The Use of Independent Mental Capacity Advocates

Background

The Mental Capacity Act (2005) created the Independent Mental Capacity Advocacy Service. The role of an Independent Mental Capacity Advocate (IMCA) is to support and represent people at times when critical decisions are being made about their health or social care. An IMCA is involved when the person lacks capacity to make such decisions themselves and usually when they do not have family or friends who can represent them. However, an IMCA can be appointed even if family and friends are available, if that is thought to be in the person’s interests. The areas of decision-making in which an IMCA may be used are safeguarding situations, changes in accommodation, care reviews, serious medical treatment and circumstances involving the Deprivation of Liberty Safeguards (DoLs).

Summary

This briefing summarises the main points in the Department of Health’s annual report on the Independent Mental Capacity Advocacy Service: The Sixth Year of the Independent Mental Capacity Advocacy Service 2012-2013 (February 2014).


It covers the period April 2012 to March 2013.

Practice Areas:
Practitioners and managers in adult services; safeguarding coordinators.

Status:
Department of Health Report.

The Report’s Findings

In 2012/13 the pattern of year-on-year increases in the overall number of referrals to the Independent Mental Capacity Advocacy Service continued, with the number of referrals to IMCAs rising by 4% to 12,381. However, there were wide disparities in the rates of IMCA referrals in different local authority areas that cannot be explained by population differences alone. The Report considers it likely that these disparities are the consequence of the duties and powers under the Mental Capacity Act (2005) not being well embedded in some areas. The Report considered each of the areas of decision-making in which IMCAs can be involved.
Safeguarding

55% of local authorities reduced the number of IMCA referrals they made in safeguarding cases. Over the last two years the use of IMCAs in safeguarding cases has been falling (1,564 in 2010/11; 1,533 in 2011/12; 1,482 in 2012/13), while the number of safeguarding cases has been rising (up 11% from 2010/11 to 2011/12; up 2% from 2011/12 to 2012/13). In 2012/13 there were over 173,000 reported safeguarding alerts. Only 1,482 of these cases were referred to IMCAs. This means that fewer than 1% of people who were referred to local authorities for safeguarding received the assistance of an IMCA.

There were 86,820 completed safeguarding cases for which an outcome was recorded. 29% resulted in no further action, suggesting that safeguarding measures were put in place for about 60,000 people. The number of IMCA referrals at 1,482 was only 2.5% of this 60,000.

Changes in Accommodation and Care Reviews

The number of IMCA referrals in connection with decisions about changes in accommodation was 5,353, a 9% increase. However, the number of IMCA referrals for reviews was only 1,203 (- although a low number, itself an increase of 16% on the previous year). It is not clear whether 4,000+ reviews are taking place without IMCAs or whether these reviews are not taking place at all following a change in accommodation.

Serious Medical Treatment

1,907 referrals, a 9% increase, were made to IMCAs in connection with serious medical treatment decisions. The Report suggests that this reflects a better understanding of the role of the IMCA in end of life care for people with dementia.

Deprivation of Liberty Safeguarding

There was a fall to 1,907, a 3% decrease, in the numbers of referrals to IMCAs in DoLs cases.

The Report was particularly concerned about the fall in the number of referrals under section 39D of the Mental Capacity Act (2005). This section is concerned with someone who is the subject of a DoLS authorisation and who has an unpaid person, usually a family member or friend, appointed to speak for them as their ‘relevant person’s representative’ (RPR). In these cases, an IMCA must be appointed if requested by the person or the RPR or if the local authority believes an IMCA is necessary to help the person exercise their right to challenge a DoLS authorisation or have it reviewed. The Report sees the presence of IMCAs in these situations as important because of the safeguards they are able to offer. They can: support family members concerning the right to challenge a DoLS authorisation; negotiate less restrictive conditions; ask for independent mediation and/or challenge the DOL authorisation in the Court of Protection at no cost.
**IMCA Consultations**

The Report also reported on the findings of consultations with IMCAs.

Outcomes identified by IMCAs:

- Improved decision-making processes;
- Increased liberty or autonomy;
- Identification of issues not previously addressed;
- Provision of specialist knowledge and questioning;
- Different and better outcomes.

Obstacles to good practice identified by IMCAs:

- Lack of effective communication with referrers;
- Delays by decision makers in taking action;
- Lack of clarity about who the decision-maker was;
- Lack of a ‘working together’ ethos in safeguarding;
- The size of caseloads and the pressure to spend less time with each person.

**Report Recommendations**

- Commissioners need to take account of the year-by-year increase in the number of people with a statutory entitlement to referral to an IMCA;
- Local authority safeguarding coordinators should consider the statistics in the Report and report to their Safeguarding Adults Boards on whether a sufficient number of IMCA referrals are being made in their areas;
- Local authorities and IMCA organisations to carry out audits of recent changes in accommodation and reviews to identify cases in which people could have benefited from an IMCA but did not receive one;
- Local authorities and NHS trusts should have policies on when people who are the focus of safeguarding and care reviews should be represented by IMCAs. (This reiterates the Mental Capacity Act Code of Practice.);
- Supported decision-making should be adopted more widely within safeguarding practice in order to assist more people to make their own decisions about their safeguarding plans. And before a care plan or a protection plan is made, the question should always be asked about whether any less restrictive safeguarding action which would interfere less with the person’s basic rights and freedoms may be possible;
• Before a care plan or a protection plan is made, the question should always be asked about whether any less restrictive safeguarding action which would interfere less with the person’s basic rights and freedoms may be possible;

• Introduce the heading ‘liberty’ into all care plans to assist staff to consider ways of promoting liberty as part of care planning;

• IMCA organisations, local authorities and the NHS should continue to be alert to possible Deprivations of Liberty (DoL). IMCA organisations should alert local authorities and the NHS of the need either to prevent a DoL by changing the care plan or applying the DoL safeguards 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.