- March 2012 and also reflects back on the five year period April 2007- March 2012.

The role of the IMCA is to represent and support people at times when critical decisions are being made about their health or social care. They are involved when the person lacks capacity to make these decisions themselves and mainly when they do not have family or friends who can represent them. The Deprivation of Liberty Safeguards (DOLS) were implemented on the 1st April 2009. IMCAs have an important role to support people who may be subject to these safeguards.

Data about the IMCA service is added by IMCA providers to a national database maintained by the Health and Social Care Information Centre. This report presents the information recorded on this database, and was collected on the 15th October 2011.

Key results

During the fifth year there was a 9% increase in referrals from the previous year.

The numbers have more than doubled in five years.

However there are still wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences.

There were a total of 11,899 eligible instructions for the IMCA service in England.

Increases/ Decreases in decision types

- Accommodation 4,916 (Increase of 6%)
- Serious medical treatment 1,743 (Increase of 5%)
- Safeguarding 1,533 (Decrease of 2%)
- Care reviews 1,032 (Increase of 34%)
- Deprivation of Liberty Safeguards 1,979 (Increase of 18%)

There has been a year on year increase in instructions to the IMCA service since it began in 2007 (when there were 5266 cases).The numbers have more than doubled in the five years.

However there are still wide disparities in the rate of IMCA instructions across different local areas which cannot wholly be explained by population differences. It is likely that in some areas the duties under the MCA are still not well embedded. The duty to refer people who are eligible to IMCAs is still not understood in all parts of the health and social care sector.

The Mental Capacity Act Code of Practice states that local authorities and NHS trusts should have policies on when IMCAs should be instructed to represent people who are the focus of safeguarding adults'/ adult protection procedures and care reviews. Model policies have been developed by ADASS and SCIE. Local policies are needed in both health and social care – including when to instruct IMCAs for continuing NHS healthcare reviews.

Safeguarding

For the first time in five years, the number of cases where IMCAs have been representing people who were subject to safeguarding has declined.

There are 1,533 safeguarding IMCA referrals in the context of national data showing there are over 130,000 reported safeguarding cases per year.

Care Reviews

The number of instructions for care reviews has increased; the increase of 34% is the largest percentage increase in type of referral. However it continues to be low in absolute numbers, in comparison to accommodation decisions.

There is approximately one care review referral for each four accommodation referral.

This raises some questions:

- Are care reviews being consistently undertaken after moves?
- Where an IMCA has been involved in the decision to move a person, why are three quarters of them not invited to support and represent the person in subsequent reviews?

Department of Health guidance states that it is good practice for local authorities to undertake a review within three months of a person moving to new accommodation or where there have been other major changes to the support plan. Otherwise, reviews should take place at least annually. The guidance, contained *in Prioritising need in the context of Putting People First (DH 2010a*) also says that 'adults lacking capacity are likely to need more frequent monitoring arrangements than other service users' (Section 146).

For people receiving continuing healthcare, the NHS continuing healthcare practice guide (DH 2010b) recommends that reviews should similarly take place by the relevant PCT within three months of the decision to provide continuing care, and then at least annually.

DOLS

Deprivation of Liberty Safeguards instructions showed an increase of 18%.

Reflections

IMCAs are asked to reflected on their cases and input their reflections in the database. These included:

- the importance of effective communication;
- the importance of providing consistent support while decisions were being made;
- identifying options;
- focusing on good outcomes;
- being ready to take a case to the Court of Protection if necessary.

Court of Protection

Court of Protection judgements continue to be of importance in guiding decision making, in the context of how to weigh up protection with recognising autonomy.

The case of *CC v KK* raises the issue of a) needing to have sufficiently detailed alternative plans to allow a person who may or may not lack capacity to weigh up the alternatives and make a choice where possible; and b) making capacity assessments after the detailed alternatives have been identified and presented. This also has implications for IMCA services who seek a capacity assessment prior to working with a client. This should no longer happen.

Recommendation

1. It is recommended that commissioners recognise that the number of people statutorily eligible for the IMCA service continues to increase on a year by year basis.

2. It is recommended that both local authorities and IMCA organisations consider the implications of the CC v KK case and act according to the Court's guidance.

3. It is recommended that both IMCA organisations and local authorities continue to be alert to possible Deprivations of Liberty (DoL). IMCA organisations should alert local authorities and the NHS for the need either *to prevent* a DoL by changing the care plan, or *to apply* the DoL safeguards, if the person is in a care home or hospital. If the possible DOL is the result of a care package in the community, a referral to the Court of Protection is required.

4. It is recommended that local authorities ensure that all those who would benefit from IMCAs in their Reviews all receive one.

5. It is recommended that Mental Capacity Act leads in CCGs monitor compliance with the requirement for making referrals to IMCAs as part of their MCA responsibilities.

6. It is recommended that safeguarding coordinators consider these statistics and that a) all Safeguarding Co-ordinators review the basis on which they make referrals to IMCAs; and b) that Safeguarding Co-ordinators who work in the areas identified in Appendix A with a star review why referrals to IMCAs are at the level they are.

7. It is recommended that IMCAs continue to follow Court of Protection advice given in judgements.

IMCA CASE STUDY

Mr Smith was 94, and the care home where he lived for three months requested a DOLS authorisation because he persistently asked to return to his home. He was unable to walk more than a short distance unaided; he needed prompting to remember to eat and drink.

The supervisory body commissioned the IMCA service to support him through the process, since he had no family or friends in the UK to be consulted. The IMCA who was instructed already knew Mr Smith, due to having been instructed in the decision to move him into the care home following a stay in hospital recovering from serious injuries received in a fall.

The IMCA had spent a lot of time in conversation with Mr Smith over the making of that decision. He told her of his earlier history: as a wartime pilot, he was shot down over Burma and walked through enemy territory to freedom, despite being quite severely burned – he was still scarred. He had, after the war, learned to dive, and spent some years diving with Jacques Cousteau. He continued taking exploring and diving holidays in the Far East well into his 80s.

The IMCA's report to the BIA provided evidence that Mr Smith had always had a high tolerance of risk. The BIA assessed that his wish to return home was not a decision made with capacity, since he could not remember relevant information such as his disability and need for personal care and prompting. However the IMCA explained that he had sufficient money to enable adaptations to be made to his house, and could also well afford carers in his own home. The IMCA had suggested at that time of admission that necessary adaptations to Mr Smith's home could be facilitated as soon as possible. Mr Smith was indeed, at the time of the DOLS assessment process, on the waiting list for an OT assessment of his house.

The BIA found that Mr Smith was being deprived of his liberty; she authorised this for a short period of time only, as the best available option, to allow the adaptations to his house to be made, and care staff employed, to enable him to go home. A best interests decision was made to move him back home as soon as possible. The OT involved Mr Smith in choosing how the adaptations were to be made (she took him to the house when she went to assess it.) A former neighbour and good friend, living in another country, came over for a month and helped Mr Smith choose care staff he liked.

Mr Smith successfully returned to his own home, and even managed a holiday abroad, with carers, in the home of his former neighbour.

Source: Supervisory Body reporting on the contribution made by the IMCA

MAIN REPORT

1. The first five years of the IMCA service

The Mental Capacity Act 2005 created the Independent Mental Capacity Advocate (IMCA) service – and, equally importantly - the legal duty to instruct the IMCA service in certain situations. The purpose of the IMCA service is both to empower and to safeguard people who may lack the capacity to make critical decisions.

The IMCA service started in 2007 when it provided a service for 5,266 people and has been providing a statutory service for five years. During 2010-2011, it provided a service for 11,899 people. This is an increase of 120% over the five years.

The duty to instruct the IMCA service applies to specific decisions for people who lack capacity to make those decisions. The decisions identified in the original Act were: serious medical treatment and a move to, or a change in, long term accommodation. Regulations then introduced two further decisions where an IMCA service may be instructed: adult protection and care reviews. Apart from adult protection cases, where additional criteria do not apply, eligibility is targeted to those without the support of family and friends to assist in decision-making. IMCAs have been providing support to people in all these areas since April 2007. Two years later, IMCAs were given additional duties under the Deprivation of Liberty Safeguards.

What is unique about the IMCA service is that it is a statutory service provided by the voluntary sector; that it is a national service provided by some 60 local providers; and that it sets out to empower as well as to safeguard. It is accountable to local commissioners as well as local clients; it works with both the NHS as well as the 152 local authorities; and it is designed to support and represent people as well as challenge and change organisations and their practices. It works on the interface of law, social care and health care, and at a time when commissioners are looking very closely at all their services, the IMCA service remains the organisation best placed to report to commissioners on the effectiveness of mainstream services to effectively meet the needs of those with mental impairments.

The Deprivation of Liberty Safeguards

The Mental Capacity Act 2005 was amended by the Mental Health Act 2007. This added the Deprivation of Liberty safeguards. These safeguards focus on some of the most vulnerable circumstances that people in our society can find themselves in: where for their own safety and in their best interests, people need to be accommodated under care and treatment regimes that have the effect of depriving them of their liberty, but where they lack the capacity to consent to the regime.

The Deprivation of Liberty Safeguards (DOLS) extended the IMCA role to act as a key safeguard to people who may be subject to this legislation.

There are three distinct IMCA roles in the Deprivation of Liberty Safeguards. These are referred to by the Sections in the amended Mental Capacity Act where they are described.

- Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.

- Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.

- Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

These roles have distinct powers and responsibilities. Collectively in the report they are referred to as the DOLS IMCA roles.

The data

Since the IMCA service began in April 2007, IMCA providers have been recording details about each case on a national database maintained by the Health and Social Care Information Centre. This report provides information from the IMCA organisations, about recorded IMCA instructions which were made on or between the 1st April 2011 and the 31st March 2012.

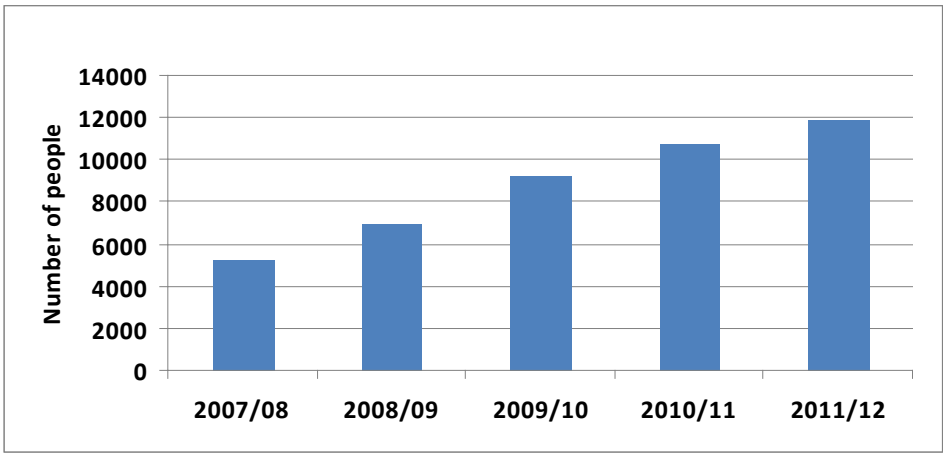
The database records data for England and Wales. This report only includes the data for England. The data presented here was collected on the 15th October 2012. There is some slight variance with the figures contained in the earlier annual IMCA reports due to data being added late by IMCA providers. All the data in the report only refers to eligible referrals – so where an IMCA service receives a referral which is not eligible – for example because the person is under the age of 16, these referrals are mainly not progressed and not reported here. This is consistent with previous reports, where the focus is on the number of people who benefited from the service, not the referrals made.

2. The people who receive IMCA support and representation

There were a total of 11,899 people receiving IMCA support and representation during year 5. This represents an increase of 9% on the previous year.

The total number of referrals for the first five years show an increase of 120% over the five years, with some 6000 more people benefiting from IMCA support and representation in the last year than in the first year of the IMCA service (Table 1).

Table 1 Number of people receiving IMCA support/representation over the last 5 years



A*ccommodation decisions* continue to dominate the work of the IMCA and they have increased by 6% from last year. There are now nearly 5000 accommodation decisions involving representation from IMCAs. The accommodation decisions continue to be the largest category of decision requiring support in each year (Tables 2 and 3).

The figures also show a year on year increases in all areas of IMCA work nationally, with one exception (Tables 4-6).

***Adult protection* cases have seen a small decline (2%) over the last year, from 1564 to 1533, which is surprising** (Table 7). Local authorities report that adult protection cases generally appear to be increasing across the country, so it is not clear why the numbers of adult protection cases with IMCA support have decreased from last year.

Table 2: Referrals: by decision type over the last 5 years

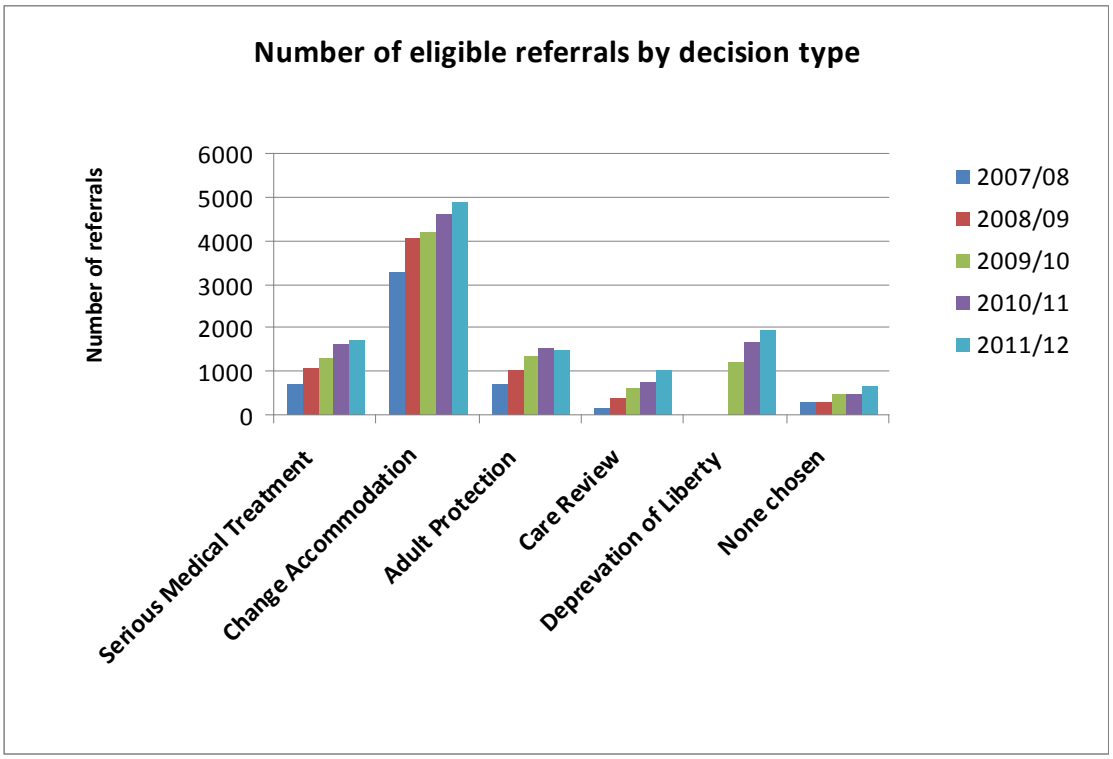


Table 3: Number of referrals over the last 5 years

	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty
2007/08	728	3304	725	199	0
2008/09	1093	4086	1071	412	0
2009/10	1331	4207	1371	620	1257
2010/11	1657	4619	1564	767	1683
2011/12	1743	4916	1533	1032	1979

Table 4: Serious Medical Treatment (SMT) cases with IMCA support over the last 5 years

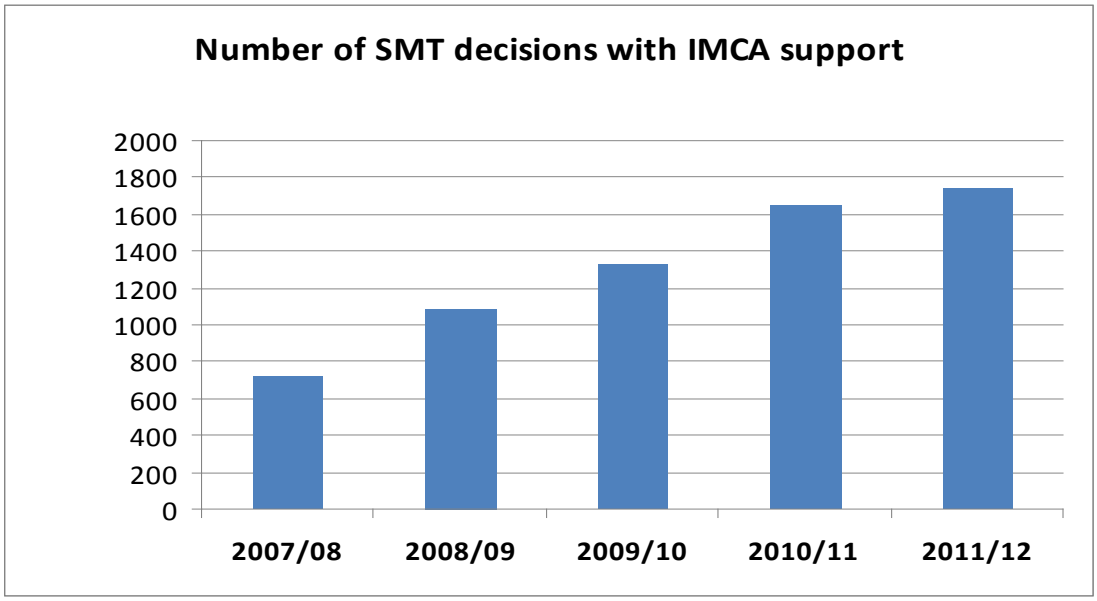


Table 5: Change of Accommodation cases with IMCA support over the last 5 years

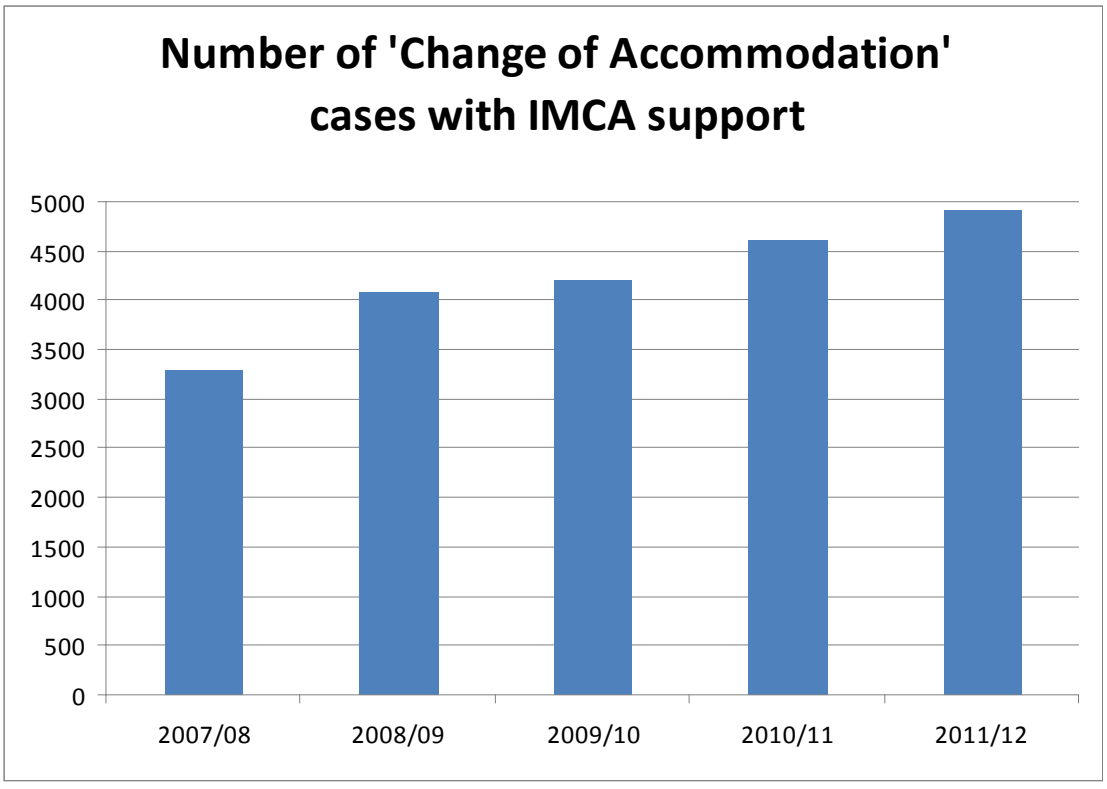
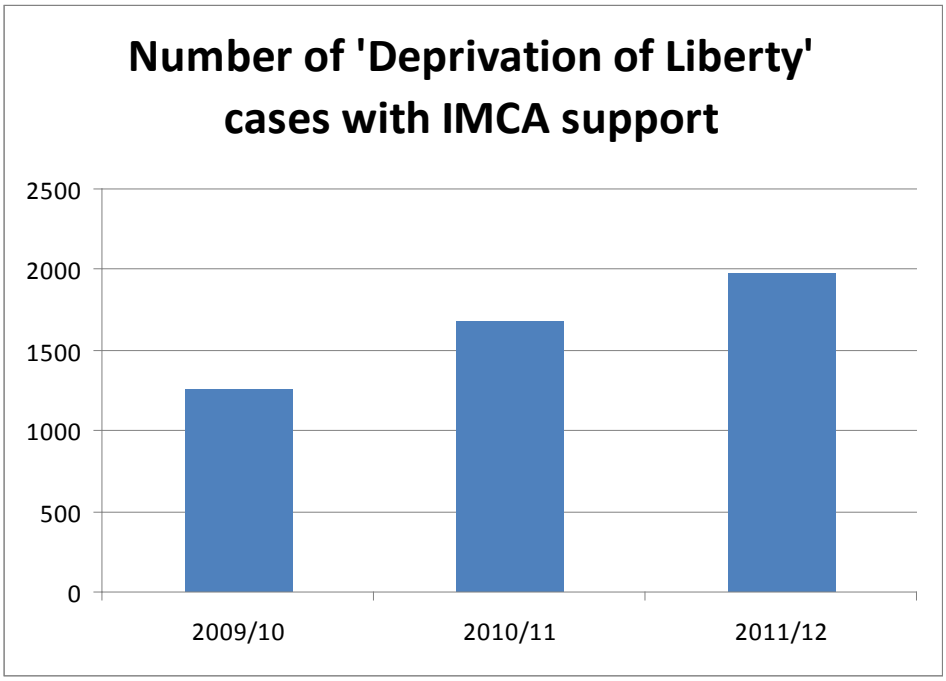


Table 6: Deprivation of Liberty cases with IMCA support over the last 3 years *



* The Deprivation of Liberty Safeguards were introduced in 2009.

Table 7: Adult Protection cases with IMCA support over the last 5 years

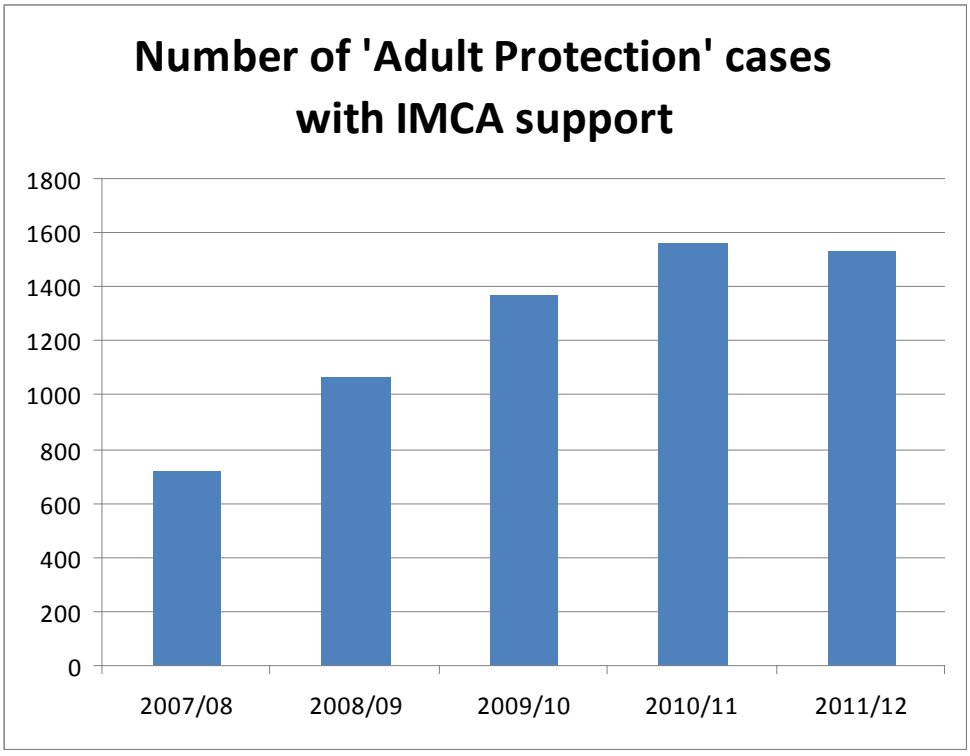
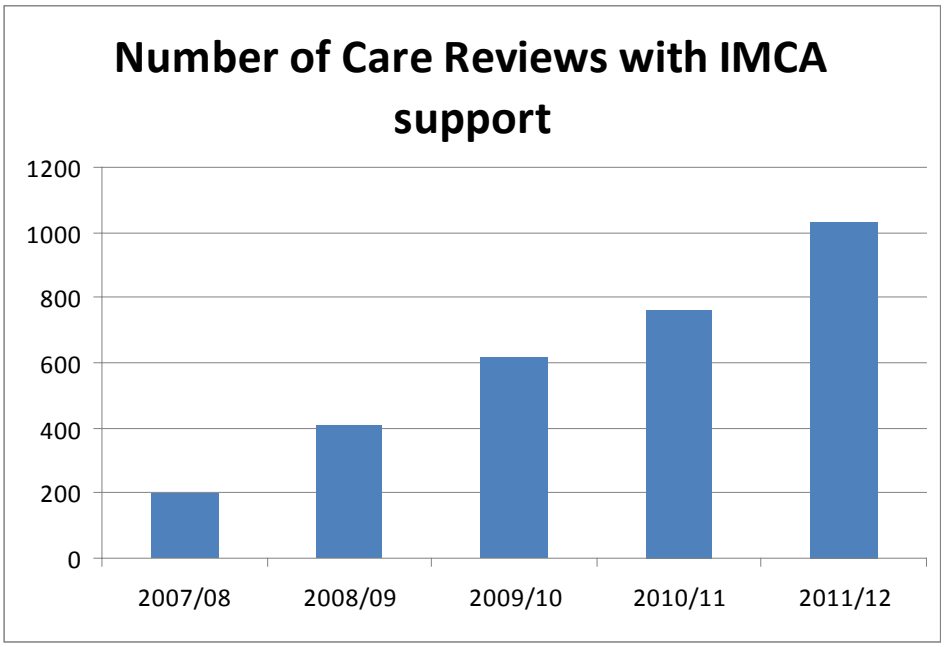


Table 8: Care Reviews with IMCA support over the last 3 years

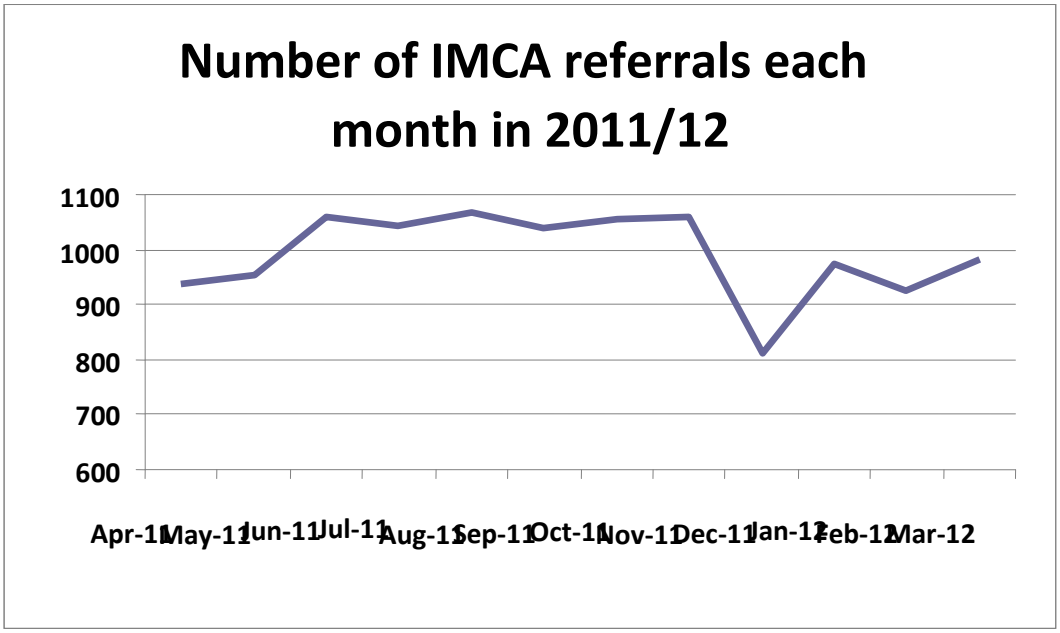


The number of *DOLS instructions* in the fifth year (1,979) shows an increase of 18%. There were nearly two thousand DOLS referrals to IMCAs in the last year. These decisions are now more than that for serious medical treatment (SMT) – while last year they were of similar magnitude. (Tables 3 and 6)

The number of *care reviews* has increased by 32%, which is the highest percentage increase. However the numbers are the low, and at 1,032 they are still the lowest of the five types of decision. (Tables 3 and 8)

We looked at the total numbers of eligible instructions during 2011/12 by months. There is one clear dip during the month of December. This may reflect holiday patterns in local authorities and NHS trusts affecting levels of instructions. The dip in the previous year during August appears not to be repeated during 2011. (Table 9)

Table 9: IMCA referrals by month during 2011/2012.



The people who benefit from the IMCA service

We collected information on the gender and age of the people who receive IMCA support (Tables 10 and 11) and also about the nature of their disabilities or impairments.

Overall gender differences continue to be small. However:

- There are slightly higher numbers of men receiving IMCA support for serious medical decisions than women.

- For safeguarding/adult protection cases the reverse is found: there are one third men and two thirds women.

- For accommodation decisions, care reviews and DOLS there is little difference between the number of men and women being supported by the IMCA service.

Age

There has been very little difference in age categories over the last five years (Table 11). As before, some 60 per cent of clients are over 65 years of age and 35 per cent are aged 80 or above. The latter category, those aged 80 or above, has increased. The number of people aged 80 or above who are receiving support form IMCAs is 4263. This increased from 3804 last year – a sizeable increase. IMCAs can be provided to people aged 16 and 17 and there were 40 such referrals last year. This number remains low, although is increasing.

We examined age variations in the reasons for instructions (Table 12).

- The age profile for serious medical treatment decisions stands out as being significantly different. There are fewer older people receiving serious medical treatment in the group that receive IMCA support.

- In all other groups it is people aged 80 and above who are the largest age group. This includes the population who are subject to the Deprivation of Liberty safeguards.

- The difference between the numbers and proportions who 'change accommodation' and then go on to have a care review involving an IMCA is also surprising. Far fewer people in each of the categories carry on to have a care review.

Table 10: Type of eligible instruction by gender during 2011/12

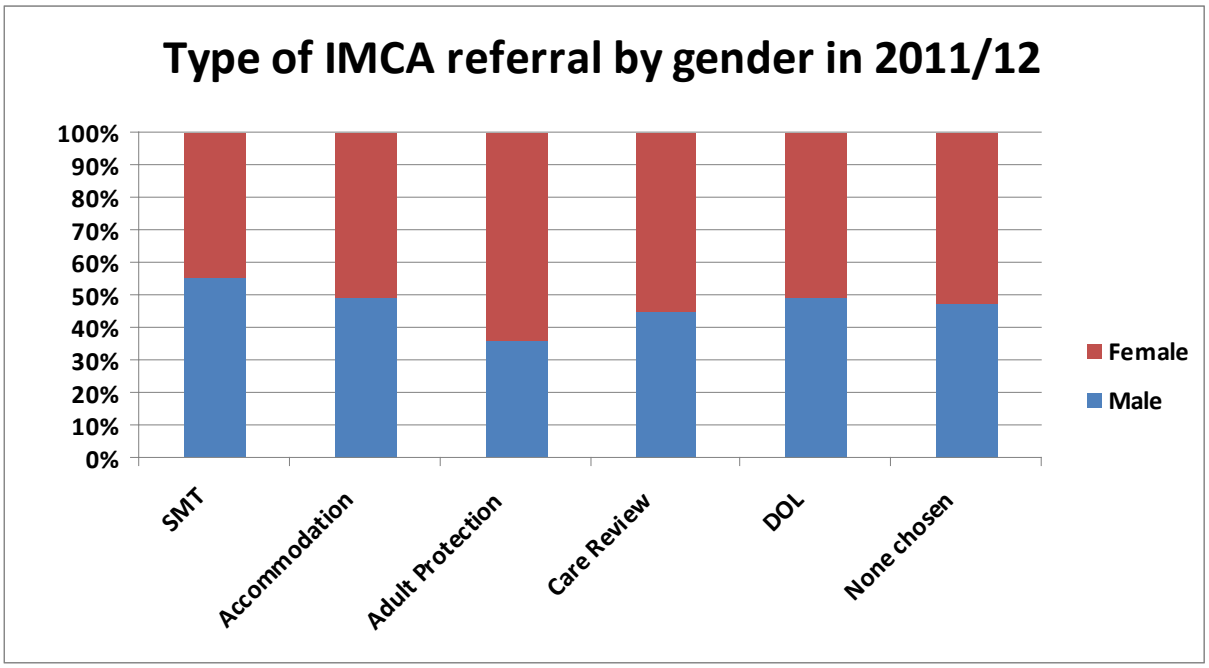


Table 11: Instructions by age profile for last 5 years

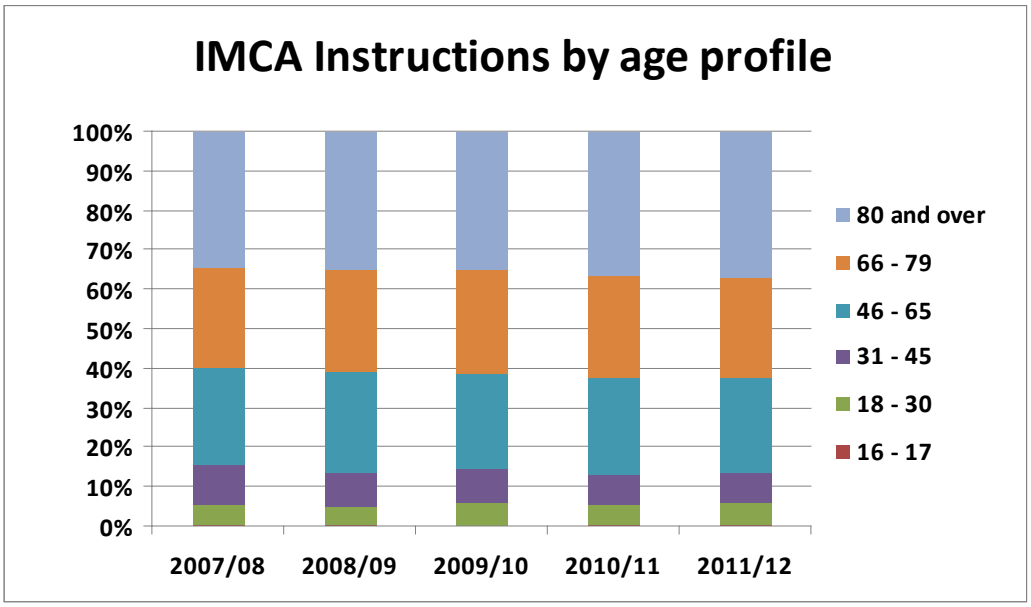
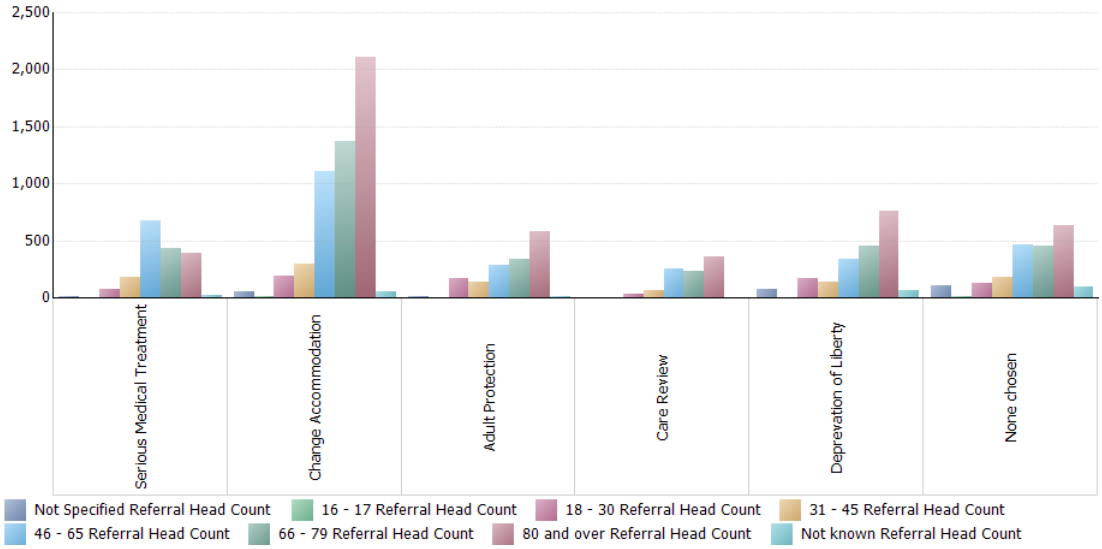


Table 12 Age profile by reason for instruction, 2010-11



Ethnicity

The ethnicity of the people receiving IMCA support, where known, is broadly in line with the population of England for the relevant age groups (Table 13)

Table 13: Ethnicity of people receiving the IMCA service, 2011/12

Ethnicity	Number	%
White	10,572	88.8
Asian or Asian British	257	2.2
Black or Black British	380	3.2
Chinese	39	0.3
Other	136	1.1
Unknown	515	4.3
Total	**11,899**	**100**

Types of impairment

The IMCA service is for people who have a mental impairment. The first stage of a mental capacity assessment is to identify if a person has an impairment of the function of the brain.

We examined the different mental impairments recorded, in Table 14 and Table 15. The most common impairments for people receiving the IMCA service in year 3 were:

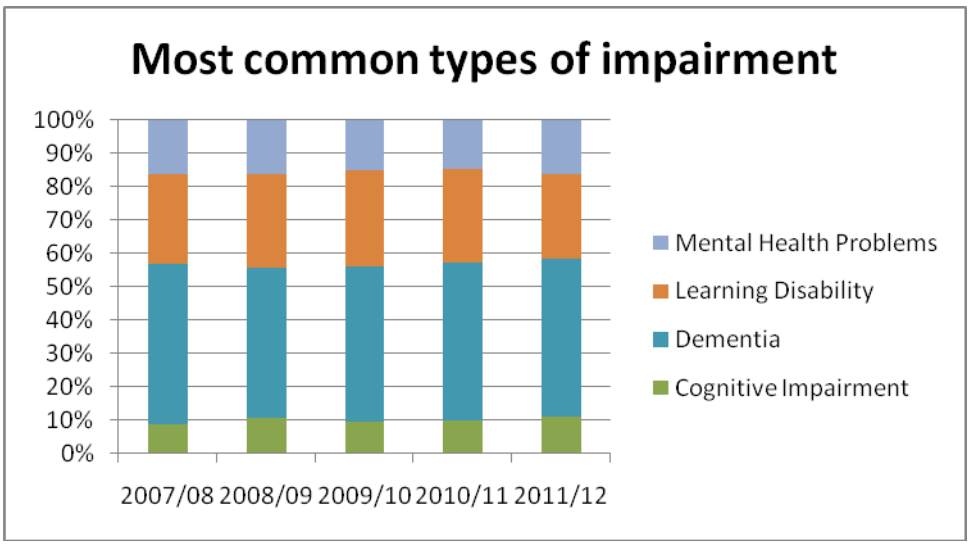
- dementia (38%),
- learning disabilities (20%) and
- mental health problems other than dementia (13%).

These are very similar to the figures for the previous year. The profile of impairment has not changed over the past 5 years.

Table 14: Number of IMCA cases by type of mental impairment, 2011/12

Mental Impairment	Number	%
Acquired Brain Damage	640	5.4
Autism Spectrum Condition	265	2.2
Cognitive Impairment	1,050	8.8
Combination	357	3.0
Dementia	4,545	38.2
Learning Disability	2,444	20.5
Mental Health Problems	1,531	12.9
Not Specified	308	2.6
Other	277	2.3
Serious Physical Illness	429	3.6
Unconsciousness	53	0.4
Total	**11,899**	**100.0**

Table 15: Impairment and type of instruction, over the past 5 years



3. Where were people staying when the IMCA was instructed

We asked where the person was staying at the time of the IMCA instruction, where this was recorded (Tables 16 and 17). There was little change over previous years.

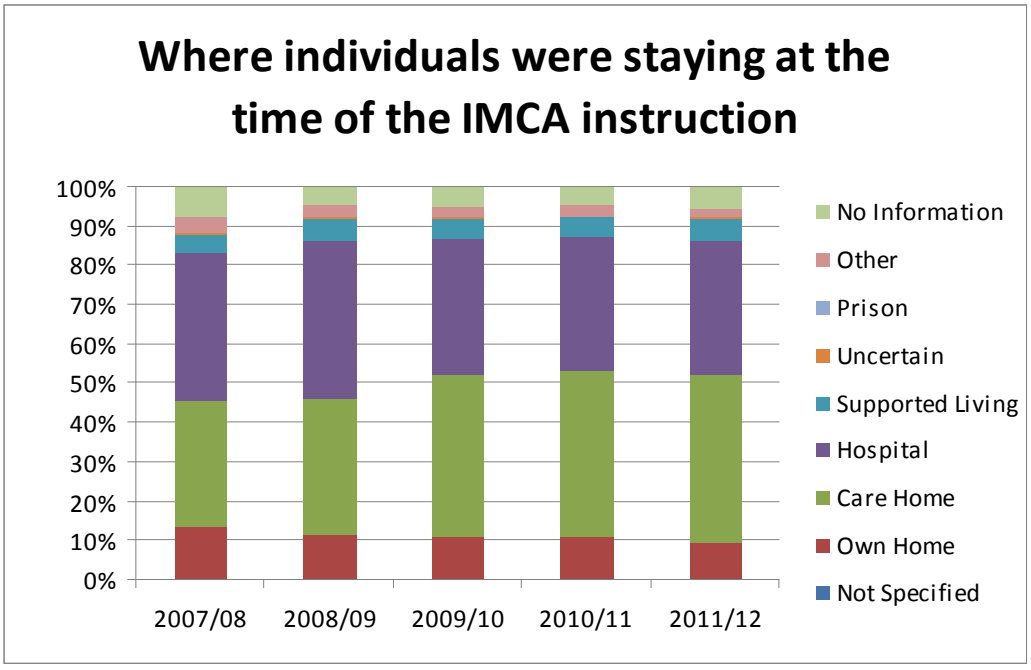
The largest group of people in 2011-12 were:

- 5080 people staying in a care home (43%), followed by
- 4032 people in a hospital (34%).
- Fewer than 10% were in their own homes (this is down from 16% last year).
- The number in supported living was low (674) – but had increased by 25% over the last year.

Table 16: Where people were staying at the time of instruction in each of the last 3 years

	Not Specified	Own Home	Care Home	Hospital	Supported living	Uncertain	Prison	Other	No Information	Total
2009/10	36	987	3820	3219	477	12	2	272	452	9277
2010/11	78	1105	4544	3687	530	33	4	298	508	10787
2011/12	27	1134	5080	4032	674	38	3	249	662	11899

Table 17: Where people were staying at the time of the instruction over the last 5 years.



Where the person was at time of instruction

We were interested in where people were staying or living at the time of instruction, for each type of decision (Table 18).

Of those people living at home and receiving IMCA support, the largest proportion were people with adult protection/safeguarding referrals.

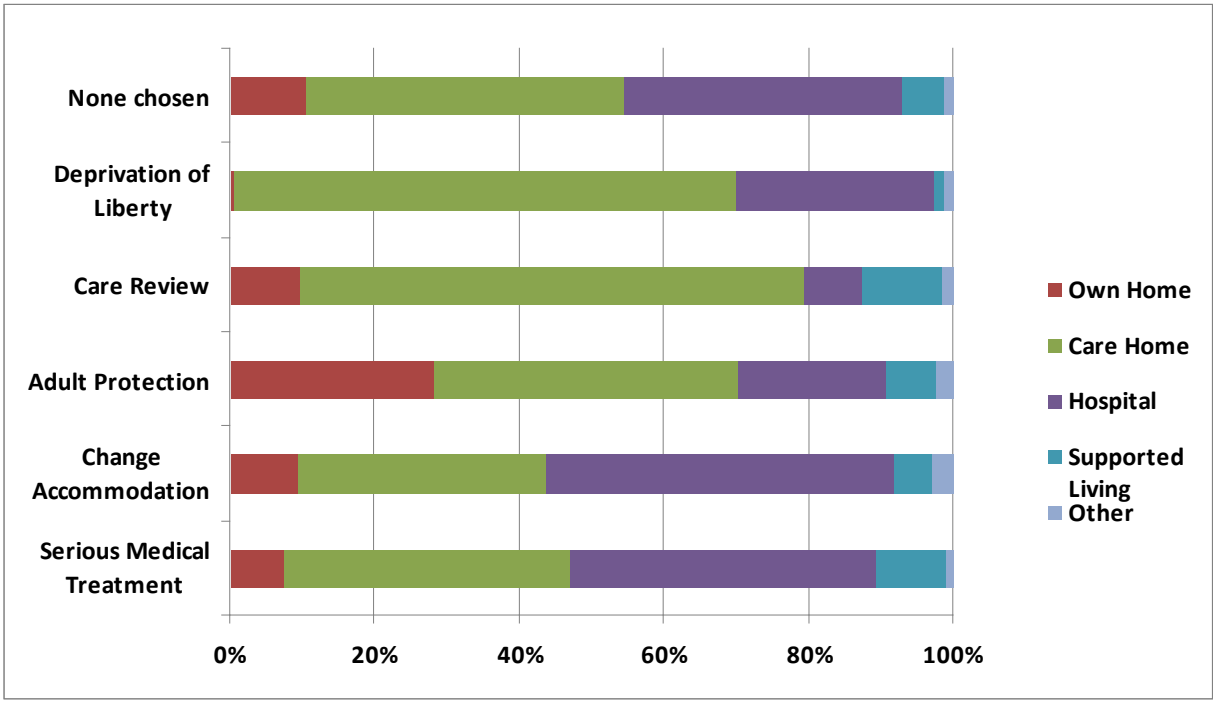
Nearly a third of the safeguarding referrals were for people living in their own homes, in the community. Over a third of those receiving IMCA support for safeguarding were in care homes.

People receiving IMCA support and representation for care reviews were mainly living in care homes; some 70% were in these settings. Only 10% were in their own homes – which raises questions about whether care reviews in the community may not be perceived as generally requiring an IMCA.

Referrals for a change of accommodation came for people in all settings; however the largest category was for people in hospitals.

Deprivation of liberty referrals should only take place for people in care homes/ nursing homes and hospitals. The small numbers in supported living may be people about to be moved into a care home or hospital.

Table 18: Where people were staying for different IMCA instructions, 2011- 12



4. Serious medical treatment decisions

There is a duty to instruct an IMCA when a serious medical treatment decision needs to be made in the best interests of someone lacking capacity to make that decision, where the person does not have anyone appropriate to consult. Serious medical treatment is defined broadly in regulations.

One thousand and seven hundred and thirty two referrals were made to IMCAs for serious medical treatment decisions.

IMCAs were involved in a range and number of medical decisions (Table 19).

Some of the numbers in the categories are surprising in some respects, with nearly twice as many referrals for dental treatment as for cancer. There were 223 referrals for DNAR and 60 for artificial nutrition and hydration.

There were 23 referrals for major amputations. There were five referrals for ECT. The largest category was for 'medical investigations'.

Table 19: Serious medical treatment decision, 2011-12.

Serious Medical Treatment	Number of IMCA referrals	% of all SMT IMCA referrals
Not Specified	39	2.2
Cancer Treatment	126	7.2
Hip / Leg Operation	30	1.7
DNAR	223	12.8
Medical Investigations	322	18.5
Serious Dental Work	233	13.4
Affecting Hearing/Sight	47	2.7
ECT	5	0.3
Major Surgery	74	4.2
Major Amputations	23	1.3
ANH	60	3.4
Other	561	32.2
Total	**1,743**	100.0

5. IMCAs and Safeguarding

The Information Centre collect statistics on the total number of ‘safeguarding alerts’ in local authorities. For the same period, for 2011-12, the Information Centre reported 130,000 safeguarding alerts in the 121 local authorities which reported this data. This figure had increased by about 23% from the previous year.

IMCAs can only support those who lack capacity. It is not known how many of the 130,000 people lacked capacity to make their own decisions in relation to safeguarding.

The number of people benefiting from the support and representation of IMCAs in adult protection cases is 1,533 and the number has declined. Both these issues are of concern. It is not clear why only 1% of people who are subject to safeguarding referrals and investigations receive the support of an IMCA. It is also not clear why the number has declined, when the overall number of people receiving IMCA support has increased by 9%.

The Local Authorities which have made fewer or the same IMCA referrals for adult protection in the last year than in previous years are highlighted with a ‘*’ in Appendix A.

Safeguarding

For the first time in five years, the number of cases where IMCAs have been representing people who were subject to safeguarding has declined.

There are 1,533 safeguarding IMCA referrals in the context of national data showing there are over 130,000 reported safeguarding cases per year.

6. The outcomes of the accommodation decisions

We were interested in where a person was staying at the time an IMCA was instructed.

Of the accommodation decisions,

- almost half were about where a person should move to after a stay in hospital (48%).
- other accommodation decisions involved people living in care or nursing homes (34%),
- and small numbers from their own home or some form of supported living.
- for the remaining accommodation decisions, the original accommodation was recorded as 'other'. (Table 20)

When looking at all decision types,

- the largest group of people in 2011-12 were staying in a care home – 5080 people (43%);
- this was followed by 4032 people being in a hospital (34%) when an IMCA was instructed.
- fewer than 10% were in their own homes (this is down from 16% last year).
- the number in supported living was low – but had increased by 25% over the last year.

We compared where the person was staying when the IMCA with instructed with the outcome of the accommodation decision where this is known. However the data for Table 21 is very poor. The table is based on only 5577 out of the 11,899 possible cases; and even within these, there are a large number who have been labelled as 'TBD – to be decided'. There are many reasons why this table is unsatisfactory – a combination of inputting omissions, early entries and also some persons dying before a decision was made or where the decision is yet to be made may in part explains why so much data is missing here.

There are other problems. The lack of a clear distinction between 'own home' and 'supported living' also makes some of these results difficult to interpret. For example, if someone is living in their own home and the outcome of the accommodation decision is to provide a package of support to allow them to continue to live there it is not clear whether the IMCA provider recorded the outcome as 'own home' or 'supported living' (It should be 'own home'). Where a person is shown to stay in the same type of accommodation they may still have moved, for example, from one care home to another.

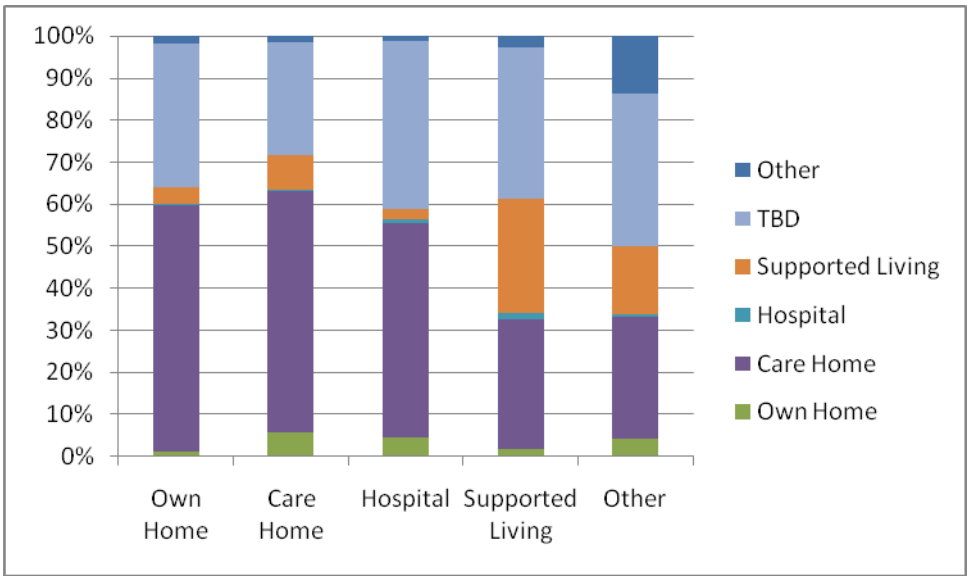
The table suggests that:

- very few people who are in their own homes, stay in their own homes; most move into care homes, but some move into supported living;
- most people in care homes stay in or move to other care homes; but some do return to their own homes and some move to supported living.
- most people in hospitals move to care homes
- people in supported living are most likely to have a diversity of accommodation decisions.

Table 20: IMCA referrals by where people were at the time of the referral, 2011-12 (numbers)

	Not Specified	Own Home	Care Home	Hospital	Supported Living	Uncertain	Other	No Information	Total
Serious Medical Treatment	3	125	673	722	162	5	20	33	**1,743**
Change Accommodation	11	454	1,639	2,315	256	19	146	76	**4,916**
Adult Protection	4	422	629	304	103	7	39	25	**1,533**
Care Review	4	98	706	82	111		18	13	**1,032**
Deprivation of Liberty	2	12	1,336	525	29	3	26	46	**1,979**
None chosen	3	23	97	84	13	4	3	469	**696**
Total	**27**	**1,134**	**5,080**	**4,032**	**674**	**38**	**249**	**662**	**11,899**

Table 21: Outcomes of accommodation decisions, 2011-12.



IMCAs may have an impact on the type of accommodation but also on the choice of accommodation, how well a particular care home will represent the person's best interests and on the support the person receives whether in their own home or in a care home. These can happen by IMCAs providing information to the care home provider about the person's history, needs and wishes.

IMCA reports are an important provider of 'life story' information for a person. Having statutory rights to look at information provided in both social care files and NHS files, allows IMCAs to build up a picture of the person's previous experiences and wishes and this is invaluable in developing personalised care in the future. It is possible that there are no further opportunities to put together 'life story' work after a move has taken place.

7. The Deprivation of Liberty Safeguards

This report provides data on the third year of the IMCA roles in the Deprivation of Liberty Safeguards, as these safeguards began at a later date than the rest of the MCA.

The three roles are:

- Section 39A IMCAs: Supporting and representing people who are being assessed as to whether they are being, or need to be deprived of their liberty.
- Section 39C IMCAs: Covering gaps in the appointments of relevant person's representatives for people who are subject to an authorisation.
- Section 39D IMCAs: Providing support to a person or their unpaid relevant person's representative in relation to their rights where a deprivation of liberty has been authorised.

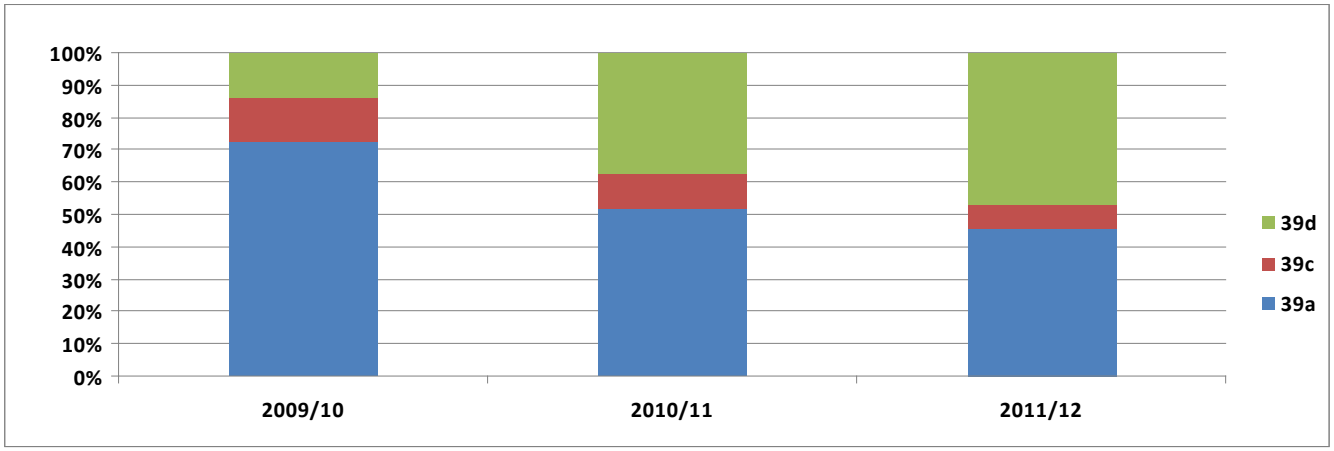
Total numbers of IMCA DOLS referrals have shown a steady increase. In the first year there were 1235 IMCA DOLS referrals; in the second year there were 1667 and in the third there were 1949 (Tables 22-25).

We examined the breakdown of the DOLS instructions in Table 22. There has been little change in 39a and 39c IMCAs. However 39d IMCAs have increased dramatically: from 174 in the first year, to 620 in the second year and 910 in the third year.

Table 22: Breakdown of IMCA DOLS support for each of the last 3 years

	39a	39c	39d	Total
2009/10	898	163	174	1,235
2010/11	873	174	620	1,667
2011/12	888	151	910	1,949

Table 23: Distribution of different IMCA-DOLS support for the last 3 years



To help understand these changes it is helpful to relate this to the statistics published for DOLS activity across over the last three years.

Section 39A IMCAs must be provided for those people who are either:

- being assessed as a result of an application for a standard authorisation, or
- being assessed for a potential unlawful deprivation of liberty (also referred to as third party requests)

where the person does not have anyone independent (e.g. a family member or friend) who can support and represent them during the assessment process.

The rate of section 39A instructions related to applications for standard authorisations has decreased from 12.5% to 9.7% and then to 7.8% (Table 25).

Both 39C and 39D IMCAs are only available to people who are subject to an authorisation.

Section 39D instructions are shown to have increased significantly over the three years. The 39D IMCA is an important safeguard to ensure both the person and their relevant person's representative understands their rights when an authorisation is in place.

This includes the IMCA ensuring that the person and their representative understand that they have the right to have an authorisation reviewed, and they have the right to access the Court of Protection. The increased use of 39D IMCAs is welcomed. The table in the appendix shows which local authorities are high users of 39D.

The ADASS/SCIE good practice guide covering this area recommends for *"supervisory bodies to instruct 39D IMCAs at the start of **all** standard authorisations where a person has a family member or friend appointed as their representative. This gives the person and their representative the opportunity to meet a 39D IMCA and so that they are in a better position to decide if they need the support of one at that point, or sometime in the future. "*

It is possible that early instruction of a 39D IMCA in the Stephen Neary case[1] may have ended his unlawful deprivation of liberty sooner. IMCAs can support family members (who are appointed as the relevant person's representative) about the right to challenge the DOL authorisation. They can also negotiate less restrictive conditions to remove the deprivation, they can ask for independent mediation and/ or they can challenge the DOL in the Court of Protection at no cost.

We looked at the reason recorded for the 612 section 39D IMCA instructions in 2011/12 (Table 26). They may be instructed by the supervisory body because the person or their relevant person's representative requests this support, or because the supervisory body believes that it would be of benefit to either or both.

[1] Steven Neary; LB Hillingdon v Steven Neary (2011) EWHC 1377 (COP). Available on www.bailii.org

In contrast to the 39D instructions, there is a downward trend in the number of 39C instructions as a proportion of people who were subject to a standard authorisation at the end of the quarter Also the number of 39C instructions was lower in 2011/12 than in the previous year and in the year before that.

This trend probably reflects both IMCA providers and supervisory bodies gaining a better understanding of the circumstances when the requirements for 39C IMCA instruction will be met.

Specifically there first needs to have been a family member or friend who has been appointed as the relevant person's representative, but is either unwilling or unable to continue in this role. Secondly there needs to be no one else available in the person's network who could step into this role. It is possible that in many cases where a 39C IMCA has been instructed, the supervisory body, to comply with the legislation, should have instead appointed a paid relevant person's representative.

Table 24: Types of IMCA DOLS support in 2011/12

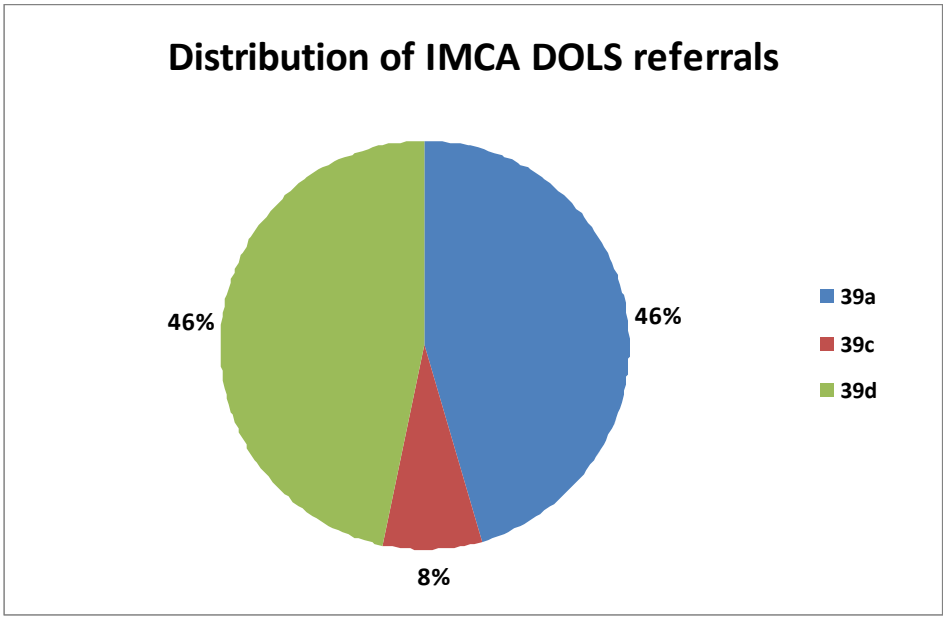
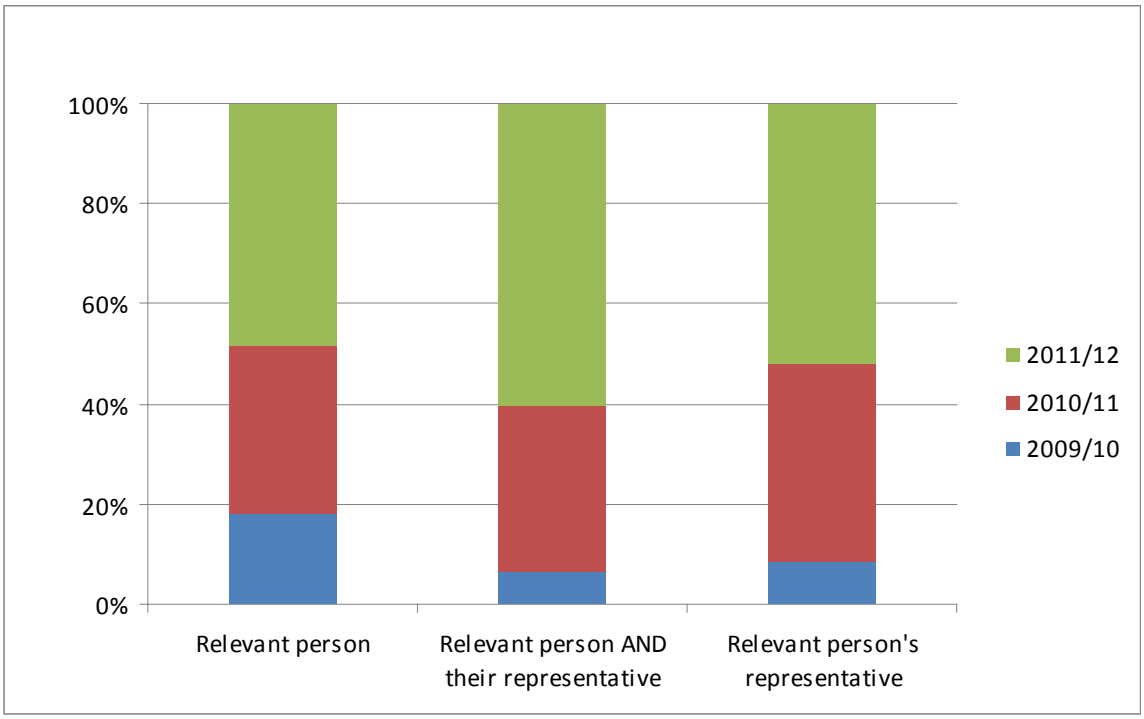


Table 25 Section 39A instructions as a proportion of total DOLS assessments

	2009/10	2010/11	2011/12
Applications for standard authorisations*	7,157	8,982	1,1393
Section 39a IMCAs	898	873	888
% of 39A instructions from all IMCA DOLS assessments	**12.5%**	**9.7%**	**7.8%**

* This data is from the separate DOLS collection published by the Information Centre.

Table 26: Who 39D IMCAs were requested to support



8. IMCA reports

IMCAs are required to produce a report for the person instructing them. There is a legal requirement for these reports to be taken account of, when decisions are being made.

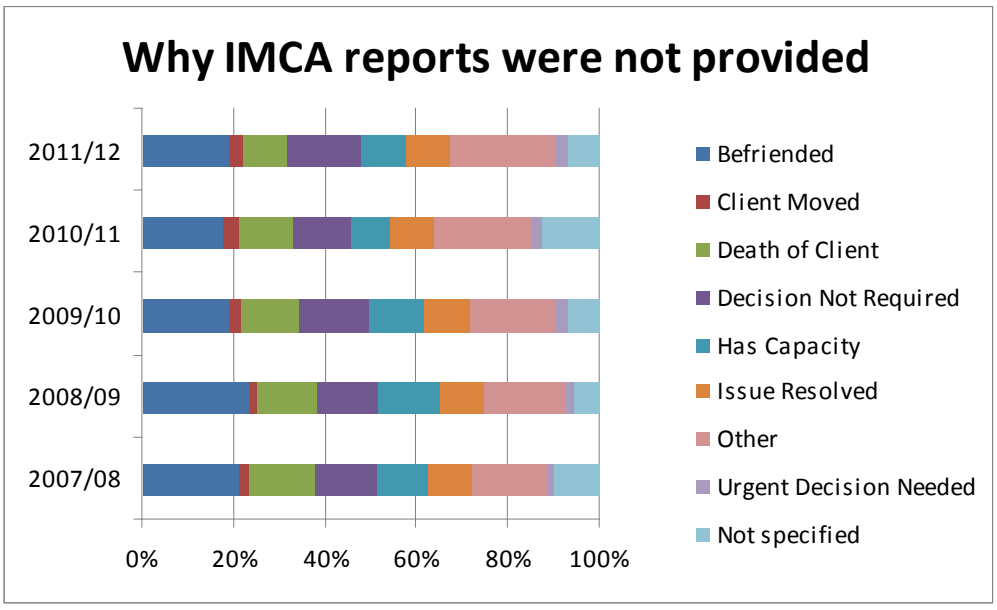
IMCA reports were provided for just fewer than 70% of the 8948 eligible instructions which had been marked closed by the time this data was drawn.

Table 27 show the reasons why reports were not provided for 30% of the cases. These include, amongst other, that the person was found to have capacity and that a decision was not required or the client had died.

Table 27 Reasons why IMCA reports were not provided

	Befriended	Client Moved	Death of Client	Decision Not Required	Has Capacity	Issue Resolved	Other/ not specified	Report submitted	Urgent Decision Needed	Total
2007 /08	273	27	189	177	148	121	358	3346	18	4,657
2008 /09	438	31	252	253	258	184	464	3978	29	5,887
2009 /10	427	58	282	344	280	226	596	5466	53	7,732
2010 /11	414	77	279	306	208	226	811	6378	56	8,755
2011 /12	502	77	263	420	276	257	815	6261	77	8,948

Table 28 Comparisons of reasons why IMCA reports were not provided



9. Reflections of IMCAs

IMCAs are asked to reflect on each of their cases, on working with the people who made the referrals, and to consider the outcomes that were achieved. These reflections are inputted into the national database.

We first show in Table A the range of people who make referrals to the IMCA service. This shows that large numbers of different professionals refer clients to the IMCA service and IMCAs need to engage with and work with a very large number of different professions.

Table A: Examples of Professionals making referrals to the IMCA service

Social worker	Dols team	Ward manager	Discharge team	Safeguarding team
Care home manager	Older persons mental health team	LD service	Consultant in Intensive care	Care Management team
Care Manager	Continuing Care team	Consultant psychiatrist	MCA Co-ordinator	Mental Health Act office
CPN	CMHT	Staff nurse	Named Nurse	Hospital social work team
Nurse Reviewer	Joint Commissioning Manager	Doctor	Consultant Cardiologist	LD Community Nurse
Behaviour Support Specialist	Dementia Care Team	Assessment Team	Review Team	Brokerage Team
Dentist	Support Team	Alternative Futures team	Supported Living manager	Reassessment Team
Hospice	Doctor HIV ward	Early intervention in psychosis team	Speech and Language team	AMHP
Re-ablement Team	OTs	Orthogeriatric Care Team	Junior Doctor, Rheumatology	Best Interest Assessor
GP	Gastroenterology Team	Burns Unit	Key Worker	Physiotherapist
Respiratory Consultant	SALT	Registrar	Physical and Sensory Disability team	HM Prison
GPs	Child social worker	Community Care worker	Senior Dental officer	SEQUAL team
Nursing home	Continuing Care Team	McMillan Nurse	Campus Renovation team	Special Needs team

Head matron	Registrar	Cardiology	High Dependency Unit	Urgent Care team
Funding Authority	Solicitor	MIND	Stroke Team	Official Solicitor
Pathway Coordinator	Senior Practitioner	Investigation Officer	Complex case sister	Legal department

We then present a selection of reflections by IMCAs on their work. We have loosely categorised them into different headings, to illustrate some of the factors which lead to cases 'going well' and cases which posed 'difficulties'.

There are large numbers of comments on the importance of good communication. There are also comments where IMCAs are critical of their own work as well as critical of others. There are some comments on cases which illustrated good outcomes, as well as a sizeable number of cases which terminated because the person was found to have capacity; was found to have relatives who could appropriately be consulted or who had died before the decision had been made. These comments are not statistically representative; but they were chosen to illustrate some key themes in relation to the work of IMCAs.

The reflections in Table B suggest the following are important: good communication; speed of response; working well with other professionals; being pro-active; identifying 'all the options' and ensuring they are considered; personal skills, person centredness, advocating effectively.

The same table also illustrates some of the difficulties that were experienced: when cases are slow to be progressed within health and social care; when cases need to carefully weigh up issues of protection and autonomy; when health conditions make a person's future uncertain; when multiple impairments lead to few available options; when there are disagreements between family members or between professionals; where the decision to be made is one of many with different people involved in each; and where risks are perceived differently and managed differently by different people.

Table B: IMCA's comments on cases which went well and cases with difficulties.

IMCA's comments on their cases

<u>Cases which went well</u>

a. There was good communication. I was pro-active about seeking information
b. Responded quickly. Worked together well with everyone.
c. I ensured that all options were fully covered.
d. I took the referral and did the case all on the same day – meeting with the client and attending BIA meeting and writing the report.
e. We received a letter of complement from the Neuro-psychologist at the hospital

f. The hospital was conscientious in seeking the views of the IMCA prior to the decision being made to operate.
g. The consultant was very person centred and aware.
h. The IMCA was the most consistent person in this client's life, ensuring that information on the client's background and best interests was available to all the changing professionals.
i. High levels of diplomacy were needed, and used, to ensure that the needs of the client did not get overlooked in the tussle between the LA and the care provider.
j. Previous involvement from IMHA had made relatives and ward staff very wary of advocacy and high levels of skills were needed to manage this.
k. I steered the MH team through the best interests decision making

Difficult cases

a. A great deal of effort and contact was needed to move this case forward. It seemed to be the bottom of everyone's priority.
b. A complex case about controlling obesity while balancing with liberty/autonomy
c. Difference of opinions with prognosis made this a difficult case.
d. Frustrating case as I could not identify a decision maker – no one wanted to be seen as one,
e. A complex case: the client had multiple sensory impairments and I did multiple visits to possible placements.
f. There were difficulties between the family and care management. The IMCA gave everyone a lot of time and space.
g. Client insisting on going home as the client did not want her daughter to access her property.
h. Quick response to an urgent situation – patient with Korsacoff's Syndrome fit for discharge but at risk alone at home.
i. This was an extremely complex case requiring 2 IMCA reports; there was an IMHA as well as an IMCA and also the possibility of a DOLS. The client changed their mind half way through the case and this influenced my representations significantly. The outcome however for the client was very good. It was all worth it.
j. This case had two decision makers. The first wanted me to consider the proposal that the son would be removed from the household in my client's best interests. Then there was a different decision maker who took a completely different tack. He felt that better and further case work was needed at his end. He got the adult protection alert switched off and began to minimise the risks through social work.
k. This was a long and complex case involving a formal challenge against the housing policy of the borough – which was won. Unfortunately the client was diagnosed with a terminal illness shortly before any move, and it was felt best that the proposal should be withdrawn – thus the case was closed.

Table C shows some reflections on the importance of good communication – and the problems of poor communication. This included situations where a DOLS authorisation took place before a BIA spoke to the IMCA – which should not have happened; it includes situations where it

appeared hard to contact decision makers and situations where contact was not difficult but being 'heard' or listened to, was difficult.

Table C: IMCAs raising issues to do with poor communication

Poor Communication
a. Authorisation took place before the BIA spoke to the IMCA. b. Unable to get information from LA about how they were going to deal with the situation. c. I spent more time chasing the decision maker than with the client. d. I had to be assertive to ensure that the doctor listened. e. The case remained on duty and they did not allocate a social worker to him despite repeated requests. f. As often seems to be the case, safeguarding referrals were steeped in anxiety and it was necessary to tease out the proposed protective measures. g. Patient was discharged before the doctor was able to meet with me.

Table D shows IMCAs reflecting on some good outcomes. Interestingly several of these were about clients being able to stay in their own homes, although for the majority of clients this was not possible. Several were also about 'good moves' – and none of these were about moving to a residential care placement.

Table D: IMCA reflecting on some good outcomes

Good outcomes
a. I was able to advocate for a thorough review of support given to client and family, and this enabled her to stay in her own home which is what she wanted. b. The risks to the client were addressed in a creative manner, enabling her to remain in her own home. c. I accompanied the client and the OT on a home visit and as a result of this visit, the client was allowed to go home. d. I met the client and got him moved to hospital as he was both ill and frail. We then worked out what he needed next. e. I questioned the appropriateness of the unpaid RPR. f. I managed to locate a long lost relative using google – and they are now living together. g. The client was supported to move to her daughter's which is what they both wanted. h. Alerted social worker to possible breach of Article 8 and the need to apply to Court of Protection if they pursued the intended placement. i. The move was delayed, but the outcome has been excellent. A superb quality flat with all the latest telecare built in as discussed and agreed in the many meetings.

Table E shows that preparing for Court is a part of many IMCAs' work.

Table E: IMCAs preparing for Court

Court a. Took part in best interests decision making, but family disagreed so it went to the Court of Protection for a best interests decision. b. I prepared Court reports for two cases. c. I gave evidence to the Court of Protection… and the judge really listened.

In Table F we have gathered some comments where IMCAs were critical of aspects of their cases. In some cases the IMCAs were critical of themselves – they thought they had not spent enough time with the client, or had delayed the report due to other commitments or had not succeeded in being 'listened to'.

There were also cases where the IMCAs were critical of other professionals they were working with: this included arguments about funding; decisions without best interests meetings; and about the absence of action.

Table F: IMCA's critical reflections

Critical – self: a. I should have made more frequent contact. b. Delay in writing report due to case load. c. Change of IMCAs half way through did not help the client. d. Did not succeed in encouraging them to listen to the client's wishes. **Critical – Others** a. I found the LA in this case to be impolite and bullying. b. The decision was made and then the arguments over funding began. c. Decision made without a best interests meeting and not in line with clients wishes. d. Police involvement delayed decision – which was not in the client's best interests. e. This was a thinly veiled attempt to move the client to a block contract cheaper care home. f. Sent in complaint to hospital regarding multiple cancellations of procedure and highlighted inadequate MCA knowledge and process.

Table G shows some IMCAs appeared concerned with the question whether it was 'appropriate' to have an IMCA involved in various cases. This had the consequence of restricting access to IMCAs, sometimes inappropriately, and not always in the best interests of the client. Decisions about whether a medical decision is a 'serious medical decision' as defined in the Mental Capacity Act regulations needs to be made by medical staff and not by IMCAs. Similarly the decision about whether any family members are appropriate to consult is not a decision to be made by IMCAs.

Table G: 'Appropriate to consult'

Is it appropriate to use an IMCA?

a. It was clear to me this was not serious enough for SMT
b. Client had family in the USA who were able to be consulted
c. I refused the case as I thought it was ineligible
d. I spent long time proving ineligibility for an IMCA
e. I was torn between understanding that the referral would benefit the client although was not technically eligible
f. It was important to prove them wrong and not take the case
g. It was a fight but I won and refused the case.

Table H shows that in some instances where IMCAs had begun to work with new clients, this needed to be terminated. For example where the client regained capacity and went home, this was good news. But there were many more instances, where the client died 'in the middle' of a decision being made. This is clearly often distressing, and shows the frailty of many clients being supported.

Table H: Some abrupt endings

Some abrupt endings

a. Client died before he could be moved
b. Client regained capacity and went home
c. Relatives were identified and IMCA role ended
d. Died before decision could be made
e. Died and IMCA not informed.

10. Court of Protection

The Court of Protection during 2011/12 continued to hear many Best Interests and Deprivation of Liberty cases about decisions for people who lack capacity. Court of Protection judges continued to encourage local authorities and the NHS to refer cases to the Court where there are significant disagreements about what is in a person's best interests, and where there are disagreements about what may constitute a Deprivation of Liberty.

The NHS referred cases, for example, involving anorexia and forced feeding as well as disputes about end of life care decisions, including Do Not Attempt Resuscitation (DNAR) decisions. Local authorities referred cases about restrictions, restraint and deprivation in care home settings as well as best interests decisions about where a person should live.

IMCAs gave evidence in several of these cases; they also initiated some. We do not have statistics to be able to quantify the numbers.

Two thousand and twelve was the year when Court of Protection began to hear direct from those who were thought to lack capacity. There were several cases where judges spoke directly to those who had been assessed as lacking capacity to make the relevant decision.

The Court continues to publish many of its judgements, and these are of huge importance to all those working with people who may lack capacity. While the judgements are about specific cases and specific people, judges also illustrate how to weigh up questions of protection with autonomy, how to create a 'balance sheet' of issues before making a final decision; how to weigh happiness as well as risks.

CC v KK*

In this report we draw attention to one Court of Protection case, one that has particular implications for the work of IMCAs. This is the case of *CC v KK*, where the Court was asked to make a best interests decision about where a person should live – a decision that is referred to as an 'accommodation' decision in the IMCA regulations.

The Mental Capacity Act refers to 'accommodation' decisions when it requires IMCAs to be involved in decisions by local authorities on whether or not people who lack capacity should be placed in residential care – or whether they can be supported in the community.

The Court of Protection has recently found, in the case of *CC v KK,* that this decision (about whether to place a person in a care home or whether they should stay in the care home) cannot be made without looking very carefully at the alternatives:

> '*The person under evaluation must be presented with detailed options so that their capacity to weigh up those options can be fairly assessed. I find that the local authority has not identified a complete package of support that would or might be available should KK return home …..the statute requires that, before a person can be treated as lacking capacity to make a decision, it must be shown that all practical steps have been taken to help her to do so. As the Code of practice makes clear, each person whose capacity is under scrutiny, must be given 'relevant information' including 'what the likely consequences of a decision would be (the possible effects of deciding one way or*

another).That requires a detailed analysis of the effects of the decision either way, which in turn necessitates identifying the best ways in which options would be supported.

In order to understand the likely consequences of deciding to return home, KK should be given full details of the care package that would or might be available. The choice which KK should be asked to weigh up is not between the nursing home and a return to the bungalow with no or limited support, but rather between staying in the nursing home and a return home with all practicable support'.

This has implications for both local authorities and for IMCAs. For IMCAs this means IMCAs should:

a) seek consideration of alternatives to care homes; and should
b) seek these alternatives to be sufficiently detailed, with detailed care packages, to allow a better weighing up of the issues

It has further implications for the work of IMCAs. If the Court holds that a valid assessment of capacity cannot be made until the detailed alternatives have been identified, then valid assessments of capacity relating to the options cannot be made before an IMCA is appointed.

For those IMCA organisations which ask for a capacity assessment before they engage with a client, they should no longer do so. There has never been a requirement from the Mental Capacity Act for IMCAs to see a written assessment of capacity before they start work. And this case clarifies that the process needs to be a two stage one – where the local authority thinks someone 'may' lack capacity to make the decision, the IMCA needs to be appointed, and IMCA support needs to be given to help the person to express their wishes and feelings and weigh up the options. The final decision, about whether a person lacks the specific capacity to weigh up the specific choices, is the second stage. This may mean that, on occasion, IMCAs support a person who was thought to lack capacity, but is subsequently found to have capacity to make a decision. This is preferable to IMCAs not supporting someone who is subsequently found to lack capacity.

For most IMCA services this will mean no changes; it is simply a clarification that the local authority is expected to offer detailed options as choices.

* ***CC v KK and STCC*** *[2012] EWHC 2136 (COP)*

11. Conclusions and Recommendations

a. Overall Conclusions

During the fifth year of the IMCA service, in 2011-2012, there were a total of 11,899 eligible instructions for the IMCA service in England. This is a 9% increase from the previous year.

1. It is recommended that commissioners recognise that the number of people statutorily eligible for the IMCA service continues to increase on a year-by-year basis.

b. Accommodation decisions

The Mental Capacity Act refers to 'accommodation' decisions when it requires IMCAs to be involved in decisions by local authorities on whether or not people who lack capacity should be placed in residential care – or whether they can and should be supported in the community. There were nearly 5000 accommodation decisions in 2011-12, which is an increase of 6%.

The Court of Protection has recently made it clear in the case of *CC v KK* that the decision about whether to place a person in a care home, or to keep them there, cannot be made without clarifying what a 'return home with a care package' would entail. Assessments of capacity should follow after this and should relate to the choice of the specific alternatives.

2. It is recommended that both local authorities and IMCA organisations consider the implications of the CC v KK case and act according to the Court's guidance.

Many IMCA organisations are already alert to possible deprivation of liberty at the point when accommodation decisions and care plans are being made.

3. It is recommended that both IMCA organisations and local authorities continue to be alert to possible Deprivations of Liberty (DoL). IMCA organisations should alert local authorities and the NHS for the need either to prevent a DoL by changing the care plan, or to apply the DoL safeguards, if the person is in a care home or hospital. If the possible DOL is the result of a care package in the community, a referral to the Court of Protection is required.

a. Reviews

Local authorities are expected to carry our regular reviews of accommodation decisions and care plans. Local authorities are expected to involve IMCAs where there are no other family or friends to consult and where the person would benefit from the involvement of an IMCA. DH guidance states that people who lack capacity should have more frequent reviews than others. The Winterbourne Action plan also identifies those who are placed out of Borough as more vulnerable.

4. It is recommended that local authorities ensure that those who would benefit from IMCAs in their Reviews will receive one.

b. Serious medical decisions

Hospitals continue to increase the number of referrals for IMCA support and representation for serious medical treatment decisions for people who lack capacity. Referrals increased by 5% last year and reached 1743 cases.

5. It is recommended that Mental Capacity Act leads in CCGs monitor compliance with the requirement for referrals to IMCAs as part of their MCA responsibilities.

c. Safeguarding

Nationally, 130,000 safeguarding referrals are reported by 121 local authorities. Only 1,533 receive an IMCA.

6. It is recommended that safeguarding coordinators consider these statistics and that a) All Safeguarding Co-ordinators review the basis on which they make referrals to IMCAs; and b) that Safeguarding Co-ordinators who work in the areas identified in Appendix A review why referrals to IMCAs are at the level they are.

d. Deprivation of Liberty Safeguards

There has been an increase of 18% over the last year, of referrals to IMCAs for people who are being assessed for the DOL safeguards or have been authorised as deprived of their liberty. Nearly two thousand referrals were made.

7. It is recommended that IMCAs continue to follow Court of Protection advice in judgements.

Appendix A: IMCA Instructions by local authority 2011-2012

The tables below contain the number of eligible IMCA instructions by local authority in year 5.

Table A1: The number of IMCA referrals by local authorities from 1st April 2011 to 31st March 2012

Local authorities with a * have fewer or the same number of Adult Protection IMCA referrals this year compared to last year, and are invited to consider where all those would benefit from having an IMCA receive one.

	Serious Medical Treatment	Change Accommodation	Adult Protection	Care Review	Deprivation of Liberty	None chosen	**Total**
	Referral Head Count	Referral Head Count	Referral Head Count	Referral Head Count	Referral Head Count	Referral Head Count	Referral Head Count
BARKING & DAGENHAM	1	23	14	15	5	5	**63**
BARNET	8	41	6	9	19	1	**84**
BARNSLEY	3	14	8		12	2	**39**
BATH & NORTH EAST SOMERSET UA	8	26	1*	14	5	9	**63**
BEDFORD BOROUGH - TEMPORARY CODE	2	18	20	6	9	1	**56**
BEDFORDSHIRE		2					**2**
BEXLEY		11	5	1	5		**22**
BIRMINGHAM	36	131	38	13	30		**248**
BLACKBURN WITH DARWEN UA	5	24	8*	9	18		**64**
BLACKPOOL UA	3	10	3	10	3		**29**
BOLTON	7	21	8	5	24	2	**67**
BOURNEMOUTH UA	6	41	4*	2	24		**77**
BRACKNELL FOREST UA		12	3	6	6	3	**30**
BRADFORD	35	37	8*	3	3	12	**98**
BRENT	6	52	8	3	7	1	**77**
BRIGHTON & HOVE UA	22	54	8*	10	1	6	**101**
BRISTOL UA	47	64	12*	18	89	3	**233**
BROMLEY	3	37	9	2	1		**52**
BUCKINGHAMSHIRE	4	15	4*	3	4	1	**31**
BURY	3	11	7	1	13	1	**36**
CALDERDALE	5	4	5*	1	3		**18**

CAMBRIDGESHIRE	22	46	11*	10	22	4	**115**
CAMDEN	35	91	18*	6	14	2	**166**
CENTRAL BEDFORDSHIRE - TEMPORARY CODE	4	4	4		5	1	**18**
CHESHIRE	14	47	12*	8	14	4	**99**
CITY OF LONDON	1						**1**
CORNWALL	34	104	36	26	46	11	**257**
COVENTRY	20	25	11	5	6	4	**71**
CROYDON	16	53	4*	8	14	1	**96**
CUMBRIA	16	22	12	8	15	3	**76**
DARLINGTON UA	3	18	14*	5	5	1	**46**
DERBY UA	7	29	15*	14	7	22	**94**
DERBYSHIRE	24	70	47	26	64	37	**268**
DEVON	26	72	15*	12	12		**137**
DONCASTER	2	22	8	2	11	1	**46**
DORSET	18	49	8*	3	38	4	**120**
DUDLEY	7	41	12	5	23	2	**90**
DURHAM	5	38	9	9	20		**81**
EALING	2	22	5	1	6	3	**39**
EAST RIDING OF YORKSHIRE UA	8	28	9	3		1	**49**
EAST SUSSEX	67	82	53	36	35	7	**280**
ENFIELD	5	45	14	7	14	2	**87**
ESSEX	28	87	35*	4	77		**231**
GATESHEAD	10	12	6*	5	22	2	**57**
GLOUCESTERSHIRE	32	103	19*	17	54	1	**226**
GREENWICH	3	19	2	4	8		**36**
HACKNEY	2	34	8*	2	5	3	**54**
HALTON UA	9	2	6		3		**20**
HAMMERSMITH & FULHAM	8	18	2*	2	1		**31**
HAMPSHIRE	22	46	12*	1	27	46	**154**
HARINGEY	1	32	6	6	15		**60**
HARROW	1	14	6	1	2		**24**
HARTLEPOOL UA	3	9	4	5	3	1	**25**
HAVERING	12	48	3	5	3	1	**72**
HEREFORDSHIRE UA	4	19	7*	6	7	1	**44**
HERTFORDSHIRE	16	67	36	18	53	7	**197**

HILLINGDON		25	6	1	1	4	**37**
HOUNSLOW	3	17		3	3		**26**
ISLE OF WIGHT UA	2	4	3*			2	**11**
ISLINGTON	17	35	14	5	4		**75**
KENSINGTON & CHELSEA	8	30	3	5	10	3	**59**
KENT	54	116	24	49	18	13	**274**
KINGSTON UPON HULL UA	11	11	2	2	1		**27**
KINGSTON UPON THAMES	14	40	1		3	14	**72**
KIRKLEES	9	32	31*	9	13	6	**100**
KNOWSLEY	10	11	17	6	3		**47**
LAMBETH	14	55	10	8	8		**95**
LANCASHIRE	23	67	19*	25	67		**201**
LEEDS	43	102	56*	54	18	127	**400**
LEICESTER UA	18	59	12	8	26	2	**125**
LEICESTERSHIRE	8	41	16	6	31	2	**104**
LEWISHAM	5	33	3	5	4		**50**
LINCOLNSHIRE	2	13			9	8	**32**
LIVERPOOL	52	46	17	5	26	18	**164**
LUTON UA	4	18	14	1	14	3	**54**
MANCHESTER	27	100	5	16	22	15	**185**
MEDWAY TOWNS UA	7	15		10	1	2	**35**
MERTON	1	6	2		1		**10**
MIDDLESBROUGH UA	12	17	4*	2	5	1	**41**
MILTON KEYNES UA	7	4	3*	1	1	5	**21**
NEATH PORT TALBOT UA		2		1	2		**5**
NEWCASTLE UPON TYNE	16	27	10*	2	7		**62**
NEWHAM	1	17	3*	2	4	2	**29**
NORFOLK	11	42	9*	9	11	3	**85**
NORTH EAST LINCOLNSHIRE UA	7	20	5	7	2		**41**
NORTH LINCOLNSHIRE UA	3	18	6	2	3	2	**34**
NORTH SOMERSET UA	29	38	34	11	22	3	**137**
NORTH TYNESIDE	4	30	5*	2	3		**44**
NORTH YORKSHIRE	11	80	28	13	3	6	**141**
NORTHAMPTONSHIRE	13	41	16*	31	15	4	**120**

NORTHUMBERLAND	12	20	9*	13	1		**55**
NOTTINGHAM UA	7	42	18*	8	9	1	**85**
NOTTINGHAMSHIRE	18	44	4*	12	25	2	**105**
OLDHAM	5	13	8	4	5		**35**
OXFORDSHIRE	13	25	8*	2	84	1	**133**
PETERBOROUGH UA		20	2	2	13	2	**39**
PLYMOUTH UA	28	58	14*	21	15		**136**
POOLE UA	6	24	7		6	2	**45**
PORTSMOUTH UA	9	33	3		5	3	**53**
READING UA	2	18	4*	5	2	1	**32**
REDBRIDGE	1	24	4	3	2		**34**
REDCAR & CLEVELAND UA	2	12	7*		4	7	**32**
RICHMOND UPON THAMES	2	17	2	2		3	**26**
ROCHDALE	8	39	15	7	1	12	**82**
ROTHERHAM	1	16	4*	2	9	2	**34**
RUTLAND UA			1				**1**
SALFORD	21	23	6	5	3	11	**69**
SANDWELL	11	36	16	10	8	5	**86**
SEFTON	7	27	8	6	7	7	**62**
SHEFFIELD	14	38	10	4	8	4	**78**
SHROPSHIRE	3	17	7	3	3	1	**34**
SLOUGH UA	2	16	4	4	9	2	**37**
SOLIHULL	9	21	30	4	2	1	**67**
SOMERSET	24	37	15*	27	27	2	**132**
SOUTH GLOUCESTERSHIRE UA	20	25	3*	1	34		**83**
SOUTH TYNESIDE	8	9	12*	9	13	2	**53**
SOUTHAMPTON UA	19	41	13	1	29	5	**108**
SOUTHWARK	7	16	6	2	6	2	**39**
ST HELENS	8	8	4	7	1	1	**29**
STAFFORDSHIRE	13	34	9*	5	18	7	**86**
STOCKPORT	7	18	3*	5	3		**36**
STOCKTON ON TEES UA	4	4	6	2	5	3	**24**
STOKE-ON-TRENT UA	11	19	1*		6	1	**38**
SUFFOLK	5	24	6*	2	9	1	**47**
SUNDERLAND	14	33	7	5	18		**77**
SURREY	57	103	6	10	11	50	**237**

SUTTON	4	14	5*	3	1		**27**
SWINDON UA	20	34	11	9	13		**87**
TELFORD & WREKIN UA		20	6	9	6	1	**42**
THURROCK UA	1	9	12	3	3	2	**30**
TORBAY UA	13	30	15	3	11	1	**73**
TOWER HAMLETS	8	38	4*	7	7		**64**
TRAFFORD	4	4	1		4	4	**17**
WAKEFIELD	16	21	15*	5	18	9	**84**
WALSALL	8	15	10	1	5		**39**
WALTHAM FOREST	4	37	11	2	3	3	**60**
WANDSWORTH	12	51	14	6	8		**91**
WARRINGTON UA	18	21	14	9	17	2	**81**
WARWICKSHIRE	13	48	9	6	16	2	**94**
WEST BERKSHIRE UA	1	9	4	3	2		**19**
WEST SUSSEX	32	66	20	14	17	29	**178**
WESTMINSTER	6	36	4	4	7		**57**
WIGAN	12	48	*	7	66	2	**135**
WILTSHIRE	12	25	9*	4	18		**68**
WINDSOR & MAIDENHEAD UA	2	14	5	9	16		**46**
WIRRAL	8	29	7	1	4	30	**79**
WOKINGHAM UA		12	3	9		3	**27**
WOLVERHAMPTON	7	21	19	3	7	2	**59**
WORCESTERSHIRE	17	42	17	9	29	1	**115**
YORK UA	10	40	10	11	7		**78**
Total	**1,743**	**4,916**	**1,533**	**1,032**	**1,979**	**696**	**11,899**

Table 1B: The number of DoLS IMCA referrals by local authority from 1st April 2011 to 31st March 2012

LOCAL AUTHORITY	S39A	S39C	S39D	Total
BARKING & DAGENHAM	2	0	3	**5**
BARNET	11	3	4	**18**
BARNSLEY	9	1	2	**12**
BATH & NORTH EAST SOMERSET	1	0	4	**5**
BEDFORD BOROUGH	4	1	4	**9**
BEDFORDSHIRE	0	0	0	**0**
BEXLEY	3	1	1	**5**
BIRMINGHAM	15	12	3	**30**
BLACKBURN WITH DARWEN	6	0	12	**18**
BLACKPOOL	2	0	1	**3**
BOLTON	5	3	14	**22**
BOURNEMOUTH	10	2	11	**23**
BRACKNELL FOREST	3	1	2	**6**
BRADFORD	2	0	1	**3**
BRENT	3	0	4	**7**
BRIGHTON & HOVE	1	0	0	**1**
BRISTOL	17	2	52	**71**
BROMLEY	1	0	0	**1**
BUCKINGHAMSHIRE	4	0	0	**4**
BURY	2	10	1	**13**
CALDERDALE	1	0	2	**3**
CAMBRIDGESHIRE	5	0	17	**22**
CAMDEN	9	5	0	**14**
CENTRAL BEDFORDSHIRE	2	1	2	**5**
CHESHIRE	13	0	1	**14**
CITY OF LONDON	0	0	0	**0**
CORNWALL	14	0	32	**46**
COVENTRY	4	1	1	**6**
CROYDON	7	6	1	**14**
CUMBRIA	3	2	10	**15**
DARLINGTON	3	0	2	**5**
DERBY	6	0	1	**7**
DERBYSHIRE	49	5	10	**64**
DEVON	8	1	3	**12**
DONCASTER	7	3	1	**11**
DORSET	8	1	28	**37**
DUDLEY	6	0	17	**23**
DURHAM	10	7	3	**20**
EALING	0	1	5	**6**

EAST RIDING OF YORKSHIRE	0	0	0	**0**
EAST SUSSEX	12	4	19	**35**
ENFIELD	7	5	2	**14**
ESSEX	24	1	52	**77**
GATESHEAD	6	0	16	**22**
GLOUCESTERSHIRE	24	3	27	**54**
GREENWICH	5	0	3	**8**
HACKNEY	4	1	0	**5**
HALTON	2	0	1	**3**
HAMMERSMITH & FULHAM	0	0	1	**1**
HAMPSHIRE	13	1	13	**27**
HARINGEY	10	2	2	**14**
HARROW	2	0	0	**2**
HARTLEPOOL	3	0	0	**3**
HAVERING	1	0	2	**3**
HEREFORDSHIRE	2	3	2	**7**
HERTFORDSHIRE	25	4	24	**53**
HILLINGDON	0	0	1	**1**
HOUNSLOW	0	0	2	**3**
ISLE OF WIGHT	0	0	0	**0**
ISLINGTON	3	1	0	**4**
KENSINGTON & CHELSEA	3	0	7	**10**
KENT	12	0	6	**18**
KINGSTON UPON HULL	1	0	0	**1**
KINGSTON UPON THAMES	3	0	0	**3**
KIRKLEES	9	1	3	**13**
KNOWSLEY	2	0	1	**3**
LAMBETH	6	0	2	**8**
LANCASHIRE	24	0	43	**67**
LEEDS	16	0	2	**18**
LEICESTER	26	0	0	**26**
LEICESTERSHIRE	21	1	9	**31**
LEWISHAM	3	1	0	**4**
LINCOLNSHIRE	5	0	4	**9**
LIVERPOOL	6	1	19	**26**
LUTON	2	0	12	**14**
MANCHESTER	9	3	10	**22**
MEDWAY TOWNS	1	0	1	**1**
MERTON	1	0	0	**1**
MIDDLESBROUGH	2	0	3	**5**
MILTON KEYNES	1	0	0	**1**
NEATH PORT TALBOT	1	0	1	**2**
NEWCASTLE UPON TYNE	5	2	0	**7**
NEWHAM	3	0	1	**4**
NORFOLK	8	1	2	**11**
NORTH EAST LINCOLNSHIRE	1	0	1	**2**

NORTH LINCOLNSHIRE	0	0	3	**3**
NORTH SOMERSET	5	0	17	**22**
NORTH TYNESIDE	2	0	1	**3**
NORTH YORKSHIRE	3	0	0	**3**
NORTHAMPTONSHIRE	12	0	2	**14**
NORTHUMBERLAND	0	0	.1	**1**
NOTTINGHAM	8	1	0	**9**
NOTTINGHAMSHIRE	20	0	5	**25**
OLDHAM	2	2	1	**5**
OXFORDSHIRE	5	0	77	**82**
PETERBOROUGH	4	1	8	**13**
PLYMOUTH	10	0	5	**15**
POOLE	3	1	2	**6**
PORTSMOUTH	4	0	1	**5**
READING	1	0	1	**2**
REDBRIDGE	1	0	1	**2**
REDCAR & CLEVELAND	4	0	0	**4**
RICHMOND UPON THAMES	0	0	0	**0**
ROCHDALE	1	0	0	**1**
ROTHERHAM	7	2	0	**9**
RUTLAND	0	0	0	**0**
SALFORD	2	0	1	**3**
SANDWELL	2	1	5	**8**
SEFTON	1	0	6	**7**
SHEFFIELD	8	0	0	**8**
SHROPSHIRE	2	0	1	**3**
SLOUGH	.9	0	0	**9**
SOLIHULL	2	0	0	**2**
SOMERSET	5	0	22	**27**
SOUTH GLOUCESTERSHIRE	3	0	31	**34**
SOUTH TYNESIDE	1	1	11	**13**
SOUTHAMPTON	11	8	8	**27**
SOUTHWARK	4	0	2	**6**
ST HELENS	0	0	1	**1**
STAFFORDSHIRE	11	0	7	**18**
STOCKPORT	2	0	1	**3**
STOCKTON ON TEES	4	0	1	**5**
STOKE-ON-TRENT	5	0	1	**6**
SUFFOLK	2	2	5	**9**
SUNDERLAND	1	0	17	**18**
SURREY	6	0	5	**11**
SUTTON	1	0	0	**1**
SWINDON	3	1	9	**13**
TELFORD & WREKIN	3	1	2	**6**
THURROCK	1	1	1	**3**
TORBAY	8	1	2	**11**
TOWER HAMLETS	3	2	2	**7**
TRAFFORD	2	1	1	**4**
WAKEFIELD	8	0	10	**18**

WALSALL	4	0	1	**5**
WALTHAM FOREST	3	0	0	**3**
WANDSWORTH	2	3	3	**8**
WARRINGTON	7	1	9	**17**
WARWICKSHIRE	1	0	15	**16**
WEST BERKSHIRE	0	0	2	**2**
WEST SUSSEX	3	4	10	**17**
WESTMINSTER	4	1	2	**7**
WIGAN	49	1	15	**65**
WILTSHIRE	13	0	5	**18**
WINDSOR & MAIDENHEAD	13	2	1	**16**
WIRRAL	3	1	0	**4**
WOKINGHAM	0	0	0	**0**
WOLVERHAMPTON	4	0	3	**7**
WORCESTERSHIRE	5	8	16	**29**
YORK	5	0	2	**7**
Total	**888**	**151**	**910**	**1949**

Appendix: Useful guides and research

- For case law and discussion on the MCA:

  http://www.mentalhealthlaw.co.uk

  http://www.39essex.com/resources/newsletters.php

- For DOLS 2012 information:

  http://www.dh.gov.uk/health/2012/09/dolsfactsheet/

  http://www.scie.org.uk/publications/reports/report62.pdf

- Action for Advocacy's Quality Performance Mark for advocacy / IMCA services

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

- Good practice guides published by ADASS and SCIE on:

  Accommodation decisions and care reviews

  http://www.scie.org.uk/publications/guides/guide39/about.asp

  Access to the Court of Protection

  http://www.scie.org.uk/publications/guides/guide42/

  The IMCA roles within the Deprivation of Liberty Safeguards

  http://www.scie.org.uk/publications/guides/guide41/

  Commissioning IMCA services (revision)

  http://www.scie.org.uk/publications/guides/guide31/

- Good practice guide on serious medical treatment by Action for Advocacy

  http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=60

- Research into the difference IMCAs makes to the lives of individuals and the knowledge and practice of health and social care workers; commissioned by SCIE from the Norah Fry Research Centre at the University of Bristol.

  http://www.scie.org.uk/publications/imca/files/IMCAreportFINALv35.pdf

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