

Independent Mental Capacity Advocate Service

A response from Action on Elder Abuse

Action on Elder Abuse is a unique organisation that focuses exclusively on issues relating to the abuse of older people. We do not undertake work of a more generic nature (e.g. pensions representation, general information and advice, insurance provision etc) but instead concentrate on those situations where an older person has been abused by someone they should have been able to trust. Our definition of abuse clearly reflects this objective:

"Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person."

Our charitable object states that we shall promote the relief of elderly people and prevent elder abuse through raising awareness, education, research and the dissemination of information, and we undertake this work across the United Kingdom.

In furtherance of our charitable objectives we are seeking to create of an environment in which the abuse of older people is no longer tolerated and we are doing this, firstly, through increasing the awareness of the public and practitioners as to the nature and extent of elder abuse and, secondly, by facilitating the development of policies, procedures and cultures that both abhor and challenge such abuse.

We believe it is vital that:

It is recognised that elder abuse exists and that it may have a profound effect on the quality of life for older people.

- Both the rights and autonomy of the older person and their possible need to be protected from abuse are recognised.
- All older people have the confidence, knowledge and support to take the action they choose to counter abuse.
- Health and social care practitioners at all levels are trained to recognise the different types of abuse and to respond to the needs of both the abused and the abuser.
- Both health and social service purchasers and commissioners of care have staff and services that are responsive to the needs of the abused and the abuser.
- The responses of all statutory, voluntary and independent agencies to abusive situations are collaborative and appropriate.
- That the position of older people as citizens is given prominence in any intervention work and that they are consequently not perceived solely as victims or as abused people.
- A broad range of research is undertaken to expand knowledge of the issues.

Q 1: Funding: planning assumptions and allocation method

'Form should follow function'

In arriving at a decision on how to allocate funds the Department should focus on what will facilitate the effective development of this vital new service, rather than what will be most convenient administratively. This is consistent with the Act's intention to put people who lack capacity at the centre of the decision making process, and the belief that 'form should follow function'.

Enabling local development may lead to serious shortcomings

Providing local authorities and PCTs with funding, and the responsibility for distributing it, is immediately more attractive than setting up a central system to which bids should be submitted. However, as the funds will not be ring-fenced, and there is not statutory duty to provide the service, there could be significant variations in the commitment shown within and between regions, or between a local authority and the PCT/PCTs operating in its area. This would seem to us to strengthen the case for the Department of Health to play the lead role in managing the budget allocation from dedicated centrally-held funds for a three year implementation period, during which time problems can be identified and remedial actions taken to ensure that a smooth handover to local control can be effected.

Advocacy: a time intensive activity

Such an approach seems to be especially important given that the planning assumptions are so speculative. While we have no way of challenging or verifying the numbers of people in need of the service we are seriously concerned at the under estimate of the time taken to provide the service. There will be substantial variations in the time taken as a result of the complexity of the tasks, and given the importance of face-to-face contact with users of the service the time spent travelling will be a major factor in both urban and rural communities.

Advocacy is presently not well funded and so it will be important to invest in the infrastructure needed to deliver a quality service. This will almost certainly mean that in addition to the ratio of 1 manager to 8 advocates there will be a need for further support staff so that standards are upheld.

Q 2: Commissioning: the options

Balancing strengths and weaknesses

It seems to us that the key choice is between Options 1 and 3; Option 2 while appearing flexible and responsive might leave individual advocates so under supported as to impair the quality of their work, and with too little structure to ensure that they can seek and gain assistance to manage the complex issues that they will inevitably face in acting for people who will use the service.

Being consistent

In view of our belief that in the early stages the funding process should be led and managed by the Department of Health it would seem logical to then support Option 1 where the link between managing funds and overseeing the development of the service is maintained.

It would make sense to devolve both the funds and the responsibility for commissioning at the same time, at a later stage after problems have been identified and then resolved.

...and person centred

It may be that those people who will benefit from the development of the IMCA service are already receiving some form of support from an advocate who has supported and enabled them in relation to other aspects of their lives, building up trust and confidence over time. It will be important to respect and build on this work, even where there is no statutory basis for this having occurred.

A major concern is that IMCAs will not be available to those people who have families or friends. But our experience of running the Elder Abuse Response Line is that such networks are not always focused on the welfare and well-being of the individual and so we believe that there should be discretion to act for people with families and/or friends where circumstances suggest a need may exist.

People who because of their financial status – assets and weekly income - do not attract the interest of care managers to support them in seeking care and in making suitable arrangements, appear to be outside of the proposed service and yet may have an even greater need of the service.

Q 3: National standards

Further protection

We believe that it is vital that the development of this service should be accompanied by a set of National Minimum Standards (NMS), in common with the approach adopted across a range of other services.

Such standards should be devised in association with the various stakeholders, taking time and care to involve the experiences of users as fully as possible.

Applying to organisations and individuals

There is a clear need to ensure that both the individual advocate and the organisation with which s/he is associated are operating within a framework that sets and maintains standards relating to individual performance and organisational competence.

Standards should be based on a set of values that reflect a commitment to respect for users' autonomy and independence, maintenance of

confidentiality, and accountability. Organisations will need to demonstrate that they have the capacity to manage, train and support advocates while keeping accurate documentation – these standards will need to be developed together so that there is a good fit between what organisations can reliably offer and the skills of those whom they deploy to provide the service.

Alongside any values-based standards there are some generalised requirements, expected of any credible organisation in terms of the ways in which it goes about managing its business so as to be accountable for spending public funds. These should govern the operation of any organisation providing the IMCA service.

Q 4: Training and skills

Making links

A key feature of the NMS we propose above should be the level of training and skill available to, and demonstrated by those who provide the service. The specific context for providing the IMCA service will require advocates to have knowledge of a wide range of issues associated with the functioning of health and care services and the ethical and professional codes arranged around them.

They will need skills associated with listening, absorbing complex information, negotiating, report writing and making challenges to decisions made by assessors. In addition advocates will bring their own personal qualities that may mean that they are particularly effective in the way that they set about including and involving people.

We do not have detailed knowledge of the availability of specific training courses and are therefore hesitant to begin prescribing approaches to be adopted. However, it will be important to establish some national standards so that individuals can access appropriate training wherever they may be engaged in providing the service. We have, with financial and professional support from the Department, run a programme of training in matters associated with elder abuse for a round 300 advocates working in a wide range of settings across England.

Training underlines and highlights the need to invest in the infrastructure to support the development of the service, additional to any administrative needs. In some case it may be possible to exploit existing training opportunities, but as the service develops new needs may emerge and funding will be necessary to encourage and enable individuals and organisations to access existing and new 'modules'.

Q 5: Independence

Commissioning, with care

Just as we opened this response by suggesting that 'form should follow function', so we now suggest that respect for independence must be at the heart of the process of commissioning organisations to provide the service.

This would seem to suggest the need for specialist organisations, rather than for larger, long-established organisations to add on a new function to their existing services.

The experience of local authorities - required to establish 'independent arm's length inspection units' (under the terms of the NHS and Community Care Act 1990) – dealings with private and voluntary care providers suggests that it would be unwise to set out to build quasi-independent organisations, as they are open to the accusation of being seen as too close to funding bodies or operating as an extension of the statutory sector. It could be said that this is a feature of the systems for patient and public involvement in health, which has hampered attempts at building the reputation, credibility, independence and reach of PPI fora.

Contracting provides opportunities

Contracts and service level agreements can be made detailed and explicit to include clauses relating to the contractor's obligations to those whom they support rather to those who provide the funds.

If, as the paper suggests the concept of 'independence' is already well recognised within the world of social care, and we believe this to be as variable as many other concepts, it ought to be possible to 'borrow' from those traditions and to devise regulations that mirror the good practice which is already in place. It may prove more difficult to transfer some of that thinking and practice into the health care arena, but difficulties of implementation should not be a reason for not setting out to create such cultural changes as are required.

Q 6: Accountability

Monitoring, evaluation and compliance

Organisations providing the service will find themselves facing in two directions, though this is neither an unusual nor an insurmountable problem. They will need to keep records, as required by the NMS and further illuminated within the contract documentation against which the performance of the service can be evaluated. Where necessary, and in the light of experience and mutual agreement, changes can be made to the contract terms and conditions to enable compliance.

But most of all an organisation providing such a service needs to be judged on the basis of its performance in so far as it enhances the lifestyle, and protects and promotes the best interests of the user.

The Healthcare Commission and the Commission for Social Care Inspection each have skills, standing and authority as organisations inspecting service providers across the public, private and voluntary sectors, and local authorities and health trusts in their roles as commissioners of services. However, these apparent 'qualifications' may also be seen as reasons for compromising their capacity to judge the effectiveness of the interventions made by organisations and individuals which while acting for service users may also be challenging the quality of decision making by organisations which these two regulators have judged to be performing well.

It is worth exploring the scope for developing or making use of existing machinery such as the Legal Services Commission which manages and monitors the legal aid system, or the Advocacy Safeguards Agency operating in Scotland.

Q 7: Functions

Codes of Practice are an excellent way of demonstrating what should be done and how it should be done. The Department should trawl for best practice from within the work of existing services to inform the content of a draft code, on which it should then consult widely with a view to drafting Regulations.

Q 8: Challenging the decision maker

A basic activity

IMCAs should possess the knowledge, skills and confidence routinely to challenge those who have hitherto made decisions. IMCAs should be given the power to appear in court without involving people from the legal profession. A critical issue that may feature regularly is the decision that an individual lacked capacity to make an informed decision about their care, welfare or treatment. The Code of Practice needs to capture the key elements of making such challenges.

Q 9: Additional functions of the IMCA

Part of the local protection systems

IMCAs should have the opportunity to attend and participate in Adult Protection Committees where plans are discussed, and decisions made about the future care of people whose safety may be compromised by the behaviour of family and friends. This highlights the concern expressed in our answer to Q2 where we drew on our experience of callers to the Elder Abuse Response line to suggest that the proposal to exclude those with families and/or friends from the provisions of the IMCA service was ill advised.

Q10: Reviews

Building on existing good practice

The best decisions are those which are reviewed regularly, and where necessary changed in the light of changing circumstances.

If an IMCA had been involved in the original decision then it would seem wise and consistent to seek such involvement in subsequent review activity. However, there are considerable logistical constraints on this, and we are unclear of the extent to which they have been factored into the planning assumptions on which the consultation is based. Taken alongside extant concern about the frequency of reviews more generally, and the relative ease with which they might be sacrificed to other work pressures, we are unconvinced that IMCA services could perform satisfactorily, without matching pressure on commissioners of services from inspectors enforcing good practice general review activity as well as for those who lack capacity.

Challenging inequity

And, as mentioned above in answer to Q2 we are also concerned about those people who may have been outside the care management system due to their financial status, at the time of their admission to a home, and who are due to be reviewed, but who would not trigger a referral to the local IMCA service as s/he did not have such support at the time of the original decision. Using the 'list' of those people who made use of an advocate a year previously as a criterion for accessing the service may reinforce these unhelpful divisions that are unrelated to need or capacity, but simply reflect financial stratification. Guidance makes it clear that assessment of care needs should take place ahead of, and separate from any financial means testing activity. Financial status must not be allowed to become a default criterion for eligibility or access to the services of an IMCA, any more than it should be allowed to become a way of avoiding responsibility for assisting people to navigate their way through the care management maze.

In the event that decisions have been taken without recourse to an IMCA as a result of a medical emergency this should not subsequently be considered a reason to exclude an individual from access to the service. Indeed it may be an even more powerful reason for inviting such access and support for a person lacking capacity whose health status changes and becomes the reason for review or revision.

Q11: Regulations on serious medical treatment

We are unconvinced that producing a list of illnesses or situations giving cause for 'serious medical treatment' is the best way to proceed. We would prefer to see the primacy of a person centred approach leading to individual decisions to invoke the services of an IMCA. Good practice in risk assessment, coupled with due sensitivity to the total situation facing the individual is preferable to a static list of illnesses and conditions that impact on people's lives in different ways.

Q12: Extending the services

Ruling out

First of all we would like to rule out:

Option i (no extension) - given that we have already expressed concern that the current plan for the service is to make it available only to those people without family and friends, and our experience warns against this, we could not support the idea of 'no extension'. Our concern to ensure that those who are meeting their own care costs should not be excluded also leads us to reject this option.

Option vi (allowing local authorities/NHS Trusts to determine priorities) - equally, we feel that to leave the priority setting task to the very authorities whose actions and/or decisions may be up for challenge flies in the face of the ethos and values of the IMCA service.

Extending the reach

There are compelling reasons for supporting each of the remaining four options:

Option ii (more intensive service for most vulnerable) - appears to follow the notion of a needs driven approach though the worry could be that, as has happened with other kinds of service more resources are expended on a diminishing group of people;

Option iii (cases of dispute) - this appears to recognise that families may not always be a source of support and creators of harmony, as suggested by our experience;

Option iv (on request by one party) – again we view this as a positive step as it recognises that there is scope for disharmony within families and between friends.

Option v (extra care housing) – the characteristics of people living independently – but with varying degrees of support - in extra care housing, and the suggestion that even more people who might previously have expected to live the last part of their lives in a care home will live in such settings, points towards the need to include this growing sector of 'housing with care' within the IMCA service arrangements. Such housing is also a potential setting for conflicts and problems between people who might be considered to have 'friends' – their neighbours who become troubled by behaviour that may be associated with diminishing mental capacity.

Action on Elder Abuse
30 September 2005