Exploring the Use of IMCAs in Adult Safeguarding Processes in Gateshead

An Evaluation

Julie Irvine Sarah Beck Martha Chinouya Jeanie Molyneux

March 2013

Contents

Acknowledgements

This evaluation was commissioned by Gateshead Safeguarding Adults Board. The authors are all members of the Department of Social Work and Communities at Northumbria University and we would like to thank everyone who made this evaluation possible and who contributed to the smooth running of the process. In particular we would like to thank Cathryn Meredith, Mental Capacity Act Coordinator for all her encouragement, professionalism and help in making the evaluation happen and to Sam Milburn for making it so easy to find a Civic Centre room when needed. Finally we would like to thank all the people who were willing to be interviewed and/or take part in a focus group and who were so forthcoming with their views about the use of Independent Mental Capacity Advocates within adult safeguarding processes. Without their views and opinions, this evaluation would not have been possible.

Julie Irvine
Sarah Beck
Martha Chinouya
Jeanie Molyneux

28 March 2013

Executive Summary

This is an evaluation of the use of Independent Mental Capacity Advocates (IMCAs) in adult safeguarding in Gateshead. It was commissioned by Gateshead Safeguarding Adults Board in 2012 following a recommendation by a Care Quality Commission (CQC) inspection report to improve the uptake of IMCA referrals in adult safeguarding. Significant improvements in policy and practice have taken place in Gateshead since the CQC report was published in 2009 but the current IMCA referral rate remains low. This evaluation has therefore sought to establish the current position regarding the knowledge and use of IMCAs within safeguarding and to suggest recommendations to increase uptake.

The Mental Capacity Act 2005 created the IMCA role to empower and safeguard people who do not have the capacity to make important decisions about their health and social care needs. It is a statutory service provided by the voluntary sector. The Act also introduced a legal duty upon NHS and Local Authorities to instruct an IMCA in certain situations and gives a power to involve IMCAs in accommodation reviews and adult safeguarding situations. This discretionary power in safeguarding applies whether or not the incapacitated person has friends or family who might be consulted. In other words, the Local Authority must consider, for each person, whether they might benefit from an IMCA.

The methods used in this evaluation were chosen to permit as meaningful an exploration as possible in the short timescale available. A variety of methods were used to obtain information:

1. mapping the key stakeholders and a short review of the literature, policies and procedures in Gateshead
2. a review of anonymised case notes from files where IMCAs had been used
3. individual face to face interviews with key stakeholders
4. a focus group held to comment on the initial findings from the interviews

However the main sources of information were from stakeholders as the quality assurance systems in Gateshead meant only limited information could be obtained statistically from cases in Gateshead involving an IMCA referral. The MCA

Coordinator acted as a 'gatekeeper' to identify potential files (four in total) and participants from the Local Authority, partner Health services and the IMCA services. Out of 33 individuals approached, 14 agreed to be interviewed and four took part in a focus group.

Our findings indicate that the low use of IMCAs was widely recognised and attributed to several factors including:

- Lack of knowledge and understanding about the role and about whose responsibility it is to instruct an IMCA
- A perception that the process was too complex and created additional work,
- A lack of confidence in the previous IMCA provider
- Possible referral for an IMCA not being 'embedded' in staff thinking

Recent changes appear to have already led to improvements. Contracting with a new service provider, Your Voice Counts (YVC), has resulted in a more accessible and visible service. The development and delivery of a new training package involving both YVC and the Safeguarding Coordination team is widely credited with raising awareness and improving communication. Having prompts to consider referrals built into every stage of the safeguarding procedure was welcomed. Finally the role of the MCA Coordinator was seen as central in advising and raising awareness.

However despite the very real progress made by Gateshead Adult Safeguarding Board in its safeguarding processes and efforts to improve uptake of the IMCA service, there is still some way to go. The need to encourage staff to be more proactive has been given additional urgency through the Department of Health's publication of its fifth annual report on the Independent Mental Capacity Advocacy Service in February 2013. One of its recommendations is for all Safeguarding Co-ordinators to review the basis on which referrals are made to IMCAs and, in relation to named Local Authorities, to consider whether all those who would benefit from having an IMCA, receive one. Gateshead is one of the 54 LAs to which this recommendation applies.

Gateshead is to be commended for its priorities in raising both the strategic and operational profile of mental capacity in its 2012/2013 Partnership Plan. However it is only by adopting specific actions across the different services in health and social care settings that the referral rate for IMCAs by frontline staff will improve. There is a

need for frontline practitioners to incorporate active consideration of IMCA into their everyday practice.

Introduction

Gateshead Safeguarding Adults Board originally commissioned this evaluation to equip it to meet a recommendation of the Care Quality Commission (CQC) following its inspection of Adult Social Care in Gateshead in 2009. The inspection focused on Safeguarding Adults and Improving Health and Wellbeing for Older People and indicated improvements should be made in Gateshead Council's performance in safeguarding adults. One of the areas for development identified by the CQC was a need for Gateshead to improve the use of Independent Mental Capacity Advocates (IMCAs) in adult safeguarding processes, including staff understanding of the role, and the capacity of the IMCA provider to deliver. There has been considerable progress since this report was published in 2009 with revised policies and procedures addressing many of the original concerns. This evaluation seeks to establish the situation existing in 2012/13 regarding the knowledge about and use of IMCAs within safeguarding, acknowledge the improvements that are already taking place and make recommendations to enhance these.

The CQC had identified similar concerns about low rates of IMCA use in safeguarding during inspections across the region and indeed nationally. The Department of Health's 2009 report into the second year of the IMCA service considered adult safeguarding procedures and stated, "The duty of the local authority is to consider – for each person – whether they might benefit from an IMCA. The Department of Health is concerned that this duty to consider the specific benefit of an IMCA is not being properly applied to every individual". A more recent report (Department of Health, 2011) indicated that despite a steady increase in referrals to IMCA services nationally between 2007 and 2011, there were clear regional variations. This suggested that people who may be eligible for this service were not always being referred. The most recent review of IMCA services (Department of Health, 2013) indicates that the use of IMCAs within safeguarding actually declined slightly during 2011-12, despite an overall increase in adult safeguarding cases across the country. This is identified as a matter of concern, leading to a recommendation by the Department of Health that Safeguarding Co-ordinators consider the level of IMCA referrals within safeguarding in their areas and review the

basis on which these referrals are made. In this respect Gateshead Safeguarding Adults Board is to be commended as significant improvements have already been made in safeguarding generally and with regard to IMCA use in particular. However, in commissioning this independent evaluation from Northumbria University, the Board acknowledges that IMCA instruction in Safeguarding proceedings within Gateshead remains low and can be improved.

Aims and Objectives

The overall aim of this evaluation is to enable Gateshead Safeguarding Adults Board to meet the CQC's recommendation to "*Improve the use of IMCA in safeguarding services, including staff understanding of the role, and the capacity of the current IMCA provider to deliver".*

The objectives of the evaluation are:

- To map key stakeholders involved in safeguarding adults at risk in Gateshead;
- To explore the attitudes and knowledge about IMCA use within adult safeguarding amongst the identified stakeholders;
- To explore the reasons for low IMCA usage by key stakeholders;
- To make recommendations on how best to maximise the appropriate involvement of IMCAs in safeguarding adults at risk of harm.

Ethical Considerations

The Northumbria University Research Ethics Guidelines and the HCPC Standards of Conduct, Performance and Ethics have informed all ethical considerations regarding this evaluation. Ethical approval was provided by the Northumbria University's Ethics Committee following extensive scrutiny of the initial proposal, overall design and methodology. This means that core principles of good research practice have been observed and built into the proposal, particularly around informed consent. All participants were given information prior to interviews and gave informed written consent to be involved. They have been assured of anonymity and confidentiality with only the project team having direct access to the information provided by those who were interviewed.

Literature review

The Mental Capacity Act 2005

Mental capacity is the ability to make informed decisions. This ability can be affected by conditions such as dementia, stroke, alcohol and drug abuse, learning disabilities and serious mental health problems. The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who lack capacity and for making decisions on their behalf. Most of the Act's provisions apply to anyone over the age of 16 who lacks capacity to make a specific health, welfare or financial decision because of an impairment or disturbance in the functioning of their mind or brain.

The Act is underpinned by an important set of principles, which apply to anyone who may need to make a decision on behalf of an incapacitated person. These principles state that:

1. A person must be assumed to have capacity unless it is established that they lack capacity;
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success;
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision;
4. Any act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made in his best interests; and
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action

(Mental Capacity Act 2005, Section 1)

Capacity is time and decision specific; many people with impaired capacity will be able to make certain decisions but not others. It is therefore important that capacity is assessed in relation to the particular decision that needs to be made.

A person is assessed as lacking the capacity to make a decision, if they cannot do one or more of the following:

- Understand information given to them about the decision;
- Retain the information for long enough to make the decision;
- Use and weigh up the information as part of the decision making process;
- Communicate their decision by any means.

(Mental Capacity Act 2005, Section 3)

Once a person has been assessed as lacking capacity to make a decision, that decision must be made in his/her best interests. The Act gives a checklist of factors (Mental Capacity Act 2005, Section 4), which must be considered when making a best interests decision. This includes the consideration of the incapacitated person's past and present wishes and feelings, and consultation with relevant family members, professionals or others who may have an interest in the welfare of the person.

The Mental Capacity Act 2005 and Safeguarding Adults

The Mental Capacity Act is widely seen as enhancing the process of safeguarding adults from harm, particularly in the absence of any specific statutory framework to underpin this crucial area of health and social care practice (Manthorpe et al, 2009). Ingram (2011) identifies mental capacity as one of the two 'essential ingredients' (p78) of any safeguarding situation (the second being whether the alleged abuse is happening in an organisational context where there is a duty to protect others). Cognitive impairment is likely to increase the risk of abuse and neglect, and the assessment of an alleged victim's capacity is crucial in establishing whether their right to autonomy may be over-ridden in relation to proposed protective measures (Manthorpe et al, 2009). This point was recognised in the primary policy document on adult safeguarding, 'No Secrets':

"The vulnerable adult's capacity is the key to action since if someone has "capacity" and declines assistance this limits the help that he or she may be given."

(Department of Health, 2000, p31)

In keeping with the principles of the Mental Capacity Act, an 'unwise' decision to refuse protective measures should not be seen as indicating a lack of capacity, and such measures cannot be imposed upon a capacitated person without their consent (Redley et al, 2011).

What is an Independent Mental Capacity Advocate?

Legal judgements have repeatedly emphasised the importance of making the wishes and feelings of the incapacitated person central to the process of making decisions in their best interests (Donnelly, 2011). One of the safeguards introduced by the Mental Capacity Act 2005 to ensure that this happens is the role of the Independent Mental Capacity Advocate (IMCA). IMCAs provide independent, uninstructed advocacy for people who lack the mental capacity to make decisions about their treatment or care in specific situations. There is a legal duty for NHS bodies and local authorities to involve an IMCA when making a decision in the best interests of a mentally incapacitated adult regarding serious medical treatment or long term accommodation in residential care or hospital, if there is no other person other than paid carers whom it is practical or appropriate to consult about the decision. The Mental Capacity Act also gives a power to involve IMCAs in accommodation reviews and in adult safeguarding situations. In relation to safeguarding only, this discretionary power applies whether or not the incapacitated person has friends or family who might be consulted. The role of the IMCA was further extended by the Deprivation of Liberty Safeguards (DOLS), a detailed consideration of which is outside the scope of this evaluation.

The role of the IMCA is not to make a decision on behalf of the incapacitated person, but rather to support and represent him/her, facilitating communication and ensuring that the person's wishes and feelings have been fully taken into account within the decision making process and that all possible options have been considered. In carrying out their role, IMCAs have the right to access relevant health and social care records, meet the incapacitated person in private and seek a second medical opinion where appropriate.

The IMCA service is now in its sixth year of implementation and there is still limited research about its effectiveness. IMCAs are seen as an important safeguard for mentally incapacitated people at risk of harm (Boyle, 2011), and a study by Townsley and Laing (2011) indicates that IMCA involvement promotes positive outcomes for service users; specifically in relation to safeguarding adults, IMCAs may provide additional information which can improve understanding of complex situations. However a recent piece of research commissioned by the Department of Health suggests there remains a lack of awareness of the IMCA role and that all providers should review their guidance (Williams et al., 2012).

The IMCA Role in Safeguarding Adults

The role of the IMCA was extended by the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, to cover safeguarding adults situations. The regulations state that local authorities and NHS bodies have the power to instruct an IMCA where the following two requirements are met:

- where protective measures are being put in place in relation to the protection of vulnerable adults from abuse; and
- where the person lacks capacity to consent to these protective measures.

Guidance on the interpretation of these regulations (Department of Health, 2007) states that "where the qualifying criteria are met, it would be unlawful for the LA or the NHS not to consider the exercise of their power to instruct IMCAs for adult protection" (paragraph 10).

An IMCA may be instructed in relation to the alleged victim of abuse or neglect, or to the alleged perpetrator of such abuse or neglect. Local authorities and NHS bodies which instruct an IMCA for adults at risk are legally required to have regard to any representations made by the IMCA when making decisions concerning protective measures.

Useful practice guidance on the role of IMCAs in safeguarding has been produced by the Social Care Institute for Excellence (SCIE, 2009). Some of the key good practice points outlined in this guidance are summarised in Box 1 on the next page.

Box 1: Good Practice Points on the Role of IMCAs in Safeguarding Adults (SCIE, 2009)

- The safeguarding manager should consider whether an IMCA should be instructed for all persons at risk. Local procedures should make it clear that the safeguarding manager will hold this statutory responsibility.

- As well as considering *whether* to instruct, the safeguarding manager should also consider the most appropriate *time* to instruct an IMCA. The instruction of an IMCA should not be delayed if protective measures which will have a direct impact on the person at risk are to be taken on a best interests basis, or abuse has been established.

- Once an IMCA has been instructed they should be invited to all safeguarding adults meetings.

- The primary role for IMCAs in safeguarding adults is to represent and support the person at risk in relation to best interests decisions concerning protective measures. This includes any decision not to take protective measures.

- IMCAs may make representations on any matter relating to the safeguarding adults proceedings

- IMCAs should wherever possible produce written reports for safeguarding planning meetings.

- Safeguarding managers should receive a briefing or training on the IMCA role.

- IMCAs should receive training on local safeguarding adults procedures.

The potential benefits of involving IMCAs in safeguarding both for the person who lacks capacity and for practitioners are summarised in Box 2 on the next page.

Box 2: Potential benefits of IMCA involvement in safeguarding

- Early involvement of an IMCA ensures that the person lacking capacity has independent representation and their wishes are taken into account early in the safeguarding process (Redley et al., 2011).

- The IMCA is skilled at helping people who have difficulties with communication to make their views known (Lee-Foster, 2010).

- The independence of the IMCA can enable more objective decision-making in safeguarding situations. (Redley et al., 2011).

- The collaborative way in which IMCAs work mean that practitioners are assisted in their decision-making processes by a person with a good knowledge of the Mental Capacity Act as well as health and social care systems and community care law (Lee, 2007).

- The information brought to the attention of the decision-maker by the IMCA may be extremely useful and can often save valuable time for the practitioner. Complex decisions can be made with more confidence and in many cases more quickly due to the involvement of IMCA (Lee, 2007).

- IMCAs may advocate for the process as well as for the individual, ensuring that safeguarding procedures are followed and challenging poor practice (Gorczynska and Thompson, 2007).

- Independent advocacy is an important method of promoting service user involvement in safeguarding procedures, which historically have had a tendency to be risk-averse, leading to service users feeling excluded from a process which is intended to protect them (Wallcraft, 2012).

- IMCA involvement strengthens legal protection for people who lack capacity and who are experiencing abuse (Boyle, 2011).

The IMCA Service in Gateshead

Since 2011 Gateshead Safeguarding Adults Board has made significant progress in reviewing and revising its response to adults at risk and clearly sees this as a continuous process of improvement at both strategic and operational level. Gateshead Safeguarding Adults Board has worked to develop the safeguarding process in general and the IMCA service in particular. Four documents in particular appear to have informed the current arrangements and situation regarding the current use of IMCAs in Gateshead.

1) A *Safeguarding Adults Needs Assessment* was undertaken in 2011 to inform future priorities for the Gateshead Safeguarding Adults Board. This assessment provided an overview of the alerts, referrals made in Gateshead and a review of completed cases. It confirmed the overall uptake for the IMCA service as low, particularly with regard to instructions of IMCAs in safeguarding proceedings and noted that the contracted number of awareness raising sessions had not been delivered. It also stated explicitly that the contract for the IMCA provider would be revised and go out to tender. The general priorities identified in this review were to continue to raise awareness of the safeguarding adults agenda in Gateshead and to improve links with partners.

2) Detailed Multi Agency Policies and Procedures titled *Protecting Adults at Risk* were produced in May 2012. This set out both practice guidance and procedures to guide all agencies and practitioners in adult protection in an effort to ensure consistency across health and social care as well as the Police and voluntary organisations. It highlighted the importance of taking decisions and actions in line with the Mental Capacity Act 2005.

3) An *Independent Audit of Safeguarding Vulnerable Adults Services* was undertaken by Jan Douglas in 2012. Her brief was to audit compliance with ADASS standards, review the decision making process with regard to safeguarding adults and to review the role and remit of the Safeguarding Adults Coordination team. Although her report did not specifically address use

of IMCAs, it did note “effective and appropriate use…. of DOLs, MCA/IMCA and Appointeeship”, identified the emphasis on MCA in policy and procedures as an area of good practice and generally commented positively on recent changes and effective safeguarding services. This report has provided a sound platform for the Safeguarding Adults Board to continue and improve its strategic leadership and direction.

4) A 2012 *Safeguarding Adults Partnership Plan* replaced previous annual reports of the Safeguarding Adults Board. This plan identified key achievements in 2011/12 but importantly set out a vision for 2012/13 that included an approach to responding to statutory duties detailed within the Mental Capacity Act. ‘*Raise the strategic and operational profile of Mental Capacity and the Deprivation of Liberty Safeguards’* (page 13) is identified as one of five priorities To achieve this, a number of challenges are identified:

   i. Raise awareness of the purpose of the Mental Capacity Act throughout Gateshead, the duty to comply with its principles and the responsibilities it places on those working with and caring for adults who may lack capacity
   ii. Review and deliver an MCA/DoLS training programme, making it more accessible and better linked to practice
   iii. Deliver MCA and DoLS training across partnership agencies in order to improve practice and compliance
   iv. Monitor performance quality and assess adherence through consideration of the findings of inspection, audit, risk management and appraisal.

As will be seen later on in this evaluation, the findings indicate that many of the challenges have already been addressed. In particular, the change of IMCA provider in November 2012 increased training and awareness training, improved documentation and the setting up of multi agency working groups on mental capacity have all provided a greater understanding and compliance with legal expectations.

Methodology and Methods

The methods used to evaluate the use of IMCAs in Gateshead's safeguarding adults processes and procedures took a qualitative approach to allow a deeper understanding of the issues surrounding the use (or non-use) of IMCAs. The evaluation team were aware that the CQC report was now several years out of date and that much had improved in the approach taken with regard to safeguarding adults in Gateshead. Since 2010 new structures and services had been put into place. A Safeguarding Adults Coordination Team had been established within the Safer Communities Team (alongside Safer Families, Community Safety and Resilience Teams). Indeed it could be argued that the context had changed so significantly that an increase in the use of IMCAs would soon be assured. However, at the time this evaluation was commissioned (mid 2012), only five cases had been identified where IMCAs had been instructed in safeguarding. If Gateshead was to see any noteworthy increase, then a fuller appreciation of the factors that were preventing this needed to be established. An independent evaluation would at least provide some possible explanations and suggest a way forward.

It was agreed that a range of different methods would enable, as far as possible, a more robust set of findings. The use of different methods, taking an iterative approach where feasible, did enable triangulation to take place. The three methods adopted were:

1. A review of anonymised case notes from five files where IMCAs had been used between 2011 and 2012
2. Individual face to face interviews with key stakeholders
3. A focus group held to comment and build on the initial findings from the individual interviews

The Mental Capacity Act Coordinator acted as 'gatekeeper' to access the relevant documents and participants. That role was seen as more independent as it did not involve direct management of services or people.

The process overall took place in four distinct phases:

Phase One: Mapping stakeholders and scoping the literature

The aim of the mapping exercise was to understand the current configuration of safeguarding services within Gateshead Council. Since the CQC report was published in 2009 it was essential to establish more precisely who 'the key players' were in safeguarding and referrals to the IMCA services. Particularly important was an understanding of seven key stages of the Safeguarding Adults process and the key points for making decisions regarding an IMCA referral. This mapping and scoping exercise involved:

- An understanding of the current service provision (e.g. referral pathways, safeguarding and mental capacity processes and procedures etc.)
- A review of local policies, strategies and frameworks,
- An understanding of the safeguarding structure(s) in Gateshead

A review of the literature on safeguarding, mental capacity and the IMCA service nationally and specifically in Gateshead was undertaken together with a review of the published literature and policy documents from the Social Care Institute for Excellence, Department of Health Website, and the NHS Information Centre for Health and Social Care. This gave the authors a framework of the national and local policies, practices and structures. Representatives of key stakeholders were identified from past and current IMCA providers, other relevant service providers, staff from the Safeguarding Adults Coordination team and other managers and practitioners involved in the safeguarding adult process.

Phase Two: Review of case notes

Informed by the mapping phase, a sample of cases (N=4) that had involved the use of IMCAs during 2011/12 was reviewed by the evaluation team. Although a total of six IMCAs were instructed within Gateshead for safeguarding proceedings during this year, the MCA Coordinator stated that two were instructed by other local authorities for clients who had been placed in Gateshead. Access to the recordings was therefore not possible. Six should not be seen as particularly low compared with previous years. Seven IMCAs had been instructed in 2010/11 and only two in 2009/10 and 2008/09.

Written permission was given by a senior manager for the review of these case notes and for field notes to be taken to inform the next stage. These files were provided in an anonymised format and the intention was to identify the decision making process and reasons for referral. The files contained completed safeguarding adult Alert forms, Monitoring and Strategy records and Chronology records. IMCAs had been instructed in three of the four cases presented for analysis.

Phase Three: Interviews

Following clarification of the structure and stakeholders in Safeguarding Adults, a number of potential participants were identified from the different stakeholder groupings and then discussed with the gatekeeper to ensure relevance. The majority of people were from Community Based Services within Gateshead Council, either in the Commissioning and Business Development service or the Social Care and Independent Living Service. A small number of voluntary organisations were identified as having an interest in safeguarding either as representing carers or providing independent advocacy services. The general selection process ensured that a wide and diverse range of participants within the safeguarding structures were selected, invited and included in the sample.

The gatekeeper made an initial general approach by email to thirty three possible participants made up of service managers, team managers, senior practitioners, and other safeguarding adults managers. The previous and current IMCA service providers were also approached together with a Carers organisation. This initial approach was then followed up by an email from the University evaluation team with further information about the study and an invitation to be interviewed. Those interested in taking part in the study could reply to the researchers and arrangements were made for an interview. Once consent had been formally sought and agreed, the researchers proceeded to interview participants using a standard template interview guide with all interviews recorded and lasting an average 30 to 45 minutes. If there was no response from the first approach, a second email was sent a few weeks later, offering another opportunity to take part in the interview. Altogether 14 people were interviewed of whom four were team managers or above and one was from a voluntary organisation that provided an IMCA service. In a qualitative study of this nature, these numbers are sufficient to give credibility to the findings.

Phase Four: Focus group discussion to validate initial findings

Following the initial set of individual interviews, all those invited to the newly established Safeguarding Adults Managers network were asked, via email, if they would like to take part in a focus group where the initial findings of the study were shared and discussed with the participants. The purpose of the focus group was to ensure more rigour and trustworthiness of the findings which were presented to the four participants. The focus group took place after the inaugural Safeguarding Adults Managers' meeting. Although only four people took part, this produced considerable discussion of the initial findings and confirmed the substantial improvements in an understanding and use of IMCAs.

Findings

This section identifies the main findings from the case files, individual interviews and focus group. All recorded interviews and notes from the case files were analysed to identify key themes using a framework approach to data analysis (Ritchie & Spencer, 1994). This approach was used to classify and organise the data according to a series of main themes and concepts identified on the role of IMCAs and the safeguarding processes. These themes were then used as the basis for discussion with a focus group.

Findings from the Case Files

Unsurprisingly all the records presented a picture of on-going complex needs, fluctuating capacity and fraught or non-existent family relationships. Problems were multifaceted (significant physical and mental health issues, finance, housing and care needs). A range of service providers were often involved ranging from private and NHS nursing care providers, community health professionals, legal firms as well as social workers from a variety of teams, and sometimes from different local authorities.

However due to the very limited information provided in the files, it was not possible to identify the decision making process and reasons for referral. The Monitoring and Strategy forms included a specific question on whether an IMCA had been instructed and a supplementary question asking, if yes, what the reasons were. However these sections were not completed in sufficient detail or accuracy to provide any useful information. This was most obvious in the responses given to questions that required explanations for decision making. For example when asked to explain the reason for instructing an IMCA, the response was simply '*as an action from this meeting an IMCA has been instructed'*. In one case, the reasons were simply not given and in another, the fact of the referral was stated as an explanation in itself. In only one case was a clear rationale given such as "*support (user) with complex decision making*" and "*(user's) fluctuating capacity and being unaware of safeguarding procedures".*

The case notes were of limited use in informing interviews and merely served to illustrate the type of circumstances in which an IMCA was instructed. The files did not provide a detailed insight as to the use of IMCAs during the referral process, nor how they were used and what the challenges involved for the safeguarding manager or practitioner. Although the chronology of events was evident, there was not sufficient information to indicate where missed opportunities were.

Findings from the Interviews and Focus Group

Improvements already made

It was clear from the interviews and focus group that a considerable amount of work has already been done in Gateshead to improve the processes surrounding safeguarding adults in general and the use of IMCAs in particular. These improvements can be divided into those contextual improvements on IMCA awareness (Box 3), and those factors that had a direct impact on the use of the IMCAs (Box 4).

Box 3: Improvements identified in the overall safeguarding process as having an impact on IMCA use were:

- The creation of one team covering safeguarding and mental capacity has improved communication and understanding
- The extent of the training and awareness raising that took place during 2012
- More positive partnerships in the new team between health and social care
- The role of MCA Coordinator in advice / awareness raising was highlighted as important and helpful
- The new Quality Assurance system has enabled more accurate monitoring of the safeguarding process, including IMCA use
- The whole safeguarding process, including documentation and referral systems, is now much clearer among safeguarding adults managers
- The Safeguarding Adults Managers (SAM) network has contributed to practice development through case discussions and sharing of good practice.

Box 4: Improvements which specifically relate to IMCA use:

- The new IMCA provider, Your Voice Counts, is seen as more "outward facing" and accessible, more involved in training and willing to attend meetings with staff.
- The requirement for Your Voice Counts to respond to referrals within 48 hours has reduced delays in accessing the IMCA service
- The IMCA referral form is now much easier to use
- Your Voice Counts have been involved in developing and delivering a new training package on the role of the IMCA and safeguarding processes for managers
- Specific prompts on the safeguarding documentation / database now remind staff to consider IMCA involvement and to give reasons when this is not required. This was introduced in 2012 and is highlighted in the paper version at Stage Three (the Strategy Meeting and Stage Five (the Case Conference and Protection Plan). In the electronic version, a prompt is provided at every stage of the safeguarding process.
- A Mental Capacity Act Working Group has been established that is directly accountable to Gateshead Safeguarding Adults Board. The purpose of the MCA working group includes working together to develop MCA and DoLS practice and strengthen partnership arrangements across Gateshead. It is also tasked with providing strategic leadership in order to protect, empower and safeguard the rights of those who lack, or are at risk of lacking mental capacity and supporting the Safeguarding Adults Board.

Understanding of the role of IMCAs

Interviewees often found it difficult to articulate the role of IMCAs in safeguarding. Some said a referral should only be made for an IMCA if the service user was "unbefriended" – either had no family or friends, or those people were the alleged abusers. Only a small minority of participants were able to say that IMCA instruction should be considered in Safeguarding, whether or not the person had friends or family to support them. It was recognised that this lack of understanding was part of a wider problem about knowledge of the Mental Capacity Act in general:

"I think people are generally quite frightened of the Mental Capacity Act … and because IMCA falls within that, I think people feel unconfident in this legislation generally and an awful lot of people are avoidant about it … Some people haven't got to grips with the provisions of the Act, one of them being the creation of the IMCA role" (Interview 13).

Use of IMCAs

Unsurprisingly, there was a limited number of actual examples of IMCAs being used in safeguarding processes, reflecting the rate of referrals. However, it was encouraging to find that in those situations where an IMCA had been involved, this was seen as extremely helpful. Specific (anonymised) case examples are given in Box 5 on the next page.

Participants identified a number of important key aspects to the IMCA role:

- Providing a 'voice' for the service user
- Facilitating communication
- Independence from the process
- The ability to spend sufficient time with the person to build up a detailed picture.

"I think the purpose of the IMCA for me is to make sure that the voice of the patient is heard so that we can do our job better, to meet the needs of our patients and clients." (Interview 6)

Perceptions about use of IMCAs in the safeguarding process

There was a general recognition amongst interviewees that there was a low referral rate to IMCAs in safeguarding adults. Use is now increasing and there were positive comments about the new provider. Some participants commented that the importance of IMCA involvement is becoming more widely recognised amongst staff involved in safeguarding processes. However, most participants expressed the view that IMCA use in safeguarding needs to be further improved.

"Sometimes it's not as high profile as it should be or we've been uncertain about their role and what they can and can't do, and sometimes it's about the referral process and how we access them" (Interview 12)

Box 5: Examples of positive IMCA involvement in safeguarding:

"I'm just thinking of the case that I'm working with where this lady has got the early onset of dementia, she's been allegedly financially abused by one of her family members, there's lots of dynamics within the family…and she's just caught up in the middle of it and … the doctor's saying she hasn't got any capacity to make any decisions about her finances. She doesn't know what she's doing and then the IMCA goes out, takes the time with her, she's really upset, she knows this is happening, she said she would give [the alleged abuser] the money if he just came and asked… so you've got all of these people around her making all these judgements… and [the IMCA] sitting listening to her views and her wishes and what she actually wants... I haven't got the time to do it, the family are too emotionally involved to actually sit down and talk to her and see what's happened so that's where it's been really beneficial in this case, clearly." (Focus Group Participant)

"We've had a recent case within safeguarding […] a man with learning disabilities was allegedly assaulted by another service user with a learning disability. There was a lot of ongoing tensions between the family of the victim and the perpetrator … We came to a conclusion, worked with [the family] to say we thought it was really helpful to bring in an IMCA to represent [the alleged victim's] views and [they were] happy to do that – [they] recognised and understood that [they were] still emotionally involved and could no longer get a sense of perspective on the issue. Similarly for … the alleged perpetrator … he doesn't have any next of kin or anyone who could represent him so we instructed an IMCA for him so that we can try to get a good understanding … we need to ensure that both parties' views and best interests would be considered… because we're concerned about the welfare of both individuals." (Interview 2)

"[An IMCA] was used very effectively with a man who had [a neuro-psychiatric condition, in a residential setting] and there was an issue that came up whereby he was restrained inappropriately. [The IMCA] had known the gentleman for quite some time. He knew what made him tick in terms of restraint and support when the patient underwent a nursing or medical intervention. The IMCA shared with us methods of handling the patient because he knew where he was coming from and every patient is very different … he knew what made him frightened, what the best methods would be to hold and restrain him – I think it was the advice about reducing fear, reducing anxiety … and what he preferred in terms of his restraint. He knew what he liked and what he preferred, because he knew he had to be held. But the IMCA knew that level of detail – I was really impressed. And he also provided the meeting with a different perspective - you felt that his voice counted, the patient's voice was the centre and that's what we're talking about – the patient's voice should be the centre of everything we do and he provided that." (Interview 6)

Possible reasons for low rate of IMCA involvement in safeguarding

A variety of reasons was offered by participants to explain the low rate of IMCA involvement within safeguarding in Gateshead.

- There was some confusion about whose responsibility it is to instruct an IMCA and at what stage this would be appropriate. Consideration of possible referral for an IMCA in the safeguarding process had not been embedded in the thinking of staff (partly due to the misunderstanding of the role e.g. that if family were involved and acting in the best interests of the service user an IMCA was not needed).

  "I think sometimes in safeguarding … it's felt that the family can represent the person … but the IMCA can get to know a bit more about the case, get a handle on it, they're an independent person." (Interview 11)

- Some participants felt that staff saw the process as too complex and creating additional work, when workers have full caseloads.

- The IMCA might challenge practice or be seen as undertaking a role which the professionals involved were already fulfilling.

  "People don't see the conflict of interest and the need for impartiality… people really think that because they have a working relationship with somebody that they can advocate on their behalf." (Interview 13)

- The service user already had a general advocate – what could an IMCA add?

  "I think it's easy if there's an advocate involved, to not think beyond that and to think somebody's needs are being met." (Interview 12)

- The previous provider was seen as unresponsive. Their referral system was not clear or straightforward and there was sometimes a waiting list.

  "There was too much of a barrier in terms of justifying why an IMCA should be required" (Interview 2)

  "I felt I had to fight to get an IMCA that first time" (Interview 9)

  "Having a referral turned down put me off making other referrals" (Interview 14)

- In the past, the safeguarding documentation did not prompt staff to think about possible referral for an IMCA (the new process does this).

What needs to be done?

- Continued awareness raising and training needs to be targeted at the right people and repeated regularly. Staff who were originally trained may have moved on. Some participants commented that they had received relevant training some time ago but 'refresher' sessions were seen as important.

  "I really think a lot of people will have forgotten about the use of IMCAs in safeguarding, the message will have been lost … I think people forget about the additional bit about safeguarding because it's not a duty, it's a power … hearing it once and a long time ago isn't enough" (Interview 14)

- Continue direct contact with the IMCA provider. The provider's involvement in training was seen as helpful, and many participants also commented on the value of face-to face contact to develop working relationships and raise the profile of IMCA service. Several people mentioned the possibility of IMCAs attending team meetings to speak to staff groups.

  "A personal relationship with [the IMCA provider] is important because, even if we can just phone them to run something by them, that would be really helpful, just to have a better relationship with them." (Interview 14)

- Prompts to consider IMCA use on the safeguarding documentation were seen as helpful, although it was highlighted that the electronic version of these forms was not available to Health staff. Some participants felt that IMCA involvement should be suggested within supervision and that it would be useful for chairs of safeguarding meetings to ask specifically whether IMCA instruction had been considered.

- Greater publicity and the increased use of visual prompts such as posters, flyers and websites were suggested as ways of further raising the profile of the IMCA role in safeguarding. The dissemination of case examples was highlighted as a particularly useful way of encouraging people to consider IMCA referrals and promote best practice.

“I don’t think there’s enough material out there to tell people what it can be utilised for and there’s not enough examples of where it can work and doesn’t work … if other people knew the kind of cases that they’re involved with, it might inspire them to utilise them more” (Interview 11)

Discussion

Several key themes emerge from the findings.

Clarity of understanding about the role of an IMCA in safeguarding procedures

The evaluation highlights a lack of clarity about the circumstances in which an IMCA could be involved in safeguarding procedures. Guidance from SCIE (2009) and the Department of Health's report (2009) are clear that in relation to safeguarding, it is the duty of the local authority to consider – *for each person* - whether they might benefit from an IMCA. Despite this, there was a perception amongst a number of interviewees that an IMCA should only be involved safeguarding situations where a person was "unbefriended" with no family or friends or where the alleged perpetrator was a family member.

The benefits of using an IMCA are apparent and clearly recognised by staff. Interviewees understood the important and valuable role an IMCA could play in safeguarding in terms of their independence and ability to spend time with the person, providing a voice for the service user and facilitating communication. This resonates with previous research highlighting the benefits for service users of IMCA involvement (Townsley & Laing, 2011; Redley et al. 2011; Lee, 2007; Gorczynska & Thompson, 2007).

This underlines the need for the awareness raising and training about the role of the IMCA in safeguarding, which is already taking place, to continue and for staff to have refresher training too. The contribution of the IMCA provider to this training is very positive and perhaps could be aided by a suggestion from one of the interviewees, that the use of case examples could help staff develop a greater understanding of situations in which an IMCA could be advantageous both for the service user and for staff involved.

The need for training to be repeated regularly is highlighted in several pieces of research about knowledge of the Mental Capacity Act and the IMCA role among

health and social care staff. For example, Phair and Manthorpe (2012) surveyed staff within an acute hospital staff and found that only half of the respondents could define the role of the IMCA correctly, despite having attended training. These findings are echoed in other studies (for example Martins et al., 2011; Samsi et al., 2011; Willner et al., 2011; Willner et al., 2013). Whilst one explanation could be that it is hard for participants to recall information when 'put on the spot' in an interview (Willner et al., 2011, p169), there is a recurring theme in this evaluation and in wider research about the implementation of the Mental Capacity Act that far more is involved in embedding knowledge about the Act than simply providing appropriate training: "training in social care and health services is not usually just a matter of imparting new knowledge but needs to be put into day-to-day work" (Manthorpe & Samsi, 2009).

Continued improvement of policies and procedures to track and monitor use

A number of procedures have already been introduced both to encourage greater use of IMCAs and to monitor their use. These include an improved referral system for IMCAs, better documentation with prompts as to whether an IMCA needs to be involved and reasons for using or not using them and a new quality assurance system. Recent research (Braye et al., 2012) has emphasised the importance of robust governance arrangements in improving the quality of safeguarding processes. The perceived benefits of the improvements in Gateshead will need to be evaluated as to their effectiveness in increasing the appropriate use of IMCAs.

Collaborative working relationships and networks

The development of collaborative working relationships and networks has been perceived as particularly beneficial in expanding the understanding of the MCA coordinator and IMCAs generally. The creation of one team to coordinate safeguarding adults activity, locating the MCA coordinator with this team, the secondment of a member to staff with a professional health background and the closer contact between the IMCA provider were all seen to contribute to extending the knowledge of each other's roles and practice.

The recently established SAM network which is intended to continue to build good practice, through discussion of cases and sharing examples of good practice, has considerable potential to disseminate examples of use of IMCAs in safeguarding and thereby encourage their greater use. It will be important to keep maintaining a focus on MCA and IMCAs in this forum.

Some specific issues were raised during the interviews (by both NHS and local authority staff) about the particular challenges of implementing the IMCA service effectively within health settings. A number of factors were relevant here including the extensive and disparate nature of health services across the borough, difficulty in accessing appropriate training and the lack of priority given to the requirements of the Mental Capacity Act, particularly within busy acute settings. Different recording systems for safeguarding exist within health care which do not include prompts about use of IMCAs. It was noted that recording systems for health care staff are different and consideration could be given to incorporating prompts into health care recording systems or into developing shared systems.

Use of IMCA when a general advocate is involved

Some uncertainty exists about whether it is appropriate to refer to an IMCA in safeguarding, when a service user already has an advocate, particularly when the advocate knows the person well. The guidance from SCIE (2009) is very helpful in this respect, clearly identifying factors which would indicate that referral for an IMCA would be advantageous, for example when their specialist knowledge and skills and rights of access relevant records is needed. Greater publicity about this guide and incorporation of this information into awareness raising and training could be valuable.

Maintaining the profile of MCA and IMCA in safeguarding

The more “outward facing “ approach of the new IMCA provider, Your Voice Counts, and their greater involvement in training and in direct meetings with staff within a

short space of time has been very positively received. This is notable given the short length of time YVC has held the IMCA service provider contract. Maintaining and developing this approach would be beneficial in continuing to raise the profile of IMCAs within safeguarding procedures. Similarly the role played by the MCA Coordinator and the Safeguarding Adults Coordination team in a broader educational and advisory role also helps to sustain the profile of issues around mental capacity and IMCAs.

Other ideas were put forward by interviewees about ways in which further use of prompts might improve the use of IMCAs. These included the proposal that staff in managerial roles could discuss this with staff in supervision, when cases which might be appropriate for an IMCA arise. It was also suggested that chairs of safeguarding meetings could, as a matter of course, ask whether involvement of an IMCA had been considered in cases.

A strong message from the evaluation is that the role which IMCAs can play in safeguarding and the benefits for service users need to be consistently and regularly re-iterated through a range of approaches. These include awareness raising and training, targeted and repeated regularly, publicity, and leadership from a range of staff in managerial and supervisory roles and continuing monitoring and evaluation.

Recommendations

This evaluation has found that, although great strides have been made to increase the use of IMCAs when working with adults in safeguarding, there are still some areas that could be improved. These recommendations must, however, be considered in the wider context of continual change, improvement and enhancement that has taken place under the strategic leadership and direction of Gateshead Safeguarding Adults Board.

1. **Improving standards in recording**

   The evidence from the very few case files that were scrutinised suggests that significant improvements could be made in the standard and accuracy in all the safeguarding adults forms and in the chronology reports. This was most obvious in the responses given to questions that required explanations for decision making. At a time when professions are often required to provide evidence of their judgements and decisions, it is essential that sufficient and accurate detail is provided in the case notes

2. **Improving the level of understanding about the distinctiveness of the IMCA role**

   Despite the amount of awareness raising and attention given to the role of the IMCA and the statutory basis of the role, it is a concern that there was still a lack of awareness of the role of the IMCA and how it differs from that of a general advocate. It is both a question of understanding the statutory basis of the role through the Mental Capacity Act and the importance of someone having an independent voice if they lack capacity. It is therefore recommended that the level of training be continued and monitored to ensure all Safeguarding Adults Managers are aware of the role. This might include the standard training courses but also inviting the IMCA providers to team meetings so that their face is known.

3. **Ensuring the Chair of the strategy meetings is clear about the IMCA role**

   This recommendation is similar to that of the above but there is a distinct role for any Chair to act in a way that promotes good practice. It is recommended that all Chairs be encouraged to prompt the meeting to consider whether an IMCA referral is necessary.

4. **Ensure the IMCA profile is maintained on the agenda of the Safeguarding Adults Managers network**

   With the change of IMCA provider, current level of training and general focus on the IMCA role, it is relatively easy to keep the high profile of the IMCA role. However it is important that this focus becomes embedded in good practice and one way of ensuring this is through the SAM network.

5. **Strengthen written guidance about the role and use of IMCAs**

   Work has already begun on developing policies that clearly integrate safeguarding and mental capacity processes rather than seeing them as separate. However it is important that using IMCAs are embedded in the policies and procedures that staff are expected to follow. For example the expectations stated in the procedures section of the Multi Agency Policy and Procedures could be strengthened at Stage Three to make consideration of an IMCA part of the agenda. Reference to IMCAs could be made in the SAM Assignment Procedures. There is an argument for tailoring these policies so that they are relevant and applicable to particular settings as expectations may vary according to role and practice context. Advocacy for people who lack capacity and the associated need for representation and autonomy is ultimately a question of human rights.

Bibliography

Boyle, G. (2011) 'Early implementation of the Mental Capacity Act 2005 in health and social care'. *Critical Social Policy*, 31(3), pp365-387

Braye, S., Orr, D. & Preston-Shoot, M. (2012) 'The governance of adult safeguarding: findings from research.' *Journal of Adult Protection, 14(2), p55-72*

Department of Health (2000) *No Secrets: guidance on implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London: Department of Health

Department of Health (2007) *Adult protection, care reviews and IMCAs: guidance on interpreting the regulations extending the IMCA role.* London: Department of Health

Department of Health (2008) *The First Annual Report of the Independent Mental Capacity Advocacy Service.* London: Department of Health

Department of Health (2009) *The Second Annual Report of the IMCA service.* London: Department of Health

Department of Health (2010) *The Third Year of the Independent Mental Capacity Advocate (IMCA) Service (2009-2010).* London: Department of Health

Department of Health (2011) *The Fourth Year of the Independent Mental Capacity Advocate (IMCA) Service: 2010/2011.* London: Department of Health

Department of Health (2013) *The Fifth Year of the Independent Mental Capacity Advocate (IMCA) Service – 2011/12.* London: Department of Health

Donnelly, M. (2011) 'Determining Best Interests under the Mental Capacity Act 2005'. *Medical Law Review, 19(2), p304-313*

Douglas, J. (2012). *Independent Audit of Safeguarding Vulnerable Adults Services (Gateshead).* Unpublished report

Gateshead Safeguarding Adults Board (undated) *Draft Gateshead MCA Working Group Terms of Reference* (unpublished)

Gateshead Safeguarding Adults Partnership (2012) *Safeguarding Adults From Abuse: Multiple Agency and Procedures: Protecting Adults at Risk*

Gateshead Safeguarding Adults Board (2012) *Gateshead Safeguarding Adults from Abuse: Partnership Plan 2012-2013.* Gateshead

Gorczynska, T. and Thompson, D. (2007) 'The role of the independent mental capacity advocate in adult protection'. *Journal of Adult Protection, 9(4), p38-45*

Grant, M.J. and Booth, A. (2009) 'A typology of reviews: an analysis of 14 review types and associated methodologies'. *Health Information & Libraries Journal*, 26, 91-108

Great Britain. *Mental Capacity Act 2005: Elizabeth II.* (2005) London: The Stationery Office

Health and Care Professions Council (2012) *Standards of conduct, performance and ethics*. London: HCPC

Ingram, R. (2011) 'The four situations: a framework for responding to concerns of adult abuse or neglect'. *Journal of Adult Protection, 13(2), p75-86*

Lee, S. (2007) *Making decisions. The Independent Mental Capacity Advocate (IMCA) service.* London: Mental Capacity Implementation Programme.

Lee-Foster, A. (2010) 'Capacity to Communicate: Semse's three-year project training independent mental capacity advocates in communication skills'. *Journal of Adult Protection 12(1), p32-42*

Lindbridge, A., and Thompson, G., (unpublished report) *Gateshead Safeguarding Adults: Needs Assessment 2011- Informing Safeguarding Adults Priorities for 2012/13. (Final Draft).* Unpublished report

Manthorpe, J., Rapaport, J., Harris, J. and Samsi, K. (2009) 'Realising the safeguarding potential of the Mental Capacity Act 2005: early reports from adult safeguarding staff'. *Journal of Adult Protection, 11(2), p13-19*

Manthorpe, J. & Samsi, K. (2009) 'Implementing the Mental Capacity Act 2005: Challenges for Commissioners'. *Journal of Integrated Care, 17(3), p39-47.*

Martins, C.D.S., Willner, P., Brown, A. & Jenkins, R. (2011) 'Knowledge of Advocacy Options within Services for People with Learning Disabilities'. *Journal of Applied Research in Intellectual Disabilities, 24, p274-279*

Northumbria University (2011) *School of Health, Community and Education Studies Research Ethics Sub-Committee: Advice on ethical considerations for "Insider Researchers" in health, Social Care and Education Contexts.* Northumbria University

Northumbria University (2011) *Research Ethics and Governance Handbook.* Northumbria University

Phair, L. & Manthorpe, J. (2012) 'The use of the Mental Capacity Act among hospital patients: findings from a case study of one Acute Hospital Trust in England.' *Journal of Adult Protection, 14(6), p259-270*

Redley, M., Clare, I.C.H., Platten, M. & Holland, A.J. (2008) *The Involvement of Independent Mental Capacity Advocates (IMCAs) in Adult Protection Procedures in England: 1st April 2007 – 31st March 2008.* London: Social Care Institute for Excellence

Redley, M., Clare, I.C.H., Dunn, M.C., Platten, M. & Holland, A.J. (2011) 'Introducing the Mental Capacity Advocate (IMCA) Service and the Reform of Adult Safeguarding Procedures'. *British Journal of Social Work, 41, p1058-1069*

Ritchie, J. & Spencer, L, (1994) 'Qualitative data analysis for applied policy research' in Bryman, A. and Burges, R. (eds) *Analysing Qualitative Data* 1994 pp 173-194

Samsi, K., Manthorpe, J., Nagendran, T. & Heath, H. (2011) 'Challenges and expectations of the Mental Capacity Act 2005: an interview-based study of community-based specialist nurses working in dementia care'. *Journal of Clinical Nursing, 21, p1697-1705*

Social Care Institute for Excellence (2009) *SCIE Guide 32: Practice guidance on the involvement of Independent Mental Capacity Advocates (IMCAs) in safeguarding adults.* London: Social Care Institute for Excellence

Townsley, R. & Laing, A. (2011) *Effective Relationships, Better Outcomes: Mapping the Impact of the Independent Mental Capacity Advocate Service (1st April 2009 – 31st March 2010).* London: Social Care Institute for Excellence

Wallcraft, J (2012) 'Involvement of service users in adult safeguarding'. *Journal of Adult Protection, 14(3), p142-150*

Williams, V., Boyle, G., Jepson, M., Swift, P., Williamson, T. & Heslop, P. (2012) *Making Best Interests Decisions: People and Processes.* London: Mental Health Foundation

Willner, P., Jenkins, R., Rees, P., Griffiths, V.J. & John, E. (2011) 'Knowledge of Mental Capacity Issues in Community Teams for Adults with Learning Disabilities'. *Journal of Applied Research in Intellectual Disabilities, 24, p159-171*

Willner, P., Bridle, J., Price, V. Dymond, S. & Lewis, G. (2013) ‘What do NHS staff learn from training on the Mental Capacity Act (2005)?’ *Legal and Criminological Psychology, 18, p83-101*