Department of Health

# The Seventh Year of the Independent Mental Capacity Advocacy (IMCA) Service

1st April 2013 – 31st March 2014

March 2015

**Title:** The Seventh Year of the Independent Mental Capacity (IMCA) Service

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IMCA providers

IMCA commissioners (local authority and the NHS)

MCA-DoLS leads in local authorities and the NHS

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# Foreword

The Mental Capacity Act is a key piece of legislation that tells us how we should support those who may lack capacity. It's a great step forward for the rights of some of the most vulnerable members of our society and I'm keen to see it embedded in health and social care.

The House of Lords Select Committee, in their review last year, praised the Mental Capacity Act as a visionary piece of legislation but felt it was not widely used. We have undertaken a series of actions to promote understanding and use of the Act and we are working closely with our partners. Clearly though, there is still more to be done.

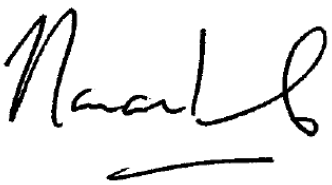
Within the Act is a statutory right to be represented by an independent advocate, in certain circumstances. Through the use of advocates we can give people a voice and support them to engage with care services and health professionals to arrive at the best possible outcome.

Advocates play a key role in ensuring that the wishes, feelings and beliefs of the individual are considered in the decision making processes. This can avoid the distress and frustration caused by unnecessarily restrictive care packages. It can empower people to enjoy as much freedom of choice and movement as possible.

As well as advocating for the individual it is important that Independent Mental Capacity Advocates (IMCAs) advocate for the Act itself; promoting its principles and, where appropriate, identifying areas where local practice could be improved to reflect best practice.

We must remember that the IMCA service is a statutory right and not a luxury. This report considers whether those individuals who should benefit from this important service are able to access it, as well as identifying areas where there is scope for improvement.

I would like to take this opportunity to thank all those IMCAs who are working tirelessly for the benefit of those fellow citizens that may lack capacity.



Rt Hon Norman Lamb MP
Minister of State for Care and Support

# Contents

# 1. Introduction/Background

### 1.1 The Annual IMCA Report

This is the Seventh Annual IMCA Report and reflects the period 1st April 2013 to 31st March 2014. The aim of this report is to look at the patterns and trends emerging across the country, with regard to the use of IMCAs, and highlight areas where more can be done to ensure that everyone has access to advocacy when they are entitled to it. As such it contains a number of observations and recommendations.

### 1.2 What is Advocacy?

Advocacy gives people who may not be able to speak for themselves a voice. Dealing with social workers, doctors and other professionals can be intimidating for anyone, but having an advocate means that there is somebody standing up for the rights of the individual and ensuring their best interests are at the heart of every decision.

Advocates are independent and represent the views and wishes of the individual without judgement or bias. Depending on the individual this may mean empowering and enabling them to communicate their wishes or it may mean speaking on their behalf. Advocates play a vital role in person-centred care ensuring the individual's wishes, beliefs and values are taken into account.

There are two types of advocacy; statutory and non-statutory. Non-statutory includes all forms of informal advocacy from family members to health and care staff – anyone who helps support and enables the individual. Statutory advocacy is a legal requirement and forms part of the relevant legislation. The Mental Health Act, Mental Capacity Act, the Care Act and NHS complaints all require the use of advocates in certain circumstances.

### 1.3 The Mental Capacity Act 2005 (MCA)

The Mental Capacity Act applies to all those aged 16 and over who may lack capacity. The test for assessing capacity is two-fold:

- A person may lack capacity if they have an impairment or disturbance affecting the mind or brain ***and***
- That impairment or disturbance means that the person is unable to make a decision at the time it must be made.

A person may be unable to make a decision if they have difficulty:

- Understanding the information
- Retaining the information

- Weighing up the information
- Communicating the decision.

If a person is unable to make a decision themselves then a best interests decision can be made on their behalf. When making a best interests decision, every effort should be made to consult with the person's friends, family, carers and anyone with a positive interest in the individual's well-being. The decision must take into account the person's wishes and feelings and should always seek to maximise the person's freedom.

The MCA states that if an individual does not have an appropriate person to support and/or represent them (usually a friend or family member) then an Independent Mental Capacity Advocate (IMCA) *must* be appointed for the following decisions:

- Change of accommodation
- Serious medical treatment
- Applications under the Deprivation of Liberty Safeguards

And *may* be appointed for:

- Safeguarding decisions
- Care reviews

### 1.4 The Role of an IMCA

IMCAs can only work with an individual once they have been instructed by an appropriate person/body. For accommodation decisions, care reviews and applications under the Deprivation of Liberty Safeguards this is likely to be the local authority or NHS organisation responsible for the arrangements. For serious medical treatment decisions this will be a medical practitioner who has responsibility for the person's treatment. And for adult safeguarding situations this will be the local authority coordinating the adult safeguarding proceedings.

Generally the role of an IMCA can be broken down into four stages:

I. <u>Gathering information</u>

As the IMCA's role is to advocate for the individual it is important that they understand their client's wishes, feelings, beliefs and values. Generally this might involve:

- Meeting the person and discussing their views (in private if appropriate)
- Examining relevant health and care records
- Discussing the case with professionals involved in the client's care
- Speaking to family, friends or anyone else who may be able to give some insight into the wishes and feelings, beliefs or values of the person
- Finding out other information which may be relevant to the decision.

II. Evaluating information

Having reviewed all the information available about their client an IMCA will then use this to understand their client's wishes and feelings about the decision at hand so that they can be accurately represented. This could involve:

- Checking that there are no further steps that could be taken to support the person to make their own decision, or be involved in the decision
- Working out what values and beliefs would influence their client's opinion on the decision at hand
- Checking that all possible options have been considered
- Considering the different options with a view to identifying the least restrictive option
- Deciding whether to ask for a second opinion or additional input.

III. Making representations

IMCAs should discuss their findings with the decision maker and raise any issues or concerns as soon as possible. Although they are not the decision-makers, IMCAs are required to produce a report which should be taken into account when arriving at a best interests decision.

IV. Challenging decisions

In many cases IMCAs should be able to resolve any issues or concerns with the decision maker before the decision is made. Where this has not been possible IMCAs may formally challenge the decision-making process. They can use local complaint procedures or try to get the matter looked at by the Court of Protection.

In the case of a DoLS application, if the client wishes to appeal the decision then the IMCA's role is to pursue that appeal regardless of whether or not they feel that the placement is in the person's best interests.

### 1.5 IMCA Data

IMCA providers are asked to input data on each referral they undertake to the national database hosted by the Health and Social Care Information Centre (HSCIC). The analysis in this report is based solely on those records in the database for the period of April 2013 – March 2014. The data was extracted in autumn 2014 to provide sufficient time for records to be input to the database. Recent investigations, however, into the robustness and completeness of the data have highlighted concerns in both areas. Later in this report we refer to future work to address this issue.

The data behind the graphs and charts included in this report is included at appendix A for reference.

### 1.6 IMCA Forum

As well as reviewing the data we also gathered the views of IMCAs at two dedicated meetings held at the Department in summer and autumn 2014. This provided an invaluable insight into front line experiences and helped inform this report. We also discussed the conclusions contained within this report with both IMCAs and the heads of some of the biggest IMCA providers.

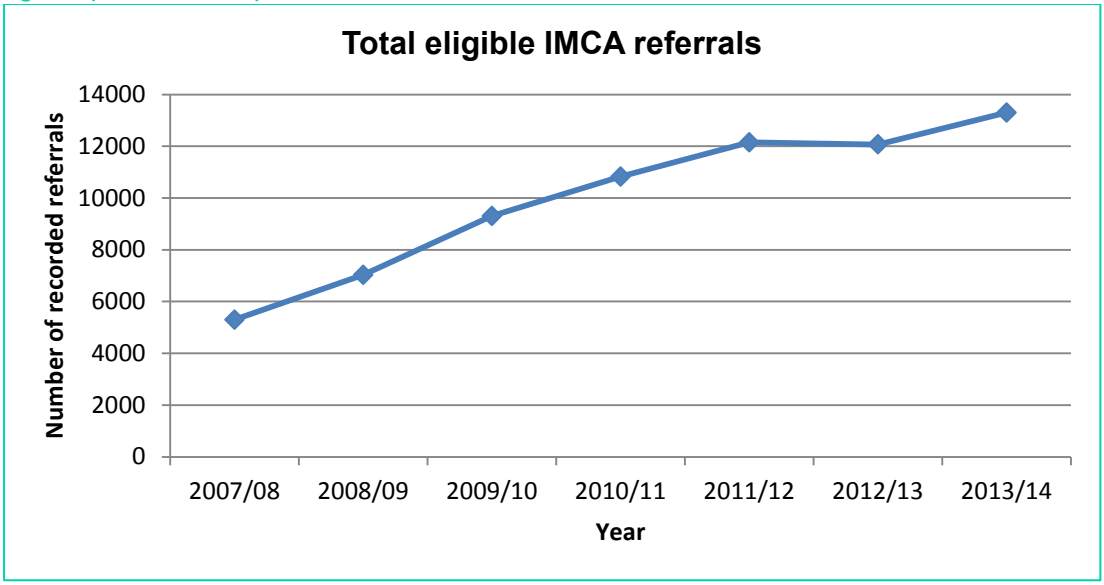
If you are interested in taking part in the next forum (usually in November) please send your contact details to IMCA@dh.gsi.gov.uk.

# 2. Number of Recorded IMCA Referrals in 2013/14

The number of IMCA referrals continues to climb with 13,301 received in 2013/14, after a slight decrease between 2011/12 and 2012/13 (Figure 1). This trend differs compared with that shown in the Sixth Annual Report. Analysis subsequent to the publication of that report identified inaccuracies in the published trends and as a result, these figures have been revised in this report.

The House of Lords Select Committee review[1] of the MCA (March 2014) highlighted concerns around awareness and implementation of the MCA and the increase in the use of IMCAs may indicate that implementation is improving. The Government response to the report – *Valuing Every Voice, Respecting Every Right* – included a number of measures designed to promote the MCA. As it was published in June 2014, it is unlikely that this would have any impact on the 2013/14 figures but we would hope to see the upward trend not only continue but increase in future years.

**Figure 1 (see data table 1)**




Broadly the split between the different decision types remains much as it was in previous years with the majority of referrals still being for change of accommodation.

[1] The House of Lords Select Committee review and government response can be found here - http://www.parliament.uk/business/committees/committees-a-z/lords-select/mental-capacity-act-2005/

Figure 2 (see data table 1)

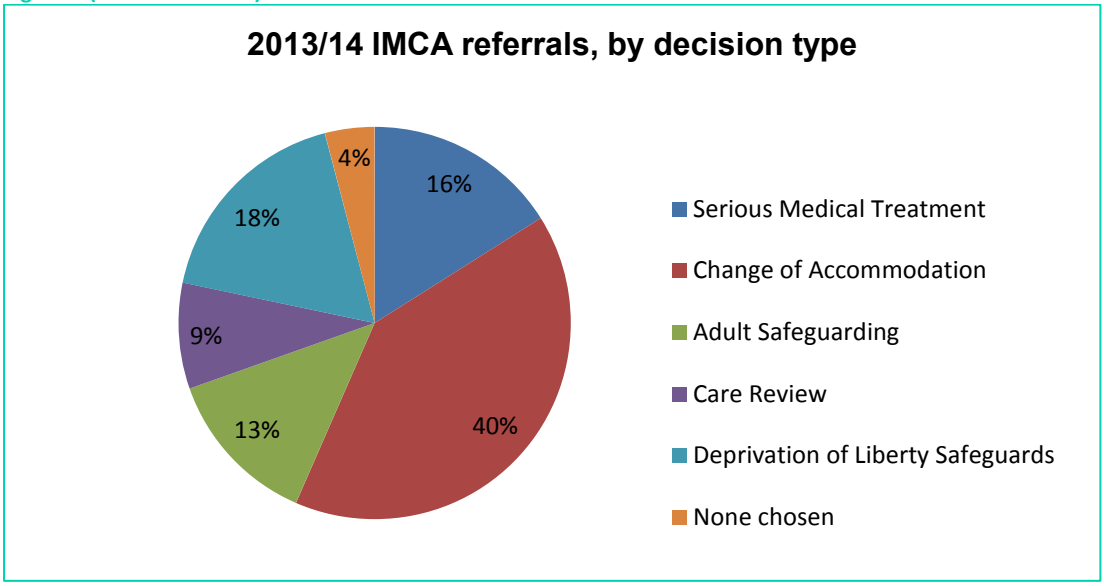
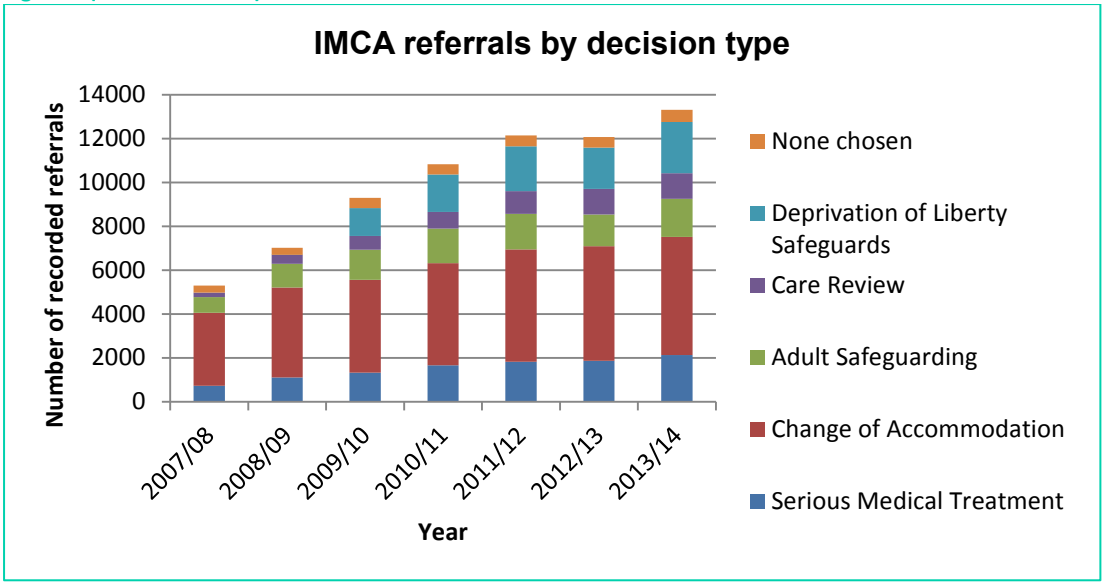



Figure 3 (see data table 1)

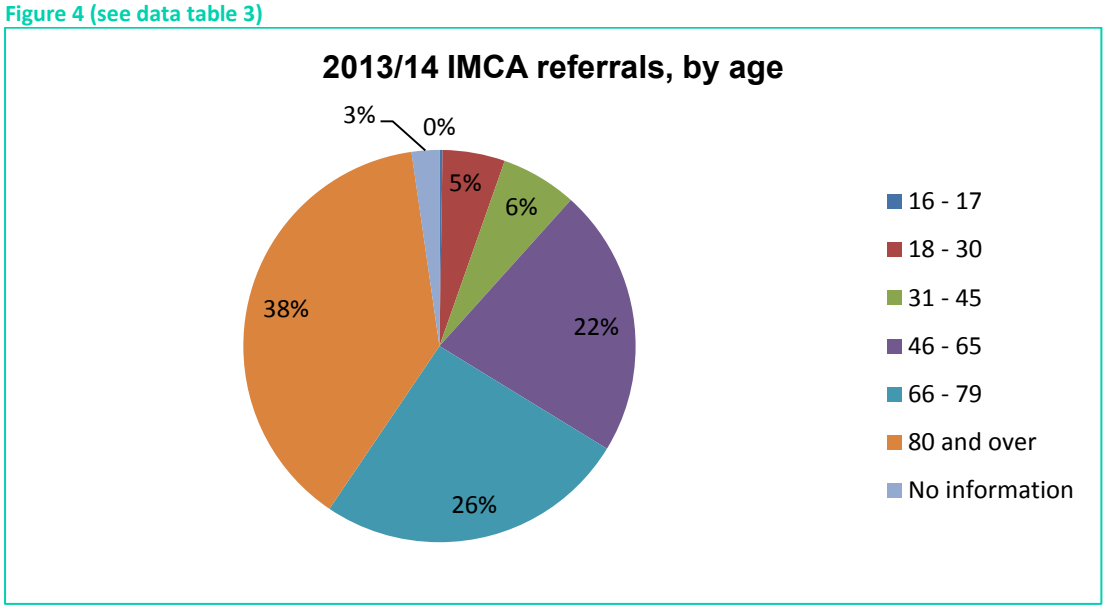


# 3. Who Uses the Service?

## 3.1 Age

Unsurprisingly perhaps, the large majority of referrals relate to people aged 65 and over. This reflects the greater prevalence of dementia in this age group. While a diagnosis of dementia does not necessarily mean that a person lacks capacity, advanced dementia can affect a person's decision making ability. It is important though that commissioners and professionals remember that advocacy is not solely a service for older people.

Figure 4 (see data table 3)




## 3.2 Gender

In 2013/14 recorded IMCA referrals related to approximately the same number of women as men continuing the trend observed in previous years. When considering this statistic we must also consider that the 2011 census tells us that there are more than twice as many women aged over 65 in care homes than men. It follows then that we may have expected to see more referrals for women than men. The cause of this is unknown and something to be monitored in future years.

## 3.3 Ethnicity

Looking at the ethnicity breakdown for referrals (Figure 5) and comparing them to the breakdown of the population, one area of note is the lack of Asian/Asian-British referrals. Generally, the demographic of the Asian community is younger and as we have already seen, the majority of referrals come from older people. Another possible factor is that Asian populations are generally underrepresented in formal care systems, the suggestion being that informal care plays a bigger part in Asian

communities. These contributing factors may, in part, explain the apparent discrepancy.

The number of Asian/Asian-British IMCA referrals should be monitored to see if this is a continuing trend, and if so, it may warrant further analysis.

Figure 5

| Ethnic Group | Percentage IMCA Referrals | Percentage Population[2] |
|---|---|---|
| White | 89.2% | 85.9% |
| Asian/Asian British | 2.6% | 7.5% |
| Black/African/Caribbean/Black British | 2.7% | 3.4% |
| Other | 0.3% | 1.0% |
| Mixed | 0.7% | 2.2% |
| Unknown | 4.5% | |

### 3.4 Mental Impairment

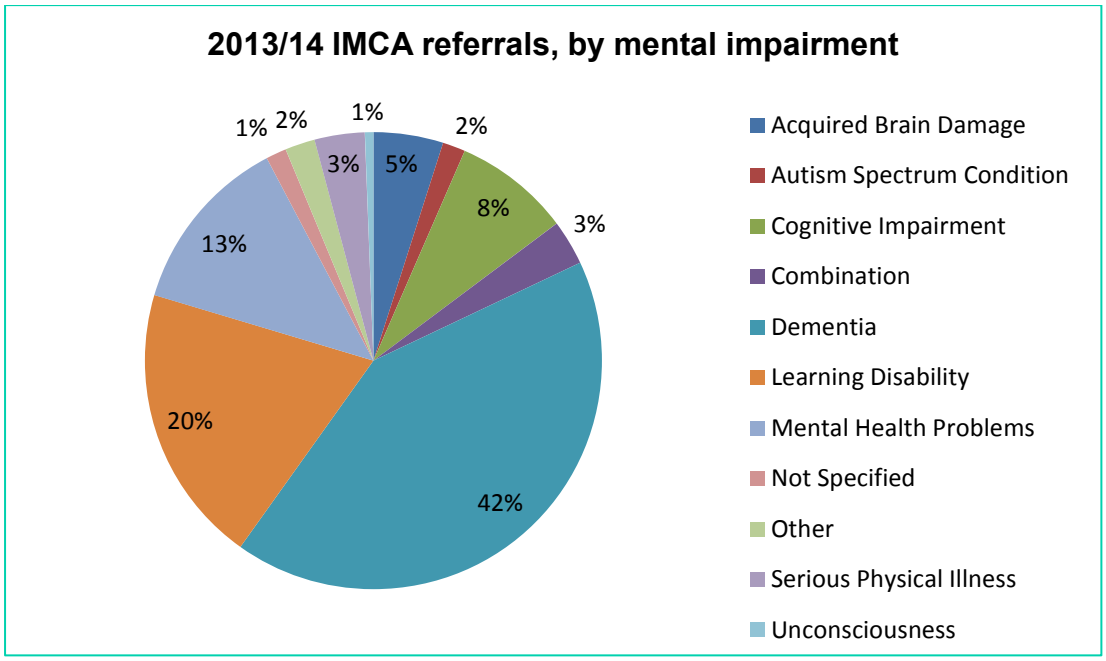
The most common mental impairment in referrals is dementia, which is not surprising given that around 800,000[3] people in the UK have dementia. It is important to note though that just because a person has dementia it does not mean that they automatically lack capacity. The MCA is clear that we must start from a presumption of capacity. It must be demonstrated that a person is unable to make the particular decision at that particular time.

Currently only about half of those with dementia receive a diagnosis which means that potentially there are people with some of the capacity issues that can arise from dementia who aren't getting access to services like advocacy. Work is being done, as part of the Prime Minister's Dementia Challenge, to increase the diagnosis rate which is the first step and we would hope to see the number of referrals regarding people with dementia increase as a result.

[2] Figures from 2011 Census

[3] Improving Care for People with Dementia – https://www.gov.uk/government/policies/improving-care-for-people-with-dementia

Figure 6 (see data table 2)

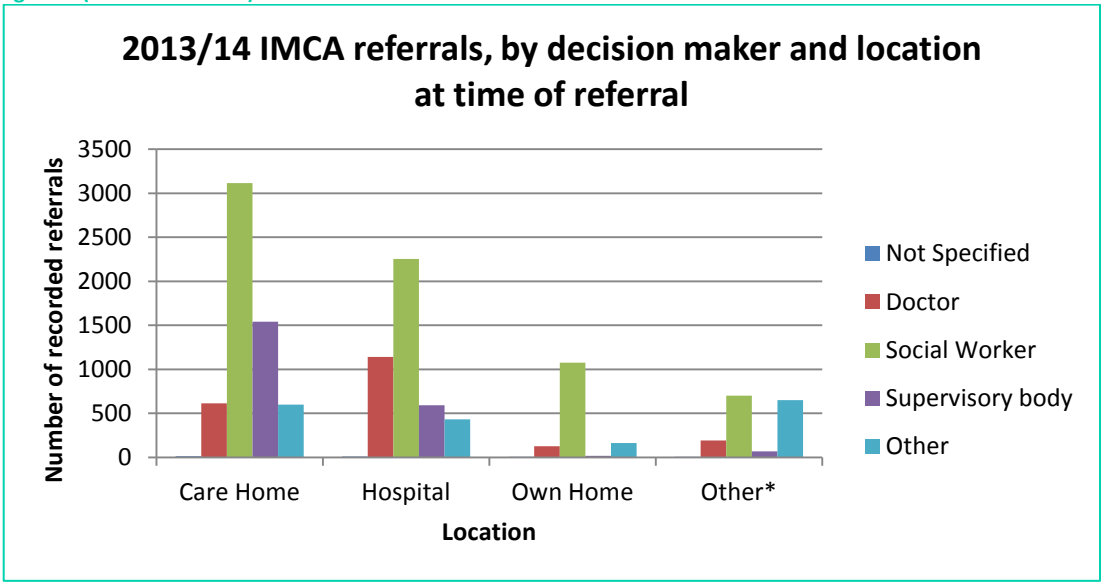



### 3.5 Who is Referring Cases and Why?

Care homes and social workers are the most common sources of IMCA referrals. Of note though is the fact that, of the recorded hospital referrals, more are from social workers than healthcare professionals. There could be a number of reasons for this but it suggests that there is a tendency to only involve IMCAs once the social worker is involved (potentially when thinking about discharge). Doctors should be considering capacity at the outset and as such we would expect to see more referrals from doctors in hospitals.

It is in the best interests of the patient that proper planning takes place at an early stage. This should include IMCAs where appropriate.

Figure 7 (see data table 4)




[4]

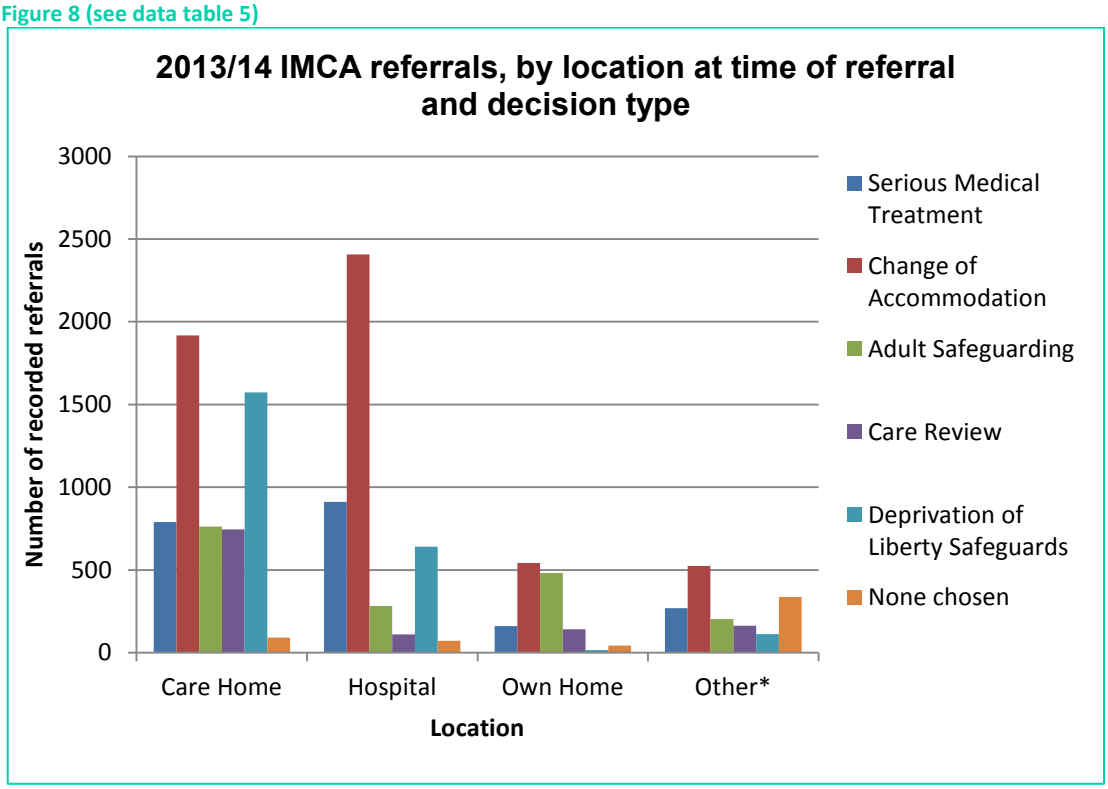
Looking at decision types (Figure 8) we can see that change in accommodation is the most common reason for an IMCA referral. Of note is that in hospital settings changes in accommodation are more common than serious medical treatment. This, combined with the fact that most of the referrals in hospitals come from social workers, not doctors, seems to suggest that the majority of hospital referrals are around patient discharge.

The definition of Serious Medical Treatment is explored later in this report and not every hospital stay will be categorised as Serious Medical Treatment. However it seems unlikely that less than half of those who lacked capacity were in hospital for treatment that would not have been "serious" in the context of the individual.

There are far fewer referrals regarding people living in their own home but this could be because of the nature of the decisions and isn't necessarily a cause for concern. However we should take steps to ensure that people with capacity issues living at home have access to appropriate support.

[4] **Other includes those in supported living, unspecified or unknown locations and any other type of accommodation*

Figure 8 (see data table 5)




[5]

[5] *Other includes those in supported living, unspecified or unknown locations and any other type of accommodation*

# 4. Change of Accommodation Decisions

This includes residential accommodation arranged by a local authority or (in a minority of cases) by the NHS which is likely to be for longer than eight weeks. It also includes a placement in hospital for a period that is likely to exceed 28 days.

## There were 5,392 recorded change of accommodation referrals in 2013/14

Figure 9 (see data table 1)

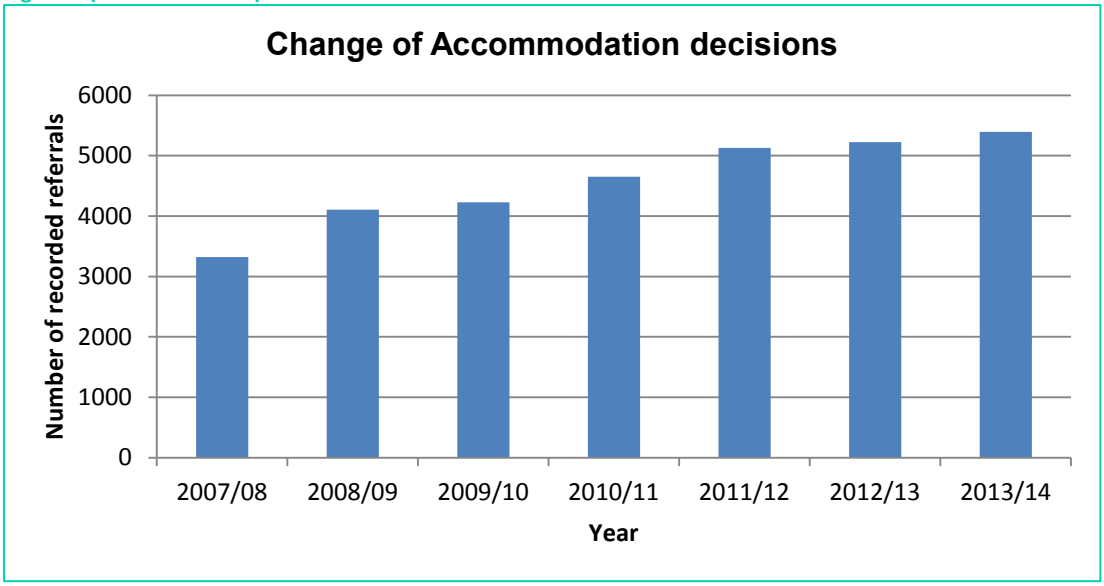
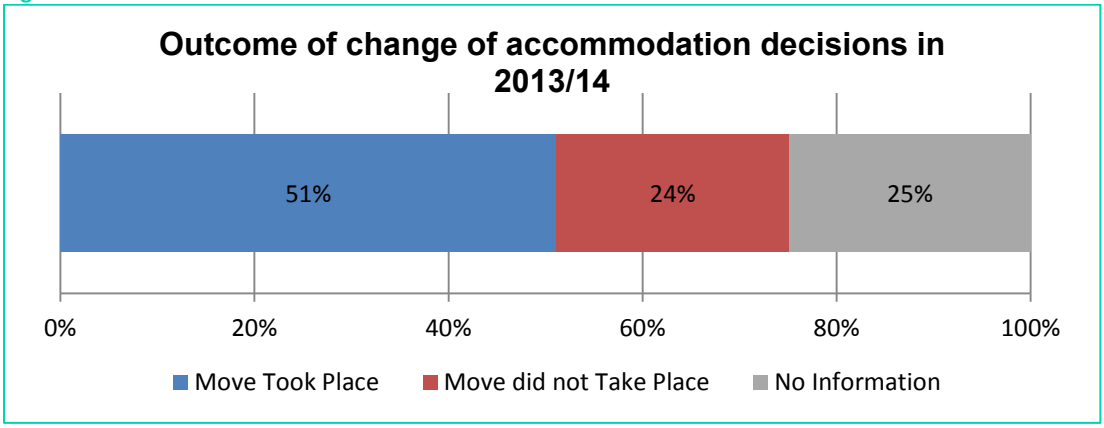



Figure 10




The MCA is clear that when it comes to making decisions about accommodation this should be done with reference to the person's wishes, beliefs and values and should maximise freedom of movement and choice. It is important that the person remains at the heart of these decisions but this can be difficult if they don't have the capacity to actively engage in the process.

This is why it's important that if the person lacks capacity and has nobody appropriate to represent them an IMCA should be involved. The IMCA will help

ensure that every effort is made to establish what the person would want and that this is represented in conversations around accommodation decisions.

The majority of the changes of accommodation decisions originate from hospitals. The most likely explanation is that this is concerned with patient discharge and where the individual will go when leaving hospital. As previously mentioned, it is important that discussions around changes in accommodation start as early as possible. We must remember that we are talking about people who can have difficulty understanding and retaining the reasons why they are in hospital and extended stays can be confusing and distressing for them. The majority of patients do not want to remain in hospital any longer than they need to and with a limited number of available hospital beds it is clearly important that effective discharge planning takes place.

**Case Study 1**

J is a middle aged man on the autistic spectrum who also has mental health issues. He has lived in a large residential mental health unit for many years. The unit was closing so a change in accommodation was necessary and as J did not have the capacity to make the decision himself a best interest decision was necessary. As J had no friends or family to represent him an IMCA referral was made.

The IMCA met with J who indicated that he was looking forward to the move and wanted to live somewhere quiet. J also expresses a desire for more independence. Some of the professionals working with J felt he should move to a residential autistic specialist unit but his social worker had identified a supported living placement that was less restrictive.

The IMCA discussed the options with J and he was keen to explore the supported living option. Professionals were concerned that this may not provide enough support for J and preferred the residential option. The IMCA made it clear that in her opinion as J had stated a preference for supported living this should be explored to see if it could meet his needs. A series of visits were arranged to the supported living placement which included an overnight stay and a day trip.

A best interest decision was held to discuss where J might live. There was some debate amongst the professionals who still favoured a residential placement but the IMCA argued for J's preference of sheltered accommodation, she pointed out that the MCA is clear that they should choose the least restrictive option.

J moved to the supported living placement and reports from his social worker say he's going well and is very happy there.

# 5. Serious Medical Treatments (SMT) Decisions

There were 2,132 recorded Serious Medical Treatment decision referrals in 2013/14

Figure 11 (see data table 1)

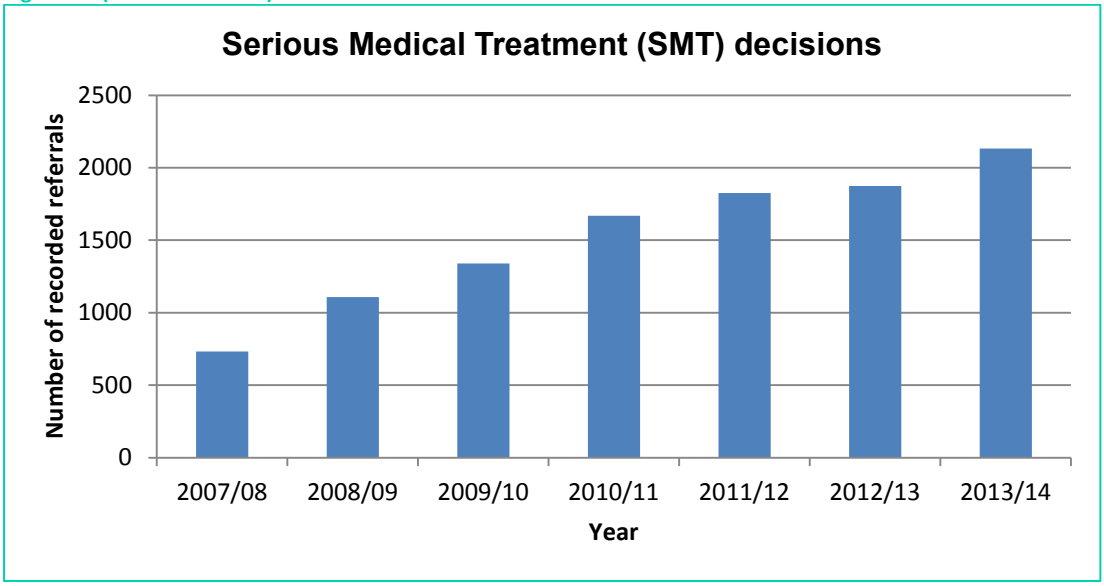
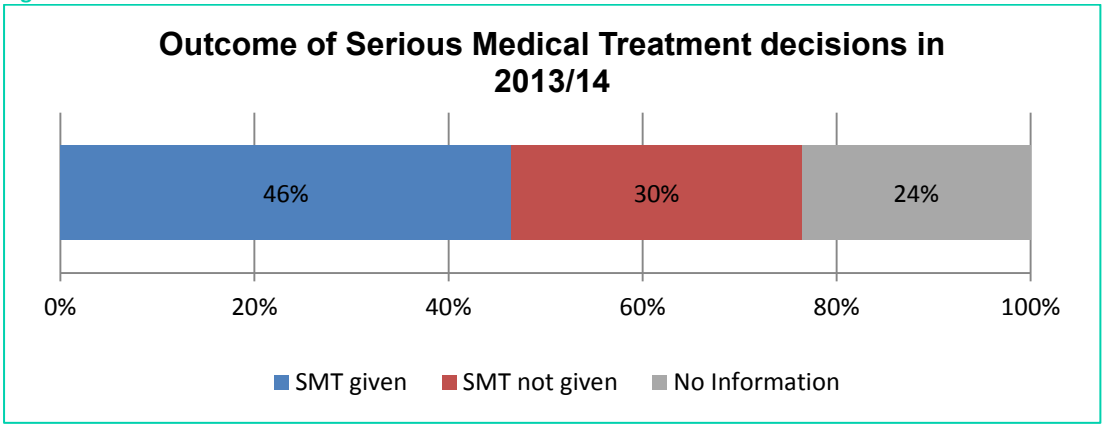



Figure 12




### 5.1 What is Serious Medical Treatment?

Serious medical treatment is defined in the MCA and includes starting a new treatment, stopping an existing treatment or withholding treatment when:

1. There is a fine balance between the likely benefits and the burdens to the patient and the risks involved
2. A decision between a choice of treatments is finely balanced
3. What is proposed is likely to have serious consequences for the patient. This may include treatment options which:

- Cause serious and prolonged pain, distress or side effects
- Have potentially major consequences for the patient (for example, major surgery or stopping life-sustaining treatment)
- Have a serious impact on the patient's future life choices.

The Code of Practice lists the following examples of possible serious medical treatments:

- Chemotherapy
- Electro-convulsive therapy
- Therapeutic sterilisation
- Major surgery (such as open-heart surgery or brain/neurosurgery)
- Major amputations (for example, loss of an arm or leg)
- Treatments that will result in permanent loss of hearing or sight
- Withholding or stopping artificial nutrition and hydration
- Termination of pregnancy.

This list is not exhaustive and whether a treatment qualifies as Serious Medical Treatment will depend on the individual and the potential impact the treatment and recovery will have on them. For some individuals it may be that any stay on hospital causes significant distress leading it to be classed as "serious" even if the treatment is fairly routine.

### 5.2 Capacity to Consent

As previously mentioned, capacity should be assessed in relation to each decision. As such, when discussing treatment options with patients clinicians should give consideration to whether the person has the capacity to decide on the correct course of treatment (or to refuse suggested treatment).

Given that dementia is the most common reason for lack of capacity in IMCA referrals (around 40%) it is interesting to note that serious medical treatment is the only area where this trend is not repeated. Equally, if broken down by decision maker, doctors are the only decision makers where learning disability is the more common cause of capacity issues.

There could be many reasons for this. It could be that the nature of what qualifies as a serious medical treatment means that they are more common among people with learning disabilities. Another, more worrying possibility, is that people with dementia are not being given the same consideration when it comes to their capacity. We have asked Kings College London to do some research into factors that may be affecting the number and type of IMCA referrals in hospitals. This research should help us to understand the reasons behind this apparent disparity.

Figure 13

**2013/14 Referrals by Mental Impairment**

| | Doctor | Serious Medical Treatment |
|---|---|---|
| Learning Disability | 600 | 804 |
| Dementia | 504 | 446 |
| Mental Health Problems | 295 | 241 |
| Serious Physical Illness | 171 | 174 |
| Cognitive Impairment | 130 | 104 |
| Acquired Brain Damage | 116 | 89 |
| Combination | 95 | 106 |
| Unconsciousness | 62 | 64 |
| Other | 46 | 47 |
| Autism Spectrum Condition | 39 | 48 |
| **Total** | **2,068** | **2,132** |

### 5.3 Number of Referrals

In 2013/14 there were 2,132 SMT referrals which accounts for around 16% of the total IMCA referrals received. Interestingly though if you break this down further and look at SMTs that were made in hospitals by doctors you find that these only account for around 6% of the total referrals. The research that has been commissioned should shed some light on the factors behind this but anecdotal evidence from IMCAs suggest a lack of understanding among clinicians of what the IMCA role is.

**Recommendation 1: That IMCAs and MCA leads in hospitals work to build links and improve awareness of the MCA and IMCA service among clinicians.**

**Case Study 2**

C has severe autism, he lives in residential care and has exhibited challenging and aggressive behaviour. C has developed a large growth which needs to be investigated but a profound fear of hospitals has made this difficult. Previous attempts to seek treatment had distressed C to the extent that he became violent and damaged waiting rooms. In view of the difficulties an IMCA referral was made.

The IMCA was unable to speak to C as he got agitated. Instead, the IMCA spoke to care staff at C's home, C's GP and staff at the hospital to gain an understanding of the situation and possible options. The consultant had tried to examine C in his home but it quickly became apparent that this would not be possible due to C's level of distress and aggressive behaviour.

A case conference was arranged to discuss C's treatment. It was agreed that C would be sedated at home and taken to hospital in a private ambulance with an operating theatre cleared ready for his arrival. There was some resistance to this plan due to the level of adjustment needed and the costs involved. The IMCA successfully argued that this option was in C's best interest as he clearly needed treatment and the level of distress meant this was the only option other than high levels of restraint. The IMCA pointed out that restraint should only be used if there was no other option.

C received treatment and recovered in his home, cared for by staff he knew and was comfortable with.

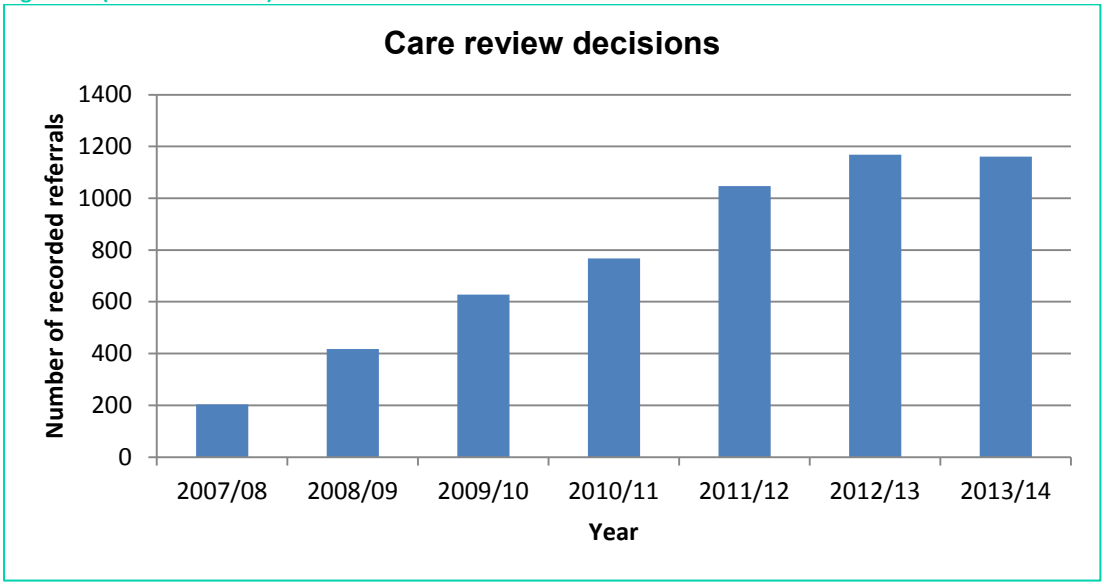
# 6. Care Review Decisions

Local authorities and NHS bodies can instruct an IMCA to support and represent a person who lacks capacity when:

- They have arranged accommodation for that person; and/ or
- They aim to review the arrangements (as part of a care plan or otherwise); and
- There are no family or friends who it would be appropriate to consult.

## There were 1,161 recorded care review decision referrals in 2013/14

**Figure 14 (see data table 1)**




This is the only decision where we see a decrease, albeit slight, in the number of recorded IMCA referrals from 1,168 to 1,161. Care reviews also continue to be the decision which receives the fewest referrals. It is important to remember that if a person lacks capacity their lack of objection to their existing arrangements should not mean that care plans should not be scrutinised and an IMCA appointed if appropriate.

It is important to remember that care plans should reflect the person's wishes as much as possible and should maximise the freedom of choice and movement available. This is not always easy as it needs to be balanced against the desire to keep people safe. The House of Lords Select committee noted that historically there has been a tendency towards paternalistic, risk averse care plans. The MCA makes it clear that we should seek to empower individuals and support them to make their own decisions, if possible.

This is a cultural shift and we are making progress but in order to continue we need to make sure we are listening to the person and taking their wishes into account. If a person lacks capacity they may struggle to communicate their views and that's why it's important that they have access to an independent advocate. Capacity can fluctuate and a person's care needs may change over time. That is why it is essential that care reviews take place to ensure the care package is still right for the individual.

**Case Study 3**

J has a learning disability and is an insulin dependent diabetic, he also suffers from epilepsy. J lives in supported living accommodation but the provider was not renewing their contract. As there was going to be a change in provider a care review was required. As this may have a significant impact on J an IMCA referral was made.

As J was unable to express his views and wishes the IMCA spoke to J's family and the existing provider to understand J's needs. J's family expressed a desire to be involved in the decision on the new provider. The IMCA discussed the tendering process with the Local Authority who advised that they didn't usually consult with the family or advocates during retendering. The contract was usually awarded to the provider who represented best value for money. The IMCA pointed out that decisions such as this should be made in the best interests of the tenant.

As a result of the IMCAs intervention the council narrowed down the tenders to 8 who met the criteria to provide the service. The IMCA and J's family were then able to meet with the 8 remaining tenders to consider which would provide the best service for J.

A new provider was selected and approved by the Local Authority (who had final say). The family advised that they felt much more engaged in the process than they ever had before, giving them much more confidence in J's care.

# 7. Adult Safeguarding

When local authorities or NHS bodies are using adult safeguarding procedures they can instruct an IMCA for a person who lacks capacity and is either:

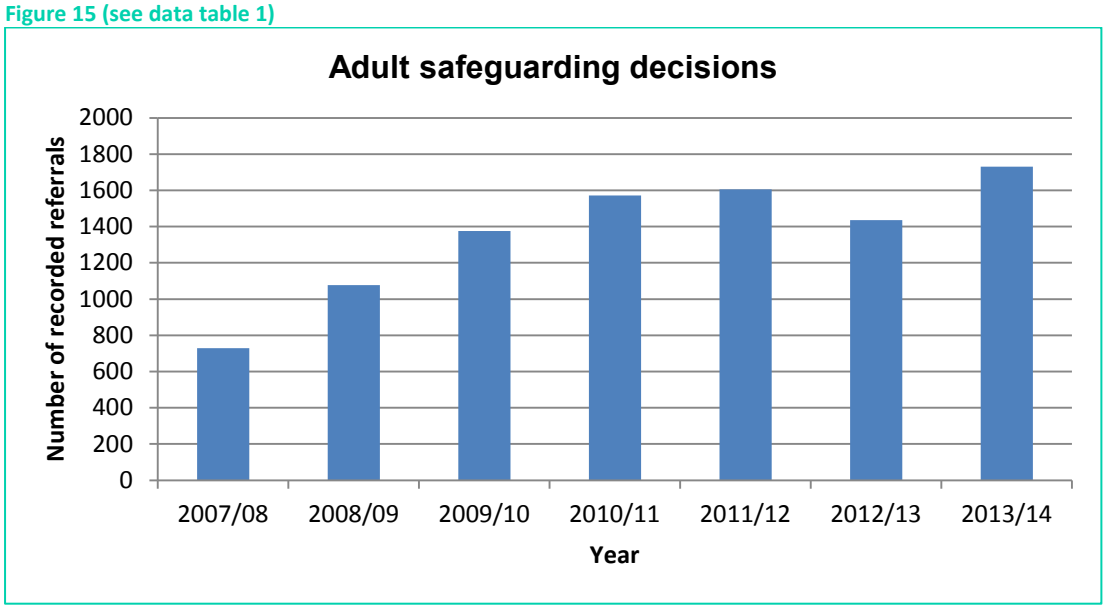
- The person who is alleged to have been abused or neglected
- A person who is alleged to have abused another person.

The local authority must be thinking about, or already taken protective measures for the person. In safeguarding situations access to IMCAs is not restricted to people who have no-one independent of services to represent them. People who lack capacity who have family and friends can still have an IMCA to represent and support them if the local authority feels it is appropriate.

It is worth noting that a case may begin as adult safeguarding and a decision taken about involving an IMCA on that basis. As the case develops it may become necessary for a change in accommodation to be considered, at that point the question of whether an IMCA should be involved should be reconsidered in relation to the accommodation decision i.e. does the move involve residential accommodation arranged by a local authority, or the NHS, which is likely to be for longer than eight weeks or a placement in hospital for a period that is likely to exceed 28 days.

## There were 1,730 recorded adult safeguarding decision referrals in 2013/14

Figure 15 (see data table 1)




In 2013/14 there were 88,280[6] concluded safeguarding referrals. Of those, 28% lacked capacity, 44% had capacity and we do not know if the remaining 29[7]% had

[6] Based on concluded referrals provided by 144 councils
[7] Figures do not add to 100% due to rounding

capacity or not. Hence, around 24,000 of these concluded referrals related to an adult who lacked capacity who could have potentially qualified for an IMCA.[8]

However, according to the IMCA database, only 1,730 IMCA referrals were made in 2013/14, equating to around 7% of the referrals where the person lacked capacity. This is concerning when you consider that of the referrals where we have information on what support was available[9], only around half were supported by an advocate, family member or friend.

There was a recommendation in the 2012/13 report that local authority safeguarding coordinators consider whether sufficient number of IMCA referrals were being made and we can see an increase this year. However, given the nature of adult safeguarding and the impact on the people involved, the fact that only half of those without capacity had support (whether that's an advocate, a family member or friend) is concerning.

Despite recommendations in the last two Annual IMCA Reports the proportion of safeguarding cases that involves IMCAs remains a cause for concern. It is therefore now essential that more is done to improve links between Safeguarding Adult Boards and IMCA services. With the introduction of the Care Act this may be a good opportunity to re-establish links between safeguarding arrangements and advocacy.

Section 10 of the MCA Code of Practice states that responsible bodies should take a strategic approach to deciding when an IMCA should be appointed for safeguarding and care review decisions. They should establish a policy for determining these decisions setting out the criteria for appointing an IMCA including the issues to be taken into account when deciding if an IMCA will be of particular benefit to the person concerned.

**Recommendation 2: Responsible bodies should ensure that they have a documented policy on when safeguarding cases should be referred to an IMCA. They should revisit the criteria within the policy to ensure that those who would benefit from an advocate have the opportunity to do so. In particular, consideration should be given to cases where there is no appropriate family member or friend to support a person who lacks capacity.**

[8] Safeguarding data taken from HSCIC Safeguarding Adults report 2013/14
[9] Based on 22,130 concluded referrals where the person lacked capacity provided by 137 councils

**Case Study 4**

B was in residential care following a stay in hospital due to extreme weight loss. There was concern about her returning home as sibling bullying had been a contributory factor to her condition (this was not her first hospital admission).

B's father spoke little English and due to the concerns her family were not considered appropriate to represent B so an IMCA referral was made. B was aware of the risk going home presented but repeatedly stated that she wanted to return to her family.

A meeting was held to discuss where B should live and it was agreed by the professionals that going home presented a risk to B's welfare. When the IMCA spoke to B about this she was so distressed at the prospect of being separated from her family the IMCA asked for the meeting to reconvene with B present so she could communicate how strongly she wished to go home.

Following B's representations it was agreed that B should go home with additional care which included activities and time outside the home, weekly meetings with the social worker, and meetings with a psychiatrist/eating disorder clinic as well as input from domestic abuse workers. It was also agreed that the situation would be reviewed again after 6 weeks.

# 8. Deprivation of Liberty Safeguards (DoLS) Decisions

There were 2,342 recorded Deprivation of Liberty Safeguards referrals in 2013/14

Figure 16 (see data table 1)

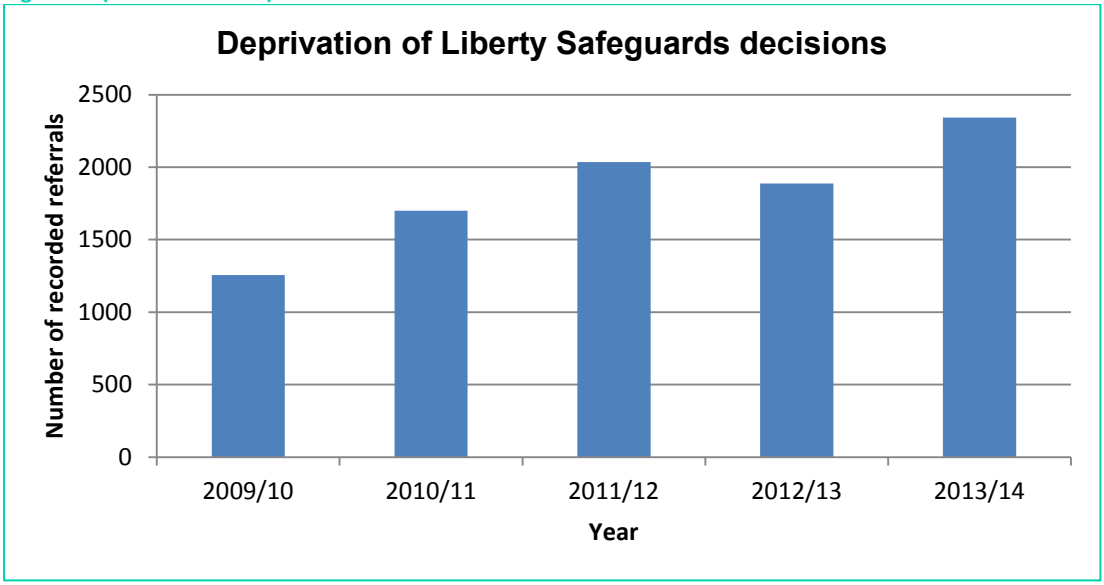
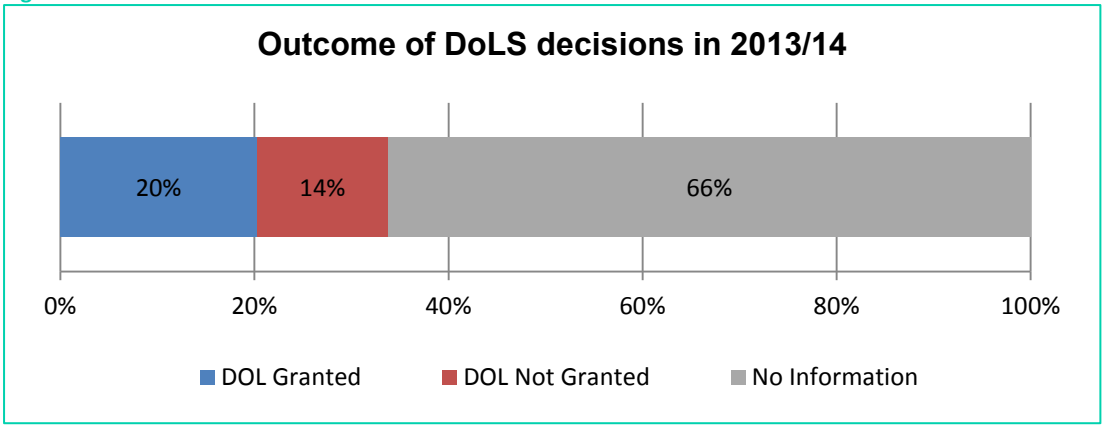



Figure 17




## 8.1 Types of Referrals

The Deprivation of Liberty Safeguards (DoLS) introduced a number of new roles for IMCAs. These are known as 39A, 39C and 39D and refer to the sections of the MCA in which these new roles are described.

### 39A IMCA

There are two 39A IMCA roles, both of which must be made available where the relevant person has no one appropriate to consult. These roles are:

- To support and represent a person during the assessment process where there is a request for a standard authorisation. The assessors are required to have regard to any representations the IMCA makes.
- To support and represent a person when a best interests assessor has been appointed by a supervisory body to determine whether there is an unlawful deprivation of liberty.

**39C IMCA**

If there is a gap in appointing a Relevant Person's Representative (RPR) then the managing authority may temporarily appoint a 39C IMCA to ensure that the person is not without representation.

**39D IMCA**

A 39D IMCA is only available if the RPR is unpaid, usually a family member or friend. The role of the IMCA is to support the person and their RPR in understanding the authorisation and their right to review and appeal. The IMCA may also request a review or make an application to the Court of Protection.

The Supervisory Body must instruct a 39D IMCA when requested by either the person or their RPR but may also appoint an IMCA if they feel the RPR could benefit from additional support and guidance.

**8.2 The Role of an RPR**

One of the key safeguards for people who are deprived of their liberty under DoLS is the appointment of an RPR. The RPR is there to represent the wishes and feelings of the person who is subject to the deprivation of liberty. It is important to recognise that this may be different from representing the best interests of the person. This can be sometimes be a difficult distinction to make.

As an unpaid RPR may often be a family member their natural instinct may be to do what they believe to be best for the person who lacks capacity, but this may be at odds with the person's stated wishes. This is particularly important in relation to appealing against a DoLS authorisation. Like everyone else, a person who lacks capacity has a right to have their appeal heard and the RPR has to enable them to do that – even if they don't agree with the appeal.

If an unpaid RPR feels that they are unable to fully fulfill their role then they can request an IMCA to support them (39D) or ask that another RPR is appointed.

**8.3 Number of Referrals**

The overall decrease in IMCA referrals for DoLS in 2012/13 (Figure 16) seems to have been an anomaly with referrals increasing again in 2013/14. The breakdown of DoLS type indicates that this dip was largely due to fewer 39D referrals but this has increased again in 2013/14.

Figure 18 (see data table 6)

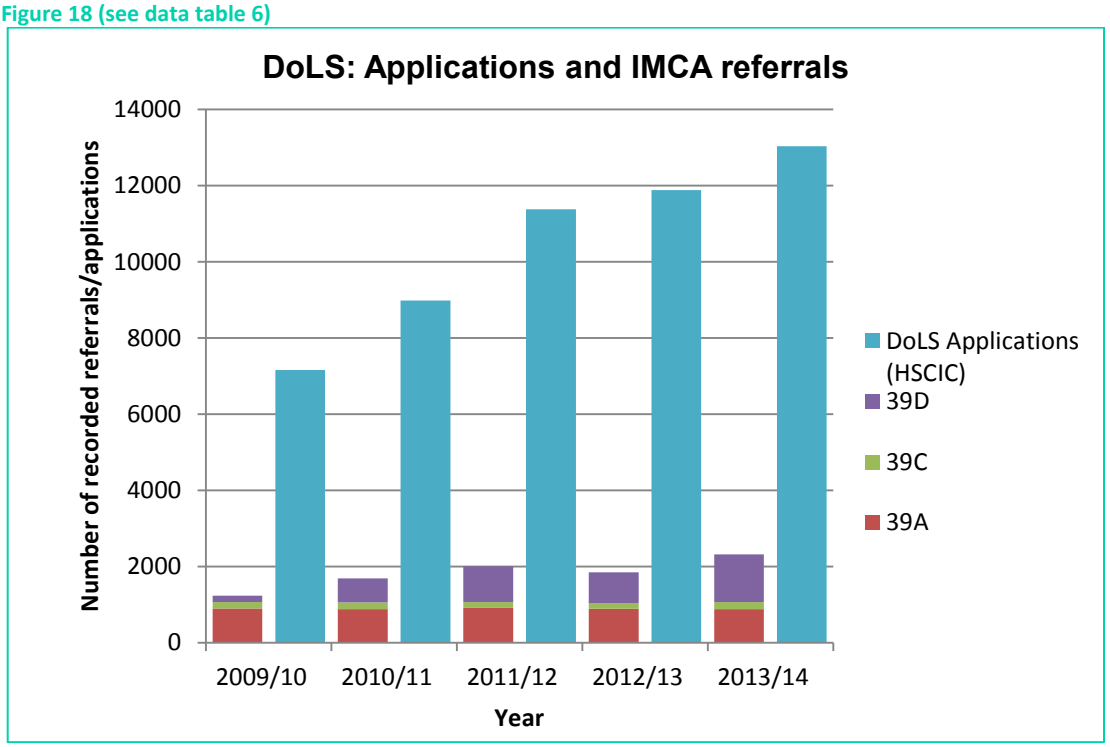
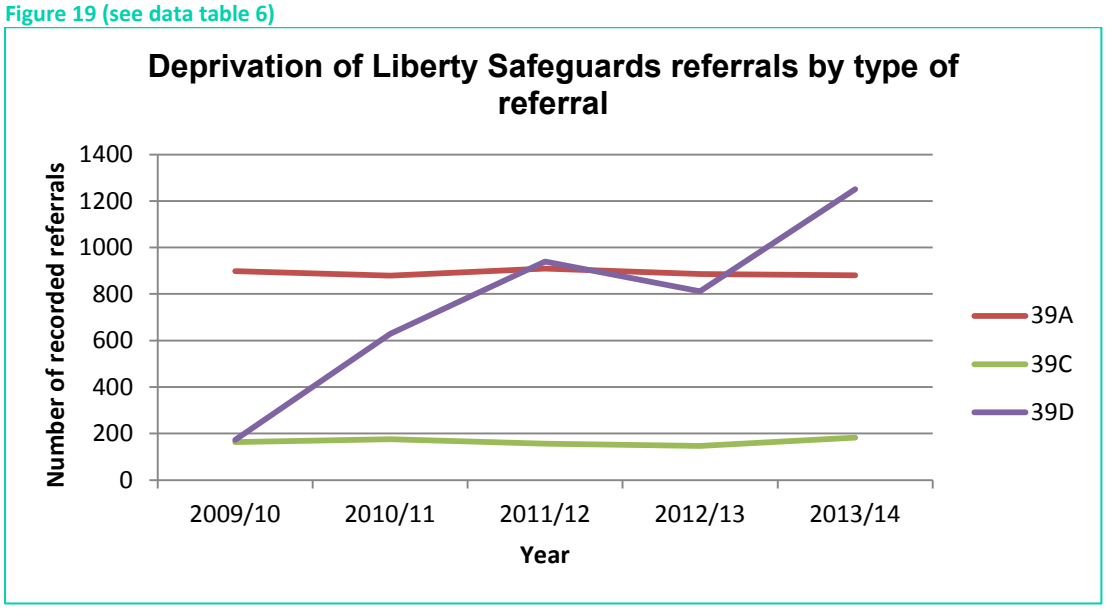



Figure 19 (see data table 6)




When we compare the number of IMCA referrals to the total number of DoLS applications received we find that, with the exception of the 2012/13 dip, the referral rate is fairly static at around 17-18% (which makes the 7% referral rate for adult safeguarding even more concerning).

There is a low take up on the use of IMCAs as the RPR (39C). This could be because most people have someone appropriate to represent them. There is

evidence[10] to suggest that a paid RPR will be more informed and engaged in the process which could potentially lead to a better outcome for the person.

It is important to ensure that the RPR is equipped to represent the person. If there is doubt then the use of an IMCA as a support (39D) could be of great help. By supporting an unpaid representative to be as informed and engaged as a paid representative we can ensure that everyone gets the appropriate level of support.

There is anecdotal evidence that 39D referrals are not being used correctly; that proper consideration is not being given to whether the unpaid representative needs or wants the support of an IMCA. Instead we are aware of instances where every case is referred for 39D support or no cases are referred.

**Recommendation 3: That local authorities review the process for providing 39D IMCA support to ensure that the right people are given access to this valuable service.**

**Case Study 5**

P has an unspecified cognitive impairment and has been residing in a residential home since being discharged from hospital 10 days ago. P had not been managing at home; she was a hoarder who kept out of date food and was at risk of falls. A care plan was in place for P but this had proved difficult as C would often refuse carers access and had been known to lash out. Prior to her most recent fall, P had been assessed as having capacity to make decisions about her accommodation and care.

An IMCA referral had been made as P's capacity was now fluctuating and she had at times become upset at being in the home and had on occasion tried to leave. The IMCA met with P who at times seemed confused about where she was, thinking she was at home. Other times she seemed happy to be in the care home describing it as "lovely". P expressed concern about her dog, who was currently being looked after by the RSPCA as the home did not allow pets. P spoke of her love for the dog and how much she missed it.

The IMCA found that the home had little understanding of the MCA or the fact that P was possibly being deprived of her liberty. At the IMCA's request a formal diagnosis of P's condition was sought, a DoLS authorisation was requested and options which included enhanced care packages which allowed P to return home to her dog were investigated.

Following the IMCAs intervention P was able to return home with a new care package. The decision maker also benefitted from increased awareness of the MCA and DoLS.

[10] CQC 2013/14 DoLS report

# 9. Looking Forward

### 9.1 Care Act Advocacy (from 1 April 2015)

Like the Mental Capacity Act 2005, the Care Act 2014 focusses on person-centred care, making it the responsibility of the local authority to involve people in their care and support assessment, planning, review and safeguarding processes. The statutory requirement for the provision of independent advocacy under the Care Act is to support that involvement where the person would otherwise have substantial difficulty being involved and has no one appropriate to support them.

The substantial difficulty requirement means that people who have capacity but still struggle to actively engage in their care planning can have the support of an advocate. Also, advocacy under the Care Act applies to the ongoing partnership between the person and the local authority whereas independent mental capacity advocacy is limited to certain specific decisions.

While those who lack capacity in relation to making a specific decision will always have substantial difficulty in being involved in a care and support process, people who are considered as having substantial difficulty may well have capacity. This means that people who are capable of making their own decisions can be helped and supported to do so by a Care Act advocate. It also means that people who lack capacity but are having to make decisions about their care and support outside the conditions in the MCA may be entitled to advocacy under the Care Act. As a result more people will be entitled to statutory advocacy than ever before.

### 9.2 DoLS Following Cheshire West Judgement

On 19th March 2014 the Supreme Court clarified the test for what constitutes a deprivation of liberty. The test (sometimes referred to as the acid test) is: “whether that individual lacks the mental capacity to consent to the arrangements for their care **and** is under continuous control and supervision **and** are not free to leave their place of residence”.

This clarified test means that significantly more individuals are now considered to be deprived of their liberty than under the previous test (which involved comparing the conditions of the individual in question to that of another individual with similar disabilities).

The clarification of the test is generally accepted as the right decision and a step forward in protecting the rights of potentially vulnerable members of society. However, the tenfold increase in the number of DoLS applications has generated a significant amount of additional work for local authorities.

It is vital that resource pressures do not reduce DoLS to paper exercises and that each case is given proper consideration. As an independent party, IMCAs have a duty to ensure that the person remains at the heart of the DoLS process and that nobody loses sight of the importance of maximising freedom for the individual.

### 9.3 Future of IMCA Data Collection

The Department of Health is currently reviewing the collection of data for statutory advocacy under the Mental Capacity Act, the Care Act and the Mental Health Act. This review will ensure that data collected on the advocacy process are relevant and timely and that the burden on data suppliers is minimised. As this review is at an early stage, we are unable to provide details of the new data collection mechanisms and the way in which they would work. As a result, there is a need for IMCAs to continue to enter records into the existing database to maintain the data flow.

Given the current resource pressures resulting from the increase in DoLS and the implementation of the Care Act it, is important that we reduce any unnecessary burden on front line IMCAs as soon as possible. To that end we have enclosed interim guidance at Appendix C which reduces the amount of fields that need to be completed.

### 9.4 Professionalising Advocacy

The House of Lords Select Committee report included a recommendation that the role of the IMCA be professionalised. This recommendation was accepted and we have worked with some of the largest IMCA providers which have produced some guidance on training and development of IMCAs (Appendix C). This includes a baseline minimum training requirement and a framework of six capabilities to be developed through continuing professional development (CPD).

**Recommendation 4: All IMCA providers should review this guidance and consider how it could be implemented in their organisation. Commissioners should also consider training standards when reviewing contracts.**

At the moment this guidance is a recommendation only. We encourage you to feedback your thoughts to us at IMCA@dh.gsi.gov.uk

# 10. Recommendations

**Recommendation 1: That IMCAs and MCA leads in hospitals work to build links and improve awareness of the MCA and the IMCA service among clinicians.**

The House of Lords Select Committee Report considered that there was a disparity between IMCA referrals in social and health care settings. This is borne out by the data trends - only 6% of total referrals were for serious medical treatment by doctors in a hospital setting. This concern is also supported by anecdotal evidence from IMCAs.

The reasons behind this are not clear but could be attributable to levels of awareness of MCA/IMCAs or differing interpretations on the meaning of "serious medical treatment". Further research to understand the reasons behind this has been commissioned from Kings College London.

**Recommendation 2: Responsible bodies should ensure that they have a documented policy on when safeguarding cases should be referred to an IMCA. They should revisit the criteria within the policy to ensure that those who would benefit from an advocate have the opportunity to do so. In particular, consideration should be given to cases where there is no appropriate family member or friend to support a person who lacks capacity.**

The last two annual reports have included recommendations around adult safeguarding yet only 7% of safeguarding referrals for adults without capacity involved an IMCA (compared to 17% of DoLS). This is a continuing concern as in half of the safeguarding referrals an adult, who lacked capacity, did not have the support of an advocate, family member or friend. Given the nature of safeguarding situations those involved should have the support of an independent advocate when needed.

**Recommendation 3: All local authorities should review their processes and procedures for providing 39D IMCA support to unpaid representatives to ensure that the right people are given access to this valuable service.**

Often an unpaid RPR may not have sufficient time or knowledge to fully engage in the DoLS process and it's important that they are provided with support to enable them to understand DoLS and also to challenge when necessary. There is evidence to suggest that proper consideration isn't being given to who might need this extra support to ensure that no one is subject to care that is more restrictive than is necessary.

**Recommendation 4: All IMCA providers should review the draft guidance on training and development and consider how it could be implemented in their organisation. Commissioners should also consider training standards when reviewing contracts.**

There was a recommendation in the House of Lords Select Committee Report, which was accepted, that the role of an IMCA should be professionalised. This recommendation was discussed with IMCAs and guidance on IMCA training and development has since been drafted by an IMCA provider, this includes

- A baseline minimum training requirement
- A framework of six capabilities to be developed through CPD

This guidance can be found at appendix D.

# Appendix A: Data Tables

Table 1 – recorded IMCA referrals by decision type

| Year | Serious Medical Treatment | Change of Accommodation | Adult Safeguarding | Care Review | Deprivation of Liberty | None chosen | Total |
|---|---|---|---|---|---|---|---|
| 2007/08 | 733 | 3,320 | 728 | 204 | 0 | 311 | 5,296 |
| 2008/09 | 1,107 | 4,103 | 1,077 | 418 | 2 | 320 | 7,027 |
| 2009/10 | 1,339 | 4,225 | 1,375 | 628 | 1,256 | 480 | 9,303 |
| 2010/11 | 1,669 | 4,651 | 1,572 | 767 | 1,699 | 470 | 10,828 |
| 2011/12 | 1,825 | 5,130 | 1,605 | 1,047 | 2,036 | 504 | 12,147 |
| 2012/13 | 1,875 | 5,223 | 1,436 | 1,168 | 1,888 | 479 | 12,069 |
| 2013/14 | 2,132 | 5,392 | 1,730 | 1,161 | 2,342 | 544 | 13,301 |

Table 2 – 2013/14 recorded IMCA referrals by mental impairment

| Mental Impairment | Referral Head Count |
|---|---|
| Acquired Brain Damage | 656 |
| Autism Spectrum Condition | 214 |
| Cognitive Impairment | 1,096 |
| Combination | 422 |
| Dementia | 5,575 |
| Learning Disability | 2,628 |
| Mental Health Problems | 1,683 |
| Not Specified | 194 |
| Other | 281 |
| Serious Physical Illness | 473 |
| Unconsciousness | 79 |
| Total | 13,301 |

Table 3 – 2013/14 recorded IMCA referrals by age

| Age | Referral Head Count |
|---|---|
| Not Specified | 161 |
| 16 - 17 | 34 |
| 18 - 30 | 683 |
| 31 - 45 | 833 |
| 46 - 65 | 2,940 |
| 66 - 79 | 3,421 |
| 80 and over | 5,085 |
| No information | 305 |
| Not known | 144 |
| Total | 13,301 |

Table 4 - 2013/14 recorded IMCA referrals by location and decision maker

| Location | Not Specified | Doctor | Social Worker | Supervisory body | Other | No Information | Total |
|---|---|---|---|---|---|---|---|
| Care Home | 14 | 612 | 3,115 | 1,540 | 599 | | 5,880 |
| Hospital | 8 | 1,140 | 2,255 | 590 | 430 | | 4,423 |
| Own Home | 5 | 126 | 1,075 | 18 | 163 | | 1,387 |
| Other[11] | 7 | 190 | 699 | 66 | 148 | 501 | 1,611 |
| Total | 34 | 2,068 | 7,144 | 2,214 | 1,340 | 501 | 13,301 |

Table 5 – 2013/14 recorded IMCA referrals by location and decision type

| Location | Serious Medical Treatment | Change Accommodation | Adult Protection | Care Review | Deprivation of Liberty | None chosen | Total |
|---|---|---|---|---|---|---|---|
| Care Home | 790 | 1,918 | 762 | 746 | 1,573 | 91 | 5,880 |
| Hospital | 912 | 2,407 | 282 | 110 | 640 | 72 | 4,423 |
| Own Home | 161 | 542 | 483 | 142 | 16 | 43 | 1,387 |
| Other[12] | 269 | 525 | 203 | 163 | 113 | 338 | 1,611 |
| Total | 2,132 | 5,392 | 1,730 | 1,161 | 2,342 | 544 | 13,301 |

Table 6 – recorded IMCA DoLS referrals and total DoLS applications

| Year | IMCA DoLS referrals | 39A | 39C | 39D | Total DoLS Applications (per HSCIC report) |
|---|---|---|---|---|---|
| 2009/10 | 1,234 | 898 | 163 | 173 | 7,157 |
| 2010/11 | 1,683 | 879 | 176 | 628 | 8,982 |
| 2011/12 | 2,005 | 909 | 156 | 940 | 11,382 |
| 2012/13 | 1,844 | 886 | 147 | 811 | 11,887 |
| 2013/14 | 2,314 | 880 | 183 | 1251 | 13,038 |

[11&9] *Other includes those in supported living, unspecified or unknown locations and any other type of accommodation*

# Appendix B: Recorded Referrals by Local Authority - April 2013 to March 2014

| Local Authority | Referrals |
|---|---|
| BARKING & DAGENHAM | 1 |
| BARNET | 56 |
| BARNSLEY | 30 |
| BATH & NORTH EAST SOMERSET | 69 |
| BEDFORD BOROUGH - TEMPORARY CODE | 67 |
| BEXLEY | 22 |
| BIRMINGHAM | 335 |
| BLACKBURN WITH DARWEN | 56 |
| BLACKPOOL | 81 |
| BOLTON | 99 |
| BOURNEMOUTH | 142 |
| BRACKNELL FOREST | 25 |
| BRADFORD | 105 |
| BRENT | 52 |
| BRIGHTON & HOVE | 97 |
| BRISTOL | 251 |
| BROMLEY | 36 |
| BUCKINGHAMSHIRE | 88 |
| BURY | 28 |
| CALDERDALE | 11 |
| CAMBRIDGESHIRE | 118 |
| CAMDEN | 218 |
| CENTRAL BEDFORDSHIRE - TEMPORARY CODE | 32 |
| CHESHIRE | 127 |
| CORNWALL | 216 |
| COVENTRY | 119 |
| CROYDON | 18 |
| CUMBRIA | 115 |
| DERBY | 108 |
| DERBYSHIRE | 252 |
| DEVON | 175 |
| DONCASTER | 61 |

| Local Authority | Referrals |
|---|---|
| DUDLEY | 105 |
| DURHAM | 1 |
| EAST RIDING OF YORKSHIRE | 48 |
| EAST SUSSEX | 213 |
| ENFIELD | 72 |
| ESSEX | 190 |
| GATESHEAD | 62 |
| GLOUCESTERSHIRE | 189 |
| GREENWICH | 42 |
| HACKNEY | 45 |
| HALTON | 28 |
| HAMMERSMITH & FULHAM | 42 |
| HAMPSHIRE | 126 |
| HARINGEY | 27 |
| HARROW | 42 |
| HARTLEPOOL | 39 |
| HEREFORDSHIRE | 48 |
| HERTFORDSHIRE | 190 |
| HILLINGDON | 49 |
| HOUNSLOW | 27 |
| ISLE OF WIGHT | 22 |
| ISLINGTON | 66 |
| KENSINGTON & CHELSEA | 44 |
| KENT | 274 |
| KINGSTON UPON HULL | 17 |
| KINGSTON UPON THAMES | 57 |
| KIRKLEES | 96 |
| KNOWSLEY | 44 |
| LAMBETH | 127 |
| LANCASHIRE | 352 |
| LEEDS | 425 |
| LEICESTER | 173 |
| LEICESTERSHIRE | 146 |

| | |
|---|---|
| LEWISHAM | 44 |
| LINCOLNSHIRE | 170 |
| LIVERPOOL | 170 |
| LUTON | 34 |
| MANCHESTER | 227 |
| MEDWAY TOWNS | 35 |
| MERTON | 3 |
| MIDDLESBROUGH | 62 |
| MILTON KEYNES | 2 |
| NEWCASTLE UPON TYNE | 94 |
| NEWHAM | 60 |
| NORFOLK | 72 |
| NORTH EAST LINCOLNSHIRE | 62 |
| NORTH LINCOLNSHIRE | 39 |
| NORTH SOMERSET | 247 |
| NORTH TYNESIDE | 37 |
| NORTH YORKSHIRE | 178 |
| NORTHAMPTONSHIRE | 92 |
| NORTHUMBERLAND | 63 |
| NOTTINGHAM | 216 |
| NOTTINGHAMSHIRE | 249 |
| OLDHAM | 55 |
| OXFORDSHIRE | 121 |
| PETERBOROUGH | 26 |
| PLYMOUTH | 145 |
| POOLE | 59 |
| PORTSMOUTH | 74 |
| READING | 38 |
| REDBRIDGE | 64 |
| REDCAR & CLEVELAND | 27 |
| RICHMOND UPON THAMES | 29 |
| ROCHDALE | 94 |
| ROTHERHAM | 41 |
| RUTLAND | 3 |
| SALFORD | 161 |
| SANDWELL | 69 |
| SEFTON | 42 |
| SHEFFIELD | 178 |
| SHROPSHIRE | 47 |
| SLOUGH | 24 |
| SOLIHULL | 42 |
| SOMERSET | 169 |
| SOUTH GLOUCESTERSHIRE | 84 |
| SOUTH TYNESIDE | 81 |
| SOUTHAMPTON | 68 |
| SOUTHEND | 51 |
| SOUTHWARK | 34 |
| ST HELENS | 29 |
| STAFFORDSHIRE | 67 |
| STOCKPORT | 45 |
| STOCKTON ON TEES | 79 |
| STOKE-ON-TRENT | 50 |
| SUFFOLK | 164 |
| SUNDERLAND | 56 |
| SURREY | 199 |
| SUTTON | 50 |
| SWINDON | 81 |
| TAMESIDE | 42 |
| TELFORD & WREKIN | 21 |
| THURROCK | 22 |
| TORBAY | 91 |
| TOWER HAMLETS | 39 |
| TRAFFORD | 68 |
| WAKEFIELD | 95 |
| WALSALL | 40 |
| WALTHAM FOREST | 92 |
| WANDSWORTH | 28 |
| WARRINGTON | 84 |
| WARWICKSHIRE | 133 |
| WEST BERKSHIRE | 15 |
| WEST SUSSEX | 197 |
| WESTMINSTER | 51 |
| WIGAN | 156 |
| WILTSHIRE | 102 |
| WINDSOR & MAIDENHEAD | 34 |
| WIRRAL | 120 |
| WOKINGHAM | 8 |
| WOLVERHAMPTON | 41 |
| WORCESTERSHIRE | 126 |
| YORK | 57 |
| **Total** | **13,302** |

# Appendix C: Interim Guidance on Completion of IMCA Database

We are currently reviewing the collection of data for statutory advocacy under the Mental Capacity Act, the Care Act and the Mental Health Act. We are considering what data should be collected and options around how this could be collected in future. In due course we will consult with stakeholders around possible options but in the interim we would welcome contributions on the future of advocacy data. Please send any comments to IMCA@dh.gsi.gov.uk

While this review progresses, there is scope to reduce the data that needs to be collected and therefore reducing the burden on frontline IMCAs. Below is a list of all the questions currently included with an indication of whether they still need to be completed or not.

| Question | Complete? |
|---|---|
| 1. Local Authority | Yes |
| 2. IMCA Provider | Yes |
| 3. Date referral received | Yes |
| 4. Is this a first referral | No |
| 5. Client ID | Yes |
| 6. Gender | Yes |
| 7. Age | Yes |
| 8. Ethnic Background | Yes |
| 9. Does the client have a disability | Yes |
| 10. Nature of clients impairment | Yes |
| 11. Primary means of communication | No |
| 12. Is the client eligible for an IMCA[13] | No |
| 13. If NO please indicate reason IMCA will not be assigned | No |
| 14. If NO close record | No |
| 15. If YES when did IMCA begin case work | Yes |
| 16. Where was the client at the time of referral | Yes |
| 17. Where did the referral come from | Yes |
| 18. Who is the decision maker | Yes |
| 19. What is the decision to be made – SMT? | Yes |
| a. Did the IMCA seek a second medical opinion | No |
| b. Was a second medical opinion obtained | No |
| 20. Change in accommodation | Yes |
| 21. Adult protection | Yes |
| 22. Deprivation of liberty | Yes |
| 23. Hours (to nearest 10 minutes) | No |
| 24. Was an IMCA report submitted to the decision maker or supervisory body | No |
| 25. What was the outcome | No |

[13] There is no need to complete the database if the person is ineligible

| | |
|---|---|
| 26. If YES enter date completed | No |
| 27. If no report submitted please indicate reason | No |
| 28. How well do you think you worked with the LA/NHS on this case | No |
| 29. How well do you think the LA/NHS worked with you on this case | No |
| 30. Were you able to ascertain the client's wishes or preferences in relation to the decision to be made | No |
| 31. Looking back at this case, how did you most contribute | No |
| 32. Where applicable, did the outcome reflect the clients wishes and preferences | No |
| 33. Where applicable, was the outcome significantly affected by the involvement of the IMCA | No |
| 34. Where applicable did the IMCA challenge the outcome | Yes |
| 35. If YES please specify route taken by IMCA to challenge the outcome | No |
| 36. Overall how satisfied were you that your involvement provided a safeguard for your client | No |

# Appendix D: Training and Continued Professional Development (CPD) for Independent Mental Capacity Advocates (IMCAs)

*NB. This draft guidance has been prepared by Jeanette Brown of POhWER in consultation with other IMCA providers.*

Training and CPD are interchangeable. However, the expectation is that advocates will undertake formal training prior to acting as an IMCA and will then continue to develop their skills through on-going CPD. This paper will outline minimum baseline requirements for both training and CPD.

Ideally (although not mandatory where impracticable) the advocate will shadow a minimum of 2 IMCA cases prior to attending the formal IMCA training. Once they have attended the training they will take on their own IMCA cases and be shadowed by an experienced IMCA for at least 6 cases, longer where necessary (unless this is impracticable, for example, whereby there are no experienced IMCAs within the vicinity). After 6 months practice the IMCA will ideally (although not mandatorily, unless contracts require) be registered on and subsequently achieve the Diploma in Independent Advocacy[14].

The minimum requirements for the IMCA training are set out here:

**IMCA Training Baseline Minimum Requirements:**

Training will provide IMCAs with:

1. Understanding of the role of an advocate and the various advocacy models
2. Understanding of the different needs, including communication needs of the people they will be working with and representing, including but not restricted to:
    a. Understanding the impact of cultural, religious and social differences
    b. Working with people who have autistic spectrum disorders
    c. Working with people who have dementia type illnesses
    d. Working with people who have behaviour which others may find challenging
    e. Working with people who have experienced a stroke
    f. Working with people who have an acquired brain injury
    g. Working with people who have a learning disability
    h. Working with people who experience mental health problems

[14] National Advocacy Qualification

[Note – points 1 & 2 may be covered by underpinning general advocacy training rather than the IMCA training. If the underpinning general advocacy training is not available then this will need to be covered in the IMCA training]

3. Ability to identify and understand the principles of the MCA 2005
4. Understand that capacity is time and issue specific and have a sound working knowledge of:
    a. How capacity assessments should be carried out in line with the Act
    b. How to challenge capacity assessments in an appropriate manner; when it is appropriate to challenge; and how to achieve positive outcomes for clients
5. Understanding of the best interest decision making process, including ensuring the person who lacks capacity is kept at the centre of the decision making process, their views are heard and central to the decisions made on their behalf, and they are empowered to be included in the process as far as possible
6. Have a sound overview of the provisions of the Act including:
    a. What decisions are included in the Act and which are excluded
    b. Section 5 of the Act – protection from liability, including restraint
    c. Lasting Powers of Attorney and Enduring Powers of Attorney
    d. The court of protection, including it's scope and limitations and:
        i. Know where to go for further information and guidance on accessing the court of protection
    e. Court appointed deputies
    f. Advance decisions to refuse treatment, including criteria for validity
    g. Advanced statements / living wills
    h. Criminal offenses of ill treatment and wilful neglect (s.44)
    i. Sound understanding of how the Act applies to children and young people, including the role of the court of protection and transitions services
    j. Rights afforded to those who lack capacity to make certain decisions themselves
    k. Overview understanding of research projects affecting those who lack capacity to consent to being a participant
    l. Overview of the rules governing access to information about people who lack capacity, especially how this affects IMCAs
7. Understanding of the Deprivation of liberty safeguards including:
    a. Identifying what factors determine deprivation of liberty
    b. Identifying what other legislative frameworks authorise a deprivation of liberty, when it is appropriate to use each of the frameworks and any overlap
    c. Ability to distinguish between urgent and standard authorisations and the role of the IMCA within these
    d. Ability to identify when someone may be at risk of deprivation of liberty and how to respond appropriately

8. Sound understanding of the IMCA role and criteria for referrals, namely:
    a. Change of accommodation
    b. Serious medical treatment
    c. Care reviews
    d. Safeguarding adults
    e. s.39A
    f. s.39C
    g. s.39D
9. Overview of how to carry out each of the IMCA roles, including good report writing practice
10. Overview of the relevant person's representative
11. Overview of the role of the court of protection in relation to IMCA cases including:
    a. When it may be appropriate to access the court of protection for IMCA challenges
    b. When it may be appropriate to support others to access the court of protection, i.e. s.39C and s.39D IMCA cases
    c. Overview of how to access the court of protection
    d. Overview of the IMCA role in cases within the court of protection
    e. Where to go to access more information about accessing the court of protection and an IMCAs role within a case that is subject to the court of protection
12. Overview of other relevant legislation and how to include this in casework, including, but not only:
    a. The Care Act 2014
    b. The Equality Act 2010
    c. Care Standards Act 2000
    d. Human Rights Act 1998
    e. Mental Health Act 1983
    f. National Health Service and Community Care Act 1990
    g. National Assistance Act 1948
    h. UN Convention on the Rights of Persons with Disabilities
    i. UN Charter of Human Rights
    j. European Convention on Human Rights

It has been recognised that IMCAs are a valuable part of the MCA for ensuring individuals who lack capacity to make certain decisions for themselves have their rights protected. It is imperative that IMCAs continue to develop their skills and knowledge and remain up-to-date with case law, legislative changes and best practice guidance. Continued development is required to ensure IMCAs progress in their skill and knowledge development and remain an effective advocate for those people who require their support. Therefore IMCA practitioners will be expected to complete yearly CPD as set out below:

**Continued Professional Development (CPD) Baseline Requirements:**

As a baseline minimum IMCAs will be expected to undertake X hours CPD (fulltime equivalent) each year. The following is a list which will count towards CPD, although this is not an exhaustive list:

- Attending relevant webinars on MCA, DoLS, MHA, HRA, etc.
- Attending relevant seminars
- Attending relevant conferences
- Attending relevant internal practitioner team meetings
- Attending relevant external practitioner meetings, including, but not only:
    - Regional IMCA forums
    - Best Interest assessor forums
    - Best interest assessor update training
    - Mental Health assessor update training
    - Supervisory Body update training
    - Mental Health Act advocate forums
- Attending update / refresher training on working with people with disabilities and communication issues including, but not restricted to:
    - Signing training, such as BSL, Makaton, Sign-a-long, spoken word signing, pictorial communication systems, Social Stories, etc.
    - Working with people with dementia type illnesses
    - Working with people with learning disabilities
    - Working with people with mental health problems
    - Working with people who have an acquired brain injury
    - Working with people who have had a stroke
    - Working with people with autistic spectrum disorders
- Attending training on reading and understanding case law
- X hours of formal reflective practice activities
- Undertake a minimum of X hours of supervision
- Peer support / supervision

**Independent Mental Capacity Advocates Capabilities:**

There are 6 capabilities IMCAs are expected to evidence on an on-going basis via Continued Professional Development. These are set out below:

1. **Key capability 1:** The ability to have a sound understanding of, and keep up-to-date with, the MCA, DoLS and other relevant legislative frameworks and relevant case law
2. **Key capability 2:** The ability to work in a manner that promotes the MCA and the rights of those who may be affected by the MCA
3. **Key capability 3:** The ability to have a sound understanding of capacity assessments, best practice and creative assessments and the ability to challenge capacity assessments in an appropriate and outcome focused manner when relevant to do so
4. **Key capability 4:** The ability to promote supported decision making for those who lack capacity: i.e. ensuring decisions made on behalf of those who lack capacity start from the point of view of the person and not the opinions of those in control of making those decisions
5. **Key capability 5:** The ability to deliver high quality instructed and non-instructed advocacy when carrying out the IMCA roles: namely:
    a. Change of accommodation
    b. Serious medical treatment
    c. Care reviews
    d. Adult protection
    e. s.39A
    f. s.39C
    g. s.39D
6. **Key capability 6:** Additional safeguard i.e. challenging decisions formally and informally

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| | **Key capability 1: the ability to have a sound understanding of, and keep up-to-date with, the MCA, DoLS and other relevant legislative frameworks** | |
| **Legislation and policy** | The IMCA will:<br>I. Be able to demonstrate a working knowledge of the MCA 2005, DoLS, current codes of practice, national and local policy and best practice guidance<br>II. Be able to demonstrate a working knowledge of other relevant legislation and their supporting codes of practice. These will include, but are not limited to: The Mental Health Act 2007, The Care Act 2014, The Human Rights Act 1998, The Equality Act 2010<br>III. Be able to demonstrate a good understanding of adult safeguarding policy and outcome focused practice<br>IV. Be able to read and understand case law and how to apply it to cases; and keep up to date with relevant case law and be able to reference this appropriately and relevantly within case work | Practice:<br>I. The IMCA will base their practice on a sound understanding of the MCA and DoLS legislation and codes of practice and ensure they work inline with national and local policy, for example the Local Authority procedure for instructing IMCAs in safeguarding adults cases<br>II. Where appropriate the IMCA will make reference to other legislative frameworks to ensure all of the person's rights are upheld, not just those relevant to MCA and DoLS<br>III. The IMCA will have a sound understanding of adult safeguarding as set out in The Care Act 2014 and promote outcome focused solutions for those they are representing<br>IV. The IMCA will keep up-to-date with relevant case law, be able to understand and interpret it and be able to use salient points within their representations |
| | **<u>Key capability 2:</u> The ability to work in a manner that promotes the MCA and the rights of those who may be affected by the MCA** | |
| **Promoting the MCA** | The IMCA will:<br>I. Promote the MCA in all aspects of their work<br>II. Make reference to the MCA in their representations<br>III. Undertake networking, engagement and educational activities where appropriate and | Practice:<br>I. When advocating on behalf of people the IMCA will explain how the MCA is underpinning their representations<br>II. The IMCA will not only make reference to the MCA in their representations, but explain how |

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| | practicable to do so | it is relevant to the person they are representing in a person-centred manner<br>III. IMCAs are well placed to promote the MCA formally and informally, providing high quality and will researched and understood information<br>IV. IMCAs will provide guidance and signposting of the MCA to professionals where appropriate |
| | **<u>Key capability 3:</u> The ability to have a sound understanding of capacity assessments, best practice and creative assessments and the ability to challenge capacity assessments in an appropriate and outcome focused manner when relevant to do so** | |
| **Understanding and challenging capacity assessments** | The IMCA will:<br>I. Promote the assumption of capacity; promote that the onus is on assessors to prove lack of capacity, not those being assessed proving they have capacity; and promote that the bar should not be set too high when assessing capacity<br>II. Promote people being given information in an accessible and meaningful way and supported to make their own decisions prior to decisions being made regarding capacity<br>III. Have a good understanding of how capacity assessments should be carried out<br>IV. Have the ability to challenge capacity assessments where appropriate to do so | Practice:<br>I. IMCAs use their knowledge as well as keeping up-to-date with relevant case law in terms of issue specific capacity assessments, therefore able to challenge when capacity assessments are too risk averse, the assessor is looking for the client to prove their capacity rather than the assessor proving lack of capacity (as should be done) and when the bar is being set to high<br>II. IMCAs will seek evidence of how information has been presented to people and whether this has met their communication, cultural, learning and other needs<br>III. Whilst IMCAs do not undertake formal assessments of capacity they will have a good understanding of how these should be undertaken and be able to guide as well as |

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| | | challenge professionals<br>IV. IMCAs will know how to challenge capacity assessments, when it is appropriate to challenge and how to promote positive working relationships between themselves, the professional and the person being assessed |
| | **<u>Key capability 4:</u> The ability to promote supported decision making for those who lack capacity: i.e. ensuring decisions made on behalf of those who lack capacity start from the point of view of the person, not the personal opinions of those in control of making those decisions and the MCA is applied** | |
| **Promoting supported decision making** | The IMCA will:<br><br>I. Have the ability to identify what the person's views, preferences and wishes are, directly or indirectly, as far as reasonably practicable<br>II. The IMCA will ensure these views made known to the decision maker<br>III. The IMCA will promote the views and preferences of the people they represent ensuring these remain central to decisions being made on their behalf | Practice:<br><br>I. The IMCA will use a variety of methods and advocacy models to gain the views, preferences and wishes of the people they represent as far as practicable.<br>II. The IMCA will ensure the person's views are taken on board by the decision maker through verbal and written communication, reports and meetings<br>III. IMCAs will be skilled at ensuring the person's views and preferences are kept central to all decisions made on their behalf by using a variety of methods including right's based and person-centred approaches and promoting the right of the person to be invited to discussions and meetings regarding them wherever appropriate |
| | **<u>Key capability 5:</u> The ability to deliver high quality instructed and non-instructed advocacy when** | |

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| | **carrying out the IMCA roles: namely:**<br>**a. <u>Change of accommodation</u>**<br>**b. <u>Serious medical treatment</u>**<br>**c. <u>Care reviews</u>**<br>**d. <u>Adult protection</u>**<br>**e. <u>s.39A</u>**<br>**f. <u>s.39C</u>**<br>**g. <u>s.39D</u>** | |
| **Ability to carry out the IMCA roles** | The IMCA will:<br>I. Have a sound understanding of instructed and non-instructed advocacy models and ability to carry these out<br>II. Have a sound understanding of each of the IMCA roles and how to carry these out<br>III. Be able to communicate effectively with a wide range of people, including those they represent and professionals<br>IV. Be able to work effectively with a wide range of people with various health and social care needs<br>V. Ensure their independence is maintained at all times<br>VI. Have an understanding of the impact of social exclusion and its impact<br>VII. Have an understanding of the social and medical models of disability<br>VIII. Have an understanding of ethical dilemmas<br>IX. Have an ability to identify and weigh up the benefits and burdens of available options and effectively advocate regarding these | Practice:<br>I. IMCAs will have the ability to carry out high quality instructed and non-instructed advocacy, understanding when each model is appropriate and identify when a person may move between the two<br>II. IMCAs will have the ability to carry out issue based advocacy recognising their role within each of the issues, having regard for the boundaries to their role in each issue and ensuring they have been appropriately instructed<br>III. IMCAs will develop a wide variety of communication methods and use communication aids and toolkits and interpreters where appropriate. They will have the ability to represent people in formal meetings and ability to challenge professionals in a non-confrontational yet effective manner<br>IV. IMCAs will be skilled at working with people with a wide variety of needs from a wide |

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| | X. Be able to keep accurate and effective case records<br>XI. Create and submit high quality reports and representations, reflecting the views of the person who lacks capacity, advantages and disadvantages of options and other considerations in a timely manner | variety of backgrounds and Including hard to reach and minority groups<br>V. IMCAs will be able to maintain positive working relations with professionals whilst still maintaining their independence<br>VI. IMCAs will be aware of the impact social exclusion can have, including discrimination, and ensure any issues are considered and responded to<br>VII. IMCAs will understand the social and medical models of disability and the impact the models can have on how decisions are made on behalf of others and will advocate to ensure people's rights are upheld<br>VIII. IMCAs will be able to recognise potential ethical dilemmas and know how to escalate issues in order to be addressed<br>IX. IMCAs will be skilled at researching and recognising the benefits and burdens of proposed options, ensure these are considered by decision makers and be prepared to challenge where they feel these are being disregarded<br>X. IMCAs will keep accurate, up-to-date records of all aspects of their casework<br>XI. IMCAs will always report to those who have instructed them, in most cases this will be via a formal written report, although occasionally (where instruction has been withdrawn for example) it may be appropriate to provide summary emails, or other ways of reporting back, in order to meet this requirement. |

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| | | IMCAs will ensure their reports reflect the views of the person they are representing, be relevant to the issues they have been instructed on and bring value to the case wherever possible. All representations will be submitted in a timely manner and whenever a deadline cannot be met this will be discussed with the decision maker where practicable to do so |
| | **<u>Key capability 6:</u> Additional safeguard i.e. challenging decisions formally and informally?** | |
| | The IMCA will:<br><br>I. Be able to recognise when, and in what manner, it is appropriate to challenge decisions<br>II. Be able to recognise when it is appropriate to challenge decisions to deem friends / family inappropriate to consult, and how<br>III. Be able to recognise when it is appropriate to challenge capacity assessments and how<br>IV. Be able to use a range of techniques for challenging decisions<br>V. Understand and be able to use the local complaints procedure<br>VI. Know which cases should be brought before the Court of Protection<br>VII. Know when it is appropriate to contact the Official Solicitor regarding a case<br>VIII. Know when it is appropriate to apply to the Court of Protection and how to do so | Practice:<br><br>I. Be able to challenge in a manner which does not alienate themselves or their client as a result<br>II. Be able to achieve positive outcomes via informal and formal challenges, whilst maintaining good working relations<br>III. Be pivotal in ensuring people's Article 8 HRA 1998 are upheld in terms of consultation and relationships<br>IV. Achieve positive outcomes for people who may well have capacity but are not being considered as such (incl. ensuring principle 2 MCA)<br>V. Be able to use informal challenges to achieve positive results<br>VI. Be able to use formal challenges to achieve positive results<br>VII. Have a good understanding of local complaints procedures and be able to use |

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| | | them<br>VIII. Be able to prompt responsible bodies to consider applying to take cases to court where appropriate to do so<br>IX. Be able to undertake the applicant role in applying to the Court of Protection where appropriate and necessary |

**Continued Professional Development Log for Independent Mental Capacity Advocates**

**Name of IMCA:**

**Period:** 01/04/?? – 31/03/??

All CPD activities relevant to your role as an IMCA are to be recorded in the log below. Collate supporting evidence in your CPD file ensuring it is referenced so as to be linked with this log.

| Date & evidence reference | Length of time spent on activity | Summary of activity | Self-reflection |
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**Total CPD hours for the year**