Learning from tragedies

An analysis of alcohol-related Safeguarding Adult Reviews published in 2017

July 2019

ALCOHOL CHANGE UK

Nothing about alcohol harm is inevitable. By working together, we can better protect those most in need.

Contents

About us

Alcohol Change UK works for a society that is free from the harm caused by alcohol.

We create evidence-driven change by working towards five key changes: improved knowledge, better policies and regulation, shifted cultural norms, improved drinking behaviours, and more and better support and treatment.

Alcohol Change UK is a leading alcohol charity formed from the merger of Alcohol Concern and Alcohol Research UK.

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Executive summary

Context

In 2017, 5,507 deaths in England were directly attributable to alcohol, an increase of 11% since 2006, while hospital admissions caused primarily by alcohol were 17% higher over the same period. The total number of hospital admissions for which alcohol was a factor was close to one million, or about 7% of all hospital admissions. Serious cuts to alcohol treatment services are making things worse, with many people in desperate need of support falling through the gaps.

Vulnerable adults are particularly at risk. They can be deeply affected by alcohol, whether as a heavy drinker themselves or as someone who is negatively affected by another person's drinking.

Research objectives

We wanted to better understand the role that alcohol plays in those situations where vulnerable adults die; and to draw out any lessons that could be learned. We analysed the 11 Safeguarding Adult Reviews (SARs) published in England in 2017 in which alcohol was identified as being a significant factor in the person's life and/or death. A SAR is commissioned following the death or serious harm of an adult with care and support needs. While each SAR can contain useful learning in its own right, we also wanted to look across all alcohol-related SARs to see whether there might be broader patterns and broader learning.

> None of these people needed to die the way they did; the tragic nature of their deaths was preventable.

Therefore we undertook an in-depth analysis of every review and analysed collective themes. The results are published within this report. We drew on previous work in this area – see Appendix 3. Before summarising the findings, it is essential to note that these SARs reveal tragic stories of human lives lost in sometimes terrible circumstances that no-one should have to go through. These people deserved better from the world around them. None of these people needed to die the way they did; the tragic nature of their deaths was preventable. We as a society owe it to the memories of these people and their families to make the most of the learning offered by these reviews and to intervene better. This is urgent, especially for those people who are alive today and are at risk of being the subject of a future SAR themselves.

Summary of findings

The overarching finding was that, perhaps unsurprisingly, most of the adults featured in these reviews had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, unfit living conditions, and experiences of a past traumatic event such as bereavement and physical or sexual abuse. In almost all cases, support services failed to cope with that complexity.

Two common stories emerged. First, a significant number of reviews (six of 11) indicated that the vulnerable adults were being exploited and abused. Their vulnerability stemmed from a range of circumstances, from severe mental health problems to disability. The cause of death in three of these cases was murder or injury from physical abuse.

> Their vulnerability stemmed from a range of circumstances, from severe mental health problems to disability.

Second, four of the SARs involved men who had become unemployed, lived alone and lost contact with their families. The cause of death in these cases was related to self-neglect and refusal of care from services. Despite the Care Act (2014) identifying people with alcohol problems as possibly needing care and support, there is little guidance in applying this legislation, or the equally relevant Mental Capacity Act (2005), to this group of people.

This report identifies some common characteristics among the adults whose deaths resulted in the SARs and considers how their alcohol misuse was perceived by the practitioners who were working with them. It reveals the extent to which alcohol is a contributory factor in a number of tragic incidents and highlights some key themes that can inform improved future practice, such as better multi-agency working, stronger risk assessments, and improved understanding and training for practitioners to help them better identify and support, in a non-stigmatising way, vulnerable people who are experiencing alcohol harm.

It also considers these cases in the context of the law and discusses how practitioners could better apply the relevant legislation to similar situations, as well as how the current guidance could better address the issue of alcohol-related self-neglect.

Recommendations

1. When carrying out Safeguarding Adult Reviews, the SAR team should always have access to and make effective use of independent expertise in alcohol misuse in order to properly assess the role of alcohol in the incident, and to ensure that lessons are effectively learned.

2. Local authorities should ensure that vulnerable adults with alcohol problems are actively supported to engage with services and should support services to adapt so that they can better serve these adults. In particular, there should be support for multi-agency systems that can coordinate assertive outreach and view the task of generating positive engagements as an important action in its own right.

3. All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers.

4. Guidance should be produced for practitioners about how to better estimate someone's level of drinking, by using sources of evidence additional to self-reporting, such as visual evidence of the person's drinking.

5. The commissioning of alcohol services should be carried out in a way that minimises levels of staff turnover and recognises the importance of continuity in supporting people with complex needs.

6. Significantly greater investment is needed in alcohol treatment services, with much of that investment funding service models like 'assertive outreach' which support the most at-risk and vulnerable individuals.

7. National guidance should be developed on how to assess alcohol-related risk, including how to address potential under-reporting of alcohol use.

8. The Mental Capacity Act 2005 Code of Practice should be amended to include specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs.

9. National guidance should be produced on applying the Mental Capacity Act (2005) to people with fluctuating capacity due to alcohol misuse.

10. National guidance should be developed on applying safeguarding thresholds to people who self-neglect due to alcohol misuse.

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Introduction

Safeguarding Adult Reviews (SARs) are produced in order to identify lessons that can be learned from cases involving serious harm experienced by an adult with care and support needs. It is intended that these lessons are applied to future cases, to prevent avoidable situations recurring. They are commissioned by the local Safeguarding Adults Board (SAB), following the death or serious harm to a safeguarded adult.

Vulnerable adults are often affected by alcohol, whether as heavy drinkers themselves or through the negative effects of someone else's drinking. This research ascertains the extent to which alcohol features in SARs in England and seeks to identify:

- the role alcohol plays in such cases
- the factors which impede or assist care
- lessons learned

This research is based on SARs published in 2017, in which alcohol was identified as playing a significant role in either the life of the individual concerned or the specific events surrounding their death.

> While we have analysed all reviews where alcohol is a factor, the level of its significance varies, and its role is always relational.

The role of alcohol in all these cases is complex. Alcohol use always occurs in the context of other factors contributing to the incident. While we have analysed all reviews where alcohol is a factor, the level of its significance varies, and its role is always relational. It is rarely the case that alcohol is the sole, or even the defining, factor in these incidents; rather, it usually emerges as part of a complicated set of causal factors, but a factor that exacerbates every other factor. Often frontline workers are so busy addressing the crises as they occur that they are unable to consistently work on the underlying alcohol use, despite the fact that improving the alcohol issue is likely to reduce the full range of problems.

> Our analysis reveals the extent to which alcohol is a contributory factor in a number of tragic incidents.

The focus of each SAR is always the primary 'serious incident'. Their terms of reference are limited to the incident itself and a specific period of time leading up to it. As a result, alcohol problems may not always come to the fore in the reviews, especially where they are a crucial part of the 'backstory' prior to the incident. Even where alcohol played a significant role in the events leading up to a serious incident, it cannot be guaranteed that it is always picked up.

Our analysis reveals the extent to which alcohol is a contributory factor in a number of tragic incidents and highlights some key themes that can form the basis of improved practice in future. It shows, for example, that all agencies involved (not just substance misuse specialists) need to be sensitive to alcohol problems, to approach it in a non-stigmatising way, and to recognise the complex role alcohol plays in relation to other issues. Agencies also need training on dealing with alcohol problems, to know where they can go for support, and to know where to refer people when they need help.

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What are safeguarding adult reviews?

In England and Wales four separate review processes are required following individual deaths or serious incidents in the health, social care and criminal justice systems:

- Safeguarding Adult Reviews for cases related to adult safeguarding
- Independent Investigation Reports (sometimes known as 'mental health homicide reviews') into the treatment and care of mentally ill people who kill others
- Domestic Homicide Reviews into the circumstances leading to homicide in the context of domestic violence
- Serious Case Reviews and Child Death Reviews for cases related to child safeguarding

Under the Care Act (2014), each local authority must have a local Safeguarding Adults Board (SAB). SABs are responsible for acting when they have "reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs)
- is experiencing, or is at risk of, abuse or neglect
- as a result of those needs is unable to protect themselves against the abuse or neglect or the risk of it" (Care Act [2014], c.23, s.42, para 1)

Safeguarding concerns can be raised by anyone in relation to any adult who meets these criteria. Often, safeguarding concerns are raised by frontline practitioners such as social workers, community nurses, police or substance misuse services. It is the job of local safeguarding adult teams and the SAB to evaluate these concerns and act on them if necessary.

If an adult meeting these criteria suffers serious harm or death, the SAB is required to carry out a SAR to determine if more could have been done to protect them. The purpose of SARs is to learn and make improvements in safeguarding practice. The Social Care Institute for Excellence (SCIE) is developing an online SAR library to help share the wider learning from SARs.

Similar reviews took place prior to the Care Act (2014), although they were not statutory. An analysis of the period 2003–2013 identified 74 such reviews from 41 English local authorities. Alcohol misuse was identified as a factor in nine cases (Hull Safeguarding Adults Partnership Board, 2014).

The framing of the Care Act (2014) makes it more likely that alcohol will be identified as an issue in SARs, for three reasons:

- The Care Act identifies alcohol (and drug) users as people who fall within its remit (s.92, para 5)
- Statutory guidance supporting the Care Act identifies self-neglect as a form of neglect
- The guidance states that someone does not need to lack capacity to be regarded as vulnerable

> Adults with chronic alcohol problems will fall within the remit of adult safeguarding.

These latter two conditions, in particular, make it far more likely that adults with chronic alcohol problems will fall within the remit of adult safeguarding.

The Care Act applies only to England. In Wales, the Social Services and Well-being (Wales) Act (2014) requires similar inquiries, known as Extended Practice Reviews (EPRs). Legislation in Scotland and Northern Ireland does not require SARs to be carried out. In Scotland, boards are called Adult Protection Committees and in Northern Ireland, they are called Local Adult Safeguarding Partnerships and Adult Protection Gateway Services.

Unlike EPRs in Wales, the Care Act does not specify that SARs have to be made publicly available, only that they must be carried out. Nevertheless, it is recognised as good practice to make reviews publicly available for learning purposes, and many SABs do so. Furthermore, although SARs do not have to be published, it is a statutory requirement for SABs to "publish an annual report detailing the findings of any Safeguarding Adults Reviews and subsequent action" (Department of Health and Social Care, 2018: s.14.136), but this does not always happen in practice.

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Reviews analysed

This report analyses 11 SARs published on Local Safeguarding Adult Board websites in 2017.

41 reviews were found in total, 15 of which mention alcohol. In 11 of the 15, alcohol is relevant to the main incident. In every case, the serious incident was the death of the adult being safeguarded.

The methodology used is outlined in Appendix 1. A summary of each incident is outlined in the Appendix 2.

Name	Safeguarding Adults Board	Date published	Type of case
RN	Worcestershire	January 2017	48 year old male who died of chronic health problems
Tom	Rochdale	February 2017	61 year old male homicide victim
Adult D	South Tyneside	May 2017	Adult male who died of health problems (age not specified)
Adult A	East Sussex	June 2017	64 year-old male who died of chronic health problems
Andrew	Waltham Forest	June 2017	39 year old male who died of alcohol-related illnesses
Carol	Teeswide	June 2017	39 year old female homicide victim
Lee	Newcastle	June 2017	24 year old male homicide victim
Ms A	Havering	June 2017	20 year old female who committed suicide
Mrs P	Isle of Wight	December 2017	Adult female who died as a result of an accident – age unspecified
Ruth	Plymouth	2017	40 year-old female who died of chronic health problems
Tom	Somerset	2017	43 year-old male who committed suicide

Carol's review received significant media coverage when published in June 2017. Its contents give a sense of the tragedies featuring in these cases.

Carol

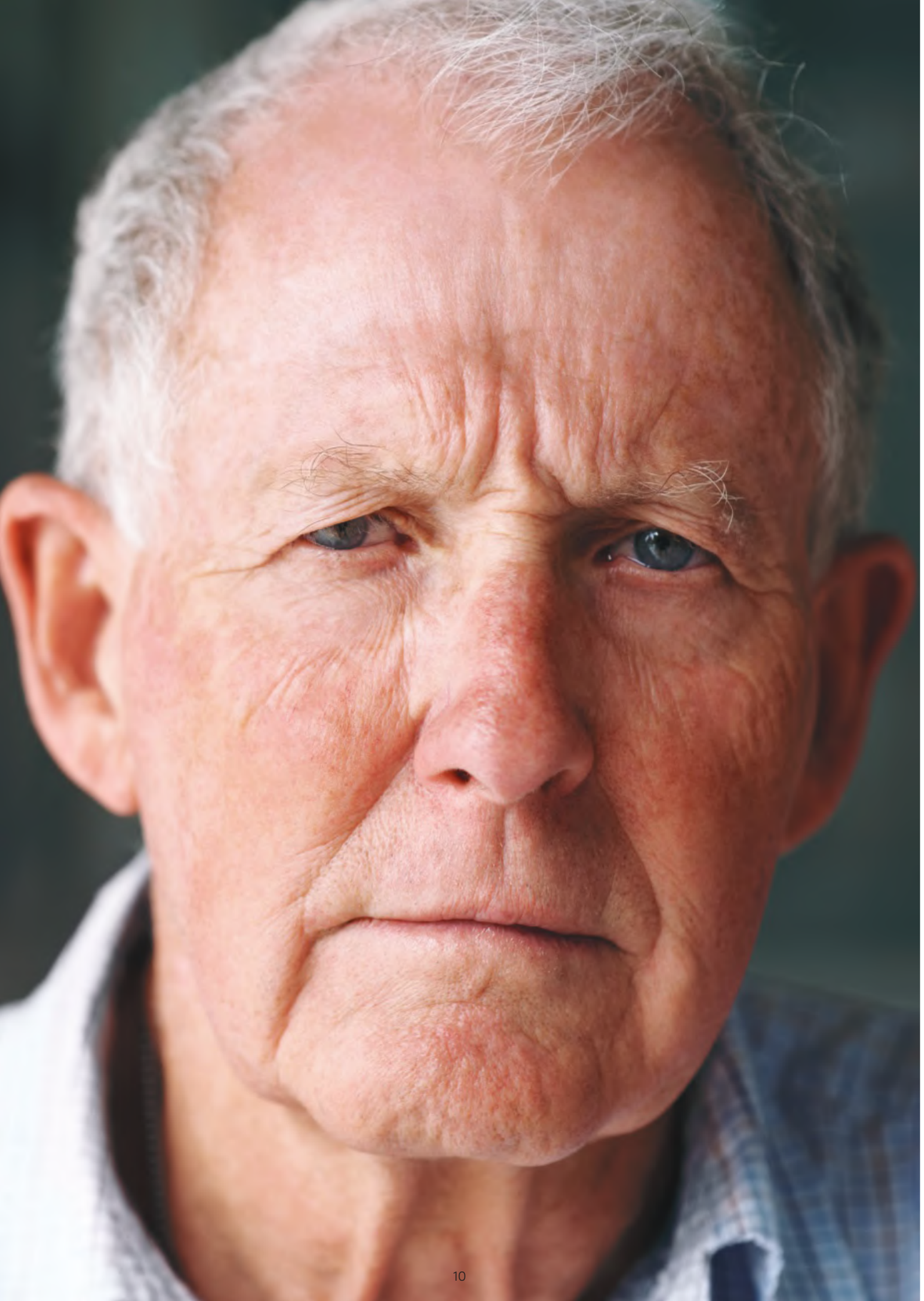
Carol was attacked and murdered in her home by two teenage girls aged 13 and 14 in December 2014. She had a long history of alcohol dependence and personality disorder. She had memory problems due to drinking and was diagnosed with emotionally unstable personality disorder.

In the three years prior to her death she had 1000 direct contacts with mental health, alcohol, ambulance and hospital services, with 472 reported incidents to the police and 175 offences. She was harassed and exploited by young people, would be scared to stay in her home and would sleep rough. Her home was used by people to take drugs and have sex. These same people stole from her and vandalised her home. (Teeswide Safeguarding Adult Board, 2017)

The reviews included in this report clearly demonstrate the range of risks associated with alcohol misuse. The subjects all had alcohol-related problems, as, in many cases, did those around them (e.g. Tom (Rochdale)). Additionally, they all had a range of complex needs, alongside their alcohol misuse. These included: mental health problems, self-neglect, chronic physical health problems, experience of trauma such as bereavement, physical and sexual abuse, and vulnerability to exploitation by others. In six of the reviews, the main factor leading to death was self-neglect and refusal of services. In three of the reviews, it was vulnerability and exploitation.

The role of alcohol in these incidents, as set out below, is serious and significant. It is imperative that learning from such reviews is captured and meaningfully informs future practice.

Recommendation 1: When carrying out SARs, the SAR team should always have access to and make effective use of independent expertise in alcohol misuse in order to properly assess the role of alcohol in the incident, and to ensure that lessons are effectively learned.



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Characteristics of the people who died

This section sets out some of the key characteristics of the people who were the subject of the SARs.

Non-engagement with services

(Lee, RN, Adult D, Andrew, Tom (Rochdale), Tom (Somerset), Ms A, Mrs P, Adult A, Carol, Ruth, RN, Adult D)

In all 11 reviews, vulnerable adults had limited or no engagement with services. In many cases, they failed to attend appointments, didn't comply with treatment, didn't accept referrals to other services, or refused to give access to their property to those who were trying to provide them with care. Some reviews described a pattern of 'disguised non-compliance', whereby the person "did not firmly refuse services but instead maintained the appearance of co-operating without actually doing so" (Adult D, s.6.36; RN)[1].

> Disengagement with social support and routine services can increase risk in unforeseen ways.

Disengagement with social support and routine services can increase risk in unforeseen ways. In Ruth's case, refusing to let a gas-check professional into her property meant that the gas company cut off her supply, leaving her without heating for the last four years of her life.

Recommendation 2: Local authorities should ensure that vulnerable adults with alcohol problems are actively supported to engage with services and should support services to adapt so that they can better serve these adults. In particular, there should be support for multi-agency systems that can coordinate assertive outreach and view the task of generating positive engagement as an important action in its own right.

Self-neglect

(Carol, Andrew, Lee, RN, Tom (Rochdale), Ms A, Adult D, Adult A, Ruth)

Self-neglect is a common theme in these reviews.

- Ms A "did not look after herself, mirroring in terms of her presentation and hygiene what she had experienced as a child" (s.4.11)
- Adult A "commonly refused intervention to meet his health and personal care needs" (s.3.2.2)
- Ruth was noted to be self-neglecting in terms of her physical appearance, hygiene, as well as the state of her flat. She was giving away possessions, had very little furniture and no heating.

Nine of the SARs drew an explicit link between self-neglect and alcohol misuse, while Adult D's review cites research finding that "75% of people who were self-neglecting experienced one or more traumatic life experiences such as physical or sexual abuse as a child and problems with mental illness or alcoholism, compared with fewer than 25% of controls" (s.6.9; Olsen *et al.*, 2007).

Exploitation of a vulnerable person

(Carol, Lee, Tom (Rochdale), Adult D)

Alcohol misuse can lead to a person becoming more vulnerable to exploitation by others. In several cases, the adults in question had their homes taken over by "unwanted persons" (Tom (Rochdale), s.7.10) who would use the premises for shelter, prostitution and drug dealing – a process known as 'cuckooing'. These unwanted persons were often described as 'drinkers' and 'friends' by the vulnerable adults, despite being abusers.

In the time leading up to Carol's death, for example, she reported three allegations of sexual assault and had a black eye from physical assault. At one point she was sleeping on a beach to avoid being at her home. In Lee's case, street drinkers would encourage him to commit crimes on their behalf.

In Adult D's case, the exploitation was less obvious, as he appeared to voluntarily pay his informal carer to run errands. However, it is believed that the carer may have 'borrowed' £4,500 from Adult D to pay off gambling debts. The carer was often present when professionals visited and influenced Adult D to refuse services. The carer was also often drinking and provided Adult D with alcohol.

In some cases, the adults were also being financially exploited, with other people waiting for them to collect support and benefit money and taking it from them.

[1] In-text citations for SARs will follow this referencing style, listing the adult's name, rather than the author name(s), for clarity. Full references can be found at the end of the report.

Domestic and child abuse

(Carol, Lee, Ms A, Mrs P, Ruth)

In five cases, the adults who died had experienced historical abuse and neglect as a child and/or domestic abuse from a partner. Often, alcohol was a factor in perpetuating abuse and violence, such as in Ruth's case where she "entered a relationship with an older man described as a 'heavy drinker', in which she was physically abused" (p.6). In other cases, the abuse was a trigger for the victim to start misusing alcohol as a coping mechanism. This can often increase both the victim's vulnerability to abuse and the likelihood that they will become an abuser. This happened in the case of Mrs P, where there were allegations of domestic abuse by both Mrs P and her husband.

Chronic health problems

(Lee, RN, Ms A, Adult D, Adult A, Ruth)

Six of the adults had chronic health problems, in addition to their alcohol dependence. Three of them had alcohol-related physical health problems, including Korsakoff's Syndrome and alcohol-related anaemia caused by malnutrition. Five had separate physical health problems, which, when compounded with alcohol misuse, caused their overall health to decline. In RN's case, a leg injury and subsequent chronic pain led to his unemployment and caused an increase in his alcohol consumption to manage the pain, deepening his existing alcohol dependence.

Mental health conditions

(Carol, Ms A, Mrs P, Ruth, Tom (Rochdale)

Five of the adults suffered co-occurring mental health conditions. These included: Borderline Personality Disorder, ADHD, Disorganised Attachment Behaviour (DAB), evidence of self-harming and suicide attempts, delirium tremens (caused by alcohol withdrawal), hallucinations, schizophrenia and depression. Ms A's review also noted that "children with DAB will most likely have experienced maltreatment from a close attachment figure and are more likely to be at risk of suffering mental health disorders and drug and alcohol problems" (s.4.6) and that "80% of looked-after children have DAB" (s.4.8). This suggests that care leavers are a group of people more likely to have complex needs, including co-occurring mental health and substance misuse problems.

Traumatic events triggering alcohol intake

(Andrew, RN, Tom (Rochdale), Ms A, Adult D, Ruth)

The death of a close friend or family member, the loss of employment and social status, or the loss of a relationship are all identified as triggering increases in alcohol consumption. For Andrew, the death of a close friend "marks the onset of a steady decline in his physical and emotional well-being and his eventual death from alcohol-related conditions arising from his self-neglect" (p.2). In Tom (Rochdale)'s case, the death of his father at age 27 "marked the start of his unhealthy relationship with alcohol" (s.3.1.2). After losing his job due to alcohol misuse, the shame he felt caused a further increase in his drinking. Ms A lost a baby through miscarriage and was thought to have been struggling with the mental health impacts. Practitioners found a 'shrine' dedicated to the baby in her flat, as well as "a pushchair with an object wrapped in a baby blanket and arranged to look like a baby sleeping" (s.7.63). She had also lost previous relationships with various foster parents. Adult D lost his mother at age 15, and also lost his job. Ruth's use of alcohol increased after she separated from her partner and child.

> In other cases, the family had become estranged from the individual.

Lack of family involvement

(Lee, Tom (Rochdale), Ruth, Carol, Andrew, RN, Ms A, Adult A)

Eight of the SARs focus on adults who were not in contact with their family during the time leading up to their death. Sometimes this was due to choice: in Ruth's case she explicitly requested that practitioners not share information with her parents. In other cases, the family had become estranged from the individual.

In many cases, this separation was caused by the individual's alcohol misuse:

- "RN's dependency upon alcohol caused rifts in the family, and those close to him became frustrated with his lack of motivation to address his problems with alcohol" (s.4.2).
- When Mr A was experiencing severe health problems and his next of kin were contacted, they "indicated that they did not wish to be contacted unless in a life-threatening emergency and Mr A was dying" (s.4.8).
- Both Ruth's parents and Tom (Rochdale)'s former partner felt that if they had been made aware of the situation, they would have been able to help practitioners gain a deeper understanding of the cause of service refusal.

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Practitioner perceptions

In many cases, misperceptions of these vulnerable adults by local services and practitioners may have contributed to a failure to fully grasp the role alcohol was playing in the situation.

Behaviours seen as personal choice

(Lee, RN, Adult D, Tom (Rochdale)

In three of the reviews, self-neglect was poorly understood, and was perceived as a 'lifestyle choice' by practitioners. This prevented a deeper analysis of the underlying causes and precluded attempts to address them. In Lee's case, his criminal behaviour was seen as a choice, rather than a symptom of his vulnerability and exploitation. Such assumptions can prevent practitioners from recognising people as vulnerable and in need of safeguarding and can lead to the under-reporting of safeguarding concerns about people with substance misuse. For example, a thematic review by Lincolnshire Safeguarding Adults Board states that "in 2013-14, 1% of referrals related to substance misuse" (Mason, 2017: p.50) which seems a surprisingly low proportion.

The failure to properly recognise or understand the relationship between alcohol misuse and other forms of self-neglect can create a serious blockage in care and treatment pathways.

Recommendation 3: All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers.

Extent of alcohol consumption

(RN, Ruth)

Practitioners sometimes underestimate the extent of alcohol consumption, either due to the client under-reporting their alcohol consumption, or hiding their drinking and its effects. In RN's case "while several professionals observed [him] drinking alcohol, no one reported seeing him drunk or passed on their concerns" (s.6.4). Those with long-term alcohol dependence often develop a tolerance to alcohol which can reduce the appearance of the symptoms which practitioners expect to see, such as obvious drunkenness.

> Those with long-term alcohol dependence often develop a tolerance to alcohol.

Recommendation 4: Guidance should be produced for practitioners about how to better estimate someone's level of drinking, by using sources of evidence additional to self-reporting, such as visual evidence of the person's drinking.

Ensuring effective working

All SARs identified specific improvements that could be made to local systems, structures and practices.

Lack of multi-agency working

(Carol, Andrew, Lee, RN, Tom (Rochdale), Ms A, Adult D, Mrs P, Adult A, Ruth, Tom (Somerset)

All 11 reviews identified lack of effective multi-agency working as a problem. It is clear that, too often, agencies work in silos and fail to effectively share information or coordinate interventions. A number of reviews identify occasions at which a multi-agency meeting would have helped practitioners to share knowledge and make a coordinated plan for the care and support of the adult in question (Adult A, RN).

When a plan of action is made, there is still a need to constantly review and reiterate care plans and risk assessments as new events occur. There is also a need to include all relevant agencies in multi-agency meetings, including alcohol services, even if they are not currently working with the adult.

> There is also a need to include all relevant agencies in multi-agency meetings.

> "What is the point of multiple assessments spanning many years, including risk assessments, and plans if they do not enable professionals across disciplines to pool their knowledge, agree priorities and targets and review their progress? [...] Working with people with multiple and complex needs, across agencies, has to hinge on coordinated assessment, care management and working with the risk of harm together." (Tom (Somerset) p.28)

In some cases, the GP was excluded (Adult D), despite being recognised as having relevant knowledge. In others, frontline practitioners did not feel their knowledge was sufficiently valued by other agencies. Friction in relationships between agencies can also lead to a situation in which individuals are not comfortable challenging decisions. For example, "Carol was discharged from alcohol services in December 2013, mainly because of lack of engagement. This was not challenged at the time by the integrated mental health team or any other agency" (s.3.4.21).

> In some cases, professionals with high workloads will refer the adult to another agency.

Four of the reviews state that no single agency or practitioner was designated 'ownership' of the case, meaning that there could be no leadership or coordination of a multi-agency response (Carol, Andrew, Lee, Adult A). Information-sharing and referrals can be viewed as merely 'for information' by the receiving agency, rather than 'for action', especially when there is no inter-agency leadership. RN's review found that some professionals assumed other agencies knew more information, and that they were in contact with the adult in question, whereas, in reality, no agency was more engaged than any other (and this may be why RN's body was not found in his home until 15 days after he died). In some cases, professionals with high workloads will refer the adult to another agency, which can lead to vulnerable adults being 'passed around' rather than helped. Practitioners with high workloads can get into a pattern of 'fire-fighting' – responding to crises and managing the adult's behaviours as they occur, rather than having the time to analyse and address the underlying causes and to plan longer-term interventions for more sustainable change.

Lack of resources

Absence of alcohol services involvement

(Carol, Lee, RN, Adult D, Adult A, Ruth, Tom (Somerset)

In five SARs, alcohol services are not mentioned, so it is assumed that they were not being accessed by the adult. Two SARs (Carol and Tom (Somerset)) report that support was being provided by an alcohol service, but this was withdrawn due to a lack of engagement. People with complex needs who are self-neglecting may require flexible, outreach-driven services in order to address their alcohol problems. However, in many of the reviews, the individual was actively resistant to receiving help. RN's GP, for example, had given him alcohol advice on 11 occasions over five years, and referred him to alcohol services – but he had not accessed the service. In Adult D's case, the local drug and alcohol service did not have the "appetite or capability to manage cases which carried higher risks" (s.6.54), and so it fell to the council to deal with these cases, despite not having the proper training.

Andrew's review comments that:

> "The decommissioning of the drug and alcohol service during the summer of 2015 had a significant impact on Andrew who was not motivated to make or attend pre-arranged appointments to address his addiction. The Outreach service was an example of a flexible service with the user at its heart, which had provided an opportunity to engage with him in the community to build a relationship and set harm reduction targets. This was not part of the contract for the newly commissioned service." (p.8)

Lee's, RN's, Tom's (Somerset), and the Lincolnshire and South Tyneside reviews also highlight the need for more assertive alcohol services. Carol's review identifies the Blue Light approach (owned by Alcohol Change UK) as one model for improving the response to people who resist engaging with services.

Lack of service capacity

(Ms A, Adult A, Mrs P)

Lack of funding for alcohol treatment services has led to a loss of resources and capacity (Alcohol Change UK, 2018). When service capacity reduces, it is generally even more difficult to provide support to those with the most complex needs. Two of the reviews highlighted the need for more mental health professionals, such as Registered Mental Health Nurses. It was also noted that with chaotic, self-neglecting individuals, services need to be flexible in their provision, adopting strategies such as assertive outreach and providing out of hours services.

> Additionally, multiple SARs found that services were not equipped to deal with high-risk cases.

Commissioning

(Carol, Andrew, Adult D)

There is a need for commissioners to understand the everyday challenges facing frontline practitioners when working with clients with complex needs. Otherwise there is a risk that the services commissioned will not be fit for purpose. Additionally, multiple SARs found that services were not equipped to deal with high-risk cases. For example, Adult D's care provider "effectively abandoned [him]" (s.6.24), leaving him without any support, and without informing any other agency or the Local Safeguarding Adults Board. It has been proposed that commissioners need to be creative, looking for flexible services that employ staff with a wide range of skills (Drink and Drug News, 2018).

More critically still, the culture of short contracts and regular re-tendering in drug and alcohol service commissioning has exacerbated a problem of lost contacts and inconsistent provision. This is identified as a specific problem in some of the reviews. Carol's review, for example, states that:

> "Alcohol services [have] less continuity in terms of service delivery [...] Contracts for this service change because of commissioning decisions every few years. Professionals have explained in the review that when the provider changes, those who had been cared for within the service lose established contacts and rapport with workers. In dealing with those who need support around alcohol dependency this is unfortunate and merits further consideration in the context of integrated commissioning and partnership working." (p.29)

> For the individual, this retelling of their life history will happen again and again with each new staff change, which is emotionally draining and demoralising.

Alcohol services are experiencing severe disinvestment and many local authorities are recommissioning with shorter and shorter contracts. Understandably, commissioning a longer contract is difficult when councils do not know if they will have the money to fund them in the future. However, constantly changing service providers erodes the ability of clients to form long-term relationships with practitioners, a key factor in ensuring successful engagement. As Adult D's review states, "professionals supporting people who self-neglect need to invest time in understanding their 'lived experience'" (s.6.10). For the individual, this retelling of their life history will happen again and again with each new staff change, which is emotionally draining and demoralising, ineffective and inefficient. When service providers change, people can disengage altogether, and their problems are likely to worsen at this point. Ruth's review suggests that local authorities should take the risk of losing relationships into account when commissioning, and "draw up plans to mitigate the risk" (p.45).

The loss of contact with complex and vulnerable individuals is made much worse when there is continuous churn in services.

Recommendation 5: The commissioning of alcohol services should be carried out in a way that minimises levels of staff turnover and recognises the importance of continuity in supporting people with complex needs.

Not appropriate for dual diagnosis or complex needs

(Andrew, Ms A, Adult D, Adult A, Ruth, Tom (Somerset)

Five SARs observed particular problems when there were multiple needs or a dual diagnosis: where people experience both substance misuse issues and mental health problems. These problems are often linked and exacerbate each other:

- "In general, services are commissioned and organised to deliver support for either one issue or the other and rarely together. People usually fall between the two services where they cannot receive support for either issue, until they have addressed the other issue. Their overlapping needs mean this group is in most need of specialised services but often do not receive adequate support." (Andrew, p.19)
- Tom (Somerset) "did not receive mental health input since he declined to address his addictions." (p.29)

Public Health England has published guidance on care for people with dual diagnosis, which sets out in detail how effective multi-agency care pathways should be established and maintained. The guidance notes that primary care often has no capacity to support those with dual diagnosis, although this is where the majority of such people will be treated. For example, "emergency department services often do not undertake an alcohol/drug or mental health assessment" (2017: p.16).

> Alcohol services can provide support and skills which can be used to improve other negative situations in a person's life.

A flexible outreach service had been working with Andrew in the community, "build[ing] a relationship and sett[ing] harm reduction targets" (p.8). Unfortunately, this service was decommissioned and this style of working was not part of the new contract for the replacement service. This meant that Andrew, who had multiple complex needs and was self-neglecting which prevented him from making and attending formal appointments, ultimately was not receiving support from alcohol services from this point onwards. Alcohol services can provide support and skills which can be used to improve other negative situations in a person's life, for example, by "reducing vulnerability factors, motivational interviewing and drug refusal training" (Mason, 2017: p.38).

The closure of services, as well as the lack of capacity to provide effective outreach services to people with complex needs is, without doubt, a consequence of continuing, severe disinvestment.

Recommendation 6: Significantly greater investment is needed in alcohol treatment services, with much of that investment funding service models like 'assertive outreach' which support the most at-risk and vulnerable individuals.

Poor risk assessment

(Carol, Adult D, Tom (Rochdale), Ms A, Mrs P, Ruth)

Six of the reviews report that risk assessment and risk management were not used properly by agencies. In many cases, risk assessments were not undertaken, or failed to consider key risks. At other times, the risk assessments became outdated when new risks arose, such as alcohol services discharging a client due to lack of engagement. For example, "the risks presented by Ruth's decision that information is no longer shared with her parents, who had acted as reporters of concerns or were able to corroborate Ruth's self-reports in the past, [we]re not explored" (p.26).

Lack of alcohol specialist or clinical input

(Carol, Adult D, RN, Ruth)

The SARs identify a range of moments at which specialist clinical input, or the expertise of alcohol services, would have helped identify needs. In terms of mental capacity, Carol's review states that a senior clinician should carry out a formal capacity assessment when a person has complex needs. Earlier clinical input may also have helped other professionals learn about and take into account Carol's Borderline Personality Disorder.

Ruth's review also suggests clinical input would have been useful in assessing Ruth's physical wellbeing in a general health check. Symptoms, such as her weight loss, could have been picked up, and would have indicated the extent of her alcohol consumption, malnutrition and self-neglect.

Heavy drinkers tend to under-report their alcohol intake, so specialist input can help establish more accurate assessments of alcohol consumption. This is a key concern, since establishing risk associated with alcohol is largely contingent upon accurately assessing the levels, and patterns, of consumption.

Recommendation 7: National guidance should be developed on how to assess alcohol-related risk, including how to address potential under-reporting of alcohol use.

High thresholds for support

For safeguarding concerns

(Lee, Tom (Rochdale), Carol)

Due to lack of funding and capacity, many agencies have prohibitively high thresholds for engaging with service users. Local Safeguarding Adults Boards themselves, which exist to respond to safeguarding concerns, may not act if not enough concerns about an adult have been raised within a set time frame. While not meeting this threshold, in hindsight Lee's case was serious enough to warrant intervention. Frontline practitioners are also unsure as to when alcohol misuse is severe enough to warrant a safeguarding concern – for example, on the grounds of vulnerability to harm, exploitation or self-neglect.

> People may not be able to access mental health services until they are sober, or be unable to access alcohol services if they are undergoing a mental health crisis.

Eligibility criteria for mental health services

(Ms A)

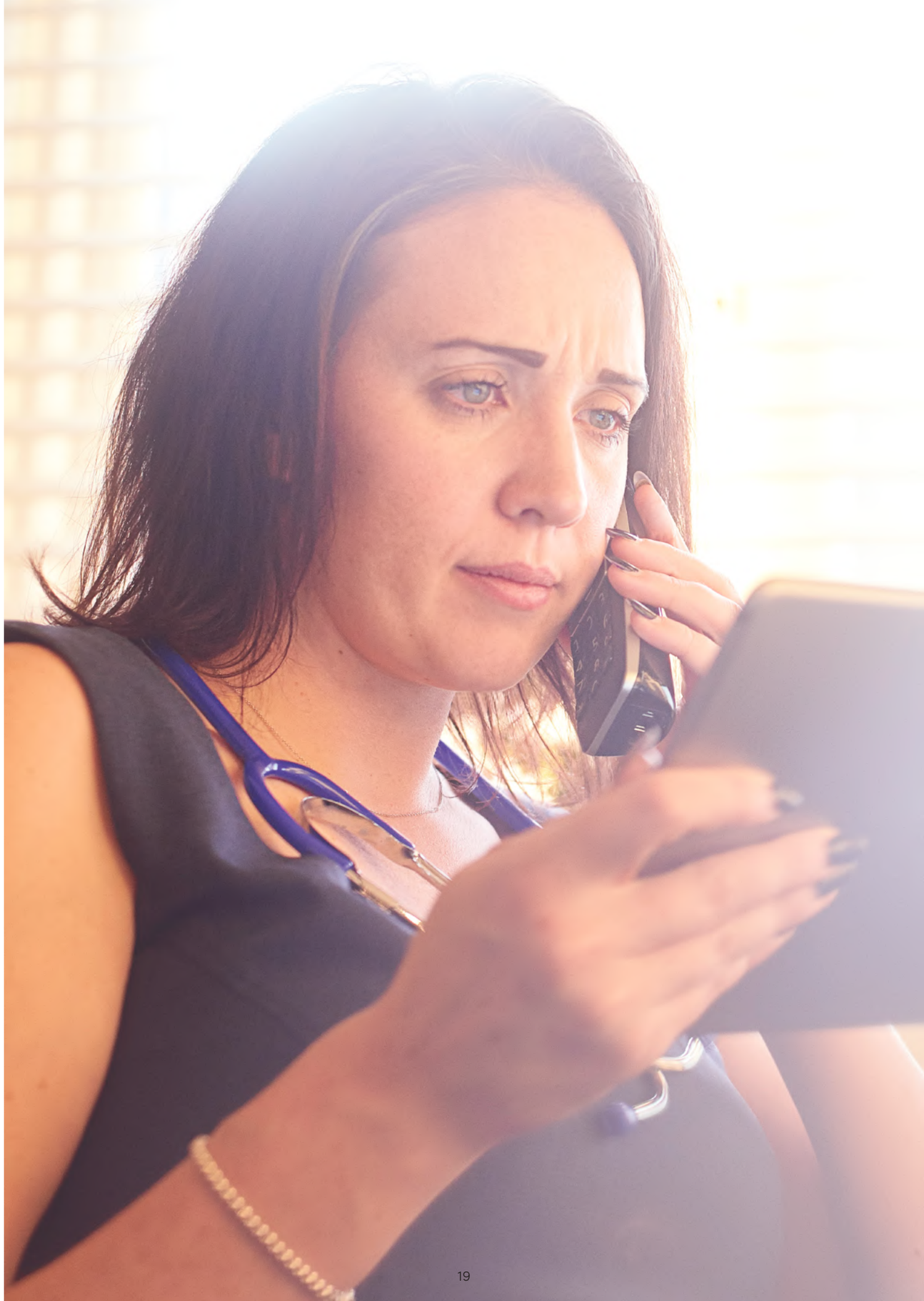
Both mental health and alcohol services often exclude the most vulnerable people due to eligibility criteria: people may not be able to access mental health services until they are sober, or be unable to access alcohol services if they are undergoing a mental health crisis. This is the case despite government guidance that there should be 'no wrong door' when it comes to service providers (Public Health England, 2017). As Ms A's review states, "Drug and alcohol service staff had referred people who are presenting in crisis to mental health services and were often informed that they did not meet the criteria, although it was also recognised that such referrals seemed to be a 'go-to' referral option for complex/high risk people" (p.27). This has been referred to as 'threshold bouncing' in a thematic review of SARs in the south-west region of England (Preston-Shoot, 2017b).

Child to adult transition

(Lee, Ms A, Carol)

In three cases, reviews emphasise the difficulty of transitioning between services designed for children and those for adults. Upon reaching adulthood, adults are more easily able to refuse services and to withhold information from their family members. Lee's family felt that, because of his severe learning disability, he was "classed as an adult while his mental capacity remained that of a child" (s.2.2). Practitioners working with Ms A stated that "young people's needs do not change significantly or automatically when they become 18. Services however appear to move immediately to a more contractual approach" (s.4.12).

> Upon reaching adulthood, adults are more easily able to refuse services and to withhold information.



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Understanding and implementing the law

A key issue for practitioners is that clients with complex needs, at high risk of serious harm or death, and with fluctuating capacity due to alcohol misuse, are often resistant to, or don't engage with, services.

At times this will require practitioners to use legal frameworks to protect these clients. In many of these reviews, these legal frameworks were not used well, were not used when they should have been, or were not considered at all.

Three pieces of legislation particularly impact on the management of this client group:

- The Mental Health Act (2007)
- The Mental Capacity Act (2005)
- The Care Act (2014)

Of these, the latter two are proving the most problematic. The SARs highlight both general problems with the application of this legislation and problems specific to alcohol misuse. The following sections explore the challenges associated with the latter two pieces of legislation.

Need for legal advice and 'legal literacy'

(Carol, Lee, Tom (Rochdale), Adult A, Ruth)

> Better 'legal literacy' amongst frontline workers could have made a significant difference.

Better 'legal literacy' amongst frontline workers could have made a significant difference to a number of the reviews, including knowing the value of seeking legal advice at the point of crisis. Training in this area could be of real benefit. Arguably, the guidance around this legislation – and perhaps the legislation itself – also needs to be improved to better match real situations on the ground.

Two SARs highlight how legal knowledge and advice were not used.

- Lee: "No legal advice was sought and the possibility of Court of Protection proceedings were not pursued." (s.4.6.5)
- Adult A: "Mr A's mental capacity was not appropriately addressed and the legal requirement for decisions to be made in his best interests therefore not met." (s.6.2.14)

The Care Act (2014)

The Care Act (2014) created a new framework for safeguarding adults. In particular, it recognised that self-neglect is a form of neglect. This brings many people with alcohol problems into the safeguarding framework.

A person is defined as self-neglecting when they present with one or more of the following:

- Lack of self-care, including hygiene, nutrition, hydration and health
- Lack of care of one's environment, including squalor and hoarding
- A refusal of services which would mitigate the risk of harm (Braye, Orr and Preston-Shoot, 2015: 2).

Under this definition, all subjects of the SARs reviewed here could be defined as self-neglecting, as their non-engagement with services fulfils the third requirement of the definition. The possible causes of self-neglect can include alcohol misuse itself, past trauma or loss (including bereavement or the loss of a relationship) - all of which are common features in this snapshot of SARs (Braye, Orr and Preston-Shoot, 2015). However, this does not necessarily mean they lack mental capacity (SCIE, 2011).

Self-neglect is a recent concept in the safeguarding sector, and, as such, may not have been fully recognised by many of the practitioners in these SARs. Furthermore, even among those with knowledge of self-neglect, alcohol misuse is less readily perceived as self-neglect compared to other behaviours such as hoarding or lack of personal hygiene. This may be due to the stigma around alcohol misuse or the belief that it is merely a 'lifestyle choice' rather than a symptom and cause of other underlying issues.

Indeed, in three of the reviews, it was noted that self-neglect was perceived as a 'lifestyle choice' by practitioners. (RN, Adult D, Tom (Rochdale)). According to Adult D's review:

> "Agencies respected Adult D's autonomy in decision making, even though the choices he made exposed himself to harm [...] No-one appeared to gain any insight into why he behaved as he did [...] The RMM appeared to take the view that having established that Adult D was largely capable of caring for himself, then the squalor in which he lived once his living conditions deteriorated following his return to his deep cleaned home, was a personal choice on his part." (s.6.7, 6.8)

> The Care Act recognises that people can have mental capacity but still self-neglect.

There is also confusion, as highlighted in both Andrew's and RN's reviews, around self-neglect and mental capacity. Practitioners assume that "if a person has mental capacity then by definition they can choose their lifestyle and are making a conscious choice" (RN: p.13). However, the Care Act recognises that people can have mental capacity but still self-neglect. Research published by the Social Care Institute for Excellence also states that a person who is self-neglecting may also have mental capacity (Braye, Orr and Preston-Shoot, 2015).

Although practitioners are unable to force compliance under the Care Act (2014), the local authority has a duty to safeguard adults. This problem has variously been described as:

- "finding the right balance between respecting a person's autonomy and fulfilling their duty to protect the adult's health and wellbeing" (Waltham Forest Safeguarding Adults Board, 2016: p.3)
- "the fraught boundary between personal responsibility and public obligation" (Preston-Shoot, 2017b: p.27)

Andrew's review points out that where there is a serious risk to the health and wellbeing of an individual, it may be appropriate to raise self-neglect as a safeguarding concern; however, the Care Act statutory guidance also advises that interventions on self-neglect are usually more appropriate under the parts of the Care Act dealing with assessment, planning, information and advice, and prevention (Andrew: p.15).

According to Braye *et al.* (2015), best practice for working with those who are self-neglecting is:

- to understand the individual's life history
- to strengthen practitioner-client relationships
- to use creative, flexible interventions
- to involve the individual
- to promote multi-agency working

Some SARs highlighted the lack of understanding amongst practitioners of Section 42 of the Care Act, which details when and how to raise a safeguarding concern and what local authorities must do when there is a safeguarding issue. Adult D's review shows how the Care Act assessment can be misunderstood by professionals. While in a residential respite facility, Adult D was assessed and found that he could care for himself, and so his self-neglect was seen as a personal choice. However, the assessment took place in a different location to his home and at a time when his level of alcohol consumption was lower. Therefore it failed to consider key factors. Additionally, a care assessment does not necessarily negate the presence of self-neglect. Tom (Rochdale)'s review states that the Care Act assessment can be a useful tool to "gain as much information as possible" (p.49), even if the circumstances do not indicate a need for an assessment.

The Mental Capacity Act (2005)

What is mental capacity?

Under the Mental Capacity Act (2005), which applies in England and Wales, a person over the age of 16 can be assessed as not having the capacity to make a particular decision at the particular time it needs to be made. If this is the case, it is possible to take appropriate actions on behalf of and in the best interests of the individual, without their consent.

Lack of training in mental capacity

(Carol, Lee, Ms A, Ruth, Mrs P, Andrew, Tom (Rochdale)'s, Adult A)

> Understanding of mental capacity and how to assess it is not robust.

Eight of the reviews highlight the lack of understanding of mental capacity by frontline practitioners: both as a concept that could be applied in these cases and in terms of how to apply and assess it in practice. Ms A's review observes that "some practitioners [...] have a broad understanding of mental capacity principles [...] but not detailed knowledge" (p.21). Adult A's review recommends strengthening knowledge with respect to the Mental Capacity Act (2005) and how to conduct referrals to the Office of the Public Guardian and the Court of Protection (p.47). Carol's review comments that, "Among professionals, the understanding of mental capacity and how to assess it is not robust, which impacts upon professionals responding effectively to cases which are complex, limiting the risk assessment and professional response" (p.23).

How does the Mental Capacity Act apply to people with alcohol misuse problems?

The legal aspects of the Mental Capacity Act (2005) are especially complex, and it is not always obvious how it applies to people with alcohol misuse problems. The Mental Capacity Act 2005 Code of Practice provides statutory guidance for practitioners in applying the Act in practice. Despite containing many useful case studies in its 300 pages, it does not specifically address mental capacity in the context of alcohol misuse, which is a serious gap (Department for Constitutional Affairs, 2007).

> Mental capacity can fluctuate, meaning a person could have mental capacity at one point in time and not at another.

The Code recognises that mental capacity can fluctuate, meaning a person could have mental capacity at one point in time and not at another. This is particularly relevant to those with alcohol problems. The guidance suggests that if it is thought a person will be able to regain capacity at a later point, and if it is practical, then the assessor should wait to assess capacity. However, this is challenging if an individual continually moves in and out of capacity due to intoxication, or spends the majority of their waking hours intoxicated with some moments of lucidity. It is this dynamic that limits the application of the Act to people with alcohol problems.

Moreover, Andrew's review notes that mental capacity can be further reduced by the addictive nature of severe alcohol dependence (p.17). Whether intoxicated or not, the person may not have the mental capacity to make decisions which are not influenced by their desire for alcohol.

> "The Mental Capacity Act advises you need to wait until a person is sober before you think about capacity. However, when a person is a chronic alcohol user it could be argued that they are never sober. More so that their ability to reason about whether they want to stop drinking is significantly impaired due to the addictive nature of their alcohol use. Therefore, is someone who is a chronic alcohol user ever in a space where their addiction is not impacting on their ability to reason?" (p.17)

Mental capacity is time and decision-specific

A mental capacity assessment is complicated to carry out in practice. This was highlighted in the SARs under this review as well as in the Lincolnshire thematic review, which noted that "practitioners were not confident in applying the MCA, particularly where the person's capacity may be fluctuating due to their substance misuse" (Mason, 2017: p.5). In fact, the effects of alcohol misuse can be so hidden that they are not considered at all when assessing mental capacity (Braye and Preston-Shoot, 2017b).

Assessments are time and decision-specific, meaning that a person could lack mental capacity to decide whether to go to hospital when they were suffering from acute alcohol withdrawal but could have capacity to decide what to eat for lunch when sober. Updated NICE guidelines on decision-making and mental capacity state that "there is a lack of evidence from the UK on the effectiveness and acceptability of approaches to capacity assessment that are in line with the meaning of mental capacity as outlined in the Mental Capacity Act" (National Institute for Health and Care Excellence, 2018: p.40).

The first principle: assume capacity

Tom (Rochdale)'s review states that "when not heavily intoxicated, [Tom] was capable of specific decisions, for example completing forms. Professionals therefore reached a decision that Tom met the first principle in the Mental Capacity Act 2005 i.e. a presumption of capacity" (s.5.2.8). However, this fails to address his potential lack of capacity when he was intoxicated. The symptoms of alcohol use are listed in the Mental Capacity Act Code of Practice as a potential 'impairment of the brain or mind' which can be a cause of lack of capacity (Department for Constitutional Affairs, 2007). This may have prompted practitioners to assess Tom's capacity when intoxicated as well.

The first principle of the MCA is to assume the adult has capacity unless proven otherwise. However, it has been noted that this "is sometimes used by a practitioner faced with a person who is self-neglecting and refusing to engage, to reach a superficial conclusion that the person has capacity; meanwhile the supporting evidence of degree of harm that is occurring, may indicate a need for a closer look" (Waltham Forest Safeguarding Adults Board, 2016: p.11).

> The first principle of the MCA is to assume the adult has capacity unless proven otherwise.

Of the 11 reviews, three of the adults had their mental capacity assessed on one occasion (RN, Tom (Rochdale), Adult A) and one twice (Lee). Only Adult A was deemed to lack capacity to make care decisions and Lee to lack capacity in relation to risk and to keeping himself safe when alone in the community, although the lack of understanding of mental capacity among practitioners meant that both Adult A and Lee continued to be treated as though they had capacity and could refuse treatment. When Lee was determined to lack capacity, further options, such as an application to the Court of Protection, were not explored. This was because the agencies did not have full knowledge of the Mental Capacity Act. In all other cases, the adult was assumed to have capacity and was not assessed further, despite indications that an assessment was needed. For Adult D, an assessment was attempted but he refused to admit practitioners into his property. In three cases, although capacity was assumed, practitioners reported that they couldn't be sure whether the adult understood the consequences of their choices – a key requirement for capacity (Ms A, Mrs P, Adult D).

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Recording assessments

(Carol, Andrew, RN, Lee, Tom (Rochdale), Ms A, Adult D, Adult A, Mrs P, Ruth)

As well as a lack of training or understanding of mental capacity in contexts of alcohol misuse among practitioners, and potentially a lack of defined good practice on this issue, many practitioners also failed to record their assessments of mental capacity. This is especially important in the event of a serious incident, such as the death of the adult, as written evidence is essential to understanding past events. Even if practitioners are following the first principle of mental capacity, and assuming the adult does have capacity, it is still necessary to record and evidence this decision. Assessing mental capacity is not a standalone exercise: the outcome of the assessment can lead to other legal assessments, such as 'best interests decision-making' and 'requests for authorisation of deprivation of liberty'. The lack of recording of such assessments was so severe in Mr A's case that the review stated, "the missing assessments, the absence of appropriate action to secure best interests on occasions when capacity had been assessed, the deprivation of liberty without authority and the failure to seek authority for care and treatment, all indicate that Mr A's mental capacity was not appropriately addressed and the legal requirement for decisions therefore to be made in his best interests not met." (s.6.2.14).

> If practitioners do not follow "relevant guidance they will be expected to give good reasons why".

The third principle: the right to make unwise decisions

The Mental Capacity Act Code of Practice is a statutory document, meaning that if practitioners do not follow "relevant guidance they will be expected to give good reasons why they have departed from it" (Department for Constitutional Affairs, 2007: p.1). The Code emphasises that "it is important to acknowledge the difference between unwise decisions, which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up information about a decision, particularly if someone makes decisions that put them at risk or result in harm to them or someone else" (Department for Constitutional Affairs, 2007: p.50). This problem is highlighted in Carol's review:

> "Whether an individual has mental capacity to make decisions defines how an individual is managed in the context of their finances, health and social care needs. An individual who is deemed to have full mental capacity may make unwise and what may seem irrational choices, but they are entitled to do so." (p.36)

Don't just judge behaviour

It's also important not to judge mental capacity based solely on behaviour, appearance or "assumptions about [someone's] condition" (Department for Constitutional Affairs, 2007: p.43). This works both ways – it shouldn't be assumed that someone is mentally incapacitated because they appear to be intoxicated, but neither should it be assumed that they have capacity because of "good social or language skills, polite behaviour or good manners" (Department for Constitutional Affairs, 2007: p.59). This is what happened in the case of Adult D: "some practitioners might have felt slightly intimidated by Adult D's professional standing and his ability to express himself, which he was said to have used in order to 'exert control over the situation'" (s.6.42). It should also not be assumed that a demonstrated ability to make simple decisions necessarily indicates a person's ability to make a more complex decision (Waltham Forest Safeguarding Adults Board, 2016). Similarly, RN's "age, relatively independent life [and] general presentation as a person who knew the consequences of his actions" (s.6.12), led practitioners to assume rather than assess his mental capacity. It was also noted that RN's level of alcohol consumption was hidden, highlighting the fact that severe alcohol misuse, while it should trigger a capacity assessment, is often not obvious.

Decisional and executive capacity

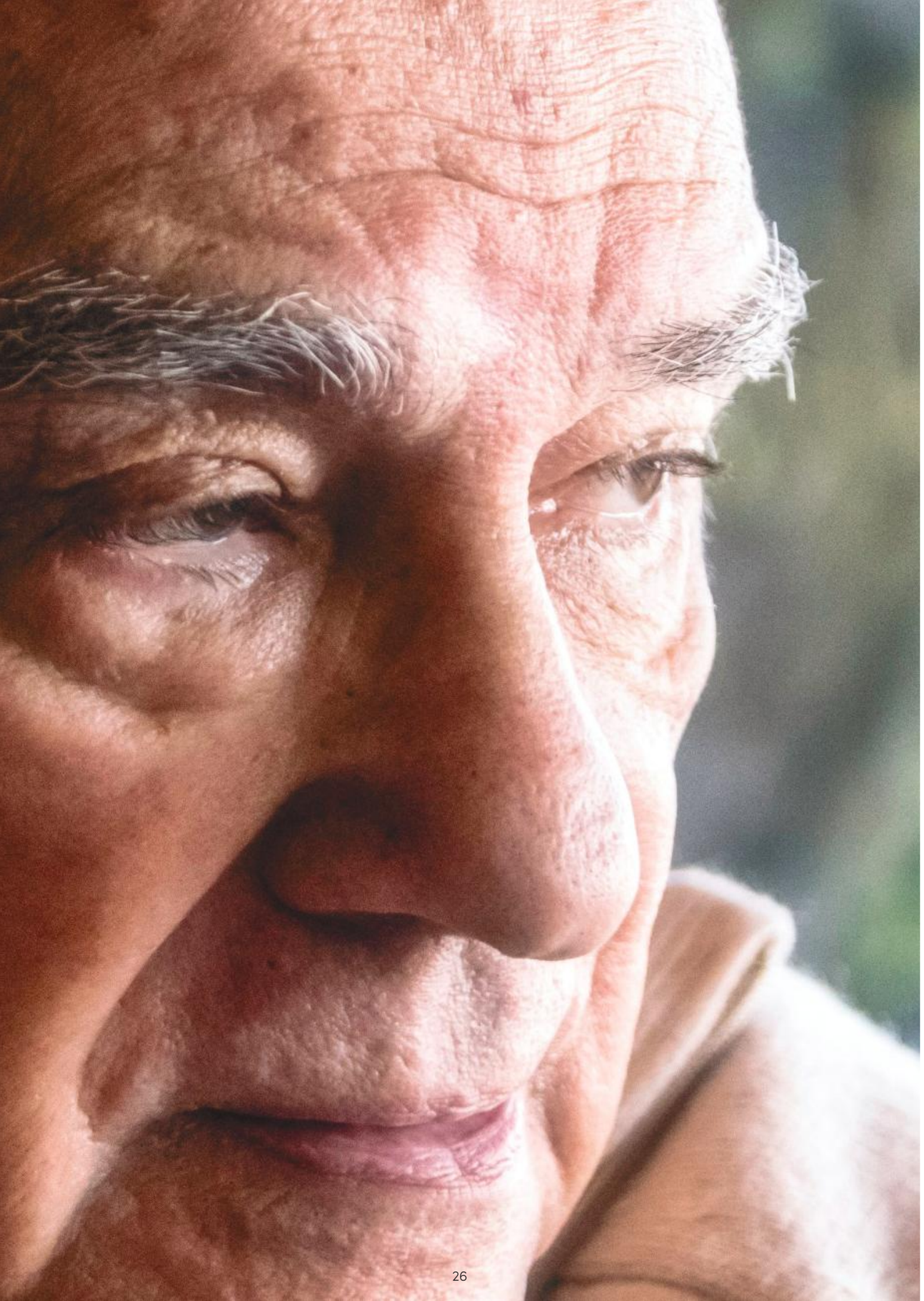
Finally, it is important to assess both decisional and executive capacity. This idea has been proposed by Braye *et al.* (2011). Decisional capacity, covered by the Mental Capacity Act, is where a person can show that they can understand, retain, use and weigh up the information needed to make a decision. In contrast, executive capacity is the ability for a person to actually carry out that decision.

Both of these can can be impaired by alcohol misuse. Executive capacity can be impaired, such that someone can be in no fit state to make it to an appointment that they had previously decided to attend. A person's decisional capacity may be impaired due to them understanding, but not being able to use, the information to make a decision. The London Borough of Waltham Forest's self-neglect policy recommends using the 'articulate-demonstrate' method, requiring the person being assessed to both articulate their decision and demonstrate how they would carry it out.

Recommendation 8: The Mental Capacity Act 2005 Code of Practice should be amended to include specific guidance for working with individuals with alcohol misuse or dependence, especially when they are likely to have complex needs.

Recommendation 9: National guidance should be produced on applying the Mental Capacity Act (2005) to people with fluctuating capacity due to alcohol misuse.

Recommendation 10: National guidance should be developed on applying safeguarding thresholds to people who self-neglect due to alcohol misuse.



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Conclusions

The Safeguarding Adult Reviews analysed here highlight that alcohol misuse is an important aspect of vulnerability, abuse and risk.

There is also a specific gap in frontline workers' knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to this group.

Without a thorough understanding of how to work with this client group, professionals will not be able to respond effectively to their needs and protect them from harm. This analysis also highlights that much work remains to be done to improve adult safeguarding in this area.

At the most general level, non-alcohol specialist workers need to better understand and respond to alcohol misuse and, in particular, how to work with people with alcohol problems who are not in contact with services.

There is also a specific gap in frontline workers' knowledge about applying the Mental Capacity Act (2005) and the Care Act (2014) to this group, linked to a lack of national guidance on this.

Our analysis also highlights failings with the commissioning and provision of alcohol services. Constant service changes caused by the current commissioning system negatively affect vital relationships and damage engagement. And the under-developed response from alcohol services to vulnerable heavy drinkers, which make it less likely that people will attend and remain engaged with alcohol services.

The Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol.

At the national level, work is required to clarify how the Mental Capacity Act and the Care Act should be intelligently applied to vulnerable adults who are misusing alcohol. In particular, the challenges of applying the concept of self-neglect to substance misusers and applying the Mental Capacity framework to people with fluctuating capacity need to be urgently addressed if more unnecessary deaths are to be avoided.

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All URLs are correct at the time of writing. Due to SABs removing SARs from their websites, some of the URLs for the SARs may not work. The SCIE is working to develop an online repository of SARs to enable future learning in the sector. If you can no longer access an SAR through the URL provided here, you may still be able to find it in the SCIE SAR library here: https://www.scie.org.uk/safeguarding/adults/reviews/library/apply.

Appendix 1: Methodology

Forty-one Safeguarding Adult Reviews or Extended Practice Reviews which were published in 2017 are publicly available on Local Safeguarding Adult Board websites at the time of writing.

Fifteen of these 41 reviews mention alcohol, including 11 in which alcohol is relevant to the main incident.

Selection criteria:

1. Is a Safeguarding Adult Review (England) or an Extended Practice Review (Wales) (with the exception of the Mrs P review which is an Independent Review)
2. Published in 2017
3. Publicly available
4. Mention alcohol
5. Alcohol is relevant to the serious incident discussed (the review is carried out as a result of an incident leading to severe harm, neglect, abuse or death of the adult being safeguarded)

Limitations

The Care Act (2014) does require SABs to detail the findings of any SARs which were carried out in their annual reports but this doesn't always happen. These same limitations have been found in other thematic reviews. Therefore, it is impossible to determine the true number of SARs which were completed in 2017.

Mrs P's review in our sample is a six-page executive summary, rather than a full report. This limits the depth of analysis possible, as the summary does not provide details of the incident itself, or the life background of the adult. It didn't meet the criteria needed for an SAR, as the cause of death couldn't be linked to abuse or neglect, although abuse did take place. However, it was still included in the analysis as the lessons learned are similar to the other alcohol-related SARs.

The full SARs are also limited to focusing on a 'serious incident'. Their terms of reference are limited to the crisis itself and a set period of time leading up to it, therefore alcohol problems may not come to the fore in the reviews. As alcohol is a contributing factor to many other issues such as domestic abuse, crime, mental health and self-neglect, it may not be the main focus of the review. Therefore, it is not possible to determine how significant a reference to alcohol is in the context of the SAR, as this would be down to the author's interpretation.

List of SARs contributing to this review

Name	Safeguarding Adults Board	Date published
RN	Worcestershire	January 2017
Tom	Rochdale	February 2017
Adult D	South Tyneside	May 2017
Adult A	East Sussex	June 2017
Andrew	Waltham Forest	June 2017
Carol	Teeswide	June 2017
Lee	Newcastle	June 2017
Ms A	Havering	June 2017
Mrs P	Isle of Wight	December 2017
Ruth	Plymouth	2017
Tom	Somerset	2017

Appendix 2: Illustrative summaries of the Safeguarding Adult Reviews

Carol (Teeswide)

Carol was attacked and murdered in her home by two teenage girls aged thirteen and fourteen in December 2014. She had a long history of alcohol dependence and personality disorder and started drinking as a child. In three years, Carol had 1000 direct contacts with mental health, alcohol, ambulance and hospital services, 472 reported incidents to the police and 175 offences. Her landlord considered her as needing 24-hour care. Her local support service which helped her buy food was decommissioned. She also experienced memory problems due to excessive drinking. Carol was regularly harassed and exploited by young people and would be scared to stay in her home, resulting in her sleeping rough. As a result, her home was targeted by people as a location to take drugs and have sex. These people stole from Carol and vandalised her home.

Andrew (Waltham Forest)

Andrew was alcohol dependent. His drinking caused him to lose his job and tenancy in 2014, at which point he moved to supported housing. There he lived alone and had no contact with his family. Andrew had a long-standing relationship with a drug and alcohol worker but the service was decommissioned in 2016. In Spring 2015 his close friend and fellow housing resident died suddenly, which led to a rapid decline in Andrew's emotional well-being decline and he began to self-neglect. Andrew died in February 2016 from alcohol-related illnesses.

Lee (Newcastle)

Lee died aged 24 of multiple injuries and respiratory failure due to physical abuse. He had a learning disability and an IQ of 56, meaning his thinking and reasoning abilities were the same or better than only 0.2% of adults his age. As a result, Lee was vulnerable to bullying, exploitation and the very susceptible to the influence of others. He had a history of repeated criminal offences including drunkenness, shoplifting, burglary and begging. Lee's social behaviour was focused on pleasing people and not being rejected by his peers, to the extent that he would give away his possessions. Lee became a semi-permanent resident of a house occupied by other offenders, including his murderer. He was abused and controlled with alcohol and drugs and kept in the house until his death.

RN (Worcestershire)

RN died at age 48 due to chronic self-neglect and refusing help. His body was not found for 15 days after his death due to his history of not engaging with practitioners. RN was unemployed due to ill health from his alcohol dependence and a leg fracture which did not heal properly. He had been estranged from his family due to their perception of his alcohol use.

Tom (Rochdale)

Tom was murdered by a person who was exploiting him, who was on bail for other alcohol-fuelled violence offences. He was misusing alcohol, lost his job and was banned from driving due to alcohol misuse. He also lost his long-term relationship and moved home. He was drinking between 24 and 38 units per day. Then he began to associate with other people who had alcohol problems, who abused and exploited him. They began staying in his home and stealing his money and possessions. Tom was self-neglecting and not buying himself food. He also had diagnosed depression.

Ms A (Havering)

Ms A died by suicide in December 2015 by jumping from a window of her flat, aged 20. She died under the influence of alcohol. Ms A was a care leaver and suffered physical and emotional abuse and neglect at her parental home as a child. She was removed from her siblings whose care placements were more successful than hers. She was sent back to live with her mother intermittently. She had had a miscarriage which deeply affected her. Ms A had a history of fabricating illness, taking on different aliases and personas, impersonated a nurse to try to steal insulin from a hospital, convinced professionals to prescribe her methadone. She was unable to care for herself in her physical appearance or environment.

Mrs P (Isle of Wight)

Mrs P had multiple health issues and hospital visits, mental health problems and alcohol misuse. There were multiple reports of domestic abuse by her husband and to her husband. She was receiving full time care from her husband, bed bound and doubly incontinent, consuming three bottles of wine a day. Her cause of death cannot be linked to abuse or neglect so it's an Independent Review rather than an SAR.

Adult D (South Tyneside)

Adult D was alcohol dependent. His mother had looked after him and when she died his father hired a cleaner. When his father died, Adult D moved home and was self-neglecting. He had lost job and had mental health and mobility issues. Practitioners often found human dirt covering the walls of his flat and clothes lying around which appeared to be wet through urination or covered in faeces. He consistently declined care assessments and help. In June 2013, his GP referred him to Environmental Health. It was found that he had no hot water, no shower, toilet, or food in the house and his lights were not working. He agreed to go into a respite facility while his property was deep cleaned. However this did not have a long-term effect. His mental capacity was assumed but never assessed. He had multiple long-term health conditions, such as leg ulcers, osteoporosis and diabetes. His home care package withdrew support due to his alcohol-fuelled verbal abuse of their staff. His informal carer was also drinking and suspected to be financially exploiting him. Adult D died in hospital of sepsis and multiple organ failure due to the neglect of his leg ulcers.

Adult A (East Sussex)

Adult A was alcohol dependent. He died in July 2016 at age 64. The cause of death was systemic sepsis, cutaneous and soft tissue infection of the legs, diabetes mellitus and liver cirrhosis. He had Korsakoff Syndrome as a result of his alcohol use. In August 2015 he was admitted to hospital from the nursing home where he lived so his leg ulcers could be treated. He consistently refused care and treatment. Adult A's health deteriorated and in March 2016 he was assessed as needing specialist care in a brain injury unit. In July 2016, the care home manager found that his legs were infested with maggots. His condition further deteriorated and he died the next day. In this case all legal powers were used properly, including a mental capacity assessment and detention under the Mental Health Act.

Ruth (Plymouth)

Ruth died at home aged 40 in September 2012 due to pneumonia and the blockage of an artery in her lungs. She had schizophrenia, was malnourished and alcohol dependent. She was self-neglecting, had few possessions and no heating. She also was not taking her medication for schizophrenia. Ruth had a history of drug and alcohol use and had been domestically abused in the past. She would attend services intermittently and not regularly, but would not attend alcohol services.

Tom (Somerset)

Tom died by suicide aged 43 in June 2014. He suffered multiple brain and head injuries from a young age. His final brain injury resulted in him becoming hemiplegic (weakness on one side of the body) and having aphasia (loss of ability to speak or understand spoken or written language), epilepsy and insomnia. Tom started drinking during adolescence and was receiving help for alcohol abuse at age 20. He also was misusing drugs and had several criminal convictions. Tom lived with his partner as her carer (she also had a brain injury) until 2013 when he was evicted and became homeless. Their relationship broke down when his alcohol misuse interfered with his ability to provide care. He was also letting exploitative people into the home.

Stock photo. Posed by model.

Appendix 3: Brief literature review of recent studies of multiple serious incident reviews

This is not the first analysis of multiple serious case reviews. As far back as 1995 the Zito Trust published Learning the Lessons, which analysed over 400 recommendations from serious incident reports in mental health services over the previous 27 years – though only four of these related to substance misuse (Sheppard, 1995).

In 1998 Alcohol Concern (one of Alcohol Change UK's predecessor organisation) and Drugscope published The Unlearned Lesson, which explored whether these inquiry reports were under-representing the role of substance misuse Ward and Applin, 1998). It looked at 17 inquiries into homicides by mentally ill people. In thirteen of these cases the killer had an identifiable history of alcohol or drug misuse (and in the fourteenth the victim had an alcohol problem). Yet, despite the presence of substance misuse only one of the inquiries made recommendations related to alcohol (or drug) misuse.

The Unlearned Lesson identified three themes which remain significant:

- Alcohol misuse is a major cause of the risks of harm to self and others which are the focus of inquiry reports;
- Alcohol services are not impacting sufficiently on the management of these risks;
- The combination of mental disorder and alcohol misuse is a significant cause of risk and remains poorly managed. It also highlighted that at the process level:
- Inquiry reports should be making recommendations about the management of alcohol misuse and that alcohol services should be learning lessons from these reports.

Alcohol Concern returned to this theme in 2016 when it worked with the charity Action on Violence and Abuse to review the role of alcohol misuse as a factor in domestic homicide reviews (DHRs). This research reviewed 39 randomly chosen DHRs and found that:

- In 22 DHRs (56% of the 39) the perpetrator of the homicide is identified as experiencing problems with alcohol;
- In 15 DHRs (38%) both the victim and perpetrator are identified as experiencing problems with alcohol. Every case in which the victim has an alcohol problem, the perpetrator also has a problem.

This emphasised the fact that alcohol is correlated with risk and highlighted the absence of involvement of alcohol services in these cases: only three of the victims/perpetrators were engaged with alcohol services.

Six other research studies into multiple reviews have highlighted the significance of alcohol misuse in serious incidents:

- The National confidential inquiry into suicide and homicide by people with mental illness 2017 reported that 88% of patients committing homicides had alcohol or drug problems and that 45% of patients committing suicide had a pattern of alcohol misuse.
- A 2016 Home Office review of Domestic Homicide Reviews reported that substance use was mentioned in just over half of a sample of DHRs.
- The Independent Police Complaints Commission statistics on deaths during or following police contact (2016-7) identified 14 people who died in or following police custody, eleven of whom were known to have a link to alcohol or other drugs.
- In 2015, the London Borough of Sutton's Safeguarding Adults Board undertook an analysis of seven recent serious incident reviews which were all related to substance misuse.
- Ofsted's evaluation of serious case reviews related to children provides an analysis of 147 serious case reviews completed between 1 April 2009 and 31 March 2010. It highlighted alcohol and drug misuse as a common feature of the families involved.
- Somerset Local Safeguarding Children Board's analysis of 13 young adult safeguarding reviews found 12 had patterns of substance use and misuse.
- The Camden and Islington NHS Trust analysis of 19 serious incidents within the Trust stated that 'there were some themes that carried across more than one incident, alcohol being the most prevalent factor.

Mental disorder and substance misuse

A number of research reports also emphasise the level of risk associated with the combination of mental disorder and substance misuse:

- The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness 2017 commented that "our findings add to the evidence that much of the risk to others from mental health patients is related to co-existing drug or alcohol misuse rather than mental illness itself."
- The Home Office Domestic Homicide Reviews report commented that among perpetrators and victims the presence of both substance use and mental health issues was more common than either issue occurring alone.
- The IPCC report on deaths in custody identified that of fourteen people who died in or following police custody in 2016-7 at least five had combined substance use and mental health concerns.
- The Ofsted research says that the most common characteristics of the families reviewed were domestic violence, mental ill-health, and drug and alcohol misuse. Frequently, more than one of these characteristics were present.
- The Sutton research called for a review of care pathways for residents with co-existing substance use and mental health problems.
- In Somerset's analysis of 13 young adult safeguarding reviews 8 had a dual diagnosis of mental disorder and substance misuse.
- All the patients with alcohol related harm in the Camden and Islington analysis would also have had mental disorders.

Broader themes

These and other research reports also identify non-alcohol specific findings which are commonly identified in serious incidents.

The inadequacy of risk assessment was a commonly occurring theme in the Home Office review of Domestic Homicide Reviews: 82% of 33 reviews highlighted this as an issue. Other research such as the Hundred Families review of homicides by mentally ill people, the Sutton research and Crichton (2011) and Preston-Shoot (2017) highlight the same theme. More specifically, the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness comments that: "A greater focus on alcohol and drug misuse is required as a key component of risk management in mental health care, with specialist substance misuse and mental health services working closely together as reflected in published guidance."

A 2008 Healthcare Commission report highlighted the impact of mergers and organisational change, stating that "if not carefully managed, the process of organisational change can divert management away from maintaining service quality. It is important to recognise that, while mergers and other organisational changes will continue to be necessary in some situations, there is clear evidence that they also bring with them a high degree of risk, if not handled appropriately by senior leaders."

Other key problems identified in reviews include inadequate care planning and record keeping; and a need for better joint working, information-sharing and communication; and poor understanding of adult safeguarding and protection procedures.

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