Guidance for Commissioners on the Independent Mental Capacity Advocate Service

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1. Executive summary

Turning Point was funded by the Department of Health to produce guidance for commissioners on the Independent Mental Capacity Advocate (IMCA) service. Local authorities and NHS trusts have a statutory duty to instruct IMCAs from 1 April 2007.

The guidance will be an important reference point both for commissioners and independent advocacy organisations in commissioning or providing the IMCA service.

Objectives of the guidance

- To ensure that commissioners have an understanding of the issues to consider in commissioning the IMCA service, and of the main implications of the Mental Capacity Act.
- To give practical guidance to commissioners of IMCA services on the steps needed to commission IMCA, and to develop sustainable, high-quality IMCA services.
- To give examples and illustrations from advocacy commissioning to help illustrate good practice in commissioning IMCA, and provide information and useful web links.

Main conclusions

- IMCA services should, wherever possible, be provided by independent advocacy organisations.
- IMCA commissioning needs to take place in the context of effective implementation of the Mental Capacity Act (2005).
- IMCA commissioners need to work closely with PCT commissioners to ensure consistent approaches across health and social care settings.
- Commissioning IMCA services should, wherever possible, act as a catalyst for the development of local advocacy.

Recommendations

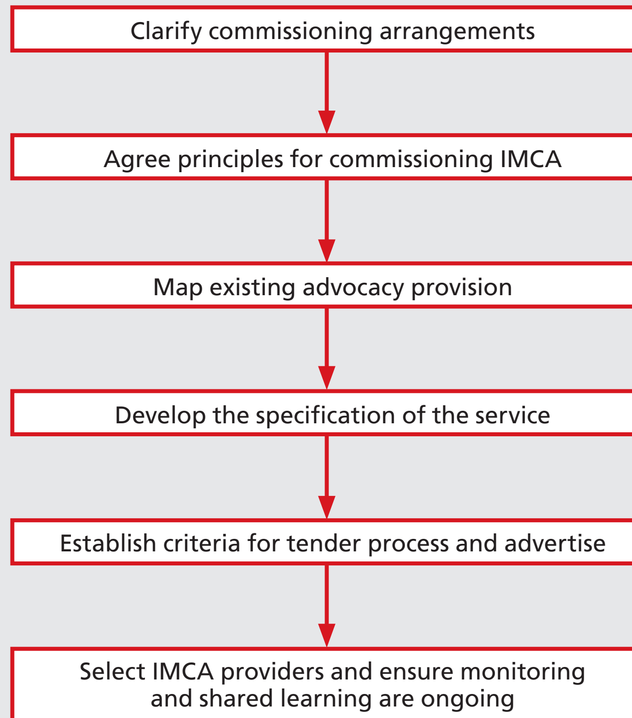
Commissioners:

- Commissioners have a good understanding of the way independent advocacy is provided.
- Commissioners have a good understanding of the Mental Capacity Act and the role of the IMCA service.
- Commissioners follow good practice in establishing effective IMCA services (see next page).
- Commissioners work closely with PCT colleagues to ensure consistent approaches across health and social care settings.
- Commissioners consider IMCA services being provided by advocacy organisations outside the local area where necessary to develop appropriate high quality services.

Independent advocacy organisations:

- Develop experience in supporting people who lack the capacity to make some decisions.
- Consider the implications of the Mental Capacity Act and of the IMCA service on the way independent advocacy is provided.
- Consider how the IMCA service can build on independent advocacy provision locally, particularly with regard to groups who may currently not receive advocacy provision.
- Consider the need for joint working with other IMCA service providers to meet the needs of a range of client groups.

Step-by-step guidance for commissioners of IMCA



Conclusion

The introduction of the Independent Mental Capacity Advocate service has far-reaching implications for people who have no close relatives, friends or any other person to help protect their interests and who may at present have little or no say concerning major decisions about their lives. The challenge for commissioners is to consider the interface between this new statutory role and the existing independent advocacy sector, considering how to capitalise on the new opportunities the role presents and to overcome some of the challenges presented in commissioning robust, sustainable high quality IMCA services.

2. Background

The Mental Capacity Act (2005) (see Department of Constitutional Affairs website www.dca.gov.uk for more information on the Mental Capacity Act) creates a new service: the Independent Mental Capacity Advocate (IMCA). From 1 April 2007, there is a legal obligation for local authorities and NHS bodies to instruct an IMCA for people who lack capacity, and have no close relatives or friends, when decisions are made about serious medical treatment or change of residence, for example moving to a hospital or care home.

This guide is aimed primarily at local authority and PCT commissioners who are charged with leading the commissioning of IMCA services. The IMCA commissioning process will be led by local authority commissioners in England, who are encouraged to commission jointly with primary care trusts given that the IMCA service will cover both health and social care decisions.

It sets out the issues commissioners need to be aware of in making informed decisions about IMCA and establishing robust processes for commissioning the service, ensuring high quality effective provision, and, where appropriate, makes some suggestions on how to build on existing advocacy services.

The guide is not intended to be prescriptive and recognises the value of local solutions in commissioning IMCA. It has been developed through working closely with a diverse group of commissioners, a range of independent advocacy organisations, and the seven advocacy organisations that have been involved in piloting the IMCA service.

The challenge for commissioners is to meet the statutory obligations set out in the Mental Capacity Act. It will also be good practice to consider how the IMCA service can build on and complement existing effective advocacy services wherever possible.

The issues for commissioners of IMCA are complex: in some areas there are well-established, effective advocacy providers who are well-placed to provide IMCA services. In other areas, however, there is little or no existing advocacy, or specialist provision of advocacy, that is organised around the needs of separate care groups.

It is also important to acknowledge that the IMCA service is new and that this guide can only reflect the issues which present at this time: it will be important that commissioners and advocacy providers communicate openly with each other and are reflective, enabling them to learn from their experience of commissioning and delivering the IMCA service.

Aims and objectives

The objectives of the guide are:

- To ensure that commissioners have an understanding of the issues to consider in commissioning the IMCA service, and of the main implications of the Mental Capacity Act.
- To give practical guidance to commissioners of IMCA services on the steps needed to commission IMCA, and to develop sustainable, high-quality IMCA services.
- To give examples and illustrations from commissioning practice to help illustrate good practice points, and provide sources of information and advice.

The guide will also be useful to existing and prospective independent advocacy organisations that wish to deepen their understanding of the IMCA role and to explore the implications of providing the IMCA service.

Methodology

A project steering group made up of commissioners, representatives from the Department of Health and experienced practitioners from the advocacy sector was established at the beginning of the project in July 2005. The steering group met every three months to oversee and guide the work of the project.

Commissioners' networks in London and the North of England were consulted at an early stage of the project to identify the core themes associated with commissioning of IMCA.

Commissioners and advocacy providers have shared their perspectives on the key issues for commissioners of IMCA and advocacy more generally and these have been used in this guide to show how commissioners have tried to improve practice and solve problems. These case examples and perspectives from commissioners are intended to develop commissioners' understanding of the important issues to consider in commissioning effective IMCA services. The case studies reflect the views and experiences of the commissioners we met.

Twelve site visits were carried out using semi-structured interview techniques to gather examples of effective approaches to advocacy commissioning and examples of advocacy approaches for people who lack capacity to make certain decisions. The site visits also provided an opportunity to explore in some depth the particular challenges for commissioners and independent advocacy organisations of providing the new IMCA service.

The seven advocacy organisations involved in piloting the IMCA service were consulted on their experience of IMCA provision and their views on the particular issues for IMCA commissioners.

A meeting was held with commissioners and practitioners to test the principles of the guide against real-life scenarios facing commissioners. In total, Turning Point consulted with 75 people to inform the development of this guidance.

It has not been possible within the scope of this project to map good advocacy practice; instead the document aims to share what commissioners and advocacy organisations have learnt and to present a range of perspectives on the commissioning of advocacy. We are grateful to commissioners, individuals and advocacy organisations for their contributions, and acknowledge that other organisations are doing similar work. Further work is needed to learn more about the benefits of effective advocacy, and the models that are used by advocates and advocacy organisations for working with people who are not able to instruct their advocate.

3. Understanding independent advocacy

‘Advocacy is a way of ensuring that people have some control over their lives. It is a way to make sure that a person’s voice is heard when decisions are made. It involves looking at choices, enabling people to know their rights, helping to defend those rights and getting the person’s voice heard.’
(Advocacy Network – Leeds)

‘An independent advocate’s role may…help people say what they want, secure their rights, represent their interests and obtain services that they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice.’
(Advocacy Charter, 2002)

Independent advocacy is important because a person may need support to express their views, or may need encouragement to answer questions. The aim of advocacy in all its forms is to ensure that people are not deprived of their rights through lack of information, lack of resources or lack of someone to speak up for them. Above all, advocates assist the person who may have difficulty making decisions to participate as fully as possible.

An independent advocate can work with individuals to support them to speak up for themselves, so they can make as many decisions as possible. Advocates also ensure that the particular needs and values of people from different minority ethnic communities or faith groups are respected.

The values that frame and underpin advocacy include those of citizenship, inclusion, empowerment and independence. Advocacy organisations are experienced in working with people who are often excluded from everyday decisions which affect their lives, and whose experience will often feature social exclusion and lack of opportunity to contribute fully to the life of their communities.

Some advocacy organisations are offering a range of ‘advocacy options’ to users in the way their services are organised. Services may offer a long-term citizen advocate (who will be trained and supported by a citizen advocacy manager or co-ordinator), a paid issue-based advocate or the opportunity to develop self-advocacy skills through a self-advocacy group. This can be seen as a continuum of advocacy provision, ranging from long-term relationship building and safeguarding through a citizen advocate, to support to voice concerns or deal with specific issues which do not require a long-term presence.

The IMCA role is an important addition to this ‘advocacy continuum’. IMCA services should wherever possible be provided in an integrated way that empowers users of advocacy by connecting the provision of IMCA to other advocacy services and roles. It is useful for commissioners, local advocacy organisations, service users and service providers to consider how this continuum can be developed locally.

IMCA and the Mental Capacity Act

'The Mental Capacity Act 2005 provides a statutory framework to empower and protect vulnerable people who may not be able to make their own decisions. It makes it clear who can make decisions in which situations and how they can go about this. It enables people to plan ahead for a time when they may lose capacity.'
(Department of Constitutional Affairs)

The Mental Capacity Act creates a new service: the Independent Mental Capacity Advocate (IMCA). It provides one of the ways in which people who lack capacity in specific situations can be empowered and protected in the decision-making process. From April 2007, there is a legal obligation for local authorities and NHS bodies to instruct an IMCA for people who lack capacity when decisions are made about serious medical treatment or change of residence, for example moving to a hospital or care home.

The purpose of an IMCA is to provide representation and support for particularly vulnerable people who lack capacity and who are facing important decisions about certain serious life-changing situations (see section 7).

In most cases, an IMCA service will only be one aspect of a much wider range of work undertaken by independent advocacy organisations. Both independent advocacy and the IMCA service must be completely independent of the person making the decision and have no professional or paid involvement with the provision of care and treatment for the person who lacks capacity.

In relation to the support provided under IMCA (and in relation to advocacy more generally), there is emphasis on making every effort to establish meaningful communication with the advocacy user. Independent advocacy organisations have developed a range of approaches to working with people who may lack the capacity to instruct their advocate. This type of advocacy will be central to the Independent Mental Capacity Advocate role as advocates are asked to work with people who are assessed as lacking the capacity to make certain key decisions about their lives. This is sometimes described as non-instructed advocacy.

Independent advocacy organisations providing non-instructed advocacy will have developed their expertise in employing alternative forms of communication to enable people using advocacy to express what is important to them and to be empowered within the decision-making process.

Commissioners and service providers, as well as organisations providing advocacy, must be clear about the role of an IMCA: they are not there to give opinions, to advise, to befriend, to judge, to mediate, to rescue or to make up for shortfalls in services. The role of IMCA is characterised by active listening to establish people's preferences, even when these preferences cannot be communicated in conventional ways. In many situations IMCAs will need to add to their understanding of the individual's perspective by reviewing their care notes and talking to people who know the person well. IMCAs can then find ways to work with the advocacy user to ensure that their voice is heard. This support for people to have a voice and be heard is at the heart of all advocacy.

Key question for commissioners

How does the IMCA role differ from other forms of independent advocacy?

The IMCA role is decision-specific: it concerns decisions around serious medical treatment and changes of accommodation, as well as the discretionary extension to adult protection and care reviews. Other advocacy roles are not limited in scope in this way.

The IMCA role also has time constraints: IMCAs need to complete their work and submit their reports to fit in as much as possible within the time available to make decisions on care moves or serious medical treatment (an average of eight hours has been suggested). The pilots have been carrying out the IMCA role in an average of six hours, but with a range of two hours for very straightforward cases to twenty hours for more complex ones.

IMCA services will have to be managed in such a way that they can respond promptly to referrals, with effective systems for ensuring flexible and responsive provision.

The IMCA role differs from other forms of advocacy in that NHS bodies and local authorities will be under a duty to instruct an IMCA in making decisions on serious medical treatment and changes of residence involving people who have no close family or friends or any other person to help protect their interests. It is required that IMCAs report to the decision-maker on the factors they should take into account in making decisions about best interests on behalf of the person referred.

Commissioners will need to ensure that potential providers are clear that referrals for IMCA are made by decision-makers and not the IMCA client. IMCA referrals are therefore 'non-instructed'. The term non-instructed advocacy is often used to describe advocacy in which the client has not asked for an advocate and may find it difficult to make clear what support they want from the advocate. In IMCA services, advocates and provider organisations will need to have good frameworks for working with clients who do not instruct.

The role and functions of IMCA are defined in the Mental Capacity Act, the regulations and the Code of Practice. They set out the key steps in fulfilling these functions. Specifically, NHS bodies and the local authority will need to have arrangements in place to allow an IMCA to access medical and social care records and other relevant information to allow the IMCA to carry out their role according to the functions of the Act. In relation to IMCA, engagement protocols will also need to be developed and agreed with commissioners and service providers, that clarify the context in which the IMCA service is provided. The government is not intending to develop standards for IMCA although advocacy standards have been developed for both local schemes and by national organisations (see Useful contacts, section 8).

The IMCA will also be able to raise more general concerns around practice issues in health and social care settings; some of the IMCA pilots have established local steering groups with representatives from the local authority and NHS to oversee the work of the IMCA service. Commissioners need to consider what arrangements will be useful locally to ensure there is effective feedback between IMCA providers and health and social care providers.

4. The Independent Mental Capacity Advocate

The Mental Capacity Act recognises the crucial role that independent advocacy plays in helping people gain a voice and ensure their rights are protected. It establishes a new advocacy service for a marginalised and vulnerable group of society. This is the first time that a statutory advocacy service has been provided, although the service will only apply to people who have no close family or friends or any other person to help protect their interests.

Under the legislation, NHS bodies and local authorities have an obligation to instruct and consult an Independent Mental Capacity Advocate (IMCA) when certain decisions are being made on behalf of people who lack capacity and who do not have any family or friends.

The decisions in which an IMCA must be involved (where a person is deemed to lack capacity to make the following decisions and has no close family or friends or any other person to help protect their interests) are as follows.

Serious medical treatment

An IMCA is required when serious medical treatment is being considered for a person who has no close friends or family or any other person to protect their interests and who lacks the capacity to consent. For the purposes of the Act, serious medical treatment is defined as follows (from the regulations which accompany the Act).

Serious medical treatment is treatment which involves providing, withdrawing or withholding treatment in circumstances where:

1. in a case where a single treatment is being proposed, there is a fine balance between its benefits to the patient and the burdens and risks it is likely to entail;
2. in a case where there is a choice of treatments, a decision as to which one is used is finely balanced; or
3. what is proposed is likely to involve serious consequences for the patient.

Changes of accommodation

An IMCA is required when a person has no close family or friends or any other person to help protect their interests and lacks capacity to consent in any of the following situations.

- An NHS body proposes to place a person, who lacks the capacity to agree, in a hospital for a period likely to exceed twenty-eight days or in a care home for a period likely to exceed eight weeks.
- An NHS body proposes to move the person to another hospital for a period likely to exceed twenty-eight days or to another care home for a period likely to exceed eight weeks.
- During an assessment, under the NHS and Community Care Act (1990), of a person who lacks the capacity to agree to accommodation arrangements, a local authority proposes to provide community care services in the form of residential accommodation and to place the person in accommodation for a period likely to exceed eight weeks or where a local authority proposes to move the person to another care home for a period likely to exceed eight weeks.

Exclusions to the service

If a person has an Enduring Power of Attorney or Lasting Power of Attorney, deputy or nominee, then an IMCA will not be provided, even if the person has no close relatives, friends or any other person to help protect their interests. Exclusions also apply in relation to a person lacking capacity who falls under the Mental Health Act; if urgent medical treatment is needed; in short-term changes in accommodation; and with some precedents already established in the common law. For further information on this, please see Chapter 10 of the Code of Practice.

Extensions to the service

The Mental Capacity Act and the regulations allow for an extension of the types of situations for which an IMCA is provided, as set out below.

Adult protection

Local authorities have the discretionary power to instruct IMCAs where the person does not have the capacity to agree to the arrangements for adult protection proceedings, and the person is a possible victim or alleged perpetrator, regardless of family involvement.

Care reviews

Local authorities also have the discretionary power to instruct IMCAs to support people who have no close relatives, friends or any other person to protect their interests and lack capacity (to make defined decisions) to attend at care reviews following decisions around changes of accommodation. IMCA referrals can be made even where the IMCA was not involved in the original decision around the change of accommodation.

Bournewood safeguards

It is proposed that there will be amendments to the Mental Capacity Act (2005) to provide legal safeguards for hospital patients and those in care homes who lack capacity to consent to treatment or care but who are not and could not be detained under the Mental Health Act. In line with the Mental Capacity Act, there may be access to an IMCA to support and represent individuals during the assessment process.

The IMCA service will be evaluated by the Department of Health after a year.

Who should make the referral to the IMCA?

The duty to instruct an IMCA will depend on the type of decision being made. If it is a medical decision, the appropriate NHS body will be responsible, such as the NHS trust, PCT, etc. The local authority or the relevant NHS body will be responsible in cases of accommodation changes. There are specific duties that the responsible body has to fulfil under the Act when a situation requiring an IMCA arises. Professionals who may be affected by this new service should familiarise themselves with these duties, as outlined in the Code of Practice.

The role of the IMCA

It is important to note that the IMCA is provided to support the individual who lacks capacity, and is not the decision-maker. The decision-maker is the NHS or the local authority.

The IMCA has the following roles, which are set out in the Act.

- **To support and represent the person who lacks capacity**
    - The IMCA should take into account the guidance on best interests provided by the Code (see Appendix, section 7 for more detailed explanation on best interests), and any other relevant factors including, for example, the need to promote the human rights of the person.

  - Where the vulnerable person has communication difficulties, the advocate may consider seeking specialist help, for example from a speech therapist or translator.

- **To obtain and evaluate relevant information**
  - An IMCA can interview the person in private and examine and take copies of relevant health and social care records such as clinical records, care plans or social care assessment documents.
  - The IMCA may wish to discuss possible options with other professionals or paid carers directly involved in providing care or treatment for the vulnerable person, bearing in mind the duty of confidentiality towards the person concerned.
- **To ascertain as far as possible the person's wishes and feelings**
  - This should take into account the likely beliefs and values of the individual.
- **To ascertain alternative courses of action**
  - These alternatives need to be considered in light of the 'least restrictive' principle of the Act.
- **To obtain further medical opinion where necessary**
  - Where the decision or action concerns medical treatment, the IMCA can ask for a second opinion from a doctor with the appropriate background as to whether the proposed treatment is necessary and in the person's best interests.

In line with the Act's principles of presuming capacity and supporting the individual's own decision-making, the IMCA should also check that the person has been given adequate support to make their own decision and that the person does not have capacity in relation to the decision in question.

Challenging the decision-maker

The regulations accompanying the Act set out the circumstances in which the IMCA can challenge the decision-maker, if they feel the action proposed is not in the person's best interests. As with the disputes procedure for carers or family members, there are a number of ways to raise concerns about medical or accommodation decisions made on behalf of a person who has no close relatives, friends or any other person to help protect their interests.

The IMCA is encouraged to use informal methods to raise concerns, at the earliest stage, and it is hoped that these would be resolved through discussion with all relevant parties concerned. Where this is unsuccessful, there are more formal routes available to resolve disputes; for medical decisions this could be through the NHS complaints procedure, the Patient Advice and Liaison Service (Community Health Council in Wales). For care home moves, this could be through either the local authority or the care home's complaints procedure.

There may be occasions when the IMCA feels that insufficient regard has been given to their advice and information. In some cases, there may be significant disagreement between the IMCA and the decision-maker about whether the proposed course of action is actually in the person's best interests. In such cases, the IMCA may need to take steps to try to resolve the disagreement.

In cases of serious medical treatment, an IMCA may assist the person in obtaining a second medical opinion. The final recourse for a serious unresolved dispute would be to obtain legal advice as to whether to make a formal complaint or request permission to take a case to the Court of Protection. The advice of the Official Solicitor should be sought.

Who provides the IMCA service?

There are regulations governing the appointment of IMCAs, which set out some minimum standards that have to be met. These include the need for CRB checks, as well as the need for adequate training to establish key skills, knowledge and competencies. This training will cover issues around diversity, the law, non-instructed advocacy, case management and the IMCA role.

A comprehensive national induction programme for IMCAs is being developed (materials will be ready at the end of December 2006). The induction will link to a nationally accredited training programme for IMCAs.

The following case studies, from some of the seven organisations that are piloting the IMCA service, show the types of situations in which IMCAs will work.

IMCA case study: Changes of accommodation

Eric has learning disabilities and lives in a registered care home. Eric was diagnosed with dementia. He has no close relatives or friends to represent him. The local authority had some concerns about the levels of care provided at the home, arising from a recent Commission for Social Care Inspection (CSCI) report, and were considering whether the home could still meet Eric's needs. They had assessed Eric as lacking capacity to determine this issue. The local authority referred the matter to an IMCA as part of the care review.

The IMCA advocate spent time with Eric in private on two occasions to help ascertain his wishes and feelings and the care and support that Eric receives in the home. Although Eric was able to communicate he did not directly answer any of the IMCA's questions. He walked around the room a lot and spoke of someone he had lived with in the past. During these meetings, the IMCA also reviewed the overall condition of the home, which appeared to be clean, comfortable and hygienic.

The IMCA spoke to the care staff responsible for his care. He had two meetings with the Home Manager. The Manager showed a good spontaneous knowledge of Eric's needs, and an appropriate and empathetic manner when talking to him. The Manager explained that Eric was fond of walking around the home, and that staff at the home supported Eric to do this.

The IMCA reviewed all the relevant documentation and records. The IMCA read the most recent CSCI report for the home, which raised some questions about record-keeping, day activities and staffing levels.

The IMCA also examined Eric's case notes and care plans, and found that there were some omissions in the care plans. In general, the notes on file gave a substantial (if not fully complete) record of care, but did not have sufficient record of quality of life issues such as conversations, walks and participation in day activities.

However, there were no records of any falls, which could have been expected if the man did not receive the help he needed to walk around the home. Finally, the IMCA wanted to speak to other professionals involved in Eric's care. He spoke to Eric's GP, who said that he was called out by the home to see Eric if necessary, and was involved in the ongoing assessment and management of risks to him. The GP reported that Eric's overall health appeared to have improved since his placement at the home.

The IMCA's written report summarised these findings and concluded that overall they had seen no evidence that Eric would want or would benefit from a move.

IMCA case study: Serious medical treatment

Bill is a ninety-year-old man with learning disabilities and dementia. He lives in a supported living home. Bill has annual contact with his half-brother but the community nurse is of the opinion that there is no one in a position to represent Bill.

Bill was diagnosed with a small cancerous lesion on his temple. The community nurse had concerns about what action, if any, should be taken. After consultation with a plastic surgeon and oncologist, it was suggested that the lesion could be removed by radiotherapy or surgery. The community nurse made a referral to an IMCA.

The community nurse felt that Bill could not make the decision regarding treatment, although a formal capacity test had not been carried out.

The IMCA met with Bill and a support worker who knew him well and who helped Bill to communicate with the IMCA. The IMCA and the support worker were not able to establish a way for Bill to communicate about the decision. The IMCA spoke to professionals involved in Bill's care and reviewed his case notes. The IMCA established that Bill was very upset and angry the last time he spent time in hospital. He refused to eat or drink, and became very agitated with hospital staff that he was not familiar with.

The IMCA supported the doctor in looking at the range of treatment options for Bill, and used the best interests checklist in bringing relevant factors to the attention of the decision-maker (the consultant surgeon). The multi-disciplinary team met and decided that Bill should be an out patient for day surgery to minimize the time that Bill would have to spend in hospital. The IMCA recommended that Bill should be supported by staff from the home prior to and following the operation.

Key question for commissioners

What do advocacy organisations need to consider when developing IMCA services?

An IMCA will support people who lack capacity in specific situations. In practice, the IMCA will often be delivered through advocacy approaches that reflect good practice in working with people who have not requested an advocate. This is sometimes called non-instructed advocacy. As good practice, existing advocacy organisations interested in providing the IMCA service should be able to demonstrate their experience of delivering this form of support or, at a minimum, their insight and understanding of how to advocate for people who lack the capacity to make some decisions independently.

One of the key features of an IMCA service is the requirement that it must provide advocacy for a wide range of client groups, including people with learning disabilities, mental health needs, autism, dementia and brain injury. Commissioners will need to satisfy themselves that specialist advocacy organisations are confident in their non-instructed advocacy practice and clear as to how it could be applied to the range of people who may be referred to the IMCA service. Alternatively, independent advocacy organisations applying to provide an IMCA service may need to show that they are able to partner with other organisations to develop the knowledge necessary to work with other groups.

In practice, the IMCA role is situation and decision-specific and so has less scope for person-centred approaches, which identify issues for the advocacy client about any aspect of their life. Moreover, the circumstances and complexity of situations in which IMCA advocates will find themselves will mean that reflective supervision is essential. This supervision will be not only an opportunity for advocacy managers to support IMCA advocates, but also to ensure IMCA advocates are maintaining the boundaries of their role, fulfilling their functions as laid out in the Mental Capacity Act and learning from their experiences of advocating for people who lack capacity to make certain decisions.

The development of IMCA services invites commissioners to take a strategic approach not only to the way in which IMCA is commissioned and develops, but also to the continuum of local advocacy provision. The IMCA role is significant for small groups of people who lack the capacity to make important decisions without support. As good practice, commissioners may wish to take a long-term view that involves building local advocacy capacity to meet both the legal duty to provide IMCA, and the need for a range of advocacy options across local populations.

Shared learning: Implementing the Mental Capacity Act and commissioning IMCA

It is useful for commissioners to consider how they will work jointly with local authority leads and PCT managers who are responsible for the implementation of the Mental Capacity Act locally.

In Kensington and Chelsea, a meeting was arranged between IMCA commissioners and managers from the local authority and PCT to plan the implementation of the Act at a local level, including agreeing the process for commissioning IMCA. The meeting clarified the process for commissioning IMCA and the way in which IMCA relates to the broader implementation of the Mental Capacity Act. It was possible to identify which health and social care professionals would need to understand the role and functions of IMCA and their responsibilities for IMCA referrals.

5. Commissioning the Independent Mental Capacity Advocacy service

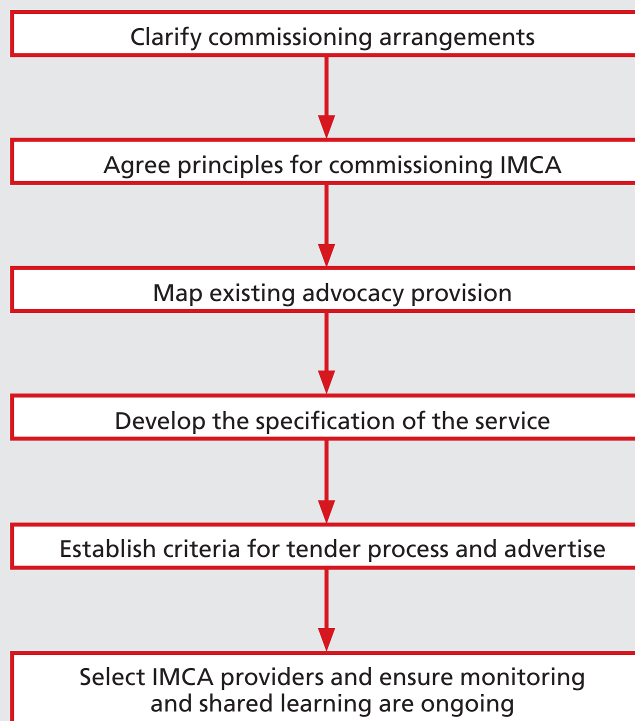
There are significant differences in the way independent advocacy has been commissioned in local areas. These differences will inform the way in which the IMCA service is commissioned. In some areas, a diverse range of advocacy providers have developed, often with a mix of funding sources through statutory funding and trusts or grants. In other areas there may only be one specialist advocacy provider working with a specific group.

Some local authority commissioners will have developed advocacy strategies and plans that underpin the local approach and communicate their commitment to providing advocacy.

This section aims to guide commissioners through the key issues and processes they need to follow in commissioning the IMCA service. The first part describes a process for commissioning IMCA. Questions and answers are used to address some of the key themes, which have been highlighted by commissioners, and there are case studies that illustrate how commissioners have addressed the challenge of commissioning effective advocacy services.

This section will set out a suggested process for commissioning the IMCA service: it is not intended to be prescriptive and commissioners may not need to follow every step depending on the current situation in relation to advocacy provision in the area. By following the process, commissioners will be able to plan for and commission the IMCA service.

Step-by-step guidance for commissioners of IMCA



Step 1. Clarify commissioning arrangements

The government has decided that the IMCA service should be commissioned jointly by local authorities and primary care trusts, which is consistent with wider government policy on commissioning services and Section 31 of the Health Act (1999). It is also important that IMCA is commissioned jointly because the IMCA service will both cover health and social care decisions.

The joint commissioning process is a learning experience both for local authorities and health trusts, enabling them to discuss and agree engagement protocols, clarifying their understandings of independent advocacy and the development of constructive feedback to individual professionals and service managers. The underlying aim of the IMCA service is to help individuals who lack capacity in specific situations and ultimately to make the best health and social care decisions for that person.

The lead responsibility for commissioning IMCA services in England lies with local authorities within the commissioning arrangements: local authorities nationally are seen as having developed greater experience of contracting with advocacy organisations.

A lead named commissioner for IMCA services should be identified. In many areas advocacy is commissioned at present according to specific client groups. IMCA, however, is a generic service, which is not specific to client groups but is intended to provide independent advocacy for a person who lacks capacity in specific situations. The pilots have shown that the vast majority of IMCA clients are people with learning disabilities or dementia.

As good practice, a local IMCA strategy should be developed that takes account of national drivers, particularly the principles and provisions of the Mental Capacity Act. The strategy should make clear how IMCA services will be commissioned and monitored. The Care Service Improvement Partnership (CSIP) regional leads can support commissioners to put the IMCA service into place (see Useful contacts, section 8, for contact details of regional leads).

Commissioners need to be familiar with existing advocacy services that are currently in their local area or neighbouring authority in order to make decisions on commissioning IMCA. Collecting information about services jointly with other agencies is a very valuable process: it may lead to new information on who can provide IMCA and it is a good way to create joint ownership of the issues. Commissioners may wish to review how many advocacy organisations are in place, which agencies they work with, how many people they support and what approaches they take to the provision of advocacy.

Commissioners can obtain immediate information from existing providers of advocacy. Providers can add to commissioners' knowledge and perspective on the levels of service needed and gaps in provision, so that the remoteness of IMCA providers can be addressed and services enabled to respond to the priorities of IMCA. Where no current advocacy provision exists and a need has been highlighted, commissioners can look for examples of best practice in adjoining areas, and through working in partnership with other relevant organisations.

Consultation will enable IMCA services to respond to diverse and changing needs and to promote equality and consistency in service provision. Consultation may include meetings with individual advocacy service providers, service forums, seminars/conferences or meetings with commissioners from other partnership areas.

IMCA should not be commissioned in isolation. In order to develop effective IMCA services, commissioners should work in close partnership with health, social care and housing agencies, to ensure that individuals who use the IMCA service have access to a wide range of generic services

to provide comprehensive packages of care. The local IMCA service should be reflected in the plans of individual agencies commissioning those services and other multi-agency partnerships. Information sharing should be encouraged, with protocols in place for sharing information across agencies.

The government wants commissioners to have the flexibility to extend the IMCA service within the resources available, to other groups and situations. Regulations specify the range of other circumstances in which local authorities and NHS bodies may provide the IMCA service on a discretionary basis. This may, for example, include involving the IMCA in a care review, or in adult protection cases where the person is particularly vulnerable. Local authorities will be required to take a strategic view in assessing local priorities and to publish the additional areas where IMCAs will be used.

Resources for IMCA services in some areas will be quite small. In this situation, the lead commissioner should consider collaborative commissioning through a regional (or sub-regional) approach: this may be more cost-effective and provide a better service. Where a regional (or sub-regional) approach is adopted, there should be a named lead commissioner for the area the service will cover.

IMCA services will need to be carefully planned. IMCA advocates need to be able to respond quickly to referrals, for example, to avoid delayed discharges or delays in serious medical treatments. Commissioners need to consider the need for flexibility in providing the IMCA service. An IMCA service across neighbouring local authorities which employs several IMCAs may be more responsive than a service which is reliant on one or two full-time IMCAs.

Commissioners may need to think about working with local advocacy providers to consider how to create the necessary capacity to deliver the IMCA service. It may be possible to deliver IMCA through the expertise of existing advocates, who will already be supporting people who may lack capacity and could be trained and supervised in the IMCA role. This arrangement builds advocacy capacity and delivers effectively the IMCA service. In this way advocates can mix the provision of IMCA advocacy, which is issue specific, with the provision of other forms of advocacy.

As good practice, commissioners may want to use the opportunity to review existing arrangements for advocacy provision more widely. Commissioners might wish to carry out a local audit to map other advocacy provision across all client groups. This might involve analysing potential local patterns of need and the target group(s) for services in order to inform decisions and to target resources.

Key question for commissioners

How do you commission an IMCA service where there are no local independent advocacy organisations, or no existing local organisations wishing to provide the service?

The government is encouraging commissioners to tender for IMCA services nationally, so experienced advocacy providers from out of area may develop new services.

Commissioners in areas where there are no potential IMCA providers should consider a regional approach, and should open discussions with colleagues in neighbouring authorities.

Time pressures on commissioners mean the IMCA service needs to be commissioned quickly. However, where commissioners feel it is viable, they should establish stakeholder engagement processes to generate interest and involvement in IMCA service provision and advocacy

more generally. Commissioners should consider existing voluntary sector organisations as stakeholders in the development of IMCA and other forms of advocacy. Commissioners should only commission organisations which are able to fulfil the functions of the IMCA service and are fit for purpose.

Commissioners may also wish to consider exploring short-term partnership arrangements where experienced independent advocacy organisations from outside the local area provide IMCA services in the short term and work in a partnership and mentoring role with local organisations who are wishing to develop their expertise and necessary structure to build capacity over time to provide IMCA services.

Step 2. Agree principles for commissioning IMCA

Commissioners should agree a set of principles that will underpin the way in which the IMCA service is commissioned and delivered. The principles below may act as a useful starting point but commissioners should agree principles with providers and other stakeholders at a local level.

Accountability: Services must be commissioned in such a way that the IMCA service can clearly demonstrate that it is primarily accountable to the people who use the service.

Independence: Services are commissioned which ensure that IMCA is independent both from the care and treatment of the person for whom they are appointed to advocate, and from the decision-maker.

Empowerment: Services are commissioned which are effective in empowering people who use them to have a voice and to be involved as fully as possible in decisions about their life.

Evidence based approach: Commissioners should continually monitor and evaluate services with a view to achieving measurably better outcomes for users of IMCA services.

Shared learning: The underlying aim of the IMCA service is to empower and protect vulnerable individuals and to improve health and social care. In commissioning arrangements commissioners should make explicit their openness to learning from the experience of IMCA advocates and IMCA provider organisations.

Quality and effectiveness: Services should be well managed and have an appropriate infrastructure to deliver high-quality IMCA.

Shared learning from a commissioner developing a vision for local advocacy that is based on principles of independent advocacy and a good commissioning process

It is important that commissioners are aware of the broader context for advocacy in commissioning IMCA services. A local authority commissioner who leads on advocacy commissioning is developing a vision for how advocacy can best meet the needs of the local population. The vision for advocacy is placed within the context of improving and personalising service delivery, which is in line with the Green Paper on social care and the White Paper on integrated health and social care, and the strategy on Improving Life Chances for Disabled People.

To inform the vision, the commissioner has established relationships and built trust with local advocacy organisations through establishing a support network for local advocacy organisations.

An advocacy joint commissioning group has also been established to agree a joint funding commitment. The commissioner is committed to developing and sustaining robust, high-quality, independent advocacy services and is exploring within the existing frameworks for advocacy development how the IMCA service can best be provided.

Where there are no current frameworks for commissioning and developing advocacy locally, the need to develop IMCA services may act as a catalyst for establishing local consultation and engagement mechanisms for commissioners, advocacy organisations and other stakeholders.

Step 3. Map existing advocacy provision

The consultation on the IMCA service made clear that both government and the advocacy sector are in favour of the IMCA service building on existing independent advocacy. The IMCA service should be viewed as an addition to the continuum of advocacy provision and should not replace existing services.
It is therefore important that where possible lead commissioners for IMCA seek opportunities to build advocacy capacity locally by working with local independent advocacy organisations to develop IMCA services. Advocacy provision nationally is patchy, so commissioners need to map the existing services in their local areas.

Commissioners should make sure local advocacy providers are aware of opportunities to provide the IMCA service, so that they can bid for the IMCA contract if they choose to do so.

Commissioners can find out more about local advocacy organisations through:

- Existing contacts
- Heads of service for care groups (older people, mental health or learning disabilities)
- Advocacy Resource Exchange (ARX) Advocacy Finder and Helpline
- Action or Advocacy online advocacy finder
- National Coalition of Citizen Advocacy Schemes regional groups
- Older People's Advocacy Alliance (OPAAL) mapping and directory of older people's advocacy in the English regions
- University of Durham list of mental health advocacy organisations.

Some advocacy organisations are extending the geographical areas in which they work.
In situations in which commissioners identify clear gaps in the provision of advocacy locally, they can choose to research regional or national advocacy organisations that are in place (see Useful contacts, section 8).

Shared learning from a commissioner of advocacy in a rural area: Extensive experience of clinical services and advocacy commissioning (Hambleton and Richmondshire joint local authority/PCT commissioner)

The particular issues for commissioners and advocacy organisations working in rural areas are:

- High risk of social exclusion in outlying areas
- Lack of infrastructure in remote areas can place additional strain on advocacy resources: mainstream service provision needs to address needs of remote communities
- Advocacy may be more costly in rural areas due to increased travel time
- Commissioners need to agree realistic activity levels with providers that account for a geographical spread of population.

The commissioner has responded to the challenge of ensuring access to quality advocacy by providing sustained funding to a generic independent advocacy organisation. The commissioner has built up good working relationships with the advocacy provider to ensure issues raised by advocacy users are fed into the local commissioning and planning process.

Lessons learned:

For IMCA it will be important to ensure efficient use of time, with IMCAs meeting clients and professionals involved in their care on the same visit, wherever possible.

Currently advocacy is commissioned across health and social care. The IMCA service is seen as an important addition to existing advocacy services.

Chief officers are identified in health and social care services to champion the role of advocacy and the importance of giving service users a voice.

Governance of IMCA is incorporated as part of scrutiny and performance management structures that are already in place for monitoring advocacy.

The PCT Board is given feedback of the effectiveness of advocacy locally and made aware of the importance and impact of effective local advocacy, and receives feedback on lessons learned through provision of IMCA service.

Generic advocacy is commissioned to meet the need of a range of client groups across the local population. The advocacy organisation gives sufficient focus to specific user groups.

Shared learning from an example of mapping local advocacy provision to inform an advocacy strategy (Buckinghamshire Local Authority)

The lead local authority commissioner for advocacy has, in partnership with local advocacy providers, developed a countywide advocacy strategy. The commissioner mapped existing provision to learn about services provided and to identify gaps. The commissioner built up a picture, through surveys and meetings, of the experience of local advocacy organisations.

This examined:

- Which organisations supported different client groups
- How they work (the advocacy model and underpinning principles)
- How they are managed
- How advocates are trained and supervised
- How they are funded
- How they are monitored and evaluated.

The information gathered was analysed and compared to statistics relating to numbers of people supported by adult social care in the county. This identified gaps in service and inconsistencies in the way services were being commissioned and monitored. The resulting information affected the development of the advocacy strategy.

Local standards have been developed in partnership with provider organisations. These standards act as a reference point both for commissioners and providers in communicating about advocacy and measuring the effectiveness of advocacy provision.

Where commissioners planning the commissioning of IMCA choose to learn about local advocacy providers in the way outlined above, they should also establish whether providers have experience in providing, or insight into advocating, for people who lack capacity.

This exercise invites commissioners to deepen their awareness and understanding of the issues around local advocacy provision; this approach is important in informing strategies for commissioning IMCA services.

Step 4. Develop the specification for the service

(A model service specification that can be adapted for local use is available from the DH/IMCA website. See Useful contacts, section 8).

Having established the principles underpinning the commissioning of the IMCA service and engaged with local advocacy providers, commissioners need to develop specifications for the IMCA service.

Service delivery should be based on agreed development plans and written service agreements and on service specifications. Commissioners should develop working relationships with providers, based on dialogue and shared objectives. Service specifications should maintain the principles of independent advocacy, set out the aims and objectives of IMCA and the levels of service expected, and clarify their referral and access criteria according to the Code of Practice in the Mental Capacity Act.

Specifications for IMCA services should make reference to the following.

Definition of the service

This should refer to the Mental Capacity Act and Code of Practice and regulations and should set out the role and functions of the IMCA.

Service principles

The service should make reference to the principles set out in the Mental Capacity Act.
The service should also make reference to more general principles that inform the provision of IMCA and independent advocacy and reflect the values of independence, social inclusion, equality and social justice.

Purpose of the service

The specification should make the purpose of the service explicit and should make reference to:

- Working to obligations set out in the Code of Practice of the Mental Capacity Act
- Representing the views of service users who lack mental capacity and who have no known relative or close friend to represent those views
- Recruiting, training and supervising suitable advocates
- Protecting service users where necessary
- Feeding back issues raised in the development of the IMCA role
- Seeking to conclude issues within appropriate timescales
- Keeping suitable records.

Outcomes

Appropriate outcomes should be agreed with the service provider to ensure value for money and good results for those requiring the service.

Methods of working

Commissioners should not be too prescriptive about methods of working in developing the service specification. Many existing independent advocacy organisations have already developed expertise in advocating for a wide range of people who lack capacity to make some decisions: this experience should enable advocacy organisations to specify their methods of working in delivering IMCA services.

The experience of IMCA providers should assist in further developing the specification as necessary. However, the provider should be able to give a full outline of its organisational structure, support and experience and specify its intended methods of working. It should be able to express its expected and intended outcomes. The provider should also state what indicators and methods would be used to evidence how individual and service outcomes have been achieved.

Engagement protocols

Commissioners should ensure that the service specification refers to the need for underpinning engagement protocols, which will set out:

- Referral and access criteria
- Clarification of confidentiality procedures
- Outline methods of working (in relation to the role and functions in the Code of Practice)
- Details of record keeping
- How advocates will access records as appropriate to role
- How decision-makers will communicate with IMCA, throughout the decision-making process and following IMCA reports
- Monitoring and accountability
- Arrangements for IMCAs to raise questions and concerns
- How to comment on or raise concerns or complaints about the IMCA service
- Contact details for the IMCA service including availability and response times.

Funding

Commissioners have dedicated resources for IMCA provision. This should be regarded as additional funding to existing resources that may already be set aside for more general advocacy provision locally.

Funding agreements should be for three years to reflect the need for stability in services. This should include funding for core costs associated with service delivery, such as management of IMCA, central administrative costs and accommodation costs.

Review

Commissioners and IMCA providers should regularly review the service specification (for example, on an annual basis) to ensure that they are sustainable and deliver value for money.

Diversity and accessibility

Commissioners should ensure that IMCA provision is responsive to the diverse needs of users IMCAs should have an understanding of the cultural background of the person, and be culturally competent. Interpretation could help the IMCA communicate with the individual.

Records and monitoring

Commissioners should make monitoring expectations clear to providers at the outset.

Monitoring and recording expectations should include the following:

- Total numbers and sources of referrals
- Number and sources of referrals accepted, broken down by age, gender and ethnicity of service user

- Number and sources of referrals refused with reasons, broken down by age, gender and ethnicity of service user
- Number of 'live' cases at the end of the quarter, broken down by case type and age, gender and ethnicity of service users
- Number of advocacy support cases closed, broken down by case type, showing number of hours spent, with summary of outcomes, with reference to decisions about serious medical treatment and changes of accommodation
- Emerging patterns of referrals (for example, by type of intervention or place referral was made from)
- Record of time taken on individual cases
- Records of any complaints or compliments the service receives and action taken in response
- Staff turnover and records of training and supervision for staff (aggregated)
- Relevant financial data on cost and expenditure.

Individual records should comply with data protection and accessibility requirements and also ensure that they record not only personal detail and requirements but also outcomes. It should be noted whether or not the outcome appeared satisfactory to the advocate and their reasons for this. It will be important that records show the methods used to arrive at any views expressed on behalf of the person.

Key question for commissioners

What do independent advocacy organisations need to have in place to be able to deliver effective IMCA services?

- Clarity of purpose and values that underpin independent advocacy and IMCA
- A model or approach to IMCA that demonstrates an understanding of advocating for people who lack capacity in the specific situations set out in the Mental Capacity Act
- Capacity, skills and infrastructure to monitor and evaluate the IMCA service
- Comprehensive induction training plans commissioned by the Department of Health, and ongoing training and development for advocates who are providing the IMCA service
- Clear and sufficient management structure and administrative support
- Policies and procedures that specifically reflect the issues around advocacy for people who lack capacity
- Effective governance arrangements to ensure accountability and continuous improvement
- Robust recruitment procedures
- Experience of thorough and comprehensive case recording.

Shared learning from PCT commissioner experienced in developing specialist advocacy services in secure settings: Creating the right conditions for effective IMCA to take place

Commissioners should facilitate an open and positive relationship between advocacy organisations and service providers. The commissioning cycle, including performance reviews, should be concerned both with the performance of the independent advocacy organisation and the extent to which the importance and value of advocacy (and IMCA) are understood by service providers. Commissioners should place emphasis on the relationships that need to be built to ensure the user's voice is understood and valued, and is directly influential in improving service delivery.

Commissioners need to feel comfortable with raising concerns about advocacy organisations; they should be the point of contact to investigate and deal with concerns, again facilitating positive relationships.

Commissioners need to take account of the infrastructure costs that are indicated in establishing robust effective advocacy organisations; management costs, including supervision, monitoring, training and planning, need to be factored into funding agreements. This will be key in commissioning effective IMCA services.

Key question for commissioners

What are the workforce and training issues for developing IMCA services?

Commissioners should ensure that advocacy organisations provide a high-quality service and that their staff are well trained.

The Department of Health is currently working with the advocacy sector to develop a nationally recognised qualification in the IMCA role.

Commissioners should be satisfied that organisations providing IMCA are able to demonstrate:

- A good knowledge and understanding of the main provisions of the Mental Capacity Act including the impact of the Act on service delivery and the functions of the Independent Mental Capacity Advocate;
- A clear understanding of the principles that underpin the provision of independent advocacy;
- The necessary skills for individuals or organisations to be effective in their role as IMCAs. Key skills include active listening, effective communication, negotiation and the ability to seek out information, impartiality and assertiveness; and
- Understanding of the sources of information and advice to provide effective IMCA in specific situations. This includes keeping up to date with good practice, impact of legislative changes, local health and social care systems, particular issues for user group(s) and local community networks

Advocacy organisations should ensure that arrangements are in place for the ongoing supervision of advocates. Supervision will be used to monitor practice, gain feedback on advocacy themes and support advocates in developing their role, maintaining boundaries and operating within the functions set out in the Act.

Advocacy organisations should ensure advocates have regular opportunities to work with other advocates for peer support, information exchange and the development of strategies for working effectively in the IMCA role.

Advocacy organisations providing the IMCA service will ensure IMCAs attend a national induction programme, an ongoing training programme and additional training as required. Advocates should only be recruited and undertake this training having gained significant experience in other advocacy roles.

Training to be an IMCA will include learning about the Mental Capacity Act and will develop the skills and knowledge needed to be able to give effective support to people who may lack capacity when decisions about serious medical treatment or moving accommodation are being taken.

Advocacy organisations that develop IMCA services will need to arrange additional training to develop their skills and knowledge of the groups with whom they do not have experience of working with and who may access the IMCA service.

Step 5. Establish criteria for tender process and advertise

(Additional guidance on tendering for the IMCA service can be found on the DH/IMCA website: see Useful contacts, section 8).

Unless there is good local experience of preferred partner tendering, national advertisement of the IMCA tenders is encouraged. This is to enable a wide range of organisations to see the adverts and be able to apply. Many authorities already involve users and carers in interviewing and in selecting service providers, and report that this is useful.

The general requirements of provider organisations should be made clear through the tender process and should include:

- Information on structure, constitution and code of practice
- Demonstration of experience of non-instructed advocacy and reference to particular groups supported, if applicable
- Experience of partnership work with statutory agencies
- Active commitment to Equal Opportunities
- Information on methods of working, with reference to advocacy approaches, including record-keeping expectations and review, arrangements for supervision and evidence of personal/ professional development plans
- Experience of working with people from ethnic minorities; those who do not have English as their first language; those who need specialist communication tools; and those who communicate through informal methods
- Confirmation of suitable recruitment procedures, including provision of enhanced POVA and CRB checks
- Agreement to work within locally-agreed multi-agency Vulnerable Adult Policy and Procedures (in accordance with No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse, Department of Health, Section 7)
- Provision of annual report including financial accounts for previous year.

Method of working

- Summary of number of non-instructed advocacy cases from previous year
- Policy documents relating specifically to working with people who may lack the capacity to instruct their advocate
- Number of advocates the provider proposes to recruit, manage and train for IMCA role and whether they will be full-time or part-time
- Description of proposed monitoring arrangements
- Identification of indicators and methods used to evidence that individual and service outcomes will be achieved
- Copy of confidentiality and comments/complaints policies.

Funding

- Providers should show annual budget for IMCA service
- Providers should show breakdown of costs against headings:
  - Recruitment
  - Direct advocacy
  - Administration and overheads
  - Management, training and supervision
- Providers should specify number of direct IMCA hours to be provided.

Outcomes

- Appropriate outcomes should be agreed with the service provider to ensure value for money and good results for those requiring the service.

Step 6. Select IMCA providers and ensure monitoring and shared learning are ongoing

The IMCA service is new and is a significant additional safeguard in empowering people to be involved in key decisions about their lives. As with any new services, commissioners should ensure there are frameworks for reflecting on, and learning from, the experiences of IMCA providers and their interface with individuals using health and social care settings.

Commissioners should ensure there are regular opportunities for IMCA providers to feed back their experiences. There should be clear arrangements for integrating this feedback into the processes of continuous review and improvement in local health and social care settings.

In addition, it is important that commissioners ensure that there are clear systems for enabling health and social care providers to feed back their experiences of IMCA services. This should include reference to the comments and complaints procedures in IMCA services.

Commissioners should make clear the arrangements they will put in place for learning from the experiences of service providers. The service specification, contract and service level agreement are key documents in clarifying the purpose and expectations of the service. It is equally important that commissioners establish regular and ongoing dialogue with IMCA providers and other stakeholders in the process. This dialogue should enable commissioners to develop their understanding of the way IMCA services work in practice and the particular challenges they will face. IMCA providers should be expected to be open to ongoing dialogue and relevant reporting.

Summary of commissioning process

Commissioners will be working within time constraints to commission the service to start from 1 April 2007. Commissioners will need to be pragmatic about the extent to which they can follow all of the steps outlined in this guide. In some cases it may be useful to consider a short-term strategy for commissioning IMCA in relation to implementation of the Act and a longer-term solution that reflects good practice in commissioning IMCA as set out in this guide.

6. A checklist for IMCA commissioners

- Have a good understanding of the Mental Capacity Act and the role of IMCA in supporting people who lack capacity, who are facing important decisions about certain life changing situations, such as serious medical treatment and changes of residence, and who do not have families and friends.
- Clarify commissioners' arrangements jointly across health and social care settings.
- Identify a lead commissioner for the IMCA service.
- Work with CSIP regional leads to consider links between IMCA commissioning and implementing the Mental Capacity Act (See Section 8- Contacts).
- Develop underlying principles for IMCA commissioning, such as accountability, independence, empowerment, evidence-based approaches, shared learning, quality and effectiveness.
- Be clear about the differences between IMCA services and other forms of independent advocacy.
- Develop a local strategy for commissioning IMCA services.
- The IMCA strategy plans should be developed in close partnership with health, social care and housing agencies to ensure that individuals who receive IMCA support also have access to a wide range of services to provide comprehensive packages of care. Referral mechanisms should be put in place, including for those who do not qualify for IMCA or other advocacy provision.
- Commissioners may want to link IMCA to other advocacy services and build capacity of advocacy locally.
- Understand the values, skills and knowledge that advocacy organisations will need to deliver effective IMCA services.
- Build a picture of local advocacy provision by engaging with existing providers and paying particular attention to those existing providers with experience of advocating for people who lack capacity to make some decisions, and to the groups of people advocacy organisations support.
- Are local advocacy organisations able to partner with other organisations providing generic advocacy or have clear plans on how to develop plans for generic advocacy?
- Consider commissioning IMCA through providers from outside the local area where necessary, if there are no current local advocacy services.
- Use service specifications and engagement protocols that underpin the delivery of high-quality, accountable IMCA services.
- Ensure there are established mechanisms for ongoing dialogue and shared learning with IMCA organisations and health and social care providers.
- Commissioners may want to refer to national or locally-agreed standards for advocacy.

7. Appendix: Summary of the Mental Capacity Act

Legislative history

Prior to the introduction of the Mental Capacity Act, there has been uncertainty about the rights of people who lack capacity and the legal obligations of the professionals who support them.

The Act clarifies the legal basis of actions and decisions taken on behalf of people who lack capacity. It aims fundamentally to support the independence and autonomy of people who may lack capacity, as well as provide protection for those that need it.

The principles of the Act apply to all people who support or work with a person who lacks capacity, regardless of the importance or complexity of the issues that are being considered.

The Mental Capacity Act came about as a result of significant lobbying and consultation from 1989, with the Law Commission five-year inquiry, which was published as a report, 'Mental Incapacity'. This was followed by two government consultation papers ('Who Decides' in 1997; 'Making Decisions' in 1999). The Act was scrutinised in Parliament by a Joint Committee of MPs and Peers before the Mental Capacity Bill was introduced in Parliament. It received Royal Assent in April 2005 and will come into force in April 2007.

Code of Practice

The Act is accompanied by statutory guidance in the Code of Practice, which provides the detail of how the Act will be applied in reality. The Code has legal status and certain groups of people have a statutory 'duty to have regard' to it.

The guidance contained in the Code must be taken into consideration by professionals, paid carers, Independent Mental Capacity Advocates, attorneys, deputies and those conducting research under the Act.

Unpaid carers and family members do not fall under the Code's statutory remit, but are still expected to adhere to the general principles as contained in the Mental Capacity Act. The Code of Practice is designed to help these informal carers apply the principles of the Act when making day-to-day decisions on behalf of a person who lacks capacity.

These day-to-day decisions are referred to as 'acts carried out in connection with the care or treatment' of a person who lacks capacity to make this decision. Carers or family members are protected from legal liability provided they follow the principles of the Act and, in particular, provided they are acting in the person's best interests. We will examine 'best interests' further below.

Values and principles of the Act

The values upon which the Act is founded aim to enhance choice and autonomy and protect the individual's right to make their own choices.

These values are contained in the following statutory principles of the Act:

- **Presumption of capacity**
  - All individuals should be presumed to have the capacity to make decisions, unless there is proof that they do not. Although this is already a common law principle, it is the first time that this right to make decisions and assumption of capacity has been stated in legislation. This principle is the fundamental starting point in supporting individuals who may lack capacity.
- **The right to be supported to make your own decision**

  - Building on this presumption of capacity, the Act places significant emphasis on the need to support people as much as possible to make their own decisions. This may be through creative communication techniques for those who lack formal communication, providing information in accessible formats, etc.
  - Someone cannot be said to be lacking the capacity to make a decision unless all possible steps have been taken to help him/her make his/her own decisions. Furthermore, simply because a person needs help to be able to make their own decision, we cannot label them as 'incapable' of making that decision.
  - Chapter 3 of the Code of Practice outlines some steps that can be taken to help individuals make their own decisions, such as considering communication aids, etc.
- **The right to eccentric or unwise decisions**
  - The Act is not concerned with the content of the decisions, i.e. whether a person makes the 'right' decision or not. Instead, it aims to clarify issues around the ability of a person to make a particular decision, regardless of whether the person chooses to make an unwise or eccentric choice.
- **All decisions to be made in best interests**
  - Once it has been determined that a person lacks capacity to make a decision, the main guiding principle is that any decisions or actions taken on their behalf must be taken in their best interests. The only exceptions to this are matters relating to research and any advance decisions the person may have made when they had capacity. Guidance on how to determine best interests is outlined below.
- **Least restrictive alternative**
  - The final principle of the Act is that of ensuring individuals are not placed under unnecessarily restrictive conditions. So when faced with a variety of options, the better decision is one which does not restrict people's freedoms and rights.

Assessing capacity

The Mental Capacity Act and Code of Practice set out a framework for making an assessment of whether a person lacks capacity to make a particular decision at a given time.

The Act sets out a functional, decision-specific approach. This is where an assessment about whether someone lacks capacity must be made in relation to a specific decision, and not about the person's capacity to make decisions generally.

Considerations before making an assessment

Prior to any assessment of capacity, it is important to remember that the starting point is the presumption of capacity, and that individuals should initially be supported to make their own decisions. This could be through providing information in an accessible format, using communication aids, trying at different times of the day or when the person is in better health, or using an independent advocate to help them express their wishes and aspirations.

A person cannot be found to be lacking capacity solely on the basis of their appearance or a diagnosis of a medical condition. This is known as the 'principle of equal consideration'. The Code outlines the broad scope of 'condition' as including mental and physical disabilities, and temporary

situations such as drunkenness as well as age-related conditions. Similarly, 'appearance' covers a range of factors such as skin colour, visible medical problems, religious dress, etc.

If it is possible that a person's capacity to make a decision will fluctuate over time, then this also needs to be taken into consideration. As a result, a decision may be delayed until the individual can make that decision themselves.

If doubts regarding their capacity to make the decision still remain, then an assessment of capacity can be made. Regarding day-to-day decisions and actions taken in connection with the individual's care or treatment, for an assessment it is sufficient that the family or professional carers have a 'reasonable belief' that the person lacks capacity.

For other decisions, there may be a professional involved who will be making the decision. For example, a solicitor in legal matters, a doctor in medical decisions, or a care manager involved in decisions about changes of accommodation.

Carrying out the assessment

The Mental Capacity Act and Code of Practice set out a two-stage of test for assessing whether a person has the capacity to make a decision at a given time.

First, for a person to be said to lack capacity, there needs to be 'an impairment of mind or brain'. This is known as the diagnostic threshold, and if no such diagnosis can be made, then the person cannot be said to have mental incapacity under the Act. This impairment can include the effects of substance misuse as well as a learning disability or mental health problem, dementia or acquired brain injury.

Secondly, the impairment needs to be such that it results in the individual being unable to make the decision in question. This part of the assessment looks at how a decision is made, not the outcome of the decision. Section 3 of the Mental Capacity Act states that a person is unable to make a decision if they are unable:

(a) to understand the information relevant to the decision;

(b) to retain that information;

(c) to use or weigh that information as part of the process of making the decision; or

(d) to communicate his/her decision (whether by talking, using sign language or any other means).

Implications for assessment include:

(a) Information must be provided in an appropriate format, as well as ensuring all relevant information is included. It is also useful to note that for more serious decisions, the individual will need a higher level of understanding.

(b) If a person can only retain information for a short period of time, this does not mean that they are unable to make the decision. Information can be recorded in a number of ways, such as pictures, writing, videos, etc.

(c) The person must be able to use the information to come to a decision as opposed to arriving at an arbitrary decision regardless of the information provided.

(d) There will be very few cases where people cannot communicate their choice in some way. Even using simple muscle movements such as blinking is a method of communicating.

Disputes regarding capacity and the Court of Protection

The result of any assessment about a person's capacity can ultimately be disputed in the Court of Protection, which is established under the Act.

The Court of Protection is a new public body that specialises in issues related to the Act. The Court covers issues that previously fell under the remit of the former Court of Protection and the High Court. These are issues around the management of property and affairs, as well as serious welfare/health decisions relating to individuals who lack capacity.

The Court will be the final arbiter on any matters relating to capacity or disputes under the Act. It can also appoint deputies to act and make decisions on behalf of someone who lacks capacity.

Determining best interests

If the assessment concludes that a person lacks capacity to make a decision at a given time, then someone else can make that decision on their behalf. In these circumstances all actions and decisions must be taken in the individual's best interests.

Whilst there is no definition of 'best interests' in the Act, there is a checklist in Section 4 of the Code of Practice which outlines how it is possible to determine what is in a person's best interests. It is essentially about placing the individual who lacks capacity at the centre of any decision being made.

The Code states a statutory checklist of factors that must, as a minimum, be considered when deciding best interests. These are:

- **Equal consideration/non-discrimination**
  - This ensures decisions about best interests are not made based on prejudiced views about a person's appearance, age, condition or behaviour. Decision-makers cannot make judgements about the quality of life of the person who lacks capacity, simply because they are older, have physical or learning disabilities, are of a particular race or religion, etc.
- **Considering all relevant circumstances**
  - 'Relevant' in this factor includes matters of which the decision-maker is aware and which it is reasonable to consider relevant.
- **Regaining capacity**
  - The decision-maker must also consider whether it is likely that the individual may regain their capacity to make the decision in the future, through, for example, medication, learning new skills, support with communicating their wishes, etc.
- **Permitting/encouraging participation**
  - This seeks to involve the individual as much as possible in decisions affecting them. As well as developing decision-making skills, this factor ensures all practicable steps have been taken to support a person to try to make their own decision.
- **Special considerations for life-sustaining treatments**
  - This encompasses treatment that a person providing healthcare regards as necessary to sustain life. When deciding best interests, the decision-maker cannot be motivated to end the life of the individual who lacks capacity. The Act makes clear that this provision does not alter existing law on assisted suicide and euthanasia.

- **The person's wishes, etc.**
  - This places the individual firmly at the centre of any decision being made. The decision-maker must consider what is or would have been most important to the person who lacks capacity, including past and present wishes and feelings, written statements and their beliefs/values.
- **The views of others**
  - This establishes the statutory right for those closest to the individual to be consulted on best-interest decisions, if it is 'practicable and appropriate'. It also includes anyone named by the individual as someone to consult; carers, attorneys/deputies, family members, etc.

Not all of these factors on the checklist will be appropriate in every situation, but it is still necessary to consider each of these, even if it is concluded that they are irrelevant to the particular decision. There may be other issues which are not included in the checklist, but which may also need to be taken into account.

The relationship between the Mental Health Act (1983) and the Mental Capacity Act

It is important that stakeholders are clear about the relationship between the Mental Health Act and the Mental Capacity Act.

Where a person's treatment is regulated under Part IV of the Mental Heath Act (1983), the IMCA does not need to be instructed as that Act contains its own safeguards.

However, detained patients would be entitled to an IMCA for any serious medical treatment that is not for their mental disorder, as long as they met the criteria for an IMCA. So, for example, a patient detained under the Mental Health Act for treatment for schizophrenia who also needed a heart operation would be entitled to an IMCA if they lacked capacity and had no friends or family.

IMCAs can also be involved, where the criteria are met, in decisions about accommodation following discharge under S117 of the Mental Health Act.

8. Useful contacts

Action for Advocacy
PO Box 31856
Lorrimore Square
London SE17 3XR
Tel: 020 7820 7868
www.actionforadvocacy.org.uk

A resource and support agency for the advocacy sector, information, training and advice. Consulting with the advocacy sector on key issues. Developed advocacy charter and standards and publish Planet Advocacy, a quarterly advocacy-related magazine.

Advocacy Resource Exchange
PO Box 282
Broxbourne EN11 1AS
Tel: 07967 622010
www.advocacyresourceexchange.net

Advocacy Resource Exchange (ARX) supports advocacy schemes nationally. It has a helpline to answer any query relating to advocacy and helps people to find an appropriate advocacy service in their area. ARX has Advocacy Finder, a comprehensive online directory of all advocacy schemes in the country, and has a Supported Voices project supporting advocacy groups in London that work with BME groups.

Age Concern
Astral House
1268 London Road
London SW16 4ER
Tel: 020 8765 7200
www.ageconcern.org.uk

Age Concern has produced advocacy standards specific to older people's advocacy and is a source of advice and information for older people. They are the main provider of specialist advocacy services for older people.

Alzheimer's Society
Gordon House
10 Greencoat Place
London SW1P 1PH
Tel: 020 7306 0606
Email: enquiries@alzheimers.org.uk
www.alzheimers.org.uk

The Alzheimer's Society is the leading care and research charity for people with dementia and their carers, providing information and education, support for carers, and quality day and home care.

ASIST
Winton House
Stoke Road
Stoke on Trent STP 2RW
Tel: 01782 845584
Email: help@asist.co.uk
www.asist.co.uk

A well-established advocacy organisation in south Staffordshire. Has well-developed practice around non-instructed advocacy (The Watching Brief) and has formed partnerships to develop quality of advocacy practice. Clear policies and procedures which underpin effective advocacy are available through the website.

BILD (British Institute of Learning Disabilities)
Campion House
Kidderminster
Worcestershire DY10 1JL
Tel: 01562 723010
Email: enquiries@bild.org.uk
www.bild.org.uk

BILD gives advice on and administers the Citizen Advocacy Funding programme, advises on non-instructed advocacy and supports advocacy organisations through training and development of appropriate policies and procedures.

Department for Constitutional Affairs
Mental Capacity Implementation Programme
DCA
Steel House
Room 502
11 Tothill Street
London SW1H 9LH
Tel: 020 7210 0025
Email: makingdecisions@dca.gsi.gov.uk
www.dca.gov.uk/menincap

Advice and guidance on implementing the Mental Capacity Act.

Department of Health
Richmond House
79 Whitehall
London SW1A 2NS
Tel: 020 7972 4310
Email: IMCA@dh.gsi.gov.uk
www.dh.gov.uk/IMCA

Follow links for: model service specifications, guidance on tendering, lessons learnt from IMCA pilots, planning for the IMCA service, IMCA regulations.

Fast Forward
67 Hertford Road
Brighton
East Sussex BN1 7GG
Tel: 01903 767070
Fast Forward provides training and consultancy around all issues associated with advocacy.

Frameworks 4 Change
Suite 25
41–43 Portland Road
Hove
East Sussex BN3 5DQ
Tel: 01273 204932
Email: frameworks4change@ntlworld.com

Support, training and advice on advocacy-related issues. Knowledge and expertise in IMCA, non-instructed advocacy and advocacy leadership.

Headway
4 King Edward Street
Nottingham NG1 1EW
Tel: 0115 924 0800
Email: enquiries@headway.org.uk
www.headway.org.uk

Aims to promote understanding of all aspects of head injury and to provide information, support and services to people who have suffered a head injury, their families and carers.

MENCAP
123 Golden Lane
London EC1Y ORT
Tel: 020 7454 0454
Email: information@mencap.org.uk
www.mencap.org.uk

Charity working with people with learning disabilities, their families and carers. Campaigns for equality and citizenship. Provides advocacy services.

Mind
Granta House
15–19 Broadway
London E15 4BQ
Tel: 020 8519 2122
Email: contact@mind.org.uk
www.mind.org.uk

Mind is the leading mental health charity in England and Wales. They work to create a better life for everyone with experience of mental stress through developing services, influencing policy and campaigning.

National Autistic Society
393 City Road
London EC1V 1NG
Tel: 020 7833 2299
Email: nas@nas.org.uk
www.nas.org.uk

National charity for people with autistic spectrum disorders and their families. Information, advice and capacity building in advocacy for people with autism and Asperger Syndrome.

National Coalition of Citizen Advocacy Schemes
St Bede's Community Centre
Fern Grove
Liverpool L8 ORZ
Tel: 0151 733 6705
Email: joe@coalition.org.uk

Brings together advocacy groups that are committed to promoting the concept of volunteer citizen advocacy as part of their work. Campaigns on advocacy issues, acting as a voice for volunteer advocacy.

OPAAL (Older People's Advocacy Alliance)
Beth Johnson Foundation
Parkfield House
64 Princes Road
Hartshill
Stoke on Trent ST4 7JL
Tel: 01782 844036
Email: jo@bjf.org.uk
www.opaal.org.uk

OPAAL aims to promote independent advocacy with older people, contributing to the development of standards and improving access for older people including those from minority ethnic communities.

RNIB (Royal National Institute for theBlind)
105 Judd Street
London WC1H 9N
Tel: 020 7388 1266
Email: helpline@rnib.org.uk
www.rnib.org.uk

Charity offering information, support and advice to people with sight problems.

Scope
6 Market Road
London N7 9PW
Tel: 020 7619 7100
Email: cphelpline@scope.org.uk
www.scope.org.uk

Disability organisation in England and Wales, whose focus is people with Cerebral Palsy. The Leading Voices Through Advocacy project is aimed at improving access to advocacy for people with high support needs.

Sense
11–13 Clifton Terrace
London N4 3SR
Tel: 020 7272 7774
E mail: enquiries@sense.org.uk
www.sense.org.uk

Charity providing specialist information, advice and services to deaf blind people, their families, carers and the professionals who work with them. Funded to develop training materials which address the advocacy issues for deaf blind people.

Turning Point
New Loom House
101 Backchurch Lane
London E1 1LU
Tel: 020 7702 2300
Email: info@turning-point.co.uk
www.turning-point.co.uk

Turning Point is the UK's leading social care organisation, providing services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

CSIP regional leads

The Department of Health is working with the Care Services Improvement Partnership (CSIP) to create eight regional leads, one in each CSIP region in England, to support the implementation of the Act. They will promote and support events and activities that raise awareness of the Act, and assist with the education and training of those affected.

The contact details for the regional leads are as follows.

West Midlands
Dora Jonathan
Email: Dora.johnathan@nimhe.wmids.nhs.uk
Tel: 0121 678 4851

North West
Paul Greenwood
Email: Paul.Greenwood@northwest.csip.org.uk
Tel: 07795 963 509

Yorkshire and Humberside
Bruce Bradshaw
Email: Bruce.Bradshaw@RotherhamPCT.nhs.uk or Bruce.bradshaw@virgin.net
Tel: 07747 101100

South East
Keith Nieland
Email: Keithnieland@aol.com
Tel: 01256 376394

South West
David Pennington
Email: David.pennington@nemhesw.nhs.uk
Tel: 07799 627244

East
Lou Brewster
Email: Lou.brewster@nemhpt.nhs.uk
Tel: 01206 287541

East Midlands
Sylvia Manson
Email: Sylvia.Manson@eastmidlands.csip.nhs.uk

London
Sarah Haspel
Email: Sarah.haspel@londondevelopmentcentre.org
Tel: 07768 045166

IMCA pilot organisations

As part of the development work in implementing the IMCA service, seven IMCA pilots were set up in January 2006 to help identify the practical issues involved in implementing the IMCA service.

The pilot organisations are as follows.

Advocacy Matters: Warrington, Cheshire
Room 4, Bronte Unit
Hollins Park Hospital
Hollins Lane
Winwick
Warrington WA2 8WA
Tel: 01925 664000, ext. 3260
Email: hollinspark@advocacymatters.com
www.advocacymatters.com

Advocacy Partners: London and Surrey
Orchard Hill
Fountain Drive
Carshalton
Surrey SM5 4NN
Tel: 020 8642 9418
Email: teresa.g@advocacypartners.org
www.advocacypartners.org

Cambridge House Advocacy: Camberwell, London
Tel: 020 7703 5025
Email: Vicky.cowin@cambridgehouseandtalbot.org.uk
www.cambridgehouseandtalbot.org.uk

Dorset Advocacy: Dorchester
Dorset Advocacy IMCA Service
3 Princes Street
Dorchester
Dorset DT1 1TP
Tel: 01305 251033
Email: imca@dorsetadvocacy.co.uk
www.dorsetadvocacy.co.uk

POhWER: Hertfordshire
Lime Way
Harperbury
Harper Lane
Radlett
Hertfordshire WD7 9HQ
Tel: 01923 859186
Email: p.okelly@pohwer.net
www.pohwer.net

Skills for People: Newcastle upon Tyne
Key House
Tankerville Place
Jesmond
Newcastle upon Tyne NE2 3AT
Tel: 0191 281 7322
Email: terry.clibery@skillsforpeople.org.uk
www.skillsforpeople.org.uk

Speaking Up: Cambridge
1A Fortescue Road
Cambridge CB4 2JS
Tel: 01223 566258
Email: imca@speakingup.org
www.speaking.org

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We turn lives around every day, by putting the individual at the heart of what we do. Inspired by those we work with, together we help people build a better life.

Turning Point is the UK's leading social care organisation. We provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

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New Loom House
101 Backchurch Lane
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