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The Involvement of *Independent Mental Capacity Advocates* (IMCAs) in Adult Protection Procedures in England: 1st April 2007 – 31st March 2008

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Table of Contents

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Executive Summary

On 1st April 2007, as a consequence of the *Expansion Regulations* (*SI 2006/2883*), local authorities and NHS bodies in England were given the power to instruct an Independent Mental Capacity Advocate (IMCA) to support adults lacking decision-making capacity who were subject, either as alleged victims and/or as alleged perpetrators, to adult protection procedures (in Wales, corresponding provision came into effect on 1st October 2007). Using data from the National IMCA database, combined with additional quantitative data from nine IMCA service provider organisations and qualitative data from ten such organisations, we carried out an investigation of this expansion of the IMCA role. This report summarises our findings.

Between 1st April 2007 and 31st March 2008, 150 local authorities across England had made a total of 5268 eligible referrals, of which 706 (13.4%) were made in relation to adult protection procedures. By June 2008, 485 (68.7%) of these 706 referrals had been closed, while 221 (31.3%) remained open. Over this twelve-month period most of the 150 local authorities in England had made between one and five referrals.

Based upon a sample of 204 people who had received the services of an IMCA from the nine provider organisations, we found that the clients of the adult protection extension were predominantly women (63%) and that the largest proportion were 80 years old or more (21%). The majority (89%) were from a White ethnic background. The two most conditions most frequently reported as having affected clients' decision-making capacity were dementia (45.1%) and learning disability (24%). The three single most common types of abuse were financial abuse (26%), physical abuse (19%), and neglect (17%), but a significant proportion (24%) of adults had experienced multiple forms of abuse. In over half of all cases, family members were the alleged perpetrators (57%), while care staff were identified as the alleged perpetrators in only 11% of cases. The criminal justice system was involved in more than a third of cases (36.3%). While half of these resulted in no further action, the

remainder were investigated formally by the police, and eleven of those investigations led to an arrest (14.9% of the cases initially reported).

Our qualitative data strongly suggests that IMCAs, their managers, Adult Protection leads, and social workers all believe that the new IMCA service is a benefit to adults who are subject to adult protection procedures. However, the IMCAs and the managers who were interviewed also told us that the extended service raised a number of significant operational tensions. Chief among these was uncertainty about the point at which, during adult protection procedures, the involvement of an IMCA should take place. This issue arose because, rather than simply complying with a local authority's instruction to act, the IMCAs and their managers wanted to ensure that any prospective client was eligible for the service. In other words, they wished to satisfy themselves that, as the result of a functional assessment, they could be sure that the individual lacked capacity in relation to one or more protective measures. When an IMCA receives an instruction to act *early* in a case, prior to the formulation of any protective measures, there may be uncertainty as to whether the client is entitled to the service. Furthermore, the lack of any proposed protective measures raises issues of the appropriateness of attempting to ascertain the client's wishes, values and beliefs in relation to such measures. In contrast, however, where an IMCA is instructed *late*, for example, shortly before a meeting to decide upon protective measures, there may be very limited time available in which to meet the client. In such circumstances, the IMCA may be unable to confirm that the client lacks relevant capacity, let alone to meet him or her, or gather relevant information from his or her health and social care records, professionals, and family members.

IMCAs and their managers told us that some professionals acting in Adult Protection Teams have little understanding of the *MCA* or the role of IMCAs. As a result, they said, they felt that, in addition to fulfilling their own IMCA role (promoting the client's voice and representing his or her interests), they were also ensuring that the other members of Adult Protection Teams understood their duties under the *MCA*. In contrast, none of the social workers or Adult

Protection leads we interviewed admitted to us any deficiencies in their understanding of the *MCA*. Nevertheless, they welcomed the involvement of IMCAs in adult protection procedures, seeing them as valuable contributors to the protection of the best interests of the alleged victims. All our interviewees, regardless of their role, were agreed that involvement in adult protection procedures is demanding, because of the strong emotions aroused by allegations of abuse, the diversity of the work within this area, and the unique features and circumstances of each individual case.

Whilst, importantly, the updating of *No Secrets* should ensure that policy is in line with the *MCA*, what is required in the context of adult protection, where individual cases can vary hugely, is much greater operational clarity. IMCAs and members of Adult Protection Teams need to identify and clarify between themselves the nature and extent of IMCA involvement in each individual case. The need for such clarify is discussed in more detail in the final section of this report.

Part 1
The involvement of IMCAs in adult protection procedures

1.1 Introduction

Part 1 sets out the purpose of our research project and introduces the relevant legislation and policies for the involvement of Independent Mental Capacity Advocates (IMCAs) in the protection of adults (aged 18 years or more who lack the capacity to make decisions about one or more protective measures). These procedures are sometimes referred to by the acronym POVA (Protection of Vulnerable Adults) and at other times as *Safeguarding Adults* procedures. This report uses the expression 'adult protection' and 'adult protection procedures' unless direct reference is being made to the document *Safeguarding Adults* (ADASS, 2005), which uses '*Safeguarding Adults'* or '*Safeguarding Adults* procedures'.

1.2 The purpose of the project

The research reported here was carried out between December 2007 and July 2008, and was commissioned jointly by the Social Care Institute for Excellence (SCIE) and the Department of Health. It forms part of a wider initiative to support the implementation of the *Mental Capacity (England and Wales) Act 2005* (hereafter, the *MCA*) by studying its immediate impact. This research examined the specific impact in England of the *Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations* (*SI 2006/2883*) introduced under s. 41 of the *MCA*, which gave English local authorities the power to extend their IMCA service to adult protection procedures.

1.3 Five documents relating to the involvement of IMCAs in adult protection procedures

While the *MCA* provides a statutory, albeit discretionary, framework for the involvement of IMCAs in adult protection procedures, four other documents are also important. The relevant points of these five documents, presented in chronological order, are summarised below.

No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.
This important document, which reflected growing awareness that adults as well as children could be the victims of abuse, was published in 2000 under s. 7 of the *Local Authority Social Services Act 1970*. As its title indicates, it extended to adults the responsibility that local authorities already held for the protection of children, and provided guidance for setting up similar multi-agency procedures.

No Secrets defines abuse as a violation of an individual's human and civil rights and specifically identifies six different types of abuse: physical, sexual, psychological, financial or material, neglect or acts of omission, or discrimination (s 2.7). It describes an adult as 'vulnerable' – that is, as someone at particular risk of abuse and therefore in need of 'adult protection' – if he or she is aged 18 years or more and 'is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (s 2.3).

No Secrets asserts that if an adult has 'capacity' and declines the assistance of an Adult Protection Team this limits the help that he or she may be given. It does not, however, specify how capacity is to be assessed beyond the recommendation that consideration should be given to his or her emotional, physical, and intellectual state, and the possibility that he or she might be subject to intimidation or undue influence.

While acknowledging that advocates have a legitimate role in adult protection procedures, *No Secrets* offers no guidance as to when an advocate should be involved in these procedures, what his or her responsibilities are, or to his or her rights of access to the alleged victim, to members of the Adult Protection Team or more generally to the facts of the case.

The Mental Capacity Act 2005, & Mental Capacity Act 2005 Code of Practice

The *MCA* and its accompanying *Code of Practice*, which came into force fully during 2007, introduced, *inter alia*: a) a two-stage test of incapacity, based on status, 'an impairment of, or disturbance in the functioning of, mind or brain' (s.2 (1)) as the first stage, and a functional definition specific to the decision in question (s. 3) as the second stage; b) a duty to act in a person's 'best interests' if he or she lacks the capacity to make the decision in question; and c) statutory advocacy, in the form of Independent Mental Capacity Advocates, to represent and support defined groups of adults (those without 'appropriate' family or friends) who lack capacity to make one or more specific, and potentially life-changing, decisions.

In contrast with *No Secrets*, the *MCA* provides a precise definition of capacity, how it is to be assessed reliably, and the procedures to be followed in substitute decision-making on behalf of an adult who is found to lack the capacity to make a particular decision for him or herself.

An adult may be judged to lack capacity 'if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain' (s. 2 (1)) and is unable to: i) understand the information relevant to the particular decision; ii) retain that information; iii) use or weigh it to reach a decision; and iv) communicate his or her choice. Before reaching a judgement that someone lacks decision-making capacity, all practicable steps must be taken to support him or her to make the decision autonomously and express his or her choice.

When a decision needs to be made (or an action taken), and the person is judged to lack capacity to make that decision (or take that action) for him or herself, and no formal arrangements have already been made that cover the particular decision (for example, a Deputy or a Lasting Power of Attorney), then decision-making can be carried out on the person's behalf, in his or her 'best interests'. The *MCA* describes the factors that should be considered

when determining what is in an individual's 'best interests' (s. 4), using the so-called 'best interests checklist'. These factors include, but are not limited to: i) whether or not the person will gain or regain decision-making capacity; ii) the person's own past or present wishes; iii) the views of others, such as family or friends, who may be interested in the person's welfare; and iv) that, of the available options, the decision made (or action taken) on the person's behalf should be the one that is less restrictive of his or her rights and freedom of action.

In contrast to *No Secrets*, which preceded the new legislation, the *MCA* and its *Code of Practice, ,* offers a very detailed description of the responsibilities and rights of independent mental capacity advocacy. The features of an IMCA's role, for those who lacking capacity and fulfil the criteria for these services, are set out in s. 36(2) of the *MCA*, and are as follows:

- representing and supporting the person who lacks capacity, so that he or she may participate as far as possible in any relevant decision;
- obtaining and evaluating information;
- as far as possible, ascertaining the person's wishes and feelings, beliefs and values, or what these would be likely to be;
- ascertaining alternative courses of action – for example, looking at different care arrangements or residential homes;
- obtaining a further medical opinion, if necessary.

The *Code of Practice* to the *MCA* (Section 10.20-30) provides further guidance on the responsibilities and powers of an IMCA. He or she:

- must confirm that the person instructing them has the authority to do so;
- should interview or meet in private the person who lacks capacity, if possible;
- may examine any relevant records to which section 35(6) of the Act gives them access;
- should obtain the views of professionals and paid workers providing care or treatment for the person;

- should obtain the views of anybody else who can give information about the wishes and feelings, beliefs or values of the person;
- should obtain any other information the IMCA thinks will be necessary;
- must find out what support the person who lacks capacity has had to help him or her make the specific decision;
- must try to find out what the person's wishes and feelings, beliefs and values would be likely to be if that person had capacity;
- should find out what alternative options there are ;
- should consider whether getting another medical opinion would help the person; and
- must write a report on his or her findings for the local authority or NHS body.

It is not an IMCA's role to make one or more decisions or take one or more actions. Rather, an IMCA's role is to support and represent his or her client. This task is carried out by asking questions, raising issues, offering information at meetings, and writing a report. An IMCA has the right to challenge the decision made by a substitute decision-maker, if that decision-maker is judged not to have paid sufficient attention to the information provided or if he or she is concerned that the decision is not in the person's best interests.

***Safeguarding Adults: a national framework of standards for good practice and outcomes in adult protection work*.**

Safeguarding Adults, published by the Association of Directors of Adult Social Services (ADASS) in 2005, developed the multi-agency guidance put forward in *No Secrets* by providing both good practice standards and best practice guidance. In contrast to *No Secrets,* which is statutory guidance, *Safeguarding Adults* has no statutory force.

Like *No Secrets*, *Safeguarding Adults* recognises the prevalence of abuse among adults who are or may be in receipt of community care services, and that these men and women are potentially unable to protect themselves from harm or exploitation. *Safeguarding Adults* revises the terminology and

conceptualisation of adult protection. The terms 'vulnerable adults', which locates the risk of abuse and the need for protection in the person's inherent vulnerability (a mental or other disability, age or illness) and 'adult protection' are replaced. Instead, 'Safeguarding Adults' is used to refer to all the actions that enable an adult to 'retain independence, wellbeing and choice and to access their human rights and to live a life that is free from abuse and neglect' (page 5).

Safeguarding Adults asserts the right of adults with capacity to remain in an abusive situations should they wish to do so, but also directs readers to the *MCA*. Where an adult lacks the capacity to make a decision about his or her protection from further abuse, the guidance states that protective action should be taken on his or her behalf. However, such action should be proportionate to any risks and take into account any knowledge of the person's previously expressed wishes. This guidance is broadly consistent with the *MCA*. However, since *Safeguarding Adults* was published before the new legislation came into force, it could provide no more than interim guidance in anticipation of the Act. This is particularly relevant in relation to advocacy because, while *Safeguarding Adults* acknowledges that advocates have a role in adult protection procedures, the involvement of IMCAs was not anticipated. As a result, with respect to advocacy involvement in adult protection procedures, the guidance lacks detail. Like *No Secrets*, it does not specify precisely when an advocate should be involved, what his or her responsibilities are, or his or her rights of access to the alleged victim, to members of the Adult Protection Team or more generally to the facts of the case.

The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations (SI 2006/2883).

This statutory instrument granted 'responsible bodies' (a Local Authority or NHS body) the power to extend the arrangements for the provision of IMCAs to two further situations, when such an action was considered to be of 'particular benefit' to an individual. The two situations are: first, reviews of accommodation arrangements made by these 'responsible bodies' for defined

groups; and, secondly, of particular relevance for our research project, to adults who are alleged *victims* or *perpetrators* of abuse, who lack the capacity to agree to protective measures that have been proposed, or implemented, by a local authority. The *Expansion Regulations* require local authorities to draw up local policies identifying the circumstances under which instructing an IMCA would be of 'particular benefit' to the person concerned (it would be unlawful to have a policy *not* to involve IMCAs) and to ensure these policies are followed.

Practice Guidance: criteria for the use of IMCAs in Safeguarding Adults cases

In response to the *Expansion Regulations* giving local authorities the power to involve IMCAs in adult protection procedures, ADASS published its *Practice Guidance criteria for the use of IMCAs in Safeguarding Adults*. However, this has no statutory force and local authorities are free to adopt, adapt or ignore it as they see fit. Nonetheless, many local authorities have adopted the guidance with few or no modifications. The *Guidance* proposes, following the *Regulation,* that instructing an IMCA would be of 'particular benefit' to a person where:

- there is a risk of death, serious physical injury or illness, serious deterioration in physical or mental health, and/or serious emotional distress;
- consulting family and friends over a life changing decision is complicated by the belief they do not have the person's best interests at heart; or
- decision-makers have conflicting views over a person's best interests.

Addressing issues relating to the point at which an IMCA should become involved in adult protection procedures, the *Guidance* espouses a pragmatic approach. Sometimes it will be appropriate to instruct an IMCA *early* in the procedures, for example where immediate action is needed to safeguard the person prior to any investigations, or where the person's wishes could have a significant impact on the investigative process. Alternatively, it may be more appropriate to involve an IMCA *late* in the procedures where decisions need

to be made as a consequence of the investigation. The *Guidance* suggests that once the specific decisions prompting an IMCA's involvement have been addressed, the need for his or her continuing involvement should be reviewed. Further, it suggests that where a generic or community advocate is already supporting the person, there should, normally, be no need to involve an IMCA.

Local authority policies setting out criteria for the use of IMCAs in adult protection

The policies for involving IMCAs in adult protection procedures of ten local authorities were sent to us from the advocacy provider organisations supporting the research. In the main, these policies where either the same as, or very close to, the ADASS *Guidance*. Two policies, however, did differ from the ADASS *Guidance* in that they clearly outlined a preference for involving IMCAs early in the procedures, prior to the formulation of any protective measures. Additionally, a single local authority had in place arrangements whereby social workers did not make referrals directly to the IMCA service provider organisation; instead, they referred to their senior managers, who then made the decision about whether or not to instruct an IMCA.

1.4 Multi-agency adult protection procedures

Adult protection procedures, as described in *No Secrets,* require that multi-agency teams be established, including representatives of all the responsible and relevant agencies. So these teams may have, among others, representatives from the commissioners and providers of social care services, the police and other relevant law enforcement agencies, and advocacy services. The tasks of this multi-agency team are to:

- investigate allegations of abuse in order to establish the facts;
- take measures that will ensure, where there has been abuse, that the vulnerable person receives protection, support and redress; and
- take appropriate action with respect to the perpetrator of the abuse and/or the management of the service where the abuse occurred.

Safeguarding Adults elaborates this process further, defining eight stages, which are summarised below:

Alert	Reporting concerns of abuse or neglect, which are received or noticed within a partner organisation, and ensuring that any immediate protection needs are addressed;
Referral	Placing information about that concern into a multi-agency context;
Decision	Deciding whether the Safeguarding Adults procedures are appropriate to address the concern;
Safeguarding assessment strategy	Formulating a multi-agency plan for assessing the risk and addressing any immediate protection needs;
Safeguarding assessment	Co-ordinating the collection of information about abuse or neglect that has occurred or might occur. This may include an investigation, such as a criminal or disciplinary investigation;
Safeguarding plan	Co-ordinating a multi-agency response to the risk of abuse that has been identified;
Review	The review of that plan;
Recording & monitoring	Recording and monitoring the 'Safeguarding Adults' process and its outcomes.

From the perspective of our research, the key stages in these procedures are: i) the *Safeguarding Assessment Strategy* also known as a 'strategy meeting', where a multi-agency Adult Protection Team is convened following an allegation of abuse; ii) the *Safeguarding Assessment*, also known as an 'investigation', which involves the collection of information about the alleged victim, the abuse and the alleged perpetrator. This is also the point at which the police may become involved if it appears that a criminal offence may have been committed; and iii) the *Safeguarding Plan*, also known as the 'case conference', where, in light of the information collected during the investigation or *Safeguarding Assessment*, decisions are made about possible protective measures.

In February 2008 Ivan Lewis, the Minister for Care Services, announced a review of adult Safeguarding policy and a consultation on a revised policy is expected soon.

1.5 The provision of IMCA services in England

The research reported here investigates the operational practicalities and perceived benefits of involving IMCAs in adult protection procedures. There are 150 authorities in England (consisting of local or unitary authorities, metropolitan borough councils, London boroughs, and shire counties), which are in receipt of IMCA services from a total of 67 different advocacy provider organisations. A single advocacy provider organisation may provide IMCA services to more than one authority, through so-called joint commissioning, and a single local authority may have commissioned its IMCA service from more than one provider organisation.

1.6 Methods and data collection

All advocacy organisations providing IMCA services are required by the Department of Health to record all their referrals for the services of an IMCA – whether eligible or ineligible – on a national database. The data fields on this database are shown in Appendix A. We analysed this database to present a national picture of IMCA involvement in adult protection. Additionally, ten advocacy organisations providing IMCA services that have received a significant number of referrals from individual local authorities agreed to provide additional information on the adult protection cases they had been or were still involved in. The data fields for this additional information are described in Appendix B.

Qualitative data were collected by interviewing the manager and an IMCA from each of the ten advocacy provider organisations. In addition, each IMCA manager was asked to provide contact details for an Adult Protection lead, and a social worker (who has worked with an IMCA on an adult protection case). Hence, in addition to the IMCAs and their managers, ten Adult Protection leads and ten social workers were interviewed. The interviews

were conducted over the telephone, using a semi-structured interview schedule, which can be found in Appendix C. All the responses were recorded by hand, verbatim as far as possible. The interview data were analysed with a view to understanding the practical demands and possible benefits of involving an IMCA in adult protection proceedings. Further insight

into these matters was sought by: i) convening two focus groups at which representatives from the ten organisations discussed their experiences of IMCA involvement in adult protection; and ii) by attending *The First National IMCA Conference*, organised in London on 29th April 2008 by Action for Advocacy. Our research also benefited from collaboration with two allied projects also funded by SCIE. The first of these projects, carried out by Advocacy Partners, has involved the preparation of specialised written guidance on the role of IMCAs in adult protection. The second project, carried out by the Ann Craft Trust, has focused on training materials for use by professionals working with adults with learning disabilities who need to understand the *Mental Capacity Act.*

Table 1 The ten advocacy organisations supporting the research and the local authorities they serve

IMCA Organisation	Commissioning Authorities
Advocacy Experience	Bury, Cumbria, Oldham, Stockport, Tameside, Liverpool, Sefton
Advocacy Partners	Sutton, Merton, Croyden, Camden, Islington, Wandsworth and Tower Hamlets
ASIST	Staffordshire, Stoke-on-Trent
Cambridge House	Greenwich, Bromley, Bexley, Lambeth, Lewisham, Southwark, Westminster, Hammersmith and Fulham, Kensington and Chelsea, Brent, Ealing, Harrow, Hillingdon, Hounslow
Cloverleaf Advocacy	Calderdale MBC, North Yorkshire CC, City of York Council, Hull City Council, East Yorkshire Council, North Lincolnshire Council
Dorset Advocacy	Dorset, Bournemouth and Poole
Kingston Advocacy Group	East Surrey, London Borough of Richmond, Royal Borough of Kingston
Optua	Suffolk
South of England Advocacy Project	Cornwall, Portsmouth
Speaking Up	Cambridgeshire, Peterborough

Part 2

Adult protection referrals to IMCA provider organisations

2.1 Introduction

Part 2 comprises two sections. In the first, Section A, we present data from the Department of Health's national database of referrals for Independent Mental Capacity Advocacy. However, we became aware of some limitations to the information in this database. We therefore set up our own database to collect additional information about the referrals. Nine of the ten advocacy provider organisations supporting the research contributed to this database; the information they provided forms the Research Project dataset. In Section B, we present a more detailed analysis of the 204 clients for whom information was available from both the national database and the Research Project dataset.

Section A

2.2. Information from the national IMCA database

Background to the database information

The Department of Health's national database of referrals for Independent Mental Capacity Advocacy, to which we had direct access, is accessed through the World Wide Web and comes with a number of analytic tools. The fields are shown in full in Appendix A. They include fields relating to demographic information relating to the client and his or her disability (Section A); the referral process (Section B), the decision to be made (Section C); the work of the IMCA (Section C); and the outcome of the IMCA's involvement (Section E). Through detailed discussion at the focus days held with the ten IMCA provider organisations supporting us, and attempting to analysing the data, we identified some limitations in the information the database provides.

First, there is some variation in the way in which referrals are treated by IMCA service providers. Some organisations treat each *client* as a single referral, regardless of the number of decisions made. Others, however, following the instruction given in Section C on the database (see Appendix A), treat each *decision* as a new referral. Where organisations use the second of these

approaches, and there is more than one decision involving an IMCA, the client's demographic data appear more than once. Secondly, there is confusion around the way that IMCA organisations treat 'change of accommodation' decisions in adult protection cases. Where the protective measure for a client is a change of accommodation, some organisations have entered the case as a change of accommodation *rather than* as an adult protection case; others have entered it *both* as an adult protection case *and* then as a *new* change of accommodation case. IMCA service provider organisations are aware of these and others difficulties (such as clerical error), but expressed some frustration that once a case has been closed it is not possible for them to amend or enter new information.

From our perspective, using the database was made more difficult because the format did not allow us to exclude cases where the information was clearly missing or had been entered incorrectly. This meant that any averaged information, for example on the number of hours spent on adult protection rather other kinds of referrals, would include information that was incorrect.

Given these limitations, we decided to minimise the presentation of information drawn *exclusively* from the national IMCA database. Instead, we used the national information primarily to assist us in a more detailed analysis of a subset of referrals, for whom additional data were collected just for this project (the Research Project dataset, see Section B, below).

Referrals relating to adult protection

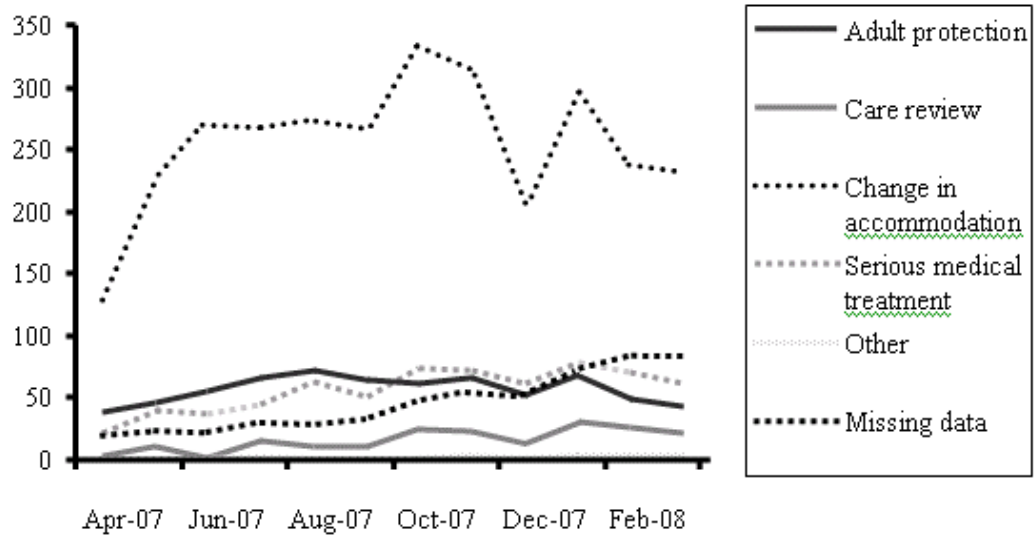
The information from the national database indicates that, in total, 5268 eligible referrals were received by IMCA service provider organisations between 1st April 2007 and 31st March 2008 of which 706 (13.4%) were made in relation to adult protection procedures. By June 2008 485 (68.7%) of these 706 referrals had been closed; 221 (31.3%) remained open. Table 2 shows the number of adult protection referrals made by the 150 local authorities. More than six out of ten authorities (62%) made between one and five referrals.

Table 2. Number of adult protection referrals made by individual local authorities

	Number of adult protection referrals						
	0	1 - 5	6 - 10	11 – 15	16 - 20	21+	**Total**
Number of authorities	17	93	22	9	7	2	**150**

While, for the reasons already discussed, the data need to be treated with caution, Figure 1 shows the number of referrals made to IMCA provider organisations relating to adult protection, compared with other types of referrals. It can be seen that change of accommodation decisions provide the main reason for referrals to be made; in contrast, 'other' decisions are almost non-existent.

Fig. 1 Number of referrals made to IMCA provider organisations each month and reasons for referral (drawn from national IMCA database)



Section B

2.3 Information from the Research Project dataset

Background to the Research Project dataset

In this Section, we focus on a more detailed analysis of a sub-group of men and women for whom we collected additional, non-routine, quantitative data (see Appendix C), provided by nine of the IMCA provider organisations supporting our project. These data related to 251 individual *clients* referred because of adult protection concerns. For 204 (81%) of these clients, we were able to successfully link our data with information from the national IMCA database; for the remainder, the client referral number was incorrect or absent (36) or the referral was made after 31st March (11).

Of the 204 clients with whom the IMCA provider organisations reported they had been working, 191 (93.6%) were recorded as eligible by the Department of Health; the remaining 13 (6.4%) were recorded as ineligible. However, since these 13 clients formed part of the IMCAs' case loads, we have included them. Only 79 (38.7%) of the 204 clients' cases were closed on 31st March, the other 125 remained open.

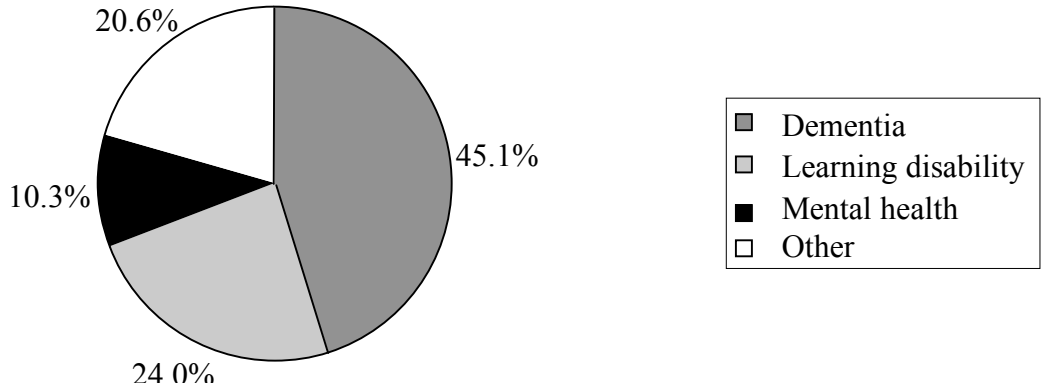
Clients' gender, age and ethnic background

The majority of the 204 clients referred to IMCA advocacy organisations for support during adult protection procedures were women (63.2%, n=129). More than half were older people (aged 65 years or more), with the largest proportion (32.8%, n=67) being 80 years of age or more, and the next largest proportion (21.1%, n=43) being aged 66-79 years. Of the 195 clients for whom this particular information was available, the majority were described as from a White ethnic background (White British: 85.6%, n=167; Irish: 3.1%, n=6; or Other: 4.6%, n=9). The remainder were reported as Black (British or Other: 3.6%, n=7) or Asian (British or Other: 3.1%, n=6).

Clinical conditions affecting clients' capacity

Figure 2 shows the clinical conditions that were reported as affecting clients' decision-making capacity in relation to adult protection.

Fig. 2 Nature of clients' clinical conditions (N = 204)

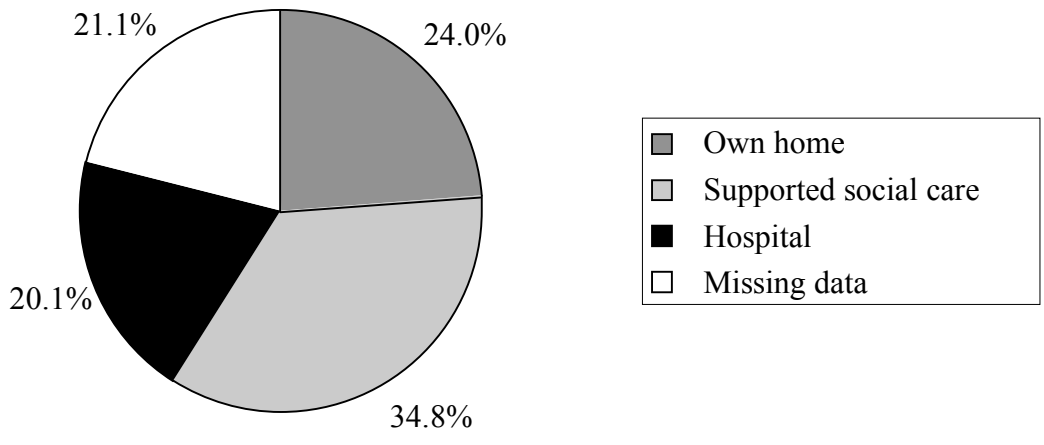


'Other' includes: acquired brain damage, autism spectrum conditions, cognitive impairment, serious physical illness, unconsciousness, a combination of conditions, and unknown impairments.

Clients' accommodation at the time of referral

Figure 3 summarises the different types of accommodation in which 202 of the clients (no data were available for two clients) were living when they referred to an IMCA provider organisation. This does not mean that these are the places where the alleged abuse took place, only that this is where the client was living when a referral relating to adult protection was made.

Fig. 3 Clients' accommodation at time of referral (N=202)

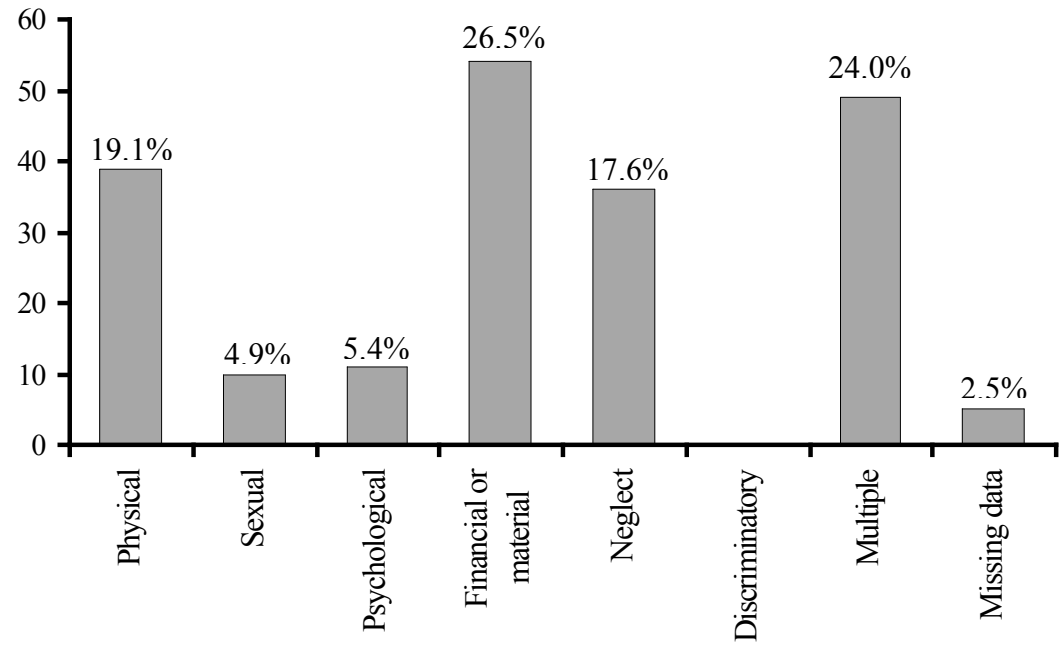


For the 161 clients for whom more detailed data were available, the majority were living in social care accommodation supported by staff (a care home sometimes with additional nursing provision, supported living, or a group home) at the time of referral (44.1%, n=71). Almost a third (30.4%, n=49) were living in their own homes, with 25.5% (n=41) in hospital.

Types of alleged abuse leading to adult protection procedures

Figure 4 shows that, of the six different types of abuse identified in *No Secrets*, clients were most often referred because of alleged financial abuse, followed by physical abuse, and then neglect. There were no cases of discriminatory abuse recorded. The category 'multiple' refers to cases in which an individual was alleged to have been the victim of more than one type of abuse and mainly comprised combinations of physical, psychological, or financial abuse and/or neglect.

Fig. 4 Types of alleged abuse (N=204)



For most types of abuse, there were similar proportions of men and women victims. There were, however, some minor variations in the experiences of the two genders: a greater proportion of men were alleged to have experienced

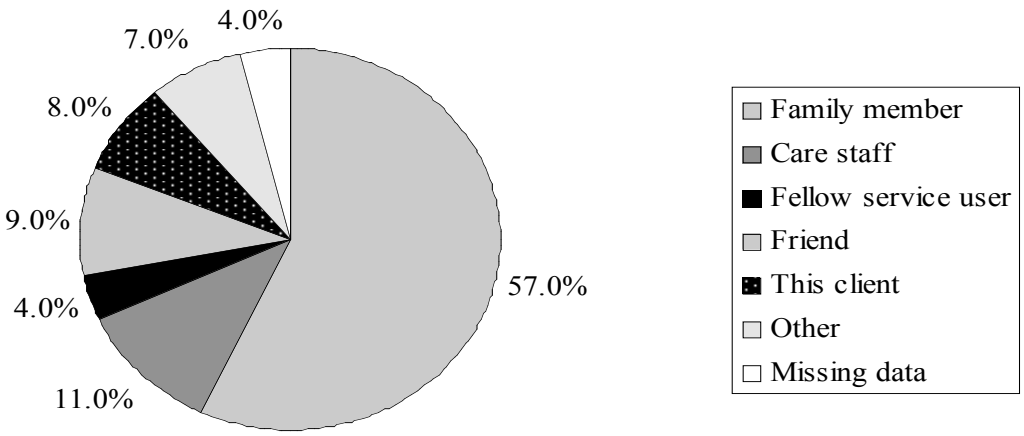
financial abuse, while a greater proportion of women experienced multiple abuse. Similarly, there were some variations in experiences according to age: younger people, aged 18-45 years, were more likely than their older peers to experience alleged physical abuse, while older people (aged 46 years or more) were more likely to be referred because of alleged financial, psychological or sexual abuse.

At referral, different types of alleged abuse were associated with clients living in different types of accommodation. For example, while the highest proportion (one in three) of referrals of men and women living in supported social care accommodation related to alleged physical abuse, the highest proportion (again, one in three) of referrals of people living in their own homes related to alleged financial abuse. Similar proportions of alleged neglect and multiple abuse were recorded for clients who were living in their own homes or supported social care accommodation.

Alleged perpetrators

As Figure 5 shows, more than four out of five of the alleged perpetrators were apparently known to the victims, with more than half being members of their own families.

Fig. 5 Alleged perpetrators (N=204)



There was some variation in the patterns of abuse by different groups of alleged perpetrators. For those clients for whom a family member was the

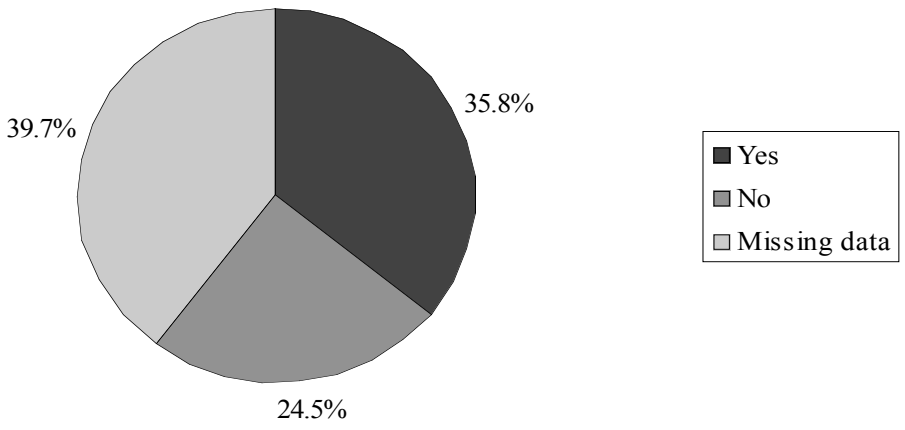
alleged perpetrator, the main types of abuse were financial, multiple, or neglect, while 'friends' were most likely to engage in financial abuse or abuse of more than one type. Where the alleged perpetrator was a member of staff, multiple abuse was most frequent, followed by physical abuse, and neglect. However, where a fellow service user was the alleged perpetrator, physical or sexual abuse was most likely to be recorded.

As Figure 5 shows, only 17 (eleven men and six women) of the alleged perpetrators were themselves IMCA clients, lacking the capacity to make decisions about protective measures. Of this group, the greatest number were aged between 46 and 65 years (41.2%, n=7), but there were three people (17.6%) aged 80 years or more. The most frequent type of abuse in which these client perpetrators had allegedly been involved was physical (58.8%, n=10), followed by sexual (23.5%, n=4) or financial (11.8%, n=2) abuse, and, lastly, neglect (5.9%, n=1).

Ascertaining clients' wishes relating to protective measures

By definition, the clients supported by IMCAs lack capacity to make decisions about protective measures, but this does not necessarily mean that they are unable to express their wishes. Figure 6 shows the number of clients whose wishes IMCAs reported they had, or had not, been able to ascertain, either directly, or indirectly.

Fig. 6. Ascertainment of clients' wishes (N=204)



IMCAs reported that, for the majority (59%, n=73) of the 123 clients (60%, N= 204) for whom data were available, they had been able to ascertain the person's wishes. For the remaining 40.7% (n=50) of clients this was, apparently, not possible.

Criminal justice system involvement

Since 125 of the 204 clients' cases remained open at the time of our analysis, these data need to be treated as preliminary. From the available information, the criminal justice system was involved in more than a third of the cases (36.3%, n=74). Half of these 74 cases resulted in no further action, but 35 (47.3%) were investigated formally by the police. Eleven of these investigations led to an arrest (14.9% of those initially reported): in eight cases the perpetrator received a formal caution; in the remaining three, the alleged perpetrator went to Court (outcome unknown).

Decision-makers

Perhaps surprisingly, for almost one in five of the 204 clients (17.6%), the professional background of the decision-maker was unknown. Where this information was available, social workers formed the majority of decision-makers (82%, n=138), with the remainder comprising Adult Protection leads, managers of social work teams, community nurses, care managers and medical practitioners.

Time spent by IMCAs on adult protection cases

It was not possible from the Research Project database to calculate the duration (from referral to closure) of the IMCAs' involvement with the 204 clients, but we were able to calculate how much time was spent by them on adult protection referrals. The mean number of hours was 13.0 (range: 1.5-89 hours; s.d. 12.7 hours).

Part 3

IMCA casework in adult protection procedures

3.1 Introduction

This part of the report presents our findings from the interviews and focus groups held with ten IMCAs and ten IMCA managers from the ten service provider organisations that supported the research. These interviews were scrutinised for what they could reveal about the demands of IMCA involvement in adult protection procedures. Where appropriate, the findings are complemented by data collected from the ten social workers and the ten Adult Protection leads whom we also interviewed (details of the semi-structured interview protocols are shown in Appendix B). The issues addressed below have been chosen because they were raised by the interviewees and are directly relevant to the policy, procedures, or practices highlighted in the documents that we reviewed briefly in Part 1.

3.2 The role of an IMCA in adult protection

Safeguarding Adults identifies three possible points during adult protection procedures where an advocate might be appointed: during the *Safeguarding Assessment Strategy* (*aka* the strategy meeting), the *Safeguarding Assessment* (*aka* the investigation) and when formulating the *Safeguarding Plan* (*aka* the case conference).

Divergence from a strategic policy towards IMCA referrals

The ADASS *Guidance* proposes that, in particular cases of serious neglect or sexual abuse, an IMCA should be instructed early on in the adult protection procedures, possibly during the formulation of a Safeguarding Assessment Strategy. Only one of the IMCAs told us that the point at which she became involved was specifically related to the nature or severity of the alleged abuse; the majority did not mention this. Indeed, a few of those we interviewed even went so far as to suggest that referrals were made as an 'after- thought', or, in contrast, as a 'knee jerk' response, to an allegation of abuse. While the majority of IMCAs we spoke to had worked with local authorities that had

policies describing the conditions under which the power to instruct an IMCA should be used, these findings suggest that these policies are not being followed.

Instructions to act in adult protection cases

The *Expansion Regulations* stipulate that a local authority must instruct an IMCA to act where it is believed a person subject to adult protection procedures will 'benefit' from his or her representation. It was quite clear from our interviews with IMCAs and their managers that they do not take an *instruction* to act alone as sufficient grounds for becoming involved. Nor did IMCAs appear to be aware of their responsibility to ensure that the person instructing them to act has the authority to do so. Rather, IMCAs reported that they seek to satisfy themselves that potential clients are eligible by asking for assurance that a functional assessment of capacity has taken place and that the person has been judged to lack decision-making capacity in respect of one or more protective measures. Such reticence about accepting referrals at face value appears to be related to concerns about the constraints, both in terms of finances and time, under which the IMCA service works. Although it may also signal that IMCAs do not trust decision-makers to make the necessary eligibility checks. In practice, this means that the point during adult protection procedures at which a referral is received is significant.

Early and late referrals to the IMCA service

There is a problem for IMCAs when an instruction to act is received at an early stage in adult protection procedures, that is, prior to any safeguarding plan. In the absence of one or more proposed protective measures it is not possible to conduct a functional assessment of the client's capacity to make a decision about the measure(s), and it is hard to see how the IMCA can feel satisfied that the client is entitled to his or her services. Moreover, in the absence of any plan, ascertaining the client's wishes, except in a very general way, is problematic. Early involvement also brings with it the possibility, which both IMCAs and their managers strenuously said they wished to avoid, of being drawn into the investigative process.

However, there are also problems when an instruction to act is received at a late stage in adult protection procedures, for example, shortly before the Safeguarding Plan meeting, to discuss and agree on the proposed protective measures. At this stage, IMCAs have very little opportunity to satisfy themselves that the client is eligible and that he or she does indeed lack decision-making capacity with respect to one or more of the proposed protective measures. There may also be little time to meet with the client to ascertain his or her wishes, gather information about the case from relevant professionals and family, and consult relevant social care records. Under these constraints, the IMCAs we spoke to reported their role is primarily that of ensuring that decision-makers are aware of, and adhere to, the *MCA*'s best interests checklist. In effect, in this situation, the IMCAs *monitor* the adult protection procedure to check that the decision-making process is client-focussed; they do not *advocate* for the client's wishes, beliefs and values. This distinction is discussed in more detail later.

Assessing the capacity of adults referred for an IMCA

The only formal eligibility criterion for involving an IMCA in adult protection are that the potential client lacks the capacity to agree to one or more of the protective measures, and that it would be of particular benefit to him or her to be represented by an IMCA. However, as described above, confirming eligibility can be far from straightforward, particularly when IMCAs are instructed early in the process. A small minority of IMCA service provider organisations said that they only accept referrals once one or more protective measures have been devised; this ensures that the assessment of clients' decision-making capacity is strictly functional.

Other IMCA managers, in contrast, report that they are willing to accept referrals at an early stage providing there is a 'reasonable belief' that the person lacks the relevant decision-making capacity, because, as one IMCA told us, in the majority of cases, such 'beliefs' prove well-founded, even where a client has little or no prior contact with social services. Some IMCAs told us that they are confident about becoming involved at an early stage in adult protection procedures because they feel well-placed both to advocate for their

clients' wishes, where these are ascertainable, and to monitor the adult protection procedures. Others, however, reported that, while willing to become involved, they have often felt uncertain about their clients' eligibility for the service. From what we were told, this uncertainty is troubling to IMCAs because of their professionalism: they want to 'get things right'. They struggle with the knowledge that, on the one hand, the IMCA service is a scarce resource for supporting particularly vulnerable adults but, on the other, they are concerned that a 'best interests' decision might be made on behalf of an adult who has the capacity to act autonomously.

Those IMCA managers wishing to see consistencies across the entire IMCA service are concerned that two different approaches to the eligibility criteria are in use.

Ascertaining a client's wishes, beliefs and values

Early involvement in an adult protection case – before the formulation of possible protective measures – did not lead to any of the IMCAs we interviewed questioning the value of meeting with a client to ascertaining his or her wishes, beliefs and values. This surprising finding may be related to their descriptions of their clients as men and women who, even with support, are rarely able to communicate any views in relation to protective measures (see Figure 6). In effect, the IMCAs are acting as un-instructed advocates, with clients, at best, expressing their wishes, beliefs and values about their present situations.

Avoiding being drawn into a Safeguarding Adults investigation

As already noted, early involvement in adult protection procedures is perceived as increasing the risk of being drawn into the investigative process. Both IMCAs and their managers described cases in which, they believed, IMCAs had been expected to obtain from the client information relevant to the investigation. Moreover, even when they were not asked to obtain information, concerns were expressed that, simply by meeting the client to ascertain his or her wishes, they might contaminate evidence that was later needed by the police. Further, it was reported that early involvement also brought with it the

possibility that family members would presume that the IMCA was working on behalf of the Adult Protection Team, rather than as an independent representative of the alleged victim. According to the interviewees, such misunderstandings of the IMCA role may have contributed to the experiences they reported of family members, in particular, attempting to obstruct, rather than support, their involvement.

IMCAs as advocates and monitors of adult protection procedures

The *MCA* and its *Code of Practice* describe the role of an IMCA as collecting and presenting a client's wishes, beliefs and values; obtaining and evaluating information relevant to the decision in question; ensuring that, when a particular course of action is considered, it is, among equally effective options, the less restrictive of a client's rights and freedom of action; and raising questions about, or challenging, decisions that appear to be contrary to his or her 'best interests'. As well as describing these features of the IMCA's role, the managers we interviewed also identified a range of additional responsibilities: knowing their local authority's adult protection policies and ensuring these are followed; knowing what is and is not an appropriate use of the *Mental Health Act*; knowing, in the broadest sense, what a client's legal rights are; making sure that capacity has been appropriately assessed; reminding members of Adult Protection Teams of their duties under the *MCA*; ensuring *Safeguarding* meetings have clear aims and objectives; encouraging Adult Protection Teams to be person-centred; ensuring Adult Protection Teams are not 'hijacked' by vociferous family members; and making sure Adult Protection Teams carry out their plans. These responsibilities go far beyond those described in the *MCA* and its *Code of Practice* and, in effect, expand the responsibilities of an IMCA from supporting and representing a client to *monitoring* adult protection procedures. That the responsibilities of IMCAs in adult protection proceedings appear to extend so far beyond their statutory formulation may be attributed to three factors: i) many IMCAs have had considerable experience of non-instructed advocacy, where overseeing a deliberative process is a core task; ii) monitoring the process may be all that an IMCA can do where it has not been possible to meet with the client and/or gather information about his or her wishes, beliefs or values; iii) IMCAs feel it

is necessary to inform members of Adult Protection Teams about their role and duties and responsibilities under the *MCA*; and iv) in a small minority of cases, IMCAs have, they told us, to guide Adult Protection Teams through their own adult protection policies .

Working with Adult Protection Teams

If it is indeed the case that professionals in local authority Adult Protection Teams do not understand their duties under the *MCA* and occasionally their own adult protection procedures, then the expansion of the IMCA role, described by their managers, goes far beyond that described in the *MCA*. Consistent with this 'mission creep', we were told by our interviewees that adult protection cases consume proportionately more time than other types of *MCA* work, and that they believe that early involvement is of particular value because of the opportunities it provides for longer and more detailed monitoring of the adult protection procedures. When amplifying this observation, some of our respondents told us that the involvement of an IMCA is a very important safeguard for their clients. Indeed, it was proposed that all men and women involved in adult protection procedures, regardless of their decision-making capacity, could benefit from similar access to advocacy.

Not surprisingly, none of the social workers or Adult Protection leads that we interviewed reported that they or their colleagues lack understanding of the *MCA* or of adult protection policies. Nevertheless, they universally welcomed the involvement of IMCAs in adult protection procedures, seeing them as valuable contributors to the protection of the best interests of vulnerable adults. The views of social workers and Adult Protection leads are discussed in more detail in Section 3.7.

3.3 Working with the police and the criminal justice system

IMCAs' uncertain knowledge of the criminal justice system

What IMCAs told us about the involvement of the police in adult protection suggested that practice varies across the country. In some local authorities, a police representative assesses all adult protection cases and decides whether or not it is appropriate for the police service to be involved. In others, it is up to members of the social services Adult Protection Team to decide whether or

not to inform a representative of the police about a particular case. In both situations, the IMCAs we spoke to reported that they have good working relationships with police officers. Nevertheless, concerns were raised about the patchy understanding of the *MCA* and the new criminal offences of wilful neglect and ill-treatment. We were told that the police service is reluctant to become involved in cases where: i) the principle witness to the abuse is believed to 'lack capacity' and therefore judged to be unable to act as a witness; ii) the alleged perpetrator of the abuse is also a service user; and iii) the alleged abuse has taken place between members of the same family and can be interpreted as 'domestic abuse'.

Our interviewees specifically requested guidance on a number of issues in this area: how to ensure that their involvement does not contaminate forensic evidence; how to avoid compromising their independence when clients disclose information pertinent to an investigation; whether or not to act as an 'Appropriate Adult' if a client is interviewed as a suspected perpetrator; how to, and indeed whether or not they should, act as a witness in court or as a litigation friend. Finally, at an organisational level, issues relating to liability for the costs of an application by an IMCA to the Court of Protection.

3.4 Best interests decisions in adult protection procedures

A range of protective measures

Statutory IMCA cases focus only on two types of decisions ('serious medical treatment' or 'changes of accommodation') and the actions that follow, whereas protective measures in adult protection cases encompass a much wider range of possible actions and decisions. These include, for example, a change of accommodation for the alleged victim and/or the alleged perpetrator, , arranging a package of social care or suitable financial management, ensuring contact by a client's family and/or 'friends' is appropriate and/or monitored, ensuring that family carers adhere to a person's care plan, and the suspension or dismissal of a member of staff. This range of possibilities brings an added complexity to an IMCA's existing role.

Best interests in adult protection

It appeared to us, based on what the IMCAs and their managers told us, that crucial to their understanding of the protection of a person's best interests is the idea of the 'less restrictive alternative'. They use their understanding of this concept to challenge proposed interventions involving protective measures that seem disproportionate to the possible risks to the client and therefore contrary to his or her 'best interests'. For instance, one manager described a case of a man, living alone but unable to understand his financial affairs, who was being financially abused; as a protective measure, he was being moved from his own home. This change of accommodation was challenged, successfully, by the IMCA on the grounds that it was unlikely to be less restrictive of the client's rights and freedom of action than other, equally effective, options. . Seemingly harder to challenge, however, were decisions to remove clients from their own homes where it was suspected they were being physically abused and/or neglected by family members living at the same address and the police were unwilling to become involved. According to one IMCA, it is more straightforward to remove the alleged victim of abuse than the alleged perpetrator.

3.5 Working with clients

Challenging capacity assessments

The IMCAs told us that, in many cases, they had concerns about the validity of the capacity assessments carried out with clients. These concerns were based on a belief that either the assessment either was not specific to the proposed protective measures, or that the information about the measures was not being presented in a format appropriate to the client's specific needs. Where it was suspected that a capacity assessment had led to a judgement that did not appear defensible, the IMCAs reported that they would mount a challenge, and cases in which this had taken place were described. These challenges, we were told, prompted discussions within Adult Protection Teams, and, occasionally, led to a reassessment of the client's capacity. Cases where a client was presumed to have fluctuating capacity appeared to be particularly difficult to resolve, however, especially where members of the person's family were involved and they were making claims about the

person's expressed wishes, values and beliefs. Issues relating to working with families are discussed in more detail below.

Gathering information from social care records

In the main, IMCAs described few difficulties in gaining access to clients' social care records. Where problems were reported, they related having to remind social care staff to provide them with access and/or of the inappropriateness of handing over the entire record rather than just the relevant parts.

Supporting a client's decision-making capacity and participation

All but one of the IMCAs we interviewed told us they routinely attempted to enhance clients' ability to express their wishes and, occasionally, to support them to attend relevant meetings. However, despite the efforts of the IMCAs, most clients were apparently unable to communicate their wishes in any coherent way (see Figure 6). The one IMCA who reported that she made no regular attempts to enhance her clients' ability to express their wishes justified her account in terms of her clients' difficulties in i) understanding that they may have been victims; and ii) understanding adult protection procedures.

Where clients were unable to communicate, the IMCAs described gathering relevant information from a range of sources: family members, paid staff and social care records. Older people with no family member who could be contacted and who had no prior contact with social services posed a potential problem. However, in such cases the IMCA's role was that of non-instructed advocate.

Working with family and friends

In contrast with clients in statutory IMCA cases, those in adult protection procedures are not necessarily without family or friends. Liaising with these family and friends, the IMCAs told us, was usually very demanding, particularly under one or more of the following conditions: when the ownership or control of financial or material assets was at issue; when family members or friends were the alleged perpetrators, and, perhaps, also denied allow access

to the client; when family members and friends were disputing the judgement that the person lacked capacity; and were intimidating members of the Adult Protection Team through their behaviour or by threatening legal action. Problems also arose when the local authority had not informed the alleged victim's family or friends either of the adult protection procedures or of the IMCA's involvement. This places IMCAs in an invidious position: they are required to maintain client confidentiality yet also need to explain to family members and/or friends why they wish to meet with the person.

Clients living in their own homes

All the IMCAs we spoke to told us about cases where they had experienced difficulties meeting with clients because family members had deliberately denied access. Neither IMCAs nor members of an Adult Protection Team have an automatic right of access to private homes and, according to our interviewees, the police are normally reluctant to become involved. Two IMCAs, whose access to their clients was being denied by family members, described how they had managed to arrange meetings by going to the clients' day centres.

Working with clients who already have an advocate

The ADASS *Practice Guidance* suggests that a local authority does not need to appoint an IMCA where an adult already has an advocate who can represent his or her interests. Some of the IMCA managers we interviewed were in agreement with this principle and were willing, where necessary, to support a general advocate to represent a person who was the subject of adult protection procedures. In sharp contrast, one IMCA manager was of the opinion that only fully trained IMCAs had the necessary skills to represent a person during adult protection procedures.

Gathering information from an alleged perpetrator

All the IMCAs recognised the importance that an alleged perpetrator, particularly a family member, might have in a client's life. However, the issue of whether family or friends identified as alleged perpetrators should be consulted about the client's wishes, beliefs and values was contentious. Some

of our interviews were adamant that under no circumstances should information be collected from alleged perpetrators since they would inevitably be unreliable as informants. Others reported a more pragmatic position in which they recognised that an alleged perpetrator might be able to provide important information about a client's wishes, beliefs and values. This was especially so where a client's social services records were either sparse or non-existent, and/or the perpetrator was a service user (or entitled to services) and/or the victim's spouse. While all the IMCAs to whom we spoke categorically rejected the idea of distinguishing between malign abuse and abuse occurring as a consequence of a person's inability to cope, making such a distinction appears, to us, in reality, to be unavoidable when considering whether or not to consult with an alleged perpetrator.

Clients living in supported social care accommodation

The key difference between representing clients living in supported social care accommodation compared with those living in their own home was ease of access to the client. Residential homes have procedures for dealing with alleged abuse that ensure, first and foremost, that the client is safe. Alleged perpetrators, if they are staff, can be suspended and, if they are residents, removed. IMCAs can also more easily meet privately with their clients. Nevertheless our interviewees rejected any suggestion that cases where clients where living in residential care were necessarily more straightforward than those involving people living in their own, or a family member's, home.

Representing alleged perpetrators

Only a few IMCAs had supported an alleged perpetrator. Those with experience of supporting alleged perpetrators emphasised that their practice had not been adversely affected: they still did their best for the client. More controversial amongst the IMCAs and their managers was the possibility of being drawn into representing the interests of an alleged perpetrator who was *not* their actual client. This was a possibility where the alleged perpetrator was the client's partner and the type of abuse was neglect, believed to have taken place within a supportive relationship in which the partner had become unable to cope with the demands of their role as a carer. Under these very

specific circumstances, some IMCAs had represented, or described themselves as willing to represent, both the alleged victim and the alleged perpetrator. This was justified on the grounds that the interests of both the client and the partner were essentially similar.

The expressed wishes of clients and their best interests

Four managers of provider service organisations raised concerns about adult protection cases where protective measures were proposed that were not consistent with the client's expressed wishes, as ascertained and represented by the IMCA. Two of the managers adopted a very clear line: if the IMCA had informed the Adult Protection Team of the client's wishes and presented those wishes vigorously, and that team had given due consideration to a possibly less restrictive option, no more could be done. Ultimately the decision-making authority lay with the Adult Protection Team. In contrast, the other two perceived such a position as problematic. One of the IMCA managers cited the example of a decision-maker who, taking a pessimistic view of the risks facing a client, excessively elevated protection over wishes. The other referred to a case where allegations of abuse were investigated but not substantiated because the police were reluctant to enter a private home. In accordance with the client's wishes, she was left in a situation where the IMCA manager considered her to be at risk of further abuse.

Cases where clients eligible for an IMCA become ineligible

Among some of the IMCAs and their managers, there was some concern about situations in which an alleged victim of abuse receiving the support of an IMCA might subsequently become '*in*eligible' for the service. One such situation involves the use, as a protective measure, of a change of accommodation when the client has family or friends who might be consulted about this change. IMCAs and their managers varied in their understandings of, and responses to, this situation. We were told by one manager that an IMCA would withdraw despite the change of accommodation being a protective measure, while another reported that, anticipating this possibility, the local authority had stipulated that an IMCA would remain involved. A third manager told us that, while the continued involvement of an IMCA could be

assumed, there was no formal agreement with the local authority that this would be the case.

3.6 Challenging decision-makers, writing reports and deciding when to exit

None of the IMCAs' or managers' observations on challenging decision-makers, writing reports, and deciding when to exit from an adult protection case raised issues that are relevant only to adult protection procedures.

Challenging decision-makers

Consistent with their understanding of their role as encompassing a responsibility to monitor the decision-making process, IMCAs see raising questions and challenging members of Adult Protection Teams as an integral contribution to the development of *Safeguarding* Strategies, Assessments and Plans. Some IMCAs provided examples in which they had only made challenges, usually formally, at the end of the process. The likelihood of such challenges seems to be where an IMCA has been instructed late in adult protection procedures and feels they have limited opportunities for participating in relevant meetings.

Writing reports

Both the IMCAs and their managers described the provision of verbal reports and written interim and final reports as an essentially straightforward responsibility, albeit one that requires consideration of the possibility that these reports can be read by alleged perpetrators and other professionals, and might ultimately be used in legal proceedings. However, from discussions with attendees at the Action for Advocacy conference, it became clear that many IMCAs report difficulties conceptualising *what* information to include in reports, *how* to write them, and *who* the audience is.

Deciding when to exit from an adult protection case

While it was not possible for us to calculate the duration of cases, the interviewees told us that this varies: some cases last days; others, several months. Longer duration appears to be associated with several factors: family

members obstructing access to a client; the protective measures being believed likely to have a significant impact on the client's life; or communication between multi-agency partners being slow and/or requiring numerous meetings. Regardless of the duration of the case, however, interviewees reported variation in the point at which they decide to end their involvement. IMCAs described closing cases when protective measures have been decided, when the adult protection procedures have ended, or when protective measures have been implemented. Some cases were described as 'fizzling out' with the IMCA having little or no idea about the outcome of the adult protection procedures.

3.7 Interagency working

Using the Department of Health's national IMCA database

IMCAs and their managers told us that the Department of Heath's online national database was inaccurate with respect to the number of adult protection cases. This was *not* considered a consequence of poor data input or the data fields themselves but rather because the database's input fields do not allow the identification of adult protection cases that are, or become, cases involving a change of accommodation. This issue is discussed in Part 2 (Section A).

Social services' understanding of the IMCA role

The most significant difficulty described to us by the interviewees related to working with local authority members of Adult Protection Teams who appear uncertain about the role of IMCAs, particularly when these same individuals also seem to lack awareness of their own authority's adult protection procedures. In addition, we were given examples of situations in which the IMCA had not been kept informed of developments in a case, including the dates and times of meetings, where it was assumed the IMCA will support an investigation by interviewing the client, and where IMCAs felt that they were placed under pressure to convince clients to agree to the proposed protective measures. Where the working relationship with Adult Protection Teams was successful, that success was attributed to good communication, a committed and knowledgeable *MCA* lead, *MCA* and IMCA training for social workers,

and clear IMCA engagement protocols. One of the managers from an advocacy provider organisation suggested that, at the start of their involvement in a particular case, an IMCA should, in discussion with the Adult Protection Team, outline the precise roles he or she would undertake.

Providing IMCA service in adult protection cases

All the IMCA managers reported that, to date, they had been able to meet local authority demands for an IMCA, although two managers told us that there have been very busy periods during which they have almost reached capacity.

Joint commissioning of IMCA services

It was reported that arrangements whereby a single advocacy organisation provides IMCA services to more that one local authority generally function satisfactorily. Three managers described how their joint commissioning arrangements have led to the development of shared policies for involving IMCAs in adult protection procedures, and protocols for joint monitoring of the IMCA service. Surprisingly, however, these otherwise successful arrangements are not accompanied by joint training programmes. Another manager told us that, among the local authorities to whom her advocacy organisation provides IMCA services, there is a range of policies for involving IMCAs in adult protection cases, with social workers having markedly different degrees of understanding of the role of an IMCA and of the *MCA*. This was not, however, presented as an insurmountable obstacle. More problematic was the experience of one manager in which the local authorities in a joint commissioning arrangement are apparently 'no longer speaking to each other' and all meetings to monitor the provision of the IMCA service have to be held separately.

Adult Protection leads' views of IMCAs in adult protection procedures

Overall, the Adult Protection leads we interviewed reported that the involvement of an IMCA benefited the alleged victims of abuse. However, they readily acknowledged that their direct experience was limited, and none of them was able to identify which cases were most likely to benefit from

IMCA involvement. One of the Adult Protection leads was vociferous in her disappointment about the service, reporting that the IMCA service provider organisation had not promoted the service vigorously, and, in a largely rural area, had appointed an IMCA whose effectiveness had been limited by a reliance on public transport. public transport.

A particular perceived benefit of involving an IMCA was reported as his or her independence from the decision-making process. This independence was seen as enabling an IMCA to foreground the 'voice' of his or her client while challenging Adult Protection Teams to reflect more deeply on their practice. Much was also made of an IMCA's ability to remind members of these teams of their responsibilities under the *MCA*. However, Adult Protection leads reported some need for greater clarity in relation to some key issues: which cases should prompt the involvement of an IMCA; the point at which an IMCA should be appointed and then, relatedly, withdraw; recognition that the financial resources for IMCA involvement in adult protection cases needs to reflect the potential duration of these cases; and the risk that differences in local authority policies for involving IMCAs could create a 'post code lottery'.

In addition, one Adult Protection lead raised the need for outcome measures for IMCA involvement in adult protection cases that go beyond a simple counting of the number of people who have received the service. Another called for IMCA training that reflects the demands of adult protection work, including knowledge of the disabilities and age of people who are likely to be eligible for the service, and the emotional strains of working with people who may have been abused. In contrast with the IMCAs, only one Adult Protection lead reported that work needs to be carried out with police forces to address their perceived reluctance to become involved in adult protection cases.

Social workers' views of IMCAs in adult protection procedures

The social workers reported that they place particular value on the independence of IMCAs, and their contribution not only as providers of information about their clients' wishes, beliefs and values but also of a 'different perspective'. None of the comments made by the social workers,

however, suggested that this different perspective was *uniquely* rooted in the *MCA* and an IMCA's responsibility to empower and protect a client by representing his or her wishes, beliefs and values and advocating for the available effective options, is less restrictive of his or her rights and freedom of action. Rather, what social workers seemed to be saying was that the involvement of an independent person, in and of itself, is valuable. In contrast with the IMCAs' reports, none of the social workers mentioned that they had required IMCAs to monitor and protect the integrity of adult protection procedures.

During the interviews, social workers described to us recent adult protection cases where an IMCA had been involved. These descriptions were generally positive. For example, in a case relating to alleged financial abuse in supported social care accommodation. An initial refusal by the police to get involved was challenged by the IMCA, who suggested that the home's management might be prosecuted under the MCA's offence of 'wilful neglect'. Based upon this advice, the police became appropriately involved in the adult protection procedures. However, some concerns were also expressed. For instance, we were told about a case of alleged abuse in supported social care accommodation. The alleged perpetrator, a member of staff, was suspended, disciplined and then transferred to another residential unit after an investigation. However, the client had expressed a wish to be involved in the prosecution of the alleged perpetrator. The police, drawing on the involvement of the IMCA in the adult protection proceedings, assumed that the client 'lacked capacity' to give evidence or act as a witness. The social worker reported that she believed that the IMCA might have challenged this assumption. In another case, the IMCA's involvement appeared confused. The client who was receiving abusive phone calls from an anonymous caller that the police investigated while the IMCA, explored with the client, somewhat incongruously, whether or not her current accommodation needs were being met.

It appears to us, however, that adult protection cases are often complex, proceeding slowly, and with the decision-maker facing dilemmas that are

difficult to resolve. We heard, for example, of a woman with fluctuating capacity who vigorously expressed an apparently autonomous wish that her co-resident partner, the alleged perpetrator of financial abuse, continued to act as her carer and make financial decisions on her behalf. We also heard of a daughter who lived with, and shared a complex emotional history with, her mother. While her mother was the alleged perpetrator of multiple abuse, she was also someone whose own decision-making capacity was severely compromised. Under such difficult circumstances, a co-operative relationship been an IMCA and all members of the Adult Protection Team is essential for developing protective measures that safeguard the 'best interests' of vulnerable adults.

Part 4
Comments & Implications

The *Expansion Regulations* giving local authorities and NHS bodies in England (and Wales) the power to involve IMCAs in adult protection procedures is a significant new development in both advocacy and adult protection. We have begun to explore this development by considering the practical demands of IMCA involvement in adult protection procedures and the benefits, if any, to the alleged victims or perpetrators who are subject to these procedures. While the service is young, it is apparent from our qualitative data that IMCAs, their managers, Adult Protection leads and social workers all believe that the new IMCA service is a benefit to adults who are subject to adult protection procedures.

The number of adult protections referrals recorded on the Department of Health database is rather fewer than might have been expected. However, the quantitative data describing the types of disabilities affecting people's decision-making capacity and the relationships of these men and women with their alleged perpetrators are consistent with expectations. The main groups are adults with dementia or a learning disability allegedly victimised by family members. If the Department of Health database is to continue to be used to record referrals and cases, more guidance is required to clarify, for those who enter data, the issues raised in Part 2 of this report: multiple entries where the IMCAs are instructed for different decisions relating to the same client, and confusion where a decision initially concerning 'adult protection' becomes one of 'change of accommodation'.

Rather than complying with a local authority's instruction to act, IMCAs and their managers wanted to be satisfied that prospective clients were eligible for their services, and lacked capacity with respect to one or more proposed protective measures. The emphasis placed on confirming that capacity has been appropriately assessed means that the point at which an IMCA becomes involved in a case is significant. When IMCAs are involved *early* on, that is

prior to the formulation of any protective measures, there can be significant uncertainty as to whether the client is eligible for the IMCA service. Moreover, involvement at this stage begs the question of whether it is even appropriate to attempt to ascertain information about the client's wishes, value and beliefs. However, where an IMCA is involved *late*, shortly before a meeting to decide upon protective measures, there may be little opportunity to meet the client and confirm that he or she lacks capacity. There is a distinct possibility that the need to confirm that prospective clients are eligible for the service may reflect the financial and time constraints within which IMCAs and their managers carry out their work. It may be necessary for the Department of Health or for local authorities to make it clear that, by making a referral to the IMCA service, an instruction is being given for the IMCA to act on that person's behalf. For their part, IMCA service providers should also start from the presumption that the person referred is entitled to the service, and proceed on this basis until there is evidence that refutes it.

The *Code of Practice* for the *MCA* summarises the role of an IMCA as that of providing help to adults who lack the capacity to make important decisions by representing their wishes, views and beliefs to professionals with responsibility for making proxy best interests decisions. Our data suggest that IMCAs are carrying out a number of tasks: i) promoting the 'voice' of their clients; ii) in situations in which it has not been possible to ascertain the client's wishes, gathering information about, and promoting, the client's values; iii) trying to ensure that members of Adult Protection Teams understand their duties under the *MCA*; and iv) monitoring the Adult Protection Teams' deliberative processes to protect their client's 'best interests'. From the interviews we carried out, it appears that the work of IMCAs is valued by social workers and Adult Protection leads because it is perceived as foregrounding and promoting the 'voices' and interests of adults lacking decision-making capacity.

IMCA casework in adult protection cases is emotionally demanding. Not only are these cases involving the alleged abuse of vulnerable people, but they often involve conflict and a lack of reliable evidence from which a clear course

of action can be devised. This is especially so in cases of 'domestic abuse', where the alleged victim and perpetrator are from the same family and may both lack some decision-making capacity. In such cases there are no readily identifiable 'villains' or easy answers. Few cases of alleged abuse are investigated by the police, and rarely lead to a caution or court appearance for the alleged perpetrator. Furthermore, IMCAs seldom have the opportunity to develop the long term and one-to-one relationship with the alleged victim that is the hallmark of generic advocacy. Rather, they are expected to be decision focused and efficient in the use of their time. In the contexts that were described to us, in which they: require confirmation that an appropriate assessment of the client's decision-making capacity has been carried out; believe that members of Adult Protection Teams have little understanding of their duties under the MCA; may be involved prior to the formulation of any protective measures; may have to deal with family members; may feel that proposed protective measures run counter to the client's wishes; and may be asked to consider a wide range of protective measures, the demands on IMCAs are very considerable. No wonder, then, that many IMCAs and their managers seem to be taking some time to understand and define their role within adult protection. As they navigate through this 'uncharted territory', IMCAs need to focus on their responsibilities in terms of the *MCA* and its *Code of Practice* and the way in which they can most effectively work to ensure that the proxy decisions are made in the clients' best interests.

At this early stage of IMCA involvement in adult protection, what is required is greater clarity on a broad range of issues that go to the heart of multi-agency working (Penhale, 2007). IMCAs and their managers need guidance on working with the criminal and civil justice systems and report writing. Members of Adult Protection Teams need to understand their local authority's adult protection procedures and need guidance on their duties under the *MCA* and how to work with an IMCA. Local authorities need to have policies setting out when an eligible adult, who is subject to adult protection procedures, would benefit from having an IMCA. It would make sense if these policies were co-authored, with the advocacy organisation providing the local authority's IMCA services.

Adult protection is marked by diversity, and cases vary widely. Once a case has been referred, the appointed IMCA and the Adult Protection Team need to establish what the IMCA's responsibilities should be with respect to that *particular* case. While it may not be possible to create 'hard and fast' rules, a clearer framework may allow greater flexibility over the remit of an IMCA's involvement in any given case. Possible examples include:

- whether an IMCA should be involved early on in adult protection procedures based on the *reasonable* belief that the person concerned lacks decision-making capacity;
- whether information relevant to an investigation could and should be collected and passed on to the police by an IMCA;
- whether an IMCA might be called upon to support a general advocate representing an adult subject to adult protection procedures;
- whether to interview an alleged perpetrator about the alleged victim's wishes, beliefs and values;
- whether an IMCA should represent the interests of both parties in alleged 'domestic abuse' where their interests are thought to be the same;
- the point at which an IMCA should exit from a case.

In raising these issues as ones where greater operational clarity might be beneficial, it is import to remember that independence is a defining feature of advocacy. It might therefore, be very important for organisations providing IMCA services to stress their independence from both the local authority commissioning their services and the Adult Protection Teams calling upon their services.

The IMCA service goes right to the heart of the present Government's focus on citizens' autonomy and choice through 'personalisation' and safeguards for those at increased risk of abuse and exploitation. At the margins, there is, inevitably, a tension between, on the one hand, respect and support for autonomy, and on the other, protection. Our research indicates clearly that

there is a need for the extra safeguards that an IMCA can offer where it is proposed to take protective measures on behalf of an adult who lacks the capacity to agree to one or more of the proposed protective measures.

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Abbreviations and Glossary of Terms

Abbreviations	
MCA	Mental Capacity Act (England & Wales) 2005
IMCA	Independent Mental Capacity Advocate
Glossary of Terms	
Alert	A report of concerns regarding abuse which is made to a *Safeguarding Adults* team.
Best interests	Mental Capacity Act 2005 (s.4) defines best interests in terms of a process in which people wishing to make a decision on behalf of a person lacking decision-making capacity must consider a number of factors about the person and the decision. These include: i) considering whether the person will regain capacity; ii) considering the person's past or present wishes; iii) encouraging and supporting the person to participate in the decision; and iv) taking into account the views of, and if practicable, consulting with, others interested in the person's welfare.
Capacity	A person's ability to make a decision for themselves where they can understand relevant information, retain this information, weigh this up as part of the decision-making process, and communicate a choice.
Case conference	A stage in the *Safeguarding Adults* procedures. A meeting of the *Safeguarding* team to coordinate a response to the risk of abuse that has been identified [*aka Safeguarding* Plan].
Client	An adult in receipt of the services of an Independent Mental Capacity Advocate.
Generic Advocacy	The range of professionals and volunteer advocacy services provided by the independent and voluntary sectors.
Investigation	Stage of *Safeguarding Adults* procedures involving collection of information about abuse or neglect that has occurred or might occur. This may include an investigation by the Police [*aka Safeguarding*

	Assessment].
Mental Capacity Act 2005 (*MCA*)	Statutory legislation to protect and empower the decision-making of adults (over 16 years of age) who are judged to lack capacity in relation to one or more decisions relating to their health, welfare, or finances.
***MCA* Code of Practice**	The primary supporting document for the Mental Capacity Act 2005 providing guidance and information on the practical implementation of the Act.
IMCA Expansion Regulations	An additional statutory instrument giving local authorities and NHS bodies the power to instruct an IMCA during *Safeguarding Adults* procedures.
Protective measures	Actions taken by the *Safeguarding Adults* team to make a vulnerable adult safe from alleged abuse or potential abuse.
***Safeguarding Adults* procedures**	Procedures designed to deal with situations of alleged abuse [*aka* Adult protection or POVA].
Strategy meeting	A stage of *Safeguarding Adults* procedures where the *Safeguarding* team gather to formulate a multi-agency plan for assessing risk and addressing immediate protection needs [*aka Safeguarding* Assessment Strategy].
Vulnerable adult	A term used by *No Secrets* (2000) to describe a person over 18 years of age 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (para 2.3).

Appendix A

National Department of Health IMCA Database Record

(A) BASICS Questions marked * must be completed for all cases	
1. Local Authority:	
2. IMCA Provider	
3. Date referral received*	DD/MM/YYYY
4. Is this a first referral?* ☐ Yes ☐ No	**5. Client ID*** **Client Information (max 30 characters)**
6. Gender	☐ Male ☐ Female ☐ Not Known
7. Age: ☐ 16 - 17 ☐ 18 - 30 ☐ 31- 45 ☐ 46 - 65	☐ 66 - 79 ☐ 80 and over ☐ Not known
8. Ethnic Background:	
☐ White British ☐ White Irish ☐ White (other background)	☐ Black / Black British (African) ☐ Black / Black British (Caribbean) ☐ Black / Black British (other background)
☐ Mixed: White / Black African ☐ Mixed: White / Black Caribbean ☐ Mixed: White / Asian ☐ Mixed (other background)	☐ Asian / Asian British (Bangladeshi) ☐ Asian / Asian British (Indian) ☐ Asian / Asian British (Pakistani) ☐ Asian / Asian British (Other background)
☐ Chinese	☐ Other Ethnic Group
9. Does this client have a disability? (choose one category only):	
☐ Mental health problems ☐ Serious physical illness ☐ Learning Disability	☐ None ☐ Not known ☐ Other general special needs (please state):
10. Nature of client's impairment (choose one category only):	
☐ Unconsciousness ☐ Autism Spectrum Disorder ☐ Mental Health Needs ☐ Serious physical illness ☐ Acquired Brain Injury	☐ Dementia ☐ Learning Disability ☐ Cognitive impairment ☐ Combination ☐ Other (please state):

11. Primary means of communication:

- ☐ English
- ☐ Other spoken language
- ☐ British Sign Language
- ☐ Words / pictures / Makaton
- ☐ Gestures / Facial expressions / vocalisations
- ☐ No obvious means of communication
- ☐ Other (please state):

12. Is this client eligible for an IMCA?

- ☐ Yes
- ☐ No

13. If NO Please indicate reason IMCA will not be assigned (select main reason only)

- ☐ Not eligible (has capacity)
- ☐ Not eligible (is befriended)
- ☐ Decision-maker did not instruct
- ☐ Not eligible (not SMT, change in accommodation, care review or safeguarding adults
- ☐ Other (please state):

14. If NO CLOSE RECORD + DATE (no more changes allowed)*

15. If YES client is eligible, when did the IMCA begin case work? DD/MM/YYY

(B) REFERRAL DETAILS

16. Where was the client at the time of referral? Specify name of hospital, care home etc.

- ☐ Own home
- ☐ Care home / care home with nursing (name)
- ☐ Hospital (name)
- ☐ Supported Living (name)
- ☐ Uncertain
- ☐ Prison (name)
- ☐ Other (please state):

17. Where did the referral come from? (e.g. hospital discharge team, social work team, care home manager. Please identify team and location).

Specify

18. Who is the decision-maker?

- ☐ Doctor
- ☐ Social Worker
- ☐ Other (if not doctor or social worker, state broad occupational group):

(C) WHAT IS THE DECISION TO BE MADE? (select one only – create new record for each decision)		
19. ☐ Serious medical treatment (SMT) ➔	What is the proposed medical treatment? ☐ Cancer treatment ☐ Hip/Leg operation ☐ DNAR ☐ Medical investigations ☐ Serious dental work ☐ Treatment that may lead to loss of hearing or sight ☐ ECT ☐ Major surgery (e.g. open heart or brain / neuro-surgery) ☐ Major amputations (arm or leg) ☐ ANH ☐ Termination of pregnancy ☐ Other (please specify)	
20. Did the IMCA seeks a second medical opinion? ☐ Yes ☐ No		
21. Was a second opinion obtained? ☐ Yes ☐ No		
22. ☐ Change in accommodation ➔ (select one box from each column)	From: ☐ Own home ☐ Care home/care home with nursing ☐ Hospital ☐ Supported living ☐ Prison ☐ Other (please state):	To: ☐ Own home ☐ Care home/care home with nursing ☐ Hospital ☐ Supported living ☐ Other (please state): ☐ To be decided
23. ☐ Safeguarding adults		
24. ☐ Care review		

25.	☐ Other (please state):
(D)	**HOURS**
26. Hours (to nearest 10 minutes)	
	With client
	Consulting others
	Obtaining and reviewing information
	Attending decision making meeting(s)
	Report writing
	Travel
	Other (please specify)
	Total house on this case:
(E)	**OUTCOMES**
27.	**Was as IMCA report submitted to the decision-maker?** ☐ Yes ☐ No
28.	**If YES, please enter the date completed:** DD/MM/YYYY
29.	**How well do you think <u>you</u> worked with the LA/NHS on this case?** ☐ very well ☐ well ☐ not well Comments:
30.	**How well do you think the <u>LA/NHS</u> worked with you on this case?** ☐ very well ☐ well ☐ not well Comments:
31.	**If NO report submitted, please indicate reason below:**

☐ Not eligible (has capacity) ☐ Not eligible (is befriended) ☐ Issue was resolved ☐ Decision no longer required	☐ Urgent decision needed ☐ Death of client ☐ Client moved ☐ Other reason (please state)

32. Were you able to ascertain the client's wishes or preferences in relation to the decision to be made (directly or indirectly)?	☐ Yes ☐ No

33. Looking back at this case, how did you most contribute? (rank those selected where 1 = lowest and 4 is highest contribution) (select those that apply)

☐ ascertained the views of the client and fed them into the decision-making
☐ asked questions on behalf of the client to ensure they were fully represented
☐ investigated circumstances through interviews or other research to feed into the decision
☐ checking the decision-making process is in accordance with the Act

34. Did the decision reflect the client's wishes and preferences (so far as you were able to establish)?	☐ Yes ☐ No ☐ Partly
35. Was the outcome significantly affected by the involvement of the IMCA?	☐ Yes ☐ No
36. Did the IMCA challenge the decision after it had been made? Comments:	☐ Yes ☐ No

37. If YES, please specify route(s) taken to challenge the decision

☐ Discussion with decision-maker ☐ Discussion with other senior staff ☐ NHS complaints procedure	☐ Local Authority complaints procedure ☐ Raised with Steering Group ☐ Legal action ☐ Other route (please specify)

38. Overall, how satisfied were you that your involvement provided a safeguard for this client?

☐ very satisfied
☐ quite satisfied
☐ not really satisfied

Comments:

(F) CASE CLOSURE

39. CLOSE RECORD + DATE

Appendix B

Semi-structured Interview Protocols

IMCA Caseworkers Interview Questions

Date ____/____/_____
Respondent's Name _____
Respondent's Organisation _____

1. Approximately how many statutory IMCA cases have you been involved in, and how many safeguarding adults cases have you been involved in?

2. At what point in a safeguarding adults case are referrals being made for IMCA involvement? (prompt - before possible protective measures have been identified, when a decision about a protective measure has been taken)

3. How much training have you received regarding AP procedures?

4. In your assessment are safeguarding adults coordinators and social workers providing you with adequate information and time to enable you to represent the best interests of the vulnerable adult? (prompt – do they understand the IMCA role?)

5. In the safeguarding adults cases you have been involved in, have the vulnerable adults been able to communicate their wishes to you about a particular decision and how have their wishes contributed to the decision-making process? (prompt: clarity over whether there is a know decision to be made)

6. When working with a vulnerable adult do you attempt to enhance their capacity to participate in decisions about proposed protective measures and if so how have you enhanced their capacity?

7. In your assessment are there differences between cases where the vulnerable adult is living in a residential home compared to cases where he or she is living in private accommodation? (prompt - difficulties where family have been involved or possible perpetrator, info sharing, assessing capacity, self-funders)

8. How do you decide when your involvement in a safeguarding adults case has come to an end? (prompt – adult's wishes communicated to decision-maker, a decision is made, a decision is executed)

9. Have you been involved in safeguarding adults cases where you believe the police should have been involved but were not? (if yes ask for elaboration)

10. In your assessment what does it mean to represent the best interests of a vulnerable adult in a safeguarding adults case? (think – protection, support, redress)

11. Have you had to represent a perpetrator of abuse, if so how did this affect your practice?

12. Under what circumstances might you challenge, or be unhappy with, the outcome of a safeguarding adults case?

13. In your assessment why is it that safeguarding adults cases are taking more than the anticipated 8 hours?

14. What messages would you like our report to communicate to the Department of Health?

15. Guidance is being developed, what would you like included?

IMCA Managers Interview Questions

Date ____/____/_____
Respondent's Name _____
Respondent's Organisation _____

1. Approximately how many safeguarding adults cases has your organisation dealt with?

2. How many IMCA contracts does your organisation hold?

3. Are some Local Authorities better to work for than others and if so why?

4. Has the joint commissioning of IMCA services thrown up any difficulties for you organisation? (think different POVA proceedings; concerns over equitable services)

5. How are you balancing your priorities with respect to statutory IMCA cases and those safeguarding adults cases where the Local Authority has the power to instruct you to be involved?

6. Have you ever experienced any tension between the IMCAs responsibility to represent a client's best interests and safeguarding adults requirement to protect a client?

7. In your assessment what are the key principles to successful IMCA involvement in a safeguarding adults case?

8. In your assessment how does the involvement of an IMCA in a safeguarding adults case protect the best interests of a vulnerable adult? (think – protection, support, redress)

9. Is there anything about IMCA involvement in safeguarding adults cases that safeguarding adults co-ordinators persistently get wrong or find particularly difficult to understand?

10. What are the main difficulties your IMCA caseworkers have experienced in safeguarding adults cases?

11. Is it possible for an IMCA to stay focused on the views and wishes / best interests of a client in respect to proposed protective measures or is it inevitable than an IMCA will be drawn in the safeguarding adults investigative process?

12. Have your IMCAs dealt with any cases that resulted in legal proceedings? If so, how did you manage these cases?

13. What messages would you like our report to communicate to the Department of Health?

14. Guidance is being developed, what would you like included?

Safeguarding adults Coordinators Interview Questions

Date ____/____/_____
Respondent's Name _____
Respondent's Organisation _____

1. Approximately how many Safeguarding adults cases have you had where an IMCA has been involved? Do you fulfil both safeguarding adults coordinators and MCA Lead roles?

2. What were your Local Authority's main considerations when drawing up its policy for involving IMCAs in safeguarding adults cases?

3. In your assessment do the principles of the MCA and IMCA (empowering and safeguarding best interests) fit well with the principles behind safeguarding adults? (think – protection, support, redress)

4. At what point in safeguarding adults proceedings are you involving an IMCA and why? (think – assessment meeting or planning meeting)

5. The *Expansion Regulations* for involving an IMCA in an safeguarding adults case require you to consider whether involving an IMCA will 'benefit' the person concerned – how do you understand benefit?

6. In your experience is the involvement of IMCA caseworkers in Safeguarding adults proceedings protecting the best interests of vulnerable adults without capacity? (Prompt – for elaboration)

7. In your assessment are there differences between cases where the vulnerable adult is living in a residential home compared to cases where he or she is living in private accommodation? (prompt - difficulties where family have been involved or possible perpetrator, info sharing, assessing capacity)

8. What messages would you like our report to communicate to the Department of Health?

Social Worker Interview Questions

Date ____/____/_____
Respondent's Name _____
Respondent's job _____
Respondent's Organisation _____

1. How many safeguarding adults cases have you been involved in where there has been an IMCA?

2. Thinking about a recent safeguarding adults case where an IMCA was involved could you please – without breaching confidentially – tell me how your client was abused; who abused them; what protective measures were considered and did the police consider a crime had been committed?

3. At what point in the safeguarding adults procedure did the IMCA become involved?

4. Was the IMCA able to communicate the client's wishes and were these considered when making a best interests decision?

5. Were there any other benefits for the vulnerable adult of involving the IMCA in the case? (think – best interests & protect, support and redress)

6. Would you be concerned if the IMCA caseworker had a different understanding of the case from you?

7. Is there anything else you would like to add about involving an IMCA in safeguarding adults cases?

8. What messages would you like our report to communicate to the Department of Health?