

Guidance to Assessing Mental Capacity and Making Best Interests Decisions

June 2021

*Created by partners of the Safeguarding Adults Board &
voluntary organisations*



Foreword from Deborah Cohen, Independent Chair Safeguarding Adults Board

Waltham Forest recently commissioned a [Safeguarding Adult Review](#), which identified the need for a refocus on the application and culture of mental capacity assessments and professional curiosity.

In light of this, Waltham Forest's Safeguarding Adults Board (SAB) felt there needed to be a greater emphasis on promoting awareness and understanding of the application of the Mental Capacity Act 2005 (MCA).

In addition, the House of Lords' MCA Select Committee report from March 2014 concluded that in the main, the MCA was highly regarded in relation to its scope, ambition and intentions.

However, the report also criticised Health for a culture of 'paternalism' and Social Care for a culture of 'risk aversion' when working with people who lack capacity and stated that the legislation was yet to be fully implemented due to a lack of awareness and understanding from some professionals.

The SAB had agreed to form the Waltham Forest MCA Subgroup that brought together a number of practitioners working day-to-day with these concerns.

Members of the Subgroup set themselves the task to demystify the MCA and to make key aspects workable in practice. The Subgroup, using their combined expertise and practical insight, have produced this guidance document.

This document sets out vital, much needed guidance for anyone concerned with seeking to apply the MCA in a whole host of situations. It explains what the law means and what proper application of the MCA code looks like in practice.

I strongly recommend this guidance across the Waltham Forest Partnership.



For more information on Safeguarding Adults Board, please see SAB [webpage](#)

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Introduction

The aim of this document is to provide clear guidance in relation to Assessing Mental Capacity and making Best Interests decisions in accordance with the Mental Capacity Act 2005 (MCA). This will be achieved primarily by the introduction of two flowcharts to support practitioners. Please note that it is not our intention to cover in any great detail the many other provisions within the legislation.

The MCA and its associated Code of Practice (MCA Code) provide a statutory framework to empower and protect those who may lack capacity to make decisions because of mental impairment. The MCA Code sets out who can take decisions, in what circumstances, and how they should do this. The MCA also enables adults to plan ahead for a time in the future when they might lack capacity, by giving them the opportunity to appoint a Lasting Power of Attorney (for property and finance and/or health and welfare) and make Advanced Decisions or Statements.

The MCA Code also places a duty on all staff (e.g. health, social care, care providers, police, housing, ambulance and fire services and volunteers) to support people to make their own decisions wherever possible and to Assess Mental Capacity and make Best Interests decisions on their behalf as required.

The MCA in general applies to those aged 16 years and over, but it is of note that some provisions are reserved for those aged 18 years and above e.g. the making of a Lasting Power of Attorney, the ability to act as someone's Attorney, the ability to make an Advance Decision to Refuse Treatment and the [Deprivation of Liberty Safeguards](#) (DoLS).

The DoLS were introduced, as an amendment to the MCA, on the 1st April 2009. In short, they provide lawful authority to detain people in care homes and hospitals for the purpose of providing necessary care and treatment in their best interests. Please note that the DoLS do not Authorise the care and treatment that is subject to either the person's consent or through applying the MCA.

As previously stated, the aim of this guidance is to support staff to assess mental capacity and make best interest(s) decisions within the parameters of the MCA and MCA Code. It was produced by Waltham Forest's MCA Subgroup in collaboration with front-line practitioners and voluntary organisations.



Explanations of terms and definitions:

ADRT

or Advance Decision
to Refuse Treatment

A refusal of a treatment that may be required in the future, made by someone who had mental capacity to make that decision at the time the decision was made. It is legally binding if it is valid and applicable.

Advance Statement

This is a statement of wishes, preferences, values and beliefs. It is not legally binding but should be considered when making a best-interests decision for someone who lacks capacity to make that decision for themselves.

Court Appointed Deputies

Individuals appointed by the Court of Protection to act on behalf of adults who lack capacity and make decisions on their behalf about health and welfare and/or property and finance.

Human Rights Act 1998

The act sets out the fundamental rights and freedoms that everyone in the UK is entitled to. It incorporates the rights set out in the European Convention on Human Rights (ECHR) into domestic law.

IMCA

or Independent
Mental Capacity
Advocates

Independent Mental Capacity Advocates were introduced as part of the MCA. This gives people who lack capacity to make certain decisions for themselves, the right to receive independent support and representation. Please see the MCA Code for full details on when an IMCA might be required.

Lasting Power of Attorney (LPA)

This allows an adult to appoint a person(s) to make decisions on their behalf in case they lack capacity to make a decision for themselves at some time in the future. There are **two** types of LPAs:

1. Health and Welfare
2. Property and Financial Affairs

Life-sustaining Treatment

This is any medical intervention, technology, procedure, or medication which a person providing healthcare regards as necessary at the time in question to sustain life.

SAR

or Safeguarding Adult
Review

This is a multi-agency process that considers whether serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented. The process identifies learning that enables the partnership to improve services and prevent abuse and neglect in the future.

Mental capacity: some key issues to consider

Mental capacity assessments are decision specific. When it is simply determined, e.g. 'Mental capacity assessed and George lacks capacity', this phrase - in law - is meaningless. The question is: 'What is the actual decision(s) in hand'? If the question is not defined with specific precision before the assessment of mental capacity is undertaken, the exercise will be pointless.

The MCA sets out five core principles which must be followed:

1. A person must be assumed to have capacity unless it is established that he or she lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him or her 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 or she makes a decision that others believe to be unwise.
4. An act done or decision made, for or on behalf of a person who lacks capacity must be done so, or made in his or her best interests.
5. Before such an act is done, or decision 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.

What is a mental capacity assessment?

A mental capacity assessment is, in many ways, an attempt to have a real conversation with the person on their own terms and applying their own values and beliefs.

Carrying out a mental capacity assessment on someone is not neutral. The assessment process itself can often be seen as intrusive to the individual and can interfere with their right 'to respect for private and family life' (under Article 8 Human Rights Act). Therefore, you must always have grounds to consider that one is necessary. Conversely, you must also be prepared to justify a decision not to carry out an assessment where, on its face, there appeared to be a reason to consider that the person could not take the relevant decision(s). It is important to understand that it is not only medical professionals (and in particular, psychiatrists) who can carry out a mental capacity assessment.

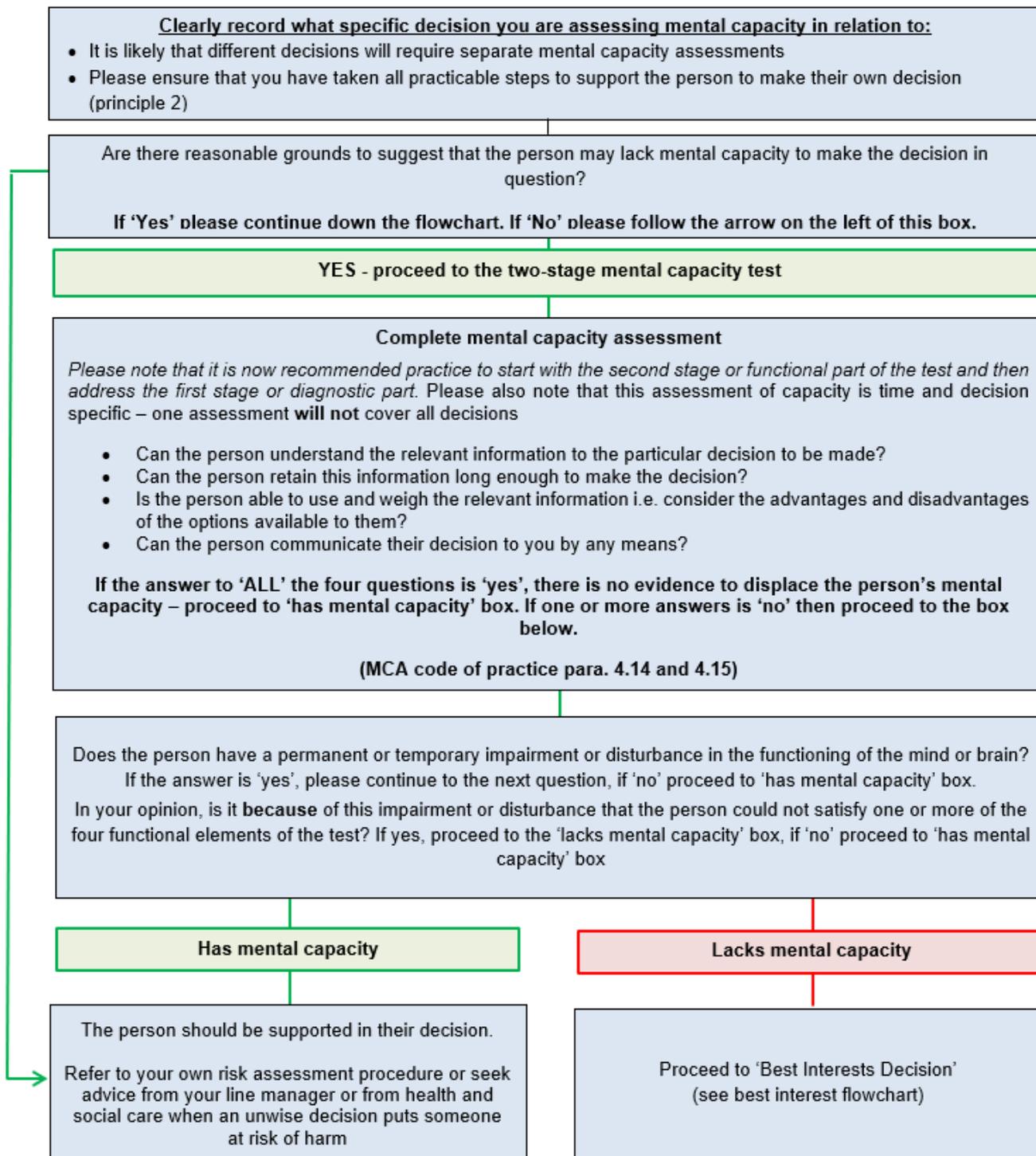
There will be some circumstances where a medical professional's expertise will be required, but that is because of their expertise, not because of the position that they hold. Another common area of difficulty is where a person gives superficially coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers (in other words, their so-called 'executive function' is impaired).

It can be very difficult in such cases to identify whether the person in fact lacks capacity within the meaning of the MCA, but a key question can be whether they are aware of their own deficits – in other words, whether they are able to use and weigh (or understand) the fact that there is a mismatch between their ability to respond to questions in the abstract and to act when faced by concrete situations. Sometimes individuals who appear to self-neglect, may do so because of an inability to action their intentions, or to make the linkage between intent and actions.

Additional information: [Resources to improve practice | Waltham Forest Council](#)

Mental capacity assessment flowchart (a)

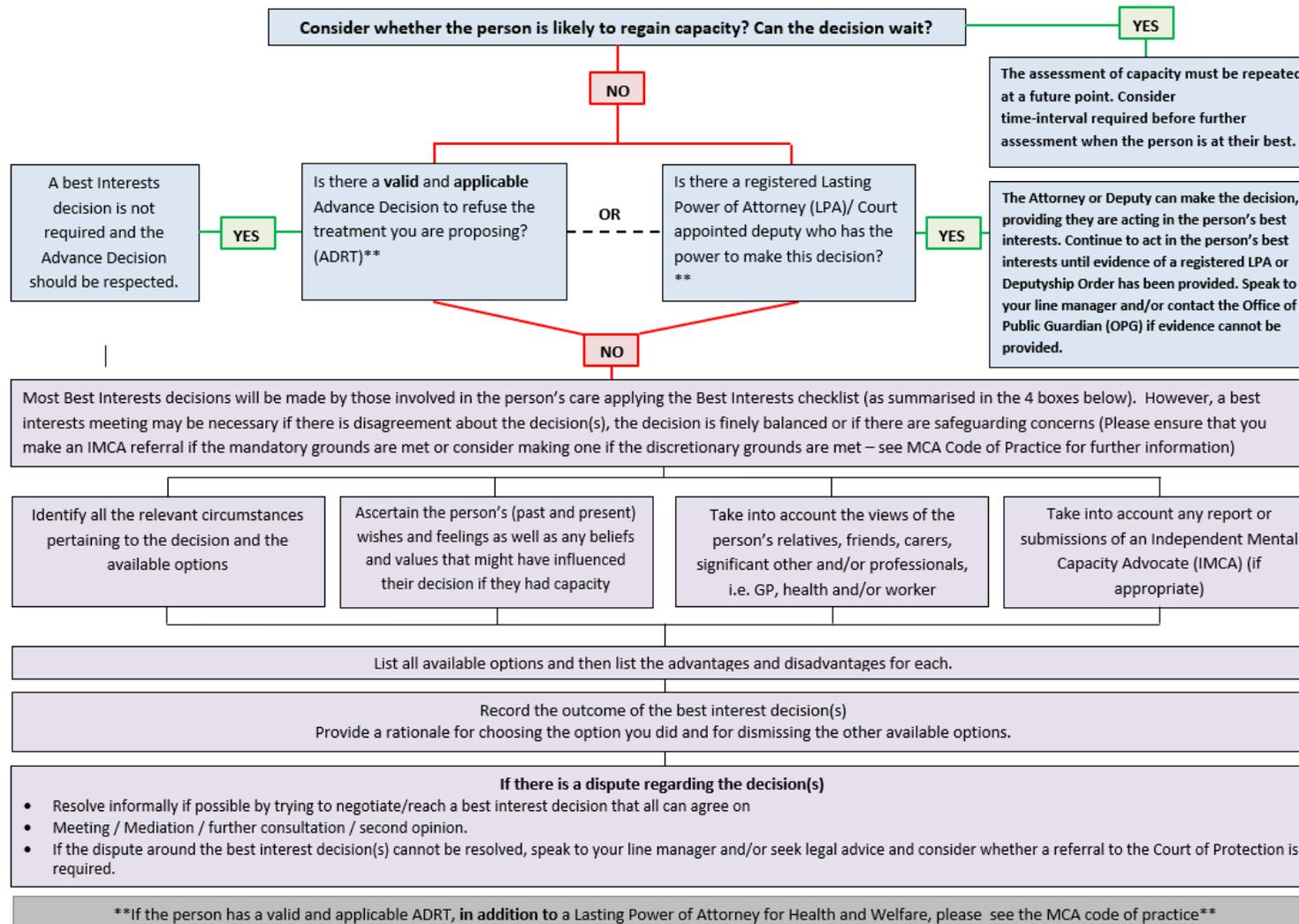
Principle 1 of the MCA is the presumption of mental capacity. However, if a person's mental capacity to make a decision is in doubt, professionals **MUST** apply the Mental Capacity Act 2005 (MCA). The ethos of the MCA, along with all effective Human Rights-based practice, is to work with people and empower where possible, rather than do things for people. This flowchart provides practical steps to support people to assess mental capacity. It is not intended to be definitive guidance - please refer to your own organisation's MCA Policy and Procedures, as well as the MCA Code of Practice for further information.



Clearly document details of your conversation with the person to evidence how you reached your decision.

Following this, if the person is found to have mental capacity to make this decision, best interest is not required.

Best interests decision flowchart (b)



Additional information that may be useful to look at alongside this: [A guide to thresholds & practice for working with people \(walthamforest.gov.uk\)](http://walthamforest.gov.uk)

Fluctuating and temporary capacity

The term 'fluctuating capacity' is not a concept expressly addressed or provided for in the MCA, although it is referred to in the Code of Practice.

It is important to distinguish between two different potential situations:

What is fluctuating capacity?

A person with fluctuating mental capacity, such as a person with bi-polar disorder, is someone whose mental impairment may lessen or become more severe over time which means that they may have periods when they are perfectly capable of making decisions and other times when they are not.

The fluctuation in someone's mental capacity can take place over a matter of days or weeks, or even over the course of each day. For example, for some people with dementia, their cognitive abilities may be significantly less impaired at the start of the day than they are towards the end. This must be considered when supporting them to make a decision or assessing their mental capacity.

How to address fluctuating capacity?

Consider whether the decision that you need the person to make is one that can wait. If it can, then delay it until the person may be able to be supported to make their own decision.

If the decision(s) cannot wait, then assess the person's mental capacity and follow the Best Interests decision making process as normal. However, be mindful that further and regular assessments may be required if the person's mental capacity fluctuates.

What is temporary capacity?

A person who has a temporary impairment of the mind or brain that affects their ability to make decisions, an example being a person suffering from a severe urinary tract infection and experiencing confusion as a result of this. Other examples would include a person who was unconscious, had a severe head injury or even the effects of alcohol or drugs.

How to address temporary capacity?

In short, this is very like the situation of fluctuating capacity insofar as if possible, delay the decision(s) until the person has regained mental capacity.

However, if the decision cannot be delayed, then assess mental capacity and follow the Best Interests decision making process as normal. It would be prudent to keep any mental capacity assessment under review and be prepared to re-assess when there are indicators that the person cognitive abilities have improved and that they may have regained capacity.

It is of note that all mental capacity assessments must be kept under review, but this is arguably even more important for those people whose mental capacity fluctuates or their loss of mental capacity is thought to be of a temporary nature.

How to establish consent?

Consent is a patient's agreement to someone - e.g. a volunteer, carer, health and / or social care professional - to provide support, care or treatment. People may indicate consent non-verbally (for example by presenting their arm for their pulse or blood pressure to be taken), verbally, or in writing.

For the consent to be valid, the service user must:

- **Be competent and have the mental capacity to make the particular decision**
- Have received sufficient information to inform the decision they are making
- The person must not be acting under duress of others

If there is any indication that the person lacks mental capacity to give informed consent, a mental capacity assessment must be carried out. Please refer to the Assessment of Mental Capacity flowchart with regards to this process.

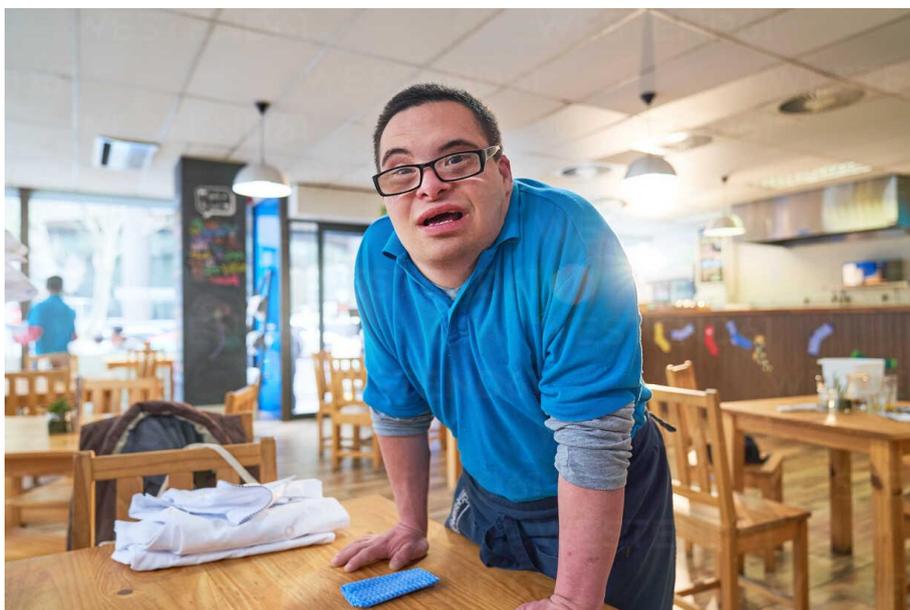
Recording and documentation for professionals

Simple Decisions: It is required practice to make reference to Mental Capacity/Best Interests in care records even for simple everyday care decisions, although detailed recording is not usually expected.

Intermediate or Complex Decisions: More formal documentation is necessary. Recording for these decisions is required to be more in-depth and demonstrate how a particular conclusion was reached during the mental capacity assessment, as well as best interests considerations as outlined in the 'Best Interests' checklist.

A balance sheet approach towards analysing the available options is also helpful i.e. listing the available options and highlighting the pros and cons of each to help reach the decision as to what is in individual's best interests.

****Please follow own agency protocol for the recording of information.***



Safeguarding and mental capacity

In situations where an adult who has care and support needs is actually, or potentially, at risk of harm/abuse the Local Authority has a statutory duty under the Care Act 2014 to offer to safeguard the person.

If there is some concern that the adult may lack mental capacity with regard to any decision(s) that needs to be made throughout the Safeguarding process, then the MCA must be applied as highlighted throughout this document i.e. the adult's mental capacity should be assessed and the best interests decision-making process followed.

In terms of advocacy, if the Local Authority feel that the adult would have 'substantial difficulty' participating in the Safeguarding process, and does not have an appropriate person (other than a paid professional) to support them, then the adult has a right to an advocate under the Care Act 2014.

Alternatively, there are discretionary powers for the Local Authority or NHS provider to instruct an Independent Mental Capacity Advocate (IMCA) for the purpose of decision(s) around the safeguarding process or any measures/services that might be offered to protect the adult. This might include significant matters such as a change of accommodation or contact with a family member or friend.

It is of note that an IMCA can be instructed under Safeguarding even if the adult has family or friends who are involved in their life if it is thought that this would be of benefit to the person.

In terms of Safeguarding, the MCA also created two criminal offences of ill-treatment and wilful neglect of someone who lacks capacity in relation to at least some aspects of their care provision. These offences can be committed by anyone responsible for the person's care and support (paid and informal carers) and can result in a custodial sentence in some instances.

If you have safeguarding concerns for adults or children, please contact the London Borough of Waltham Forest (LBWF) safeguarding team or children social care to report any safeguarding concern, or if advice and support is required.

What to do if you have concerns:

If you have safeguarding concerns for adults or children, please contact London Borough of Waltham Forest (LBWF) safeguarding team or children's social care to report any safeguarding concerns, or if advice and support is required:

Concerned about an adult?

Phone: 020 8496 3000 (at any time)

Email:
WFDliaison@walthamforest.gov.uk

Website:
<https://www.walthamforest.gov.uk/content/what-do-if-you-are-worried-about-vulnerable-adult>

Concerned about a child?

Phone: 020 8496 2310

Email:
MASHrequests@walthamforest.gov.uk

(Monday to Thursday 9am to 5.15pm, Friday 9am to 5pm) or 020 8496 3000 (out of hours)

A social worker from our Multi Agency Safeguarding Hub (MASH) will speak to you.

Considerations on the wider context of care provision

| | |
|--|---|
| The person is at the centre of their care and support | |
| <ul style="list-style-type: none"> • The person's views and wishes must always be valued and where appropriate in line with 'Making Safeguarding Personal' • The person should be informed of every step of the process • Listen to them and work towards the outcome they want |  |
| Don't walk away – walk alongside | |
| <ul style="list-style-type: none"> • People who have a cognitive impairment may find it difficult to engage with agencies – continue to support, and take time to build a trusting relationship • Present the information on the basis of their understanding when discussing the decision you need them to make. It is not necessary that the person understands every element of what is being explained to him. What is important is that the person can understand the 'salient' factors • If the person has mental capacity, do not judge them when they make an 'unwise decision'. The key to a successful assessment is patience and empathy • Work with them, provide and empower them to help themselves when possible • Always apply the least restrictive option in the person's best interest |  |
| Multi-agency approach | |
| <ul style="list-style-type: none"> • Include other agencies and organisations. Who else is involved? Who needs to be involved? • What information is held by others and/or is required? • Be guided by "A Guide To Thresholds and Practice for Working With Adults, Carers and Families in Waltham Forest", as well as guidance on "Team Around the Person" • Be guided by the "Self-Neglect Guidance" document • Work collaboratively to share risk with your colleagues from across the partnership |  |
| Think family | |
| <ul style="list-style-type: none"> • What impact is the person's behaviour having on the people around them? • What impact are the other people in the family having on the person • Is there anyone else at risk i.e. in a domestic abuse or elder abuse situation? • Does the person have a statutory right to advocacy? |  |
| Think family, think community and wider than statutory services | |
| <ul style="list-style-type: none"> • Engage the community, friends and family • With informed consent (where that can be obtained) speak to neighbours or anyone else the individual may interact with • Are there any voluntary/community organisations who could offer support? |  |
| Build trust | |
| <ul style="list-style-type: none"> • Form a relationship, start conversations to get to know the person rather than immediately focus on the issues; • Keep communication consistent • Provide reassurance: the person may fear losing control. It is important to allay such fears. • Agree to small steps • If the person is known to have fluctuating mental capacity, please plan for a time to have a discussion with the person at their least impaired and make best interest decisions at a time when the person lacks mental capacity to make a decision(s) |  |
| Build trust | |
| <ul style="list-style-type: none"> • Understand the person's background – incorporating their wishes • Always treat the person with respect and dignity • Be non-judgemental and anti-discriminatory |  |

Case examples around mental capacity:

Case study on self-neglect: George

George is a 93-year-old man who lived in his own accommodation. He had several on-going health conditions including a colostomy bag following colon cancer. He was suspected to have dementia, awaiting an assessment. George received support from several agencies including home care and was known to various health services.

A friend who helped George day-to-day had become his informal carer and raised concerns about George's ability to live independently. This friend sadly passed away in January 2018.

On the 4th of December 2018, George phoned the police thinking he may have been burgled. The police found him in a severely neglected condition, and he was taken to hospital by ambulance. Since then he has moved to a 24-hour care home where he is now thriving.

In this case recognising and reporting issues around mental capacity status and fluctuating capacity was not evident. For more information, including learning please follow link: [George's Story](#)

Case study on hospital discharge concerns (for continuing health care): Mr R

Mr R, who has physical and mental health needs, was discharged from hospital in a non-MCA compliant manner, without an appropriate advocate involved in the decision-making process.

Mr R was subject to the 'discharge to assess' scheme. This scheme is in place to relieve some of the pressure on hospital beds and place people in alternative accommodation to hospital whilst awaiting DST assessment (decision support tool) for NHS Continuing Health Care funding.

Mr R was discharged to a nursing home (paid for by health budgets). He did not have an appropriate family member or friend to advocate for him. He was referred to an IMCA, but the decision to place Mr R in a care home was made before an advocate for Mr R had been consulted. His placement subsequently broke down as the care home was not fully aware of all of his needs. Following this, he was admitted to a mental health ward. The IMCA involved raised concerns about how the hospital discharge process fits into the MCA and how important the role of an IMCA is in ensuring decisions are made in the best interests of the relevant individuals.

Barriers:

The main barrier to this case appears to be how the legal framework of the MCA fits into the Discharge to Assess process, or to be more precise, how the Discharge to Assess process fits into the MCA for those who likely lack capacity to consent to being a part of that process.

Outcome:

Mr R was moved to a placement which could not meet his needs and then admitted to a mental health hospital due to a breakdown of that placement. Could the outcome have been different if IMCA involvement had been facilitated, or indeed if the 'Discharge to Assess' process was modified?

Case study on revisiting decision: Geraldine

Geraldine is 39 and has learning disability (Down's Syndrome) and resides in supported accommodation. Six months ago, she was diagnosed with breast cancer. She has been having chemotherapy as she thinks it will cure her however, she is experiencing unpleasant and distressing side-effects. The recent tests have shown that the cancer has spread, and her condition is now terminal. Dr Ahmed made an appointment with Geraldine to discuss with her the options for future treatment and care. Geraldine is accompanied to the appointment by her support worker, Cheryl.

Process

Dr Ahmed explains the diagnosis to Geraldine, and tells her that there are two options:

- a)** To have radiotherapy which may shrink the tumour and extend her life but unfortunately will not cure her. Side effects include It may also cause soreness and swelling, and will make her feel very tired
- b)** To not have radiotherapy and make arrangements for specialist palliative care to control her pain and other symptoms, possibly at the local hospice

Dr Ahmed tries to explain in straightforward terms what the radiotherapy will involve and what palliative care can do for her, but Geraldine does not seem to understand. She becomes confused and upset.

Dr Ahmed asks Cheryl to explain the options to Geraldine in her own words. He then asks Geraldine what is upsetting her. Geraldine says she does not understand why he wants to give her treatment that will not make her better, and she does not want to leave her home. Cheryl tells Dr Ahmed that Geraldine is usually very determined about doing things for herself but can take a while to grasp complicated situations, and hates being rushed.

As the decision does not have to be made immediately, Dr Ahmed suggests that he give Geraldine and Cheryl some written information to take away, for Geraldine to read when she is less distressed.

He gives them an easy-read leaflet which explains what a patient can expect when they have radiotherapy, together with some information about the local hospice. He also undertakes to contact Geraldine's Macmillan nurse and ask her to visit and talk to Geraldine at home, when she has had time to digest the diagnosis and may feel less pressured than she does in the hospital environment.

Outcome:

The following week, the Macmillan nurse reports that Geraldine has decided that she does not want any more active treatment, and would prefer to go into a hospice when the time comes, but wants to stay at home for as long as she can.

Case study on advance decision: Marie, a Jehovah's Witness

Marie, a 63-year-old lady, has been a Jehovah's Witness since the 1970s was found to be bleeding from her duodenal ulcer. She had been found wandering and confused outside her home.

Discussing her plight with the gastroenterologists, she was adamant that she did not want treatment with any blood products; they were sure that she had full capacity to make this decision, and that she was aware that she could die without blood transfusion. Marie had received other medical treatment over the years, and her adherence to her faith, together with her steadfast refusal of blood in any circumstances, had been documented in her notes.

The conversation with the gastroenterologists was recorded in the notes, but no formal advanced decision to refuse life-saving treatment existed. Similarly, she had not created a Lasting Power of Attorney enabling refusal of life saving treatment.

Three days following her discussion with the gastroenterologists, Marie deteriorated, requiring intubation, ventilation and sedation. Henceforth, she lacked capacity for further decision-making. Her clinicians felt that transfusion would improve but not guarantee her chances of survival.

Perhaps anxious that this lady had not provided a valid advance decision to refuse a life-saving blood transfusion, the clinicians approached the Court of Protection; seeking a declaration that withholding transfusion would be lawful in her case.

The court heard from Mr Roberts, a representative of her congregation, who had known her for 40 years, and who brought with him letters from 3 other members of the religious group who knew her. Robert described Marie as a formerly active member of the congregation, who fully subscribed to the tenets of the faith (including those opposing blood transfusion) and had taught them to others. Her beliefs on this matter had been consistent. The Trust's position was that Marie had made her wishes known, even with the knowledge of impending death. When considering her now, incapacitated, the Trust did not feel that transfusion was in her best interests, since it would be an affront to her established wishes.

The court found that Marie had capacity during her early admission to decide whether to accept or refuse a transfusion; and that the advance decision she took prior to losing her capacity (to refuse transfusion) was both valid and applicable to her later more serious condition, when she had lost her capacity. It was therefore lawful to withhold transfusion.

Outcome:

Marie died on the day of the judgement.

The judge also noted that he would have granted a declaration even if she had not made a valid applicable decision, since on the facts presented to the court; both from her congregation and the clinicians, a transfusion would not have been in her best interests. This was because her wishes and feelings and long-standing beliefs and values carried determinative weight. It was also relevant that the transfusion might not have been effective in saving her life.

Waltham Forest's 'Mental Capacity Charter':

The Mental Capacity Act 2005 (MCA) is a legal framework, designed to protect and empower people who may lack the mental capacity to make their own decisions. The Act is underpinned by five key principles, which every professional must follow (see page 5).

In Waltham Forest, we pledge to:

- Recognise and support a person's human right to make specific and timely decision, which also includes supporting them to plan for the future in a time they may lose capacity to make important life decisions with regards to their health & welfare and/or property and finance
- View the 'assessment of mental capacity' not simply as a process, but as an opportunity for a meaningful conversation with the person
- Continue to support, ensure information is understood and attempt to engage with people who may have made what could be construed as an 'unwise decision'. Don't walk away
- To consider the importance of the person's present and past wishes, feelings, values and beliefs when making any best interest decision
- To promote and raise awareness of the importance of referring to advocacy services, such as IMCA (Independent Mental Capacity Advocate), IMHA (Independent Mental Health Advocacy) etc. This also includes raising awareness, promoting and referring carers to support services
- To promote public and professional awareness of the act with regards to enabling adults to make advanced decisions and plan ahead of time in the future when they might lack capacity to make important life and care decisions
- Support approaches where risk is viewed positively, thereby enhancing less restrictive practice, service provisions and intervention
- Promote good MCA practice/interventions through a culture of improvement and learning
- To raise awareness with regards to the Deprivation of Liberty Safeguards and ensuring timely referrals are being made
- To prepare for the implementation of the Liberty Protection Safeguards in April 2022
- For services to have access to the MCA policies, procedures and training. Other providers to be signposted and made aware of external multi-agency procedures, guidance and MCA training

Further reading on mental capacity:

This guidance should be read alongside:

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| <u>Mental Capacity 2005</u> | <u>Mental Capacity Act Code of Practice</u> | <u>Care Act 2014</u> |
| <u>London Multi-Agency Adult Safeguarding Policy and Procedure (2016)</u> | <u>Guide to thresholds and practice for working with adults, carers and families in Waltham Forest</u> | <u>Making Safeguarding Personal (2014 Guide)</u> |
| <u>Self-Neglect Multi-Agency Guidance</u> | <u>DOLS Code of Practice</u> | |

Other useful links:

| | | |
|---|---|---|
| <u>Age UK</u> | <u>SCIE MCA website</u> | <u>National MCA Forum</u> |
| <u>Alzheimer's Society</u> | <u>Office of the Public Guardian</u> | <u>Independent mental capacity advocate service</u> |
| <u>Mental Capacity Law and Policy</u> | <u>Essex Chambers resource on Mental Capacity law</u> | <u>National Autistic Society</u> |