EXPLANATORY MEMORANDUM TO

THE MENTAL CAPACITY ACT 2005 (INDEPENDENT MENTAL CAPACITY ADVOCATES) (GENERAL) REGULATIONS 2006

2006 No.1832

1. This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

2. Description

2.1 Sections 35 to 40 of the Mental Capacity Act 2005 (the Act) provide that independent mental capacity advocates (IMCAs) must be instructed by NHS bodies and local authorities to represent and support people who lack capacity in the circumstances specified in those sections.

2.2 Section 35(1) also imposes an obligation on the appropriate authority – in relation to England, the Secretary of State – to make such arrangements as she considers reasonable to enable IMCAs to be available in the circumstances set out in sections 37 to 39. Section 35(1) therefore gives the Secretary of State authority to provide funding for the statutory IMCA service.

2.3 This statutory instrument is to be made under sections 35 to 39 of the Act and is subject to the negative parliamentary procedure.

2.4 Section 35(2) and (3) provide that the Secretary of State may make regulations as to the appointment of IMCAs.

2.5 Section 36 gives powers to make regulations on the functions of the IMCA and the steps he must take for the purpose of discharging those functions. Section 36(3) gives power to make regulations on the circumstances in which the IMCA may challenge, or provide assistance in challenging any relevant decision.

2.6 Section 37 makes provision for an IMCA to be appointed when serious medical treatment is proposed by an NHS body. Section 37(6) defines serious medical treatment as ‘treatment which involves providing, withholding or withdrawing treatment’ of a kind to be prescribed in regulations.

2.7 Sections 37 and 38 give power to define the meaning of ‘NHS body’ for the purposes of those sections.

2.8 These Regulations contain definitions of ‘serious medical treatment’ and ‘NHS body’. They also contain provisions as to who can be appointed to act as an IMCA and the IMCA’s functions when he has been instructed to represent a person in a particular case. These functions extend to an IMCA making a challenge, or assisting in making a challenge, to any decision made affecting the person he has been instructed to represent. Under the Regulations, the provisions on appointment and function apply not only where the IMCA is instructed under sections 37 to 39 of the Act but also where he is instructed under regulations made under section 41 of the Act.

2.9 These Regulations are drafted to come into force on 1 November 2006 for the purposes of enabling the Secretary of State to make the arrangements provided for in the Regulations and on 1 April 2007 for all other purposes.

3. Matters of Special Interest to the Joint Committee on Statutory Instruments

3.1 This is the first use of the powers contained in sections 35-39 of the Act.

3.2 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 which are subject to the affirmative parliamentary procedure, have been laid in draft before Parliament on 13 July 2006 under the power in section 41 of the Act. The effect of these Regulations is outlined below.

4. Legislative background

4.1 The Mental Capacity Bill introduced to Parliament in June 2004 included provision for an “independent consultee” in response to concerns about a lack of safeguards for particularly serious health and welfare decisions in the draft Mental Incapacity Bill published in June 2003. The name of the independent consultee service and the functions were changed during the passage of the Bill, to reflect concerns that independent advocacy was key to both empowering and protecting the most vulnerable people who lack capacity to make decisions about their health and social care.

4.2 Sections 35 to 41 of the Mental Capacity Act 2005 provide for IMCAs to be available in specified circumstances to support and represent particularly vulnerable people who lack capacity to make certain important decisions.

4.3 During the passage of the Bill Ministers committed to consulting with stakeholders on how the regulation making powers in sections 35 to 41 would be used. (Hansard 2 November 2004 cols 324 and 338). The powers cover the appointment of IMCAs, the function of IMCAs and the steps required in fulfilling the IMCA role, the circumstances in which an IMCA may challenge, or provide assistance for the purpose of challenging, and the definition of ‘serious medical treatment’, as well as extending the IMCA service to other groups and situations.

4.4 Sections 37 to 39 of the Act set out the circumstances in which an IMCA must be appointed. These are:

- where an NHS body proposes to provide, withdraw or withhold serious medical treatment in relation to P (serious medical treatment is defined in the Mental Capacity Act 2005 (Independent Mental Capacity Advocates)(General) Regulations 2006 using the power in section 37(4) of the Act);

- where an NHS body or local authority propose to make certain arrangements as to P's accommodation in a hospital or care home or in residential accommodation provided in accordance with sections 21 or 29 of the National Assistance Act 1948 (c.29) or section 117 of the Mental Health Act 1983.

4.5 However an IMCA need not be appointed under these provisions unless there is no-one (other than a paid carer) whom it would be appropriate to consult in determining what would be in P's best interests. Further, section 40 provides that no IMCA need be appointed where P has nominated someone who should be consulted or where he has created an Enduring Power of Attorney, a Lasting Power of Attorney (LPA) or the Court has appointed a deputy for him.

4.6 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 provide for additional circumstances in which IMCAs may (not must) be instructed by an NHS body or local authority. These are:

- where 'qualifying arrangements' have been made by an NHS body or local authority as to the accommodation of a person ('P') who lacks capacity and a review of the arrangements is proposed or in progress;

- an NHS body or local authority propose to take protective measures in relation to P, in accordance with guidance issued by the Secretary of State under section 7 of the Local Government Social Services Act 1979 (c.42), following allegations of abuse or neglect of P or abuse of another on the part of P.

Definition of NHS Body

4.7 Regulation 3 sets out the definition of NHS body for the purpose of sections 37 and 38 of the Act. These are bodies in England which are Strategic Health Authorities, NHS foundation trusts, Primary Care Trusts, NHS Trusts or Care Trusts.

Serious Medical Treatment

4.8 Section 37(6) of the Act defines 'serious medical treatment' as 'treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations'.

4.9 Regulation 4 prescribes certain kinds of treatment by reference to characteristics of the treatment. The provision, withholding or withdrawal of such treatment is to be considered serious and an IMCA must be involved. The characteristics specified in Regulation 4 are where the decision to be made as to treatment is finely balanced, whether between the risks/burdens versus perceived benefit of a treatment or in choosing between difference treatments. It also applies where what is proposed is likely to involve serious consequences for the patient.

Examples of medical treatments that might be considered serious will be included in the Code of Practice.

4.10 The Act provides that if treatment needs to be provided to a person as a matter of urgency, it may be provided even though the NHS body has not been able to instruct an IMCA to represent the person.

Appointment requirements

4.11 Regulation 5 specifies certain minimum requirements that a person must meet in order to be appointed as an IMCA. These will apply to an IMCA whether he is instructed to act under section 37 to 39 or under regulations made by virtue of section 41. In order to act as an IMCA, a person must be approved by a local authority as meeting the appointment requirements. The IMCA service will generally be commissioned by local authorities in partnership with NHS bodies but the Regulation permits direct approval by a local authority.

4.12 The appointment requirements are as follow. The person must have appropriate experience and/or training; he must be a person of integrity and good character; and he must be able to act independently of anyone who instructs him to act as an IMCA. Regulation 5(3) expands on the requirement as to integrity and good character by specifying that a criminal record certificate or enhanced criminal record certificate must be obtained. In order for this to happen, provision must be made under sections 113A and 113B of the Policy Act 1997 to allow such certificates to be issued in relation to persons acting as IMCAs. We are taking steps to secure that the necessary provision will be in place by the time IMCAs come to be appointed.

Functions

4.13 Regulation 6 sets out the steps that the IMCA must take when he has been instructed to represent a person (“P”). The instructions must be given by someone (referred to as an ‘authorised person’) who is required or enabled to do so under the Act.

4.14 Regulation 6(3) states that the IMCA must decide in all the circumstances how best to represent and support P. Under Regulation 6(4), he has to verify that his instructions were properly issued, interview P, examine records about P to which the IMCA has access under section 35(6) of the Act, consult certain persons who may be in a position to comment on P’s wishes, feelings, beliefs or values and obtain any other information about P, or the act or decision that is proposed, as the IMCA thinks necessary. The IMCA is not required to take certain steps if it is not practicable or appropriate for him to do so.

4.15 The IMCA must then evaluate all the information in order to ascertain what support was provided to enable P to participate in making the decision in question, ascertaining what his wishes and feelings would be likely to be and what alternative courses of action are available. Where medical treatment is proposed, the IMCA must ascertain whether P would be likely to benefit from a further medical opinion. Finally, the IMCA must prepare a report for the authorised person who instructed him.

4.16 Under section 37 to 39 of the Act, and under the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, the NHS body or local authority must take the IMCA's report into account in making a decision.

Challenging decisions

4.17 Regulation 7 sets out that an IMCA can challenge decisions affecting persons who lack capacity. Regulation 7(2) gives the IMCA the same rights to challenge the decision as he would have if he were a person (other than an IMCA) engaged in caring for the person or interested in his welfare. The right of challenge extends to decisions that a person the IMCA is representing is a person who lacks capacity.

5. Extent

5.1 This instrument applies in relation to England.

6. European Convention on Human Rights

6.1 As the instrument is subject to the negative resolution procedure and does not amend primary legislation, no statement is required.

7. Policy Background

7.1 The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions, for example because of a learning disability, an illness such as dementia or brain injury or mental health problems. The clauses covering IMCAs were introduced into the Mental Capacity Bill in June 2004, in response to concerns about a lack of safeguards for the most vulnerable people in society, when facing particularly serious health and social care decisions.

7.2 The duty to involve an IMCA under sections 37 to 40 of the Act only applies to people who lack capacity to make certain decisions and who have no one whom it would be appropriate to consult as to their best interest. Under those sections of the Act, people who have the support of family or friends or those who have a power of attorney or a deputy under the Act will not have access to an IMCA.

7.3 The Government consulted between 5 July and 30 September 2005 on the details of the IMCA service, about how the regulation making powers should be used, about the operation and implementation of the service and about whether the service should be extended to other groups of people and situations.

7.4 There were 176 written responses to the consultation. In addition, some 450 people attended events to publicise the consultation. A summary of consultation responses and the Government's response to the consultation was published on 19 April 2006 and can be found at www.dh.gov.uk/consultations/closedconsultations

7.5 In the context of the definition of ‘serious medical treatment’, it was clear from responses to the consultation that it would be difficult to provide a definitive list of treatments to be considered ‘serious medical treatment’ and any list would be subject to change over time. Regulation 4 therefore specifies the characteristics of treatment which, if that kind of treatment is provided, withheld or withdrawn, will count as serious medical treatment.

7.6 Respondents to the consultation generally considered that there should be a national standard in relation to the qualifications that an IMCA must have. In response to this, the Government has decided that IMCAs should have specific training. The appointment requirements at Regulation 5(2) specify that a person must have appropriate experience or training or an appropriate combination of both to act as an IMCA. At this stage it is not possible to refer to a specific qualification. A national advocacy qualification is being developed which could be accredited by the Qualifications and Curriculum Authority (QCA) and provided by an awarding body such as the Open College Network (OCN). However, this qualification will not be available before April 2007 when the Act comes into force. In the meantime, all those appointed to act as IMCAs will be provide with induction training.

7.7 Most respondents to the consultation considered that the purposes listed in the power conferred by section 36 of the Act (see subsection (2)) fairly adequately outlined the role that they expected an IMCA to play. The functions, as specified in Regulation 6(5), reflect this.

7.8 As part of those functions, an IMCA may need to challenge a decision made by an NHS body or local authority or about the process that has been followed in relation to a person who lacks capacity. Regulation 7 reflects this and it is intended that IMCAs will use existing complaints mechanisms to resolve disputes locally as far as possible, before making use of statutory procedures. In certain cases, the IMCA may want to apply to the Court of Protection and he will be able to do so under the Act. There will be new Court of Protection rules of court to govern practice and procedures of the new Court of Protection (as provided in Part 2 of the Mental Capacity Act 2005).

8. Impact

8.1 A Regulatory Impact Assessment and Race and Equality Impact Assessment have been prepared for this instrument and are attached. They also cover the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006. Overall there will be no significant impact on businesses or the voluntary and charitable sector as a result of these regulations.

8.2 Any additional burdens will be offset by funding (of £6.5m per annum) to run the IMCA service and funding (of over £12m) to develop a programme for raising awareness and educating and training an estimated three million health and social care staff in the Mental Capacity Act 2005. This is in addition to funding of £6.5m to set up the IMCA service, including funding estimated at around £2.6m to train IMCAs during 2006/7. The intention is to commission the IMCA service locally with funding devolved through local authorities.

9. Contact

Sheila Evans at the Department of Health Tel: 020 7972 4332 or e-mail: sheila.evans@dh.gsi.gov.uk can answer any queries regarding the instrument.

REGULATORY IMPACT ASSESSMENT

1. Title

Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006

and

Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006

2. Purpose

2.1 The Mental Capacity Act 2005 (the Act) provided the statutory framework for a new service, the Independent Mental Capacity Advocate (IMCA) service. Its purpose is to help particularly vulnerable people who have no family or friends and who lack capacity to make important decisions about serious medical treatment and changes of residence, for example, moving to a hospital or a care home. The provisions in the Act are intended to come into force from April 2007.

2.2 The Act set out the basic framework for the IMCA service. These two instruments are the first use of the powers contained in sections 35 to 41 of the Act. The 'General' Regulations are covered in paragraph 5 below and the Regulations relating to 'Expansion of Role' of the IMCA service are covered in paragraph 6 below.

2.3 The purpose of the regulations is to set out the detail on how the IMCA service will be set up, in particular they:

- set out how the IMCA will be appointed under the powers in sections 35(2) and (3),
- set out the functions and role of the IMCA and how the IMCA can challenge decisions,
- define 'serious medical treatment' under the powers in section 37(6)
- define the term "NHS body" under the powers in section 37(7), and
- set out how the powers to expand the IMCA service to other groups and situations will be used under the powers in section 41.

2.4 This regulatory impact assessment (RIA) and race and equality impact assessment (REIA) - see Appendix A - apply in relation to England only. The RIA and REIA cover the two sets of regulations.

3. Background

3.1 The Mental Capacity Act 2005 provides a statutory framework for people who may not be able to make their own decisions for example because of a learning disability, an illness such as dementia or brain injury or mental health problems. The Act sets out who can take decisions, in which situations, and how they should go about this.

3.2 The clauses on the IMCA service were introduced into the Mental Capacity Bill in June 2004 in response to concerns about a lack of safeguards for particularly serious health and welfare decisions for the most vulnerable people, in the draft Mental Incapacity Bill published in June 2003.

3.3 The duty to involve an IMCA only applies to people who lack capacity to make certain important decisions and who have no family or friends. Under the Act, people who have the support of family or friends or those who have an Enduring Power of Attorney, a Lasting Power of Attorney (LPA) or a deputy under the Act will not have access to the IMCA service.

3.4 The Act includes regulation making powers to extend the service to other groups and situations and the regulations covering Expansion of Role use these powers.

4. Consultation

4.1 During the Parliamentary passage of the Act, the Government committed to consulting with interested parties about how the regulation making powers relating to the IMCA should be used.

Consultation within Government

4.2 Consultation within Government on the regulations largely involved the Department of Health (with responsibility for health and social care issues), the Department for Constitutional Affairs (DCA) (with responsibility for mental capacity issues), the Wales Office, the Home Office, the Department for Communities and Local Government and the National Assembly for Wales.

4.3 Implementation of the Mental Capacity Act is led by the Department for Constitutional Affairs, but the Department of Health is leading on the policy on the IMCA service.

Public Consultation

4.4 The Government consulted between 5 July and 30 September 2005 on regulations to be made on the IMCA service. These included:

- the operation of the IMCA service, including issues such as funding, commissioning the service, standards, training and skills needed,
- how to ensure the independence of the IMCA,
- monitoring and accountability,
- the main functions the IMCA will carry out,
- definitions of serious medical treatment, and
- whether to extend the IMCA service beyond people who have no families or friends and to situations other than serious medical treatment and accommodation.

4.5 There were 176 written responses to the consultation including individuals, the NHS and local authorities, organisations representing healthcare, independent advocacy organisations, regulatory bodies (including the Commission for Social Care Inspection and Ombudsman), and other regional and national independent sector providers and stakeholder organisations representing people who lack capacity. In addition, some 450 people attended events to publicise the consultation.

4.6 A summary of consultation responses and the Government's response to the consultation was published on 18 April 2006 and can be found at www.dh.gov.uk/consultations/closedconsultations . The Executive Summary and the Government response have been made available in an accessible version, and in Arabic, Bengali, Chinese, Gujurati, Punjabi and Somali. CD-Rom and braille versions are also available on request. Details of the consultation issues and the Government's response can be found at Annex A.

5. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates)(General) Regulations 2006

5.1 This statutory instrument is made under sections 35-40 of the Act and sets out:

- the definition of serious medical treatment,
- the appointment criteria for independent mental capacity advocates (IMCAs),
- the detail of the role of the IMCA and how the IMCA can challenge decisions,
- a definition of the meaning of 'NHS body' for the purposes of sections 37 and 38 of the Act.

Serious Medical Treatment (SMT)

5.2 Section 37(6) of the Act defines 'serious medical treatment' as 'treatment which involves providing, withholding or withdrawing treatment of a kind prescribed by regulations'. Respondents to the consultation were clear that it would be impossible to provide a definitive list of such treatments and any list setting out particular treatments would be subject to change over time. The regulations therefore set out the characteristics of treatments where an IMCA should be involved and where providing, withholding or withdrawing treatment is to be considered serious. Factors include the risk or burdens versus perceived benefit of the treatment or where the choice between treatments is unclear; or where the treatment would have serious consequences for the person. Examples of medical treatments that might be considered serious will be included in the Code of Practice.

5.3 Decision makers will only consult with an IMCA where 'serious medical treatment' is proposed to be provided or arranged by NHS bodies where the person lacks capacity to make the decision and there is no one appropriate to consult. This should not therefore impose a significant additional burden on decision makers. Information provided by the IMCA may serve to clarify a decision. Furthermore, decision makers would consult family or friends, in cases where it was not appropriate for an IMCA to be instructed, when treating someone who lacked capacity and serious medical treatment was proposed.

Appointment

5.4 The intention is to commission the IMCA service locally with funding devolved through local authorities. £6.5m per annum has been agreed to meet the running costs of the IMCA service. Commissioning arrangements will be made administratively with commissioning guidance developed centrally. We want to encourage local authorities within one area to work flexibly and in partnership to commission the IMCA service across boundaries. This could maximise use of the resources in some areas if, for example, local authorities were to make ‘lead commissioner’ arrangements.

5.5 The intention is that existing independent advocacy organisations will provide the service and many will already have administrative arrangements and standards of good practice in place. The additional burden imposed by these regulations will be minimal and encourage good practice and raise standards.

5.6 Regulation 5 on the appointment of independent advocates providing the IMCA service, set out the minimum standards that they have to meet. These include checking that a person is of good integrity and character by undertaking criminal records bureau type checks prior to appointment and taking up references. The cost of these checks will be met from running costs.

Independence

5.8 The regulations specify that the IMCA must be able to act independently of any person responsible for instructing him to act as an IMCA. This will form a part of the contracting process and will not represent an additional burden on local authority commissioners.

Training

5.7 The regulations provide that all IMCA advocates should have appropriate training and experience or a combination of training and experience. The intention is that all IMCAs receive appropriate training to help ensure a common standard of skills and knowledge. The cost of developing a national advocacy qualification will be met through Department of Health funding (see paragraph 7.4 below) together with induction training for those IMCAs appointed before the full training has been approved and accredited. This regulation does not impose any additional burdens.

Functions

5.10 The regulations sets out the detailed steps that the IMCA must follow when they have been instructed to represent a vulnerable person, to fulfil the functions set out in section 36(2) of the Act. Regulation 6 describes the duties of the IMCA but does not impose additional responsibilities beyond those set out in the Act.

Challenging decisions

5.11 IMCAs will use existing complaints mechanisms to resolve disputes locally as far as possible when these arise about a decision made by an NHS body or local authority, or about the process that has been followed in reaching a decision, in relation to a person who lacks capacity. Additional funding has been made available to meet the cost of complex cases including disputed cases as well as the situation where an IMCA takes a case to Court (see table of costs at paragraph 7.4 below).

6. The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006

Options for extending the IMCA service

6.7 The RIA for the IMCA consultation exercise set out the options for extending the IMCA service. These are set out at Annex A. The response to the consultation, including the Government response was published on 19 April 2006 and can be found on the DH website at: www.dh.gov.uk/consultations/closedconsultations

Increasing time from 4 to 8 hours per decision

6.1 Following consultation, the Government decided to look again at the planning assumptions underlying provision of the service and to increase the time allowed for each decision from four to eight hours. This meets the concerns of many who responded that the service should aim to provide an effective service for those covered already without seeking to extend statutory provision to other groups and situations (option ii in the consultation – see Annex B). The cost of this measure will be met from existing funding. The table at paragraph 7.4 below sets out the implications.

Extending service

6.2 Section 41 of the Act provides that the IMCA role can be expanded, by regulations, to other sets of circumstances. This statutory instrument gives local authorities and NHS bodies the power to extend the IMCA role to specified groups and situations (option vi in the consultation – see Annex B). They specify the circumstances in which local authorities may provide the IMCA service on a discretionary basis. These include involving the IMCA in a care review following a change of accommodation and in adult protection cases.

6.3 The regulations allow that, when accommodation arrangements have been made for a person who lacks capacity to agree to the arrangements, and a review of the arrangements is proposed, then the NHS body or local authority may instruct an IMCA to be available to represent and support the person. Statutory guidance under Section 7 of the Local Authority Social Services Act 1970 sets out current requirements for care reviews. Involving an IMCA should not place a significant additional burden on local authorities since reviews will already be undertaken and an IMCA only instructed in certain cases.

6.4 The regulations specify that an IMCA may be made available to represent and support a person, where an NHS body or local authority proposes to take, or has taken, protective measures, including measures to minimise risk. The regulation applies in relation to the person who lacks capacity to agree to one or more of the measures. An IMCA will only be instructed in adult protection cases where proceedings following guidance issued under Section 7 of the Local Authority Social Services Act 1970 have already been instigated. The IMCA involvement will not increase the number of cases and may serve to clarify a situation and avoid lengthy proceedings.

6.5 In using these discretionary powers, the NHS body or local authority must be satisfied that it would be in the benefit of the person who lacks capacity to be represented by an IMCA and they must take into account any information or report made by the IMCA in making a decision.

6.6 The Government will evaluate the IMCA service after the first year of implementation to determine if it sufficiently addressed the advocacy needs of the unbefriended. At that time, it may be possible to consider using regulation-making powers to extend access to other groups or situations if resources allow.

7. Set up and running costs

Set up costs for IMCA service

7.1 Set up costs for the IMCA service have been estimated at £6.5m for 2006/2007. £2.2m will be made available to local authorities to tender for and commission the IMCA service to enable independent advocacy organisations to employ people to act as IMCAs from January 2007. A further £500k will be used to develop and rollout a data base for collection of information about the IMCA service. £500k has been allowed to fund 7 organisations to run the IMCA service on a pilot basis between January 2006 and December 2007. These costs do not represent any additional burdens on local authorities or NHS bodies.

Training for IMCAs

7.2 The regulations require that all IMCAs receive ‘appropriate’ training. Overall IMCA training costs have been estimated at £2.6m for 2006/7. This includes costs for developing the IMCA training qualification and for developing an additional induction training package for IMCAs recruited in advance of the full training being available. None of these costs represent additional burdens on NHS bodies or local authorities and will be met by the Department of Health.

Costs for awareness raising and developing training

7.3 A programme for raising awareness and educating and training an estimated three million health and social care staff in the Mental Capacity Act generally, at a cost of over £12m is being developed. These costs are included in the set up costs for the Mental Capacity Act 2005 itself. As many staff as possible will receive a cascaded presentation before April 2007.

Ongoing running costs

7.4 Running costs are estimated at £6.5m per annum from April 2007. The table below shows the breakdown of expenditure adopting options (ii) and (vi) with no increase in the allocated annual budget of £6.5m. The Department of Health is providing annual running costs of £6.5m devolved to local authority commissioners for the IMCA service which should result in no additional costs to the frontline.

Original estimates - £6.5m

providing the IMCA to around 16,000 people who have no family or friends, at 4 hours per decision: 16,000 x £100	**£2.6m per annum**
dealing with 2,270 (14%) more complex cases (at an additional 4hours per decision) 2,270 x £100	**£227k per annum**
Any disputes arising on these cases, including taking the cases to Court	**£273k per annum**
extending the service to other groups and situations	**Up to £3.4m**

Revised estimates - £6.5m - options (ii) and (vi)	
providing the IMCA to around 16,000 people who have no family or friends, at 8 hours per decision: 16,000 x £200 (option ii)	**£3.2m per annum**
dealing with 4,000 (25%) more complex cases and any disputes arising on these cases, at an additional 8 hours per case: 4,000 x £200	**£800k per annum**
Giving local authorities discretion as to when to involve an IMCA* (option vi).Up to 12,500 extra cases at 8 hours per case: 12,500 x £200	**£2.5m per annum**
* This may include bringing in an IMCA in care Reviews or adult protection case where appropriate.	

8. Social impact (including Health Impact)

8.1 The regulations allow NHS bodies or local authorities discretion to involve an IMCA in care reviews and in adult protection cases. Involving an IMCA in care reviews will help to provide people with the most appropriate living conditions with the best use of resources for treatment and care. This has the potential to increase choice and well-being of vulnerable adults.

8.2 Involving an IMCA in adult protection cases, may help prevent and minimise the risk of abuse for particularly vulnerable adults.

8.3 The number of additional decisions where an IMCA may be involved as a result of the regulations could increase by up to 12,500. This would not mean an increase in running costs which remain at £6.5m per annum.

9. Equity and fairness

9.1 The Mental Capacity Act 2005 already provides for IMCAs for people who lack capacity who have no family or friends. The regulations on Expansion of Role extend the service to more people who lack capacity. People with learning disabilities, older people, people with mental health problems and those with brain injuries and degenerative conditions are all likely to benefit.

10. Rural proofing

10.1 There is no reason to believe that the distribution of people affected will differ in any significant way between urban and rural areas, and also no reason to suppose that the regulations will impact on rural areas any differently from the way they affect other areas.

11. Environmental impacts

11.1 There is no environment impact arising as a result of these regulations.

12. Consultation with small business: the Small Firms' Impact Test

12.1 The regulations may impact on small businesses. The "small businesses" most likely to be affected are independent hospitals, care homes and independent advocacy organisations. The impact upon them is uncertain at this stage but we anticipate that the impact of the introduction of the IMCA service generally may be to drive up standards although it may also result in some additional bureaucracy for independent advocacy organisations as they appoint and train IMCAs and receive referrals from NHS bodies and local authorities. Any additional costs should be included in the commissioning tender.

13. Competition Assessment

13.1 The introduction of the IMCA service and the measures introduced through these regulations are not expected to have a significant effect on competition as most of the resource implications are anticipated to impact on NHS bodies and local authorities. It is possible though that the proposals could have different effects on different independent hospitals and care homes, and thus affect their charges differently. They may also affect competition among independent advocacy organisations.

14. Enforcement and Sanctions

How will the proposal be enforced? Who will enforce this legislation?

14.1 The IMCA service already has a legislative base in the Mental Capacity Act 2005. The extension of the service through these regulations introduces a legal requirement to adhere to those arrangements. People who lack capacity, or others acting on their behalf, will have recourse to the courts, including the European Court of Human Rights.

Will the legislation impose criminal sanctions for non-compliance?

14.2 The legislation will not impose criminal sanctions for non-compliance.

15. Monitoring and Review

15.1 The Government believes that compliance with standards should primarily be part of contract monitoring, validated by performance assessment and service inspection evidence gathered by commissioners and by CSCI or HC. All contracts or engagement protocols between the commissioner and IMCA service provider will include agreed complaints procedures. All IMCA advocacy services will have a clear and accessible complaints procedure and be required to report complaints about them to their commissioning body.

15.2 The Department will produce an annual report on the IMCA service for the first three years following implementation. The Department with the DCA will also review any regulations made after three years.

16. Summary and Recommendations

Summary

16.1 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 are made under sections 35-40 of the Act. In summary they cover the appointment of IMCAs, training, independent, functions the challenging role of IMCAs and a definition of NHS body. Annual funding of £6.5m is being provided to fund the service with additional set up and training costs during 2006/7.

16.2 The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006 are made under section 41 of the Act. They give local authorities flexibility to extend the IMCA service within the resources available to other vulnerable groups and situations.

16.3 In summary, there are no significant additional costs or burdens imposed on local authorities, NHS bodies, small businesses or the charity and voluntary sector as a result of these regulations. Any additional burdens, such as appointing and training IMCAs that result will be balanced by annual funding provided.

Recommendation

16.4 The recommendation is that both sets of Regulations are accepted as set out in this RIA.

17. Declaration

To be completed when Regulations are laid.

I have read the regulatory impact assessment and I am satisfied that the benefits justify the costs

Signed Rosie Winterton

Date 7th July 2006

Rosie WINTERTON, Minister of State for Health Services, Department of Health

Contact point

Sheila Evans at the Department of Health Tel: 020 7972 4332 or e-mail: Sheila.evans@dh.gsi.gov.uk

Annex A

Summary of consultation on Independent Mental Capacity Advocate (IMCA)Service

General Regulations

Serious Medical Treatment (SMT)

Nearly all respondents thought that it would be impossible to have a definitive list of treatments that covered all serious medical treatment decisions relevant for the IMCA service and that the best approach was to define the characteristics of the decision that made it serious. The regulations therefore set out the characteristics of treatments where an IMCA should be involved, including the risk or burdens versus perceived benefit and choices between treatments. Examples of medical treatments that might be considered serious are to be included in the Code of Practice.

Commissioning

The majority of respondents to the consultation were in favour of IMCAs being appointed locally. The intention is to commission the IMCA service locally with funding devolved through local authorities. Local authorities will commission independent advocacy organisations in partnership with PCTs to provide the IMCA service for NHS bodies and local authorities in their locality, although the IMCAs will have the flexibility to work across boundaries if required. The regulations do not specify the local authority commissioning role but separate guidance on commissioning is being developed.

Independence of IMCAs

Most respondents thought that maintaining the independence of the IMCA from service providers was vital to the success of the service, and that this should be achieved through commissioning contracting arrangements with independent advocacy organisations. The Government agreed that it was important that;

(a) they must be completely independent of any person responsible for instructing the IMCA; and
(b) IMCA must not have any professional or paid involvement with the provision of care or treatment for any vulnerable person for whom they may be appointed to act;

The original intention was to put this in the code of practice but to make this even more clear, regulation 4(2) sets out the independence criteria (a) while (b) will be included in the Code of Practice.

Training for IMCAs

Most respondents agreed that IMCAs should have specific training and that this should be provided by local colleges or universities. The regulations provide that all IMCA advocates should receive appropriate training to help ensure a common standard of skills and knowledge. It is planned to develop a national advocacy qualification, which may be accredited by Qualifications and Curriculum Authority (QCA) and provided by an awarding body such as the Open College Network (OCN). However, this qualification will not be available before April 2007. The intention is therefore to provide all those appointed to act as IMCAs with induction training. Regulation 4 therefore refers to appropriate training and experience rather than referring to a specific qualification.

Standards

Nearly all respondents (97%) thought that there should be national standards for both individual advocates and for the independent advocacy organisations commissioned to provide the service. The Government response stated that regulations on the appointment of independent advocates providing the IMCA service should set out the minimum standards that they should have to meet. This should include requiring individual advocates to undergo Criminal Records Bureau checks prior to employment. Where relevant disclosures under those checks are made, the advocate should not be able to work as an IMCA. Independent advocacy organisations who will be commissioned to provide the IMCA service should also have to meet appropriate organisational standards as part of the commissioning/contract arrangements. This is covered under regulations 4.

Functions of IMCAs

Respondents were content with the functions listed in s36(2). Regulation 6 sets out the detailed steps that the IMCA must follow to fulfil these functions, to the extent that it is practicable and appropriate to do so, when they have been instructed to represent a vulnerable person. IMCAs will be required to submit a report of their findings.

Challenging decisions

Respondents to the consultation saw challenging as a key element of the IMCA’s role. There will be situations where disputes arise about the decision made by an NHS body or local authority or about the process that has been followed in relation to a person who lacks capacity. In such cases, the IMCA will use existing complaints mechanisms to resolve cases locally as far as possible. Respondents were divided on the question of whether IMCAs should be able to bring simple cases to Court as a last resort where there is no other way of resolving a dispute. Some thought IMCAs should have this function if they had training to do so while others felt this was outside the IMCA role or could only be done with legal support.

Regulation 7 set out the circumstances in which the IMCA can challenge or assist in challenging the decision maker and specify that an IMCA will be able to apply direct to the Court of Protection for a decision. Regulation 7 provides that an IMCA will be in the same position as an ‘ordinary friend’ or relative of the person who lacks capacity and will therefore need to seek permission of the Court of Protection to make an application. Challenges can include the decision that the person lacks capacity.

Expansion of Role Regulations

Extending the IMCA service

The consultation exercise asked for views on six options for extending the service to other vulnerable people who lack capacity who may benefit from an IMCA or other circumstances where the IMCA should be appointed. The six options were: (i) no extension; (ii) a more intensive service to the most vulnerable; (iii) provide an IMCA in cases of dispute; (iv) provide an IMCA where requested by one of the parties; (v) extra care housing; (vi) allowing LAs and/or NHS bodies to determine priorities.

Options

Responses were varied with no clear preference for one option. The Government's main priority, set out in the consultation response, is to introduce safeguards to protect the rights of individuals who do not have family or friends to advocate on their behalf. The Government is also mindful of concerns about introducing a good quality service for this group before looking to extend it further. There were concerns expressed in the consultation responses about the average time allowed for IMCAs as set out in the planning assumptions. These have therefore been revised along the lines of option (ii) to provide a more intensive service for those who have no family or friends.

In addition, responses to the consultation were concerned that there may be other situations, beyond those listed in the Act, where a person who lacks capacity may be particularly vulnerable. The regulations therefore allow LA commissioners flexibility to extend the IMCA service within the resources available to other vulnerable groups and situations. The regulations specify those other circumstances in which LAs and NHS bodies may provide the IMCA service on a discretionary basis along the lines of option (vi). These include involving the IMCA in a care review following a change of accommodation and in adult protection cases. Policy on care reviews is already good practice under statutory guidance issued under Section 7 of of the Local Authority Social Services Act 1970.

Option (i)

No additional costs beyond the estimated £3.1m for providing an IMCA for the 16,000 decisions involving people who are unbefriended. Additional costs for NHS and social care professionals were included in the Regulatory Impact Assessment for the Mental Capacity Act 2005. Additional costs were estimated at £8.2m for health care and £3.8m for social care per annum.

Option (ii)

This option would provide a more intensive service for the most vulnerable group – those who have no family or friends. The Government has now decided to revise estimates to give IMCAs 8 hours per decision and per review, this will cost an estimated £3.2m. Costs for health and social care staff would be as per option (i).

Option (iii)*

Under this option, the IMCA would be available where there is a dispute between the individual, family and health or social services about the serious medical treatment or long term care to be provided.

Disputes between the decision maker and the person who lacks capacity or their family are already provided for by existing complaints mechanisms in both health and social care.

Costs would depend on starting assumptions about the likely number of complaints or disputes. If disputes formed 13% of cases and 1% of these went to court, the estimated costs would be an additional £2.5m on top of option (i). Costs to health and social care staff would be as per option (i).

Option (iv)*

Providing an IMCA where requested. Additional public sector costs for England would range from an estimated additional £2.7m (assuming a take-up rate of 33%) to £6.8m (assuming a 75% take-up rate). Costs to health and social care staff would be as per option (i).

Option (v)* - Extra care housing.

This option would seek to extend the IMCA safeguard to people who lack capacity who are supported in extra care housing. For example, when someone is threatened with eviction. Estimated additional costs would range from around £160,000 if this affected 10% of people who lacked capacity in extra care housing, to £530,000 if it affected 33% of the people who lack capacity.

*These costs are based on allowing 4 hours per decision.

Option vi) -Allowing Local Authorities and/or NHS bodies to determine priorities

This option, covered by the regulations, will enable LAs, who commission the IMCA service in consultation with NHS bodies, to determine who are the most vulnerable people within their localities, within specified options, and to commission services accordingly.

Annex B

Basis for costs

Frequency of cases

The Department of Health has estimated that, at any point in time, 1.2 million people in England and Wales are likely to lack capacity to make decisions. Of these, around 155,000 have severe and profound learning disability, and around 350,000 have severe dementia.

Only a small proportion of these people are likely to face particularly significant decisions every year. We have estimated that there might be 39,000 decisions every year about serious medical treatment and 69, 000 decisions about moves into or between long-term care.

Of these people facing particularly serious decisions we estimate that around 15% do not have friends or family to be consulted in the decision-making process. The figure was estimated using a number of different research reports about the different client groups who may lack capacity.

Therefore the planning assumptions have included estimates of about 16,000 decisions each year in England that would require the involvement of an IMCA. The 16,000 decisions covers around 6,000 decisions about serious medical treatment and 10,000 decisions about care moves. These estimates will be reviewed following the evaluation of the IMCA pilots.

Basis for costs

The estimated total cost of one advocate is £25 per hour. This figure includes all costs such as management salaries, training, and accommodation. This would allow for an advocate salary of around £25,000 and a manager's salary of around £30,000. These are consistent with the average salaries used by the IMCA pilot organisations. The intention is that IMCAs will be commissioned from existing advocacy providers rather than from new organisations set up for the purpose of providing the IMCA service.

Following the consultation, planning assumptions have now been changed so that each advocate session will now last approximately 8 hours, the average cost per session now estimated at £200 with an advocate completing an average of 4 sessions a week. The cost per session was estimated at £172 per advocate and £26 per manager – or £200 per session. Additional costs for complex cases or where cases were disputed were estimated at £200 per case.

Additional costs for NHS and social care professionals were included in the Regulatory Impact Assessment for the Mental Capacity Act 2005. The workforce and costing model to assess cost impacts for the Act identified decisions involving people who lack capacity about significant medical decisions and about where they lived as the key areas where additional costs might accrue. Such decisions would usually involve activities or processes in which health and social care staff would be involved e.g. assessment, case conference and patient discussion.

By estimating the likely frequency of such activities or processes for each decision point before and after the Act it was then possible to estimate the annual staff cost in each case for health and social care professionals, such as doctors, nurses, social workers, care assistants. It was then possible to estimate the annual cost for each case. Allowance was made both for where processes might be quicker and for where there might not be best practice at the moment.

For the expected effects on cost of the IMCA see the Regulatory Impact Assessment for the Mental Capacity Act 2005 - available at:

http://www.dca.gov.uk/menincap/legis.htm

For the workforce requirements for the IMCA, including effects on health and social care professionals see the explanatory notes to the Mental Capacity Act - available at:

www.opsi.gov.uk/acts/en2005/2005en09.htm

(Appendix A)

RACE EQUALITY IMPACT ASSESSMENT (REIA)

Introduction

This is a Race Equality Impact Assessment (REIA) for the Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (General) Regulations 2006 and the Mental Capacity Act 2005 (Independent Mental Capacity Advocate) (Expansion of Role) Regulations 2006.

Under the Race Relations (Amendment) Act 2000 public authorities (in this case the Department of Health (DH)) are required to undertake Race Equality Impact Assessments of new polices and functions. The Race Relations (Amendment) Act 2000 states that public authorities must have due regard to the need to:

- Eliminate unlawful discrimination
- Promote equality of opportunity and
- Promote good relations between people of different racial groups

The Commission for Racial Equality (CRE) guidelines on REIAs pose the following questions in relation to policies:

- Will the proposed policy involve, or have consequences for, the people your authority serves and employs?

- Could these consequences differ according to people's racial group, for example, because they have particular needs, experiences or priorities?

- Is there any reason to believe that people could be affected differently by the proposed policy, according to their racial group, for example in terms of access to a service, or the ability to take advantage of proposed opportunities?

- Is there any evidence that any part of the proposed policy could discriminate unlawfully, directly or indirectly, against people from some racial groups?

- Is there any evidence that people from some racial groups may have different expectations of the policy in question?

- Is the proposed policy likely to affect relations between certain racial groups, for example because it is seen as favouring a particular group or denying opportunities to another?

- Is the proposed policy likely to damage relations between any particular racial group (or groups) and your authority?

We intend to consider in this document the potential impact the Mental Capacity Act 2005 (Independent Mental Capacity Advocate) Regulations 2006 will have on the population, and particularly members of Black and minority ethnic groups, to ensure that the regulations do not disproportionately negatively impact members of these groups. Any identified disproportionate impacts will be addressed and mitigated by the implementation process. In particular, this will be done through mandatory training for people who are appointed to act as Independent Mental Capacity Advocates (IMCAs), guidance to Local Authorities on commissioning the IMCA service and an awareness-raising programme for health and social care professionals.

In assessing the impact of these regulations on people in Black and minority ethnic communities, we have:

- Consulted on how the IMCA service should be set up and the regulation making powers used. As part of the consultation process which ended on 30 September 2005, the summary of the consultation paper on the IMCA service was translated into seven different languages (including Arabic, Bengali, Chinese, Gujarati, Punjabi, Somali and Urdu). An accessible version in English was also produced with a CD-Rom and braille version available on request.
- Organised specific events with the Council for Ethnic Minority Voluntary Organisations (CEMVO) and the Council of Indian Organisations as part of this consultation process
- Considered diversity issues in the response to the consultation on the IMCA service, published on 18 April 2006, which was again translated into a range of languages to support the needs of Black and minority ethnic groups.
- Consulted with black and minority ethnic stakeholders as part of the consultation on the draft Code of Practice for the Mental Capacity Act. The consultation on the draft Code closed on 2 June 2006 and the responses are currently being analysed.
- Set up seven IMCA pilots from January 2006 to inform the implementation of the IMCA service, including its implications for Black and minority ethnic communities.
- Undertaken a literature review of relevant recent research.

1. Will the proposed policy involve, or have consequences for, the people your authority serves and employs?

Yes, although it is not expected that these will significantly disproportionately affect people of any racial group.

The IMCA service was created by sections 35 to 41 of the Mental Capacity Act 2005. Its purpose is to help particularly vulnerable people who lack capacity to make important decisions about serious medical treatment and changes of residence – for example – moving to a hospital or a care home. The provisions in the Act are intended to come into force from 1 April 2007. This REIA applies to England only.

The Act set out the basic framework for the IMCA service. These regulations set out the detail on how the IMCA service will be set up, in particular they set out:

- the functions and role of the IMCA under the powers in s36(2) and (3),
- how the IMCA will be appointed under the powers in s35(2) and (3),
- the definition of serious medical treatment under the powers in s37(6),
- the definition of the term “NHS body” under the powers in s37(7),
- how the IMCA service should be extended under the powers in s41.

The regulations on the appointment of independent advocates providing the IMCA service set out the minimum standards that they must meet. This includes requiring individual advocates to undergo CRB checks prior to employment. The regulations also provide that all IMCA advocates should receive appropriate training to help ensure a common standard of skills and knowledge, and will set out requirements on independence for the IMCA.

IMCAs will be instructed to support and represent all adults who lack capacity in England, regardless of their ethnic and cultural backgrounds. IMCAs will be appropriately trained in the IMCA role and the training will include equality and diversity issues. Local Authorities who commission the IMCA service and independent advocacy organisations who recruit IMCAs will be equal opportunity employers, welcoming applications from people of any ethnic background.

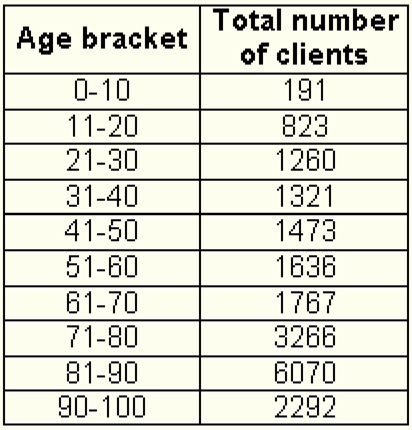
2. Could these consequences differ according to people’s racial group, for example, because they have particular needs, experiences or priorities?

Little research has been done into the correlation between racial groups and people who lack the capacity to make specific decisions. Recent figures from the Public Guardianship Office (PGO) show that a slightly lower percentage of their clients are from Black and minority ethnic groups in comparison to the results of the 2001 census. The 2001 census shows that 12.5% of the population are from Black and minority ethnic groups; PGO data show that 7.05% of their current clients are from Black and minority ethnic groups.

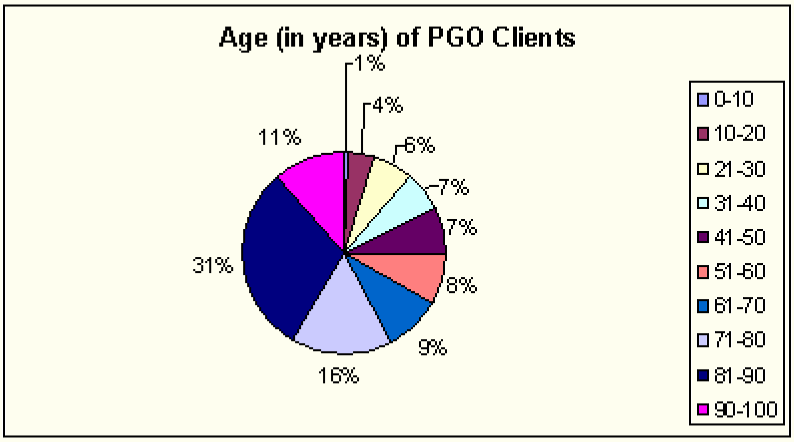
There are certain circumstances which are more likely to lead to people lacking capacity to make specific decisions, such as increased age (leading to a higher risk of dementia or Alzheimer’s disease), and physical illnesses such as strokes or other brain injury. Research has been done into the relative likelihood of people from Black and minority ethnic groups suffering from these conditions.

Age

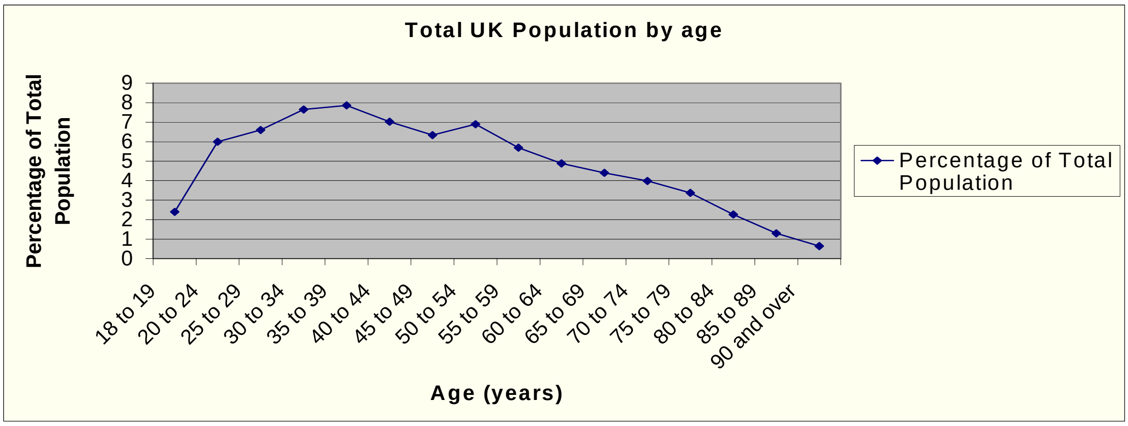
There is a correlation between increased age and a lack of mental capacity. Recent figures from the PGO show that 66.65% of their current clients are aged over 60 and 57.85% are aged over 70. More than a third of their clients are aged over 80. The following show current clients of the PGO grouped by age:

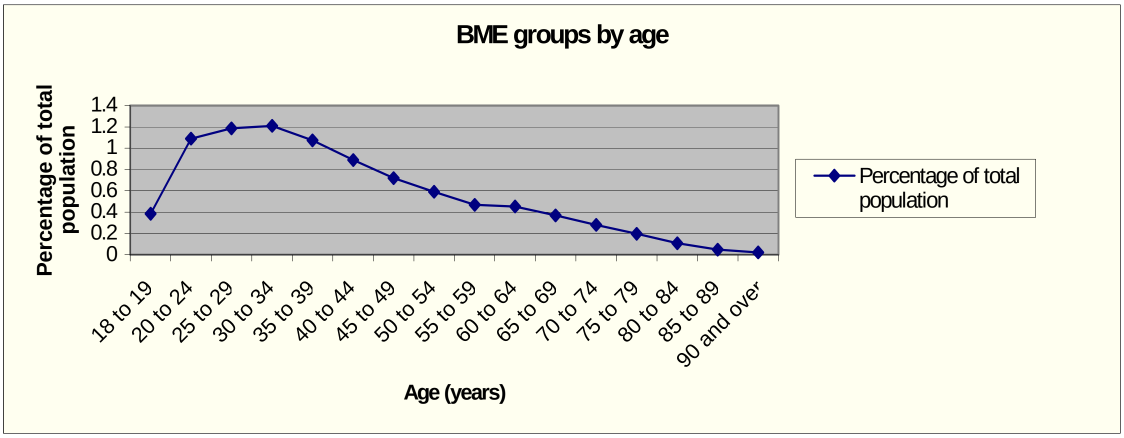


Age bracket	Total number of clients
0-10	191
11-20	823
21-30	1260
31-40	1321
41-50	1473
51-60	1636
61-70	1767
71-80	3266
81-90	6070
90-100	2292



The following charts show the total UK population by age groups and the UK Black and minority ethnic population by age groups. Data comes from the 2001 census.





Evidence from the Home Office[1] shows that there is a higher concentration of people of working age in Black and minority ethnic and immigrant groups than is present in the general population. This may be explained by patterns of migration – people who immigrate to a country tend to be of working age, or children accompanying their parents – and is likely to change, albeit slowly, to reflect the pattern of the ethnic majority as earlier 'waves' of immigrants who have settled in the UK reach retirement age. From this evidence, we would expect a slight under-representation of Black and minority ethnic groups amongst the people who will be supported and represented by IMCAs.

Physical illness

There are significant variations in physical health among people from different ethnic groups.[2] Black and minority ethnic groups as a whole were almost 25% more likely to report poor health than the majority white population, with people of Asian origin being 50% more likely to report fair or poor health. This mean that it is more likely that people from Black and minority ethnic groups are likely to have some of the physical illnesses which contribute to lacking capacity to make some decisions.

A King's Fund commissioned report[3] said that extensive research[4] shows that there are a number of barriers which minority communities face when accessing or using health and social care services.

---

[1] http://www.homeoffice.gov.uk/rds/pdfs/occ77migrant.pdf

[2] People of Afro-Caribbean origin are at much greater risk of dying from a stroke - men are 76% and women are 110% more likely to die from a stroke. They are almost 50% more likely than white people to be diagnosed with hypertension, which is a key risk factor for strokes. (See "Ethnic minorities in Britain: diversity and disadvantage" Tariq Momood et al., Policy Studies Institute 1997). There are disproportionately higher levels of coronary heart disease from people of South Asian origin. See "Heart Disease and South Asians – Delivering the National Service Framework for Coronary Heart Disease" 2004

[3] 'A Standards framework for delivering effective health and social case for black and minority ethnic Londoners' by Rukshana Kapasi, Mike Silvera 2002

In relation to accessing health services, people from ethnic minority groups (other than people of Chinese origin) are more likely to be registered with and consult GPs than the white ethnic majority. However, their rates for admission to hospital are broadly similar, despite a significantly higher rate of consultation with GPs. This may mean that people from ethnic minorities are less likely to be admitted to hospital than white people when presenting similar levels of illness.[5]

It would seem likely that a lack of effective communication may play a large part in this, as may differences in cultural idioms used to express symptoms of illness. The Study of Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) report suggests that this difference in cultural idioms may lead to misdiagnosis of mental illness.

A report published by The Joseph Rowntree Foundation [6] concluded that research 'suggests inappropriate, under-resourced services, resulting in high levels of unmet need among black disabled people in Britain'.

A report by SCOPE on behalf of the Independent Advocacy Campaign[7] outlines the lack of advocacy for people with physical, sensory, communication and profound and multiple impairments and recommended increasing provision. Another report by the National Autistic Society in 2003 ('Autism: the demand for advocacy') Identified the need for and lack of appropriate advocacy for people with autistic spectrum disorders.

Independent advocacy organised who will be commissioned to provide the IMCA service organisations and the IMCAs themselves will need to be aware of and alive to such issues when dealing with members of ethnic and cultural minority groups who may lack capacity to make decisions about serious medical treatment and care moves. This is something that will be covered in commissioning guidance and in the mandatory IMCA training. It will also form part of the review process of the IMCA service.

Religion

In the 2001 Census, 71.6% of respondents (37 million) stated their religion as Christian, while 15.5% (9.1 million) stated they have no religion and a further 7.3% (4.2 million) did not respond to the question. Some 3.1% of England's

---

[4] What seems to be the matter: communication between hospitals and patients' Audit Commission, 1993; 'Sick of being excluded: improving health and care of London's black and minority ethnic communities' The Report of the Race, Health and Social Exclusion Commission, Association of Local Government, 2000.

[5] See Nazroo in "Ethnic minorities in Britain: diversity and disadvantage" Tariq Momood et al., Policy Studies Institute 1997

[6] 'Improving support for black disabled people: lessons from community organisations on making change happen' by Becca Singh in 2005

[7] 'Advocating for Equality' by Caroline Clipson and Wendy Lewington), 2003

population and 0.7% of the Welsh population give their religion as Muslim, making this the most common religion after Christianity. Some 8.5% of London's population give their religion as Muslim; 4.1% are Hindus and 2.1% are Jewish[8].

There is evidence that people from Black and minority ethnic communities are more likely to be religious than the ethnic majority[9]. Therefore, provisions put in place to accommodate religious needs are more likely to impact on Black and minority ethnic groups, although they do not specifically target them.

The following table shows the religious beliefs of current PGO clients:

PGO Clients Religion	TOTAL
Not Available	4497
Buddhist	4
Christian	206
Church of England	1975
Greek Orthodox	6
Hindu	5
Jehovah's Witness	13
Jewish (Judaism)	24
Methodist	133
Muslim (Islam)	35
None	137
Protestant	29
Religion Not Stated	346
Roman Catholic	422
Sikh	9
TOTAL	7841

As can be seen from this table, Christians (including the Church of England, Methodists, other Protestant churches, Greek Orthodox and Roman Catholics) form the clear majority (92.43%) of applicants who state a religious faith. Muslims and Jews make up important smaller groups (1.18% and 0.8%, respectively) of religious applicants. Those who do not have a religion form 4.6% of the total.

Clearly, any needs clients have for reasons relating to their religion and beliefs will need to be taken into account by the IMCA when supporting someone who lacks capacity in relation to a particular decision. This may include, for example, any need for prayers at specific times of day. Training for IMCAs will cover cultural awareness and sensitivity including information on possible issues of concern to people because of their religion and beliefs.

---

[8] All figures are from http://www.jsboard.co.uk/etac/downloads/belief_systems.doc

[9] Modood et al, 1997

The Act also makes it clear that decisions made on behalf of a person who lacks capacity, can only be made in a person’s best interests, and Section 4 underlines that when deciding what is in a person’s best interests, the decision maker must consider:

- The person’s past and present feelings and wishes
- The beliefs and values that would be likely to influence his decision if he had capacity, and
- The other factors that he would be likely to consider if he were able to do so

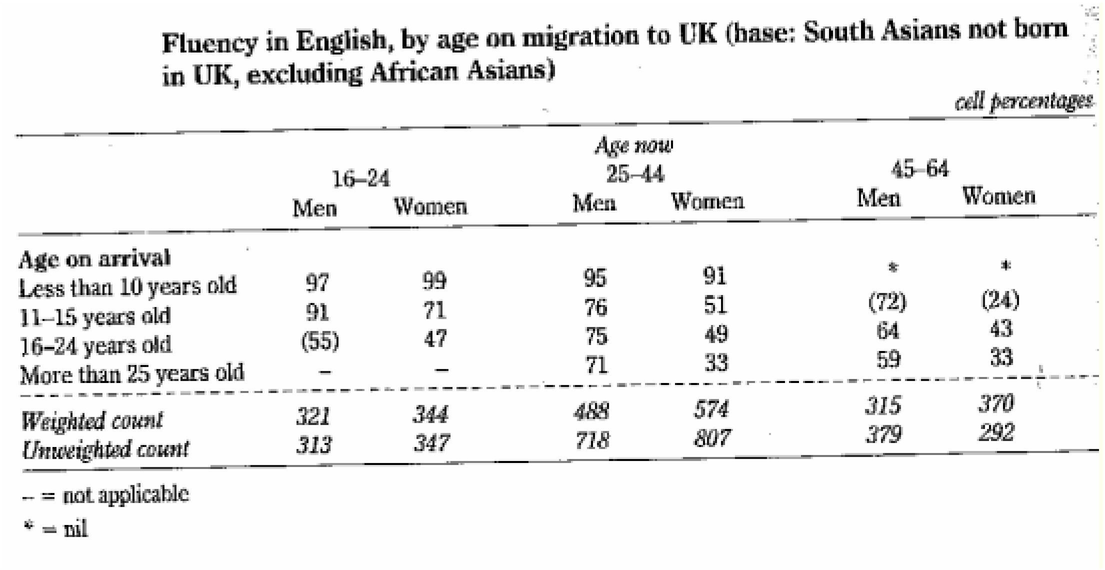
These would clearly include any religious or other beliefs and values. Examples of these may be the need for single-sex care facilities, access to religious rites and ceremonies or specific dietary requirements. The IMCA would want to include any such considerations in their report on the issues involved in the decision to be made.

Any issues relating to race that emerge from the IMCA pilots will help inform the IMCA training and the Code of Practice. In addition there will be a review of the IMCA service at the end of its first year and diversity issues will be an important element in this monitoring.

3. Is there any reason to believe that people could be affected differently by the proposed policy, according to their racial group, for example in terms of access to a service, or the ability to take advantage of proposed opportunities?

Recent studies, including the review of evidence regarding the issues surrounding access to health services for ethnic minority groups in London conducted by the Centre for Health Studies at Warwick University in 2001, have suggested that two of the main barriers to accessing health care for ethnic minorities were language difficulties and lack of knowledge about services.

The following table comes from “Ethnic Minorities in Britain; diversity and disadvantage”[10].



Fluency in English, by age on migration to UK (base: South Asians not born in UK, excluding African Asians)

cell percentages

	Age now					
	16–24		25–44		45–64	
	Men	Women	Men	Women	Men	Women
Age on arrival						
Less than 10 years old	97	99	95	91	*	*
11–15 years old	91	71	76	51	(72)	(24)
16–24 years old	(55)	47	75	49	64	43
More than 25 years old	–	–	71	33	59	33
Weighted count	*321*	*344*	*488*	*574*	*315*	*370*
Unweighted count	*313*	*347*	*718*	*807*	*379*	*292*

– = not applicable
* = nil

Institute, 1997.

An assessment of how well mental health advocacy services address the specific needs of users from Black and minority ethnic communities, concluded that mental health advocacy has failed to reflect and address the specific needs of Black and minority ethnic communities. It highlights persistent problems in mainstream services which position black service users on the margins with limited support.[11]

A mapping exercise of access to health services among Black and minority ethnic patients considered advocacy's role in helping disadvantaged people to obtain support.[12]

The introduction of the new IMCA service, that puts advocacy on a statutory basis for the first time, will help to redress some of these imbalances. Given the nature of the IMCA service, and the training and other measures we will put in place, we believe that people will not be discriminated against, or disproportionately affected in an unfair way, because of the racial group to which they belong. However the programme of monitoring and review outlined in para. 8 – which includes collecting and evaluating information from the IMCA pilots and a full review of the IMCA service carried out after its first year – will assess the impact, including any diversity issues that need to be addressed.

There is currently patchy provision of bilingual advocacy. We will be encouraging sharing of resources between different advocacy groups to meet the needs of specialist groups. We are also looking at encouraging specialist centres to provide and facilitate advocacy in different languages. A section 64 grant has been awarded to WASSR (the Westminster Advocacy Service for Senior Residents) in 2006 to undertake outreach work locally to raise awareness of dementia issues in Black and minority ethnic communities and share developing expertise nationally through workshops, development of learning materials and compiling good practice case studies.

4. Is there any evidence that any part of the proposed policy could discriminate unlawfully, directly or indirectly, against people from some racial groups?

---

[11] 'Best practice in mental health: Advocacy for African, Caribbean and South Asian communities', Asha Rai-Atkins and Anab Ali Jama, Norman Wright, Velma Scott, Chris Perring, Gary Craig and Savita Katbamna. Policy Press, 2002.

[12] 'Health Advocacy for Minority Ethnic Londoners' by Kristina Staley, King's Fund 2001.

There is no evidence that any part of the IMCA service will discriminate unlawfully against people from any racial group. Consultation responses broadly welcomed the new service and no comments were received to suggest that people from Black and minority ethnic communities would be discriminated against by the measures suggested. However we will monitor and review this (see para 8).

5. Is there any evidence that people from some racial groups may have different expectations of the policy in question?

The consultation exercise on the IMCA service attracted 176 written responses and held workshops to gather views attended by around 450 people. The consultation response from the Council of Indian Organisations reported that there is a stigma around mental health and mental capacity issues are hidden. A service dealing with these issues may be viewed with suspicion. There may be gender issues as well with a female IMCA needed to deal with female clients in this community. Organisations representing lesbians and gay men noted the difficulty for some partners of those who lack capacity to have a voice when decisions relating to their partner are being considered.

IMCAs will receive mandatory training on equality and diversity issues and training will also be provided to health and social care practitioners on the Act generally and the importance of reaching all communities. The IMCA service will be reviewed regularly with a research report analysing the findings of the seven IMCA pilots in the autumn 2006.

We are aware that Black and minority ethnic communities may have extended family networks so those who lack capacity are less likely to have no family or friends. However we do not make this assumption for all those from Black and minority ethnic communities and we are funding a voluntary organisation (see WASSR above), through a section 64 grant, to develop expertise on working with people with dementia in Black and minority ethnic communities.

6. Is the proposed policy likely to affect relations between certain racial groups, for example because it is seen as favouring a particular group or denying opportunities to another?

No, there is no evidence that this will be the case. The Act provides that anyone who lacks capacity to make certain important decisions but who has no family or friends will have an IMCA to support and represent them. The

---

[11] ‘Best practice in mental health: Advocacy for African, Caribbean and South Asian communities’, Asha Rai-Atkins and Anab Ali Jama, Norman Wright, Velma Scott, Chris Perring, Gary Craig and Savita Katbamna. Policy Press, 2002.

[12] ‘Health Advocacy for Minority Ethnic Londoners’ by Kristina Staley, King’s Fund 2001.

regulations also provide for an IMCA to be instructed for some care reviews or where adult protection proceedings have been instigated.

A programme for raising awareness and educating and training an estimated three million health and social care staff on the Mental Capacity Act at a cost of over £12m is being implemented. In each of the eight regions of the Care Services Improvement Partnership (CSIP) regional leads for the implementation of the MCA, including awareness of the IMCA service, have been or are currently being appointed. They will support and facilitate the local implementation networks and host a number of regional awareness raising events that will, via a standard presentation provided by DH, ensure a regional and local cascade of key information to key staff. Those key staff will in turn utilise the standardised presentation within their own organisations. As many staff as possible will receive a cascaded presentation before April 2007.

DH has commissioned five sets of training materials from the University of Central Lancashire. The five sets are a generic set aimed at all health and social care staff affected by the act and four discrete sets aimed at those working in acute hospitals; mental health services; residential accommodation; and in primary and community care.

The training materials (which will complement the Code of Practice, and revised, and updated versions of the Making Decisions booklets produced by the Lord Chancellor's Department in 2002) will be available electronically and in hard copy formats. The DH Mental Capacity Act Implementation Team will continue to work with national voluntary, professional and representative organisations to ensure a high level of awareness of the existence of the training materials and to continue to exploit the established willingness of those organisations to assist with the implementation of the Act, including the IMCA service.

There will be separate tailored mandatory training for people who are appointed to act as IMCAs. The regulations require that all IMCAs receive 'appropriate' training. The IMCA induction training will include working with diversity (see below).

7. Is the proposed policy likely to damage relations between any particular racial group (or groups) and your authority?

No. To the contrary, we hope that the IMCA service may reach out into Black and minority ethnic communities and provide support for their most vulnerable – those without family or friends. However, evidence suggests that those who lack capacity in the Black and minority ethnic communities are less likely to be unbefriended and so less likely to need an IMCA to support them.

8. Monitoring and Review

Review arrangements

The IMCA service will be monitored and evaluated in a number of ways.

The IMCA pilots will be developing action learning sets to cover IMCA advocacy, and collecting information on diversity. A research project to analyse the findings of the pilots will report in the autumn 2006.

The DH will evaluate the IMCA service after the first year of implementation to determine if we have sufficiently addressed the advocacy needs of the unbefriended and to monitor the take up of the IMCA service to ensure that it represents those from Black and minority ethnic communities. Thereafter the Department will produce an annual report on the IMCA service for the first three years following implementation.

In addition, section 64 grant funding (see paragraph 5 above) will be used to develop guidance on working with Black and minority ethnic communities.

Commissioning

The Government is developing commissioning guidance which will focus on the key components of good practice for local authority commissioners and for independent advocacy organisations for the IMCA service.

Independent advocacy organisations who will be commissioned to provide the IMCA service will have to meet appropriate organisation standards as part of the commissioning/contract arrangements. Local authority commissioners will be required to monitor advocacy organisations as part of the contract/ commissioning arrangements.

During 2006/07 we will be working with the Commission for Social Care Inspection (CSCI). They will be monitoring the growth of advocacy organisations and how the IMCA service is being commissioned by local authorities and report back.

In addition, Action for Advocacy (A4A) have been awarded section 64 funding to provide capacity building support to small advocacy independent advocacy organisations in improving standards and quality who will be better positioned to apply to be providers of the IMCA service.

9. IMCA Training

The Regulations require IMCAs to have ‘appropriate training and experience’. Work is continuing to develop a national advocacy qualification for England and Wales which will include basic units covering key competencies and additional pathways covering IMCA requirements. This will include training on diversity issues. However, this qualification will not be available by April 2007.

The intention is therefore to develop an induction package for training people who are appointed to act as IMCAs in England and Wales, from January 2007. The Department of Health is in the process of tendering for the development of a training programme and materials for this induction package. This could well form the basis of the IMCA pathway/unit for the national qualification.

Induction Package

The induction package will include the following elements that will address diversity issues in relation to those who lack capacity. Working with people who may lack capacity, to provide a broad overview of the issues faced when working with different client groups (those with learning difficulties, mental health problems, brain injury, dementia and multiple disabilities); working with diversity to provide a broad overview of the issues (including cultural values, Black and minority ethnic communities, young people and gender issues); and core advocacy skills (including model of advocacy, reflective practice, communication and negotiating skills).